Decision Making Business Case

LincoInshire Integrated Care System
Acute Services Review:

- **Orthopaedics (elective and non-elective)**
- **Urgent & Emergency Care**
- **Acute Medicine**
- **Stroke Services**

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Document Control Sheet

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Purpose of the document

The purpose of this Decision Making Business Case (DMBC) is to present and summarise the extensive work undertaken as part of the Lincolnshire Acute Services Review Programme with the following purpose in mind:

- To describe the proposals for reconfiguring orthopaedic, urgent and emergency care, acute medicine and stroke services across the Lincolnshire area, and to enable decision makers to decide whether there is a case to implement the changes to these four services, as set out in the document
- To demonstrate that the proposals are aligned to the national NHS Long Term Plan and local system strategy
- To demonstrate that options, benefits and impact on service users have been considered
- To demonstrate that the planned decisions have taken account of the views of patients and members of the public who may be impacted by the proposal
- To inform the necessary assurance processes including providing evidence that the proposals meet the government's four tests of service change, the additional patient care test (otherwise known as the 'NHS beds test') and other relevant best practice checks for planning service change and consultation.
- To ask the Board of the NHS Lincolnshire Clinical Commissioning Group (CCG) to make decisions in relation to the proposed service reconfiguration changes across orthopaedic, urgent and emergency care, acute medicine and stroke services.

This DMBC is written by the Lincolnshire Acute Services Review (ASR) Programme Team for the following audiences:

- The NHS Lincolnshire CCG Board which is the organisation that carries the legal responsibilities for public involvement duties and deciding whether to commission the services described in this DMBC
- The Boards of United Hospitals Lincolnshire NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) so they are informed of the proposed changes given they are likely to play a lead role in implementation if the proposals are approved
- The Health Scrutiny Committee (HSC) of Lincolnshire which will scrutinize these proposals in line with their responsibilities
- Members of the public who might be impacted by these proposals

This DMBC should be read in conjunction with the pre-consultation business case (PCBC) and the public consultation document published on 30 September 2021, which provide the background to the proposals and the content of the consultation.

For the purpose of transparency, the final draft of this DMBC will be made available publicly, but the document is not written with a public audience in mind.

Document status

Until published this is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial interests). Prior to any envisaged disclosure under the Freedom of Information Act, the parties should discuss the potential impact of releasing such information as is requested.

The material set out in this document is for decision making purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services.

1 Executive summary

1.1 Background

1.1.1 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.

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

1.1.3 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.

1.1.4 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.

1.1.5 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)

1.1.6 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

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

1.1.8 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.

1.1.9 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.

1.1.10 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.

1.1.11 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.

1.1.12 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.

1.1.13 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.

1.1.14 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.

1.1.15 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

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

1.1.17 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.

1.1.18 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.

1.1.19 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.

1.1.20 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.

1.1.21 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).

1.1.22 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.

1.1.23 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

1.1.24 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.

1.1.25 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

1.1.26 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.

1.2 Recommendations

1.2.1 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.

1.2.2 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.

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

1.2.4 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.

1.2.5 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 team.

1.2.6 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.

1.2.7 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.

1.3 Orthopaedics

Recommendation

1.3.1 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.

1.3.2 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

1.3.3 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.

1.3.4 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.

1.3.5 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.

1.3.6 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.

1.3.7 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.

1.3.8 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.

1.3.9 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.
- It is fully expected that 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.

1.3.10 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.

1.3.11 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

1.4 Urgent and emergency care

Recommendation

1.4.1 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.

1.4.2 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.

1.4.3 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.

1.4.4 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 needs to 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 model 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.

1.4.5 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.

1.4.6 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.

1.4.7 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.

1.4.8 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.

1.4.9 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.

1.4.10 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.

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

1.4.12 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.

1.5 Acute medicine

Recommendation

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

1.5.2 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.

1.5.3 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.

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

1.5.5 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.

1.5.6 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.

1.5.7 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.

1.5.8 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).

1.5.9 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.

1.5.10 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.

1.5.11 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.

1.5.12 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.

1.5.13 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.

1.5.14 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.

1.5.15 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.

1.5.16 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

1.5.17 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.

1.6 Stroke services

Recommendation

1.6.1 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.

1.6.2 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) it believes this proposal results 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

1.6.3 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.

1.6.4 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.

1.6.5 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.

1.6.6 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.

1.6.7 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.

1.6.8 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)

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

1.6.10 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.

1.6.11 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.

1.6.12 The availability of the heart centre facilities to stroke patients at Lincoln Hospital provide a valuable resource in improving access and bypassing A&E for the “direct to CT” pilot. Thus speeding door to CT scan time and door to needle/angiogram time.

1.6.13 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.

1.6.14 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.

1.6.15 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.

1.6.16 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

1.6.17 This should include a targeted, local bespoke communication and education strategy on the proposal, how to recognise stroke symptoms and how to access care, with a specific focus on the deprived areas with the longest travel times.

1.6.18 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.

1.6.19 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.

1.6.20 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.

1.6.21 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.

1.6.22 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.

1.6.23 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 Practitioner (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.

1.6.24 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

1.6.25 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.

1.6.26 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.

1.6.27 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.

1.6.28 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

1.7 Travel and transport

1.7.1 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.

1.7.2 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.

1.7.3 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

1.7.4 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.

1.7.5 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.

1.7.6 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.

1.7.7 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.

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

1.7.9 The '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.

1.7.10 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.

1.7.11 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

1.7.12 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.

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

1.7.14 Irrespective of whether the four 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.

1.7.15 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 identify mitigations.

1.8 Financial and resource implications

1.8.1 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.

1.8.2 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

1.8.3 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.

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

Figure 1 – Summary of financial impact

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**

1.8.5 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.

1.8.6 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.

1.8.7 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.

Figure 2 – Summary of financial risks and 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)

1.9 Next steps

1.9.1 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.

1.9.2 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.

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

1.9.4 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.

1.9.5 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.

2 Introduction

2.1 Background

2.1.1 Lincolnshire is one of the largest counties in England with one of the most dispersed populations. It is an upper tier county council with seven lower tier districts that have a diverse geography, comprising large rural and agricultural areas, urban areas and market towns and a long eastern coastline.

2.1.2 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.

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

2.1.4 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.

2.1.5 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.

2.1.6 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)

2.1.7 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

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

2.1.9 It should also be noted that Lincolnshire is not unique in this situation. It is widely acknowledged that acute hospitals serving rural areas face a common set of challenges, specifically high staff turnover, competition to attract and retain staff, service sustainability, public perception of the scope of services provided and a lack of modern infrastructure. Many of these were exacerbated during the COVID-19 pandemic.

2.2 Local and national context

2.2.1 The reconfiguration of acute hospital services has always formed a key part of the Lincolnshire health and care system's transformation plans, including in the most recent articulation through the *Lincolnshire's NHS Long Term Plan 2019-24* (which is the local response to the NHS Long Term Plan). The Lincolnshire plan:

- Responds to Lincolnshire's specific strengths, challenges and requirements;
- Clarifies a shared future ambition for health services in Lincolnshire so it can work to make these a reality; and

- Identifies the specific priorities for improvement and how these will be achieved. In order to i) Improve the health of the population ii) Improve quality and iii) Reduce inequalities.

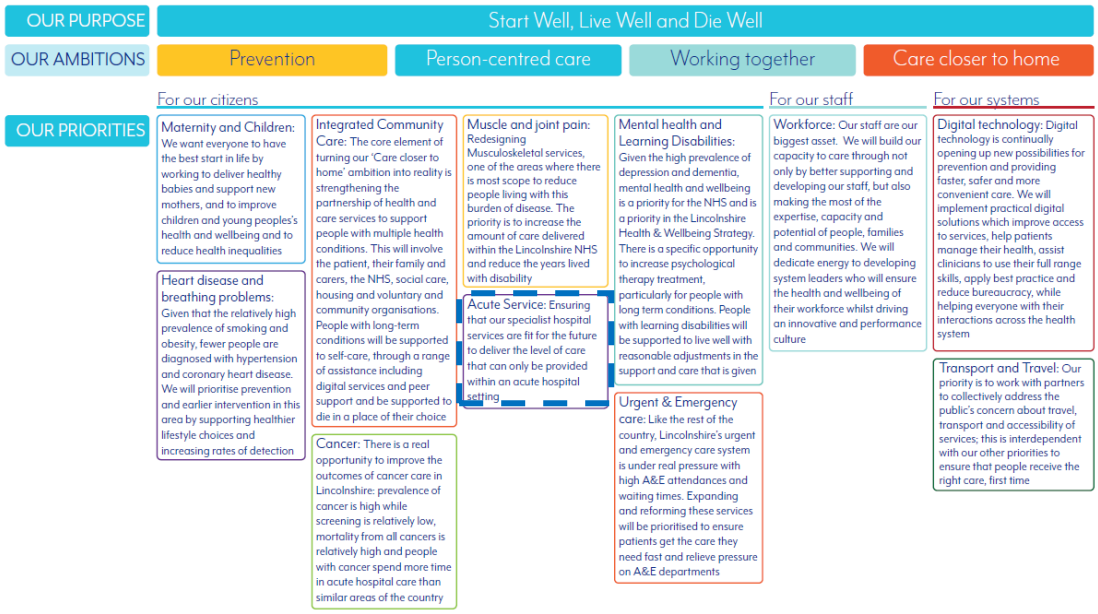
2.2.2 The *Lincolnshire's NHS Long Term Plan 2019-24* has been developed in partnership across the local health and care system and is grounded in local knowledge, with a strong understanding of:

- The views of the people in Lincolnshire who use and deliver NHS services, established through the extensive planning work and the recent years of improving care;
- The current and future needs of the Lincolnshire population, established through detailed public health analysis; and
- The opportunities to improve performance and remove unwarranted variation, established through benchmarking with other similar counties.

2.2.3 Following an analysis of population needs, citizen feedback and performance benchmarking 11 priority areas were identified where the health and care system can make the biggest impact in terms of improving the quality and efficiency of care in Lincolnshire.

2.2.4 One of these priorities is *'Acute Services: Ensuring that our specialist hospital services are fit for the future to deliver the level of care that can only be provided with an acute hospital setting'*.

Figure 3 – Lincolnshire health and care system's purpose, ambitions and priorities



2.2.5 The delivery of this system priority has been through the Lincolnshire Acute Services Review (ASR) Programme, the aim of which has been to develop a set of recommendations on the optimal configuration of acute hospital services across Lincolnshire to maximise clinical, operational and financial sustainability.

2.2.6 The initial scope of this programme covered eight services; Acute Medicine, Breast, General Surgery, Haematology & Oncology, Orthopaedics, Stroke, Urgent & Emergency Care, Women's and Children's.

2.2.7 However, as the work progressed its scope narrowed to focus on four of these services; orthopaedics, urgent and emergency care, acute medicine and stroke services. Which are the focus of this Decision Making Business Case (DMBC).

2.2.8 The change proposals set out in this DMBC for these four service areas all fully align to the national NHS Long Term Plan. The table below provides as overview of this alignment.

Figure 4 – Alignment of service change proposals to national NHS Long Term Plan

NHS Long Term Plan Commitments	Service Change Proposal			
	Orthopaedics	Urgent & Emergency Care	Acute Medicine	Stroke Services
NHS staff will get the backing they need				
Supporting our current staff	✓	✓	✓	✓
Enable productive working	✓	✓	✓	✓
Boost 'out of hospital' care				
A new NHS offer of urgent community care		✓	✓	
Supporting people to age well			✓	
Reduce pressure on emergency hospital services		✓	✓	
Pre-hospital urgent care – implement UTC model			✓	
Reforms to hospital emergency care – SDEC				✓
Cutting delays in patients being able to go home				
Better care for major health conditions				
Short waits for planned care				
Planned services are provided from a 'cold' site where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in – manging complex, urgent care on a separate 'hot' site allows trusts to provide improved trauma assessment and better access to specialist care, so that patients have better access to the right expertise at the right time	✓			
Stroke care				
Reduction in number of stroke-receiving units and increase in number of patients receiving high quality specialist care				✓
Modernise the stroke workforce with a focus on cross-speciality and cross-profession accreditation of particular 'competencies'				✓
Implementation and further development of higher intensity care models for stroke rehabilitation				✓

2.3 Overview of process to date

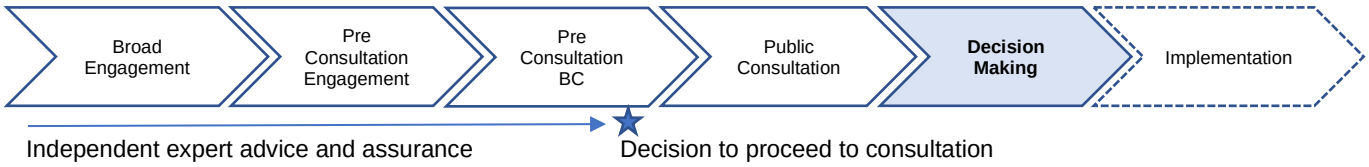
2.3.1 The recommendations put forward in this decision-making business case stem from a lengthy process of discussion and engagement with patients, the public, partner organisations and health and care professionals, spanning over seven years.

2.3.2 They take account of feedback from the formal public consultation, as well as reviews of service change proposals undertaken by clinical experts and an assessment of impact undertaken by the local health system.

2.3.3 Decision-making responsibility falls solely with the NHS Lincolnshire CCG. As such this document, whilst set in the context of the Lincolnshire Integrated Care System, is owned by the NHS Lincolnshire CCG Board.

2.3.4 This business case is provided to the NHS Lincolnshire CCG Board at the decision-making stage of the process, implementation will not commence until a decision has been made.

Figure 5 – Overview of process to date



2.4 Broad engagement

2.4.1 In July 2018 a number of public events were held across Lincolnshire to find out participants' views on the case for changing particular health services and on the possible directions of change. For example, testing views on the principle of concentrating some services in specialised 'centres of excellence', or the principle of separating urgent and planned care.

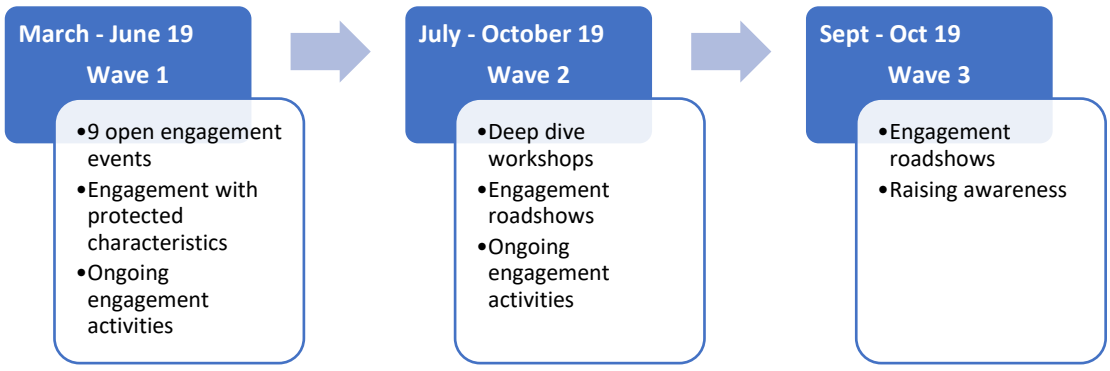
2.4.2 These engagement events did not cover specific options for the future provision of services and the potential impact changes may have. However, they were used to discuss the evaluation criteria for service change originally developed through the Lincolnshire Health and Care (LHAC) programme, therefore providing an opportunity to consider the public's views on the criteria and the relative importance that might be attached to each of them.

2.5 Pre-consultation engagement

2.5.1 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. It was a chance for everyone to learn more about the local NHS's current thinking on the future of the services it provides and a way to get meaningful feedback from patients, their representatives, the public, NHS partners and staff about what services may look like going forward. This included pre-consultation engagement on the emerging options in the Acute Services Review and ran through to October 2019.

2.5.2 The various waves of communications and engagement incorporated a number of activities to give as many people as possible the opportunity to get involved and share their views in a way that suits them.

Figure 6 – Overview of Healthy Conversation 2019 approach



2.5.3 A questionnaire was made available in online and paper formats, in the main languages in Lincolnshire and offered in other formats to enable the public and other stakeholders to share their views. It covered topics such as digital technology, travel and transport along with specific service areas including orthopaedics, urgent and emergency care, acute medicine and stroke services. A total of 649 completed questionnaires were received and analysed.

2.5.4 Over 200 general feedback forms were received via post, email, online and from the various events attended. These included nine open events in Boston, Louth, Skegness, Grantham, Sleaford, Gainsborough, Lincoln, Stamford and Spalding with 365 attendees; roadshows such as market days, supermarkets and shopping centres where over 400 leaflets were handed out and 55 feedback forms received; locality workshops in Boston and Grantham with 49 attendees over four days as well as a range of community meetings such as The Blind Society and Toddler Groups with 139 attendees.

2.5.5 Lincolnshire's Health Scrutiny Committee were provided with regular reports on the topics with the HC2019 engagement campaign and were updated in March, May, June, July, September, October 2019 and March 2020.

2.5.6 This was supported by widespread communications activities such as attendance at key stakeholder meetings, staff briefings, social media updates as well as posters and leaflets distributed widely.

2.5.7 The Lincolnshire NHS organisations also commissioned a local specialist, The People's Partnership, to undertake a specific piece of engagement work, in order to ensure the Healthy Conversation 2019 exercise captured the views and concerns of hidden and hard to reach communities across the county. The People's Partnership undertook a detailed, and bespoke engagement in order to understand these views.

2.6 The Pre Consultation Business Case

2.6.1 The Pre Consultation Business Case (PCBC) was prepared by system partners to provide assurance to local governance Boards and NHS England and Improvement that the system has thoroughly considered a range of requirements before deciding to move to public consultation on the proposed service changes.

2.6.2 These requirements, each of which is set out in detail in the PCBC, included:

- A detailed case for change, supported by system partners
- The proposed changes to acute services
- Alignment of these proposals with NHS policy and plans
- A clear description of the enablers required for the proposed service changes
- Governance and decision making arrangements
- Clinical assurance of the proposals, including the East Midlands Clinical Senate
- A description of the public engagement that has occurs in the development of the proposals

2.6.3 An overview of the preferred change proposal, case for change and anticipated benefits for each of the four NHS services as set out in the PCBC is provided below.

Figure 7 – Orthopaedics: overview of change proposal, case for change and anticipated benefits as set out in the PCBC

Change proposal	
• 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	
Case for change (pre-pilot)	**Anticipated benefits (identified through pilot)**
• Lack of 'protected' planned orthopaedic surgery beds across ULHT means high volumes of medical emergencies experienced all year round result in fewer beds being available for planned orthopaedic surgery • On average, around 10 patients a month have planned orthopaedic surgery cancelled on day of surgery dues to a lack of beds, which is a poor experience for patients and their families • Failure to consistently set referral to treatment time targets – limited separation of planned and unplanned orthopaedic surgery made attainment and sustainment of target a challenge • High doctor and nurse vacancies	• Reduction in waiting times for planned orthopaedic surgery, which means patients get seen quicker • Cancellation on the day of planned surgery due to lack of beds reduced • Length of stay reduced • ULHT out-performing many other hospitals in terms of length of stay • Improvement in overall patient experience and satisfaction • Number of patients going to the private sector for planned orthopaedic procedures, funded by the local NHS, reduced • Remove need for temporary staff to cover vacancies and make service more attractive to junior doctors which supports long term sustainability

Figure 8 – Urgent and emergency care: overview of change proposal, case for change and anticipated benefits as set out in the PCBC

Change proposal	
• Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre (UTC)	
Case for change	**Anticipated benefits**
• National shortage of emergency medicine (A&E) doctors, which means greater competition between hospitals for doctors and over reliance on doctors employed on a temporary basis • Emergency medicine doctors are very difficult to secure, which in turn can lead to medical staffing vacancies and risk to patient care – which can ultimately lead to service and patient safety concerns • Limited success to recruit and retain staff to work in Lincolnshire's A&E departments, despite huge efforts • Independent clinically-led reviews have concluded in interests of safety A&E department at Grantham and District Hospital should not reopen 24/7 unless sufficient staff can be recruited and retained on a long term sustainable basis • A&E service at Grantham and District Hospital has, since 2007/8, only dealt with a limited range of presenting emergency conditions and services are similar to UTC – yet description of the service as an A&E still in place • Using description of A&E for current service at Grantham and District Hospital creates unrealistic expectations and misunderstandings about level of service that is and can be provided from the site	• 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 • Vast majority of patients (estimated to be around 97%) 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). Access to treatment would further improve for children because the UTC team would broaden to include community and primary care staff (e.g. GPs) who are more experienced and familiar with treating children than a traditional, non-paediatric A&E team. • Patients would spend less time in the UTC compared to an A&E department due to the different model of assessment and management it uses. Specialist follow-up input would be arranged as required • 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 3%, which is equivalent to 2 patients a day on average) currently attending the Grantham and District Hospital A&E who wouldn't be able to have their care needs met by the UTC, care would be received at an alternative site with the right facilities and expertise to ensure better clinical care outcomes

Figure 9 – Acute medicine: overview of change proposal, case for change and anticipated benefits as set out in the PCBC

Change proposal	
• Develop integrated community/acute medical beds at Grantham & District Hospital, in place of the current acute medical beds	
Case for change	**Anticipated benefits**
• Rising demand for acute medical bed services and more patients have complex needs • Local acute medical bed services struggle to recruit enough doctors and nurses which means i) services cannot consistently deliver the level of quality aspired to ii) need to fill vacancies with temporary staff, which is not always possible iii) increased service and patient safety concerns • Grantham and District Hospital faces further staffing challenges due to i) it's A&E department sees a limited range of presenting emergency conditions because of small size and limited availability of specialist staff ii) which in turn means its medical beds treat fewer patients with a local level of care need compared to Lincoln County Hospital and Pilgrim Hospital, Boston	• Acute medical provision would continue to be delivered at Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term - including a more sustainable medical and nursing workforce. • The majority of patients (estimated to be around 90%) cared for in the acute medical beds at Grantham and District Hospital would continue to be cared for in the integrated community/acute medical beds • The proposed model would deliver a more comprehensive local service provision at Grantham hospital, specifically in relation to the 'frail' population, thereby reducing pressure on acute hospital sites at Lincoln and Boston • The preferred proposal for change would enable Grantham and District Hospital to build a centre of excellence for integrated multi-disciplinary care (particularly for frail patients), which supports both improved community-based management of long term conditions and reduced lengths of stay in hospital beds • An estimated 10% of patients (equivalent to 1 a day on average) currently cared for in the acute medical beds at Grantham and District Hospital would not be able to have their care needs met in the integrated community/ acute medical beds. Instead, they would receive their care at an alternative site with the right facilities and expertise to ensure the best outcomes

Figure 10 – Stroke: overview of change proposal, case for change and anticipated benefits as set out in the PCBC

Change proposal	
• Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation team.	
Case for change	**Anticipated benefits**
• National best practice is hyper-acute stroke units should admit a minimum of 600 patients a year – below this level doctors and nurses in hospital stroke services risk becoming deskilled, which in turn means patients may not get the best or safest care • Lincoln County Hospital admits around 670 stroke patients a year and Pilgrim Hospital, Boston around 500 patients a year • Even when considering growth in size and age of local population over next 5 years Pilgrim Hospital, Boston is unlikely to admit 600 stroke patients a year, every year • More doctors, nurses and therapists are required to deliver existing hospital stroke services, but there are not enough locally or nationally – this means significant problems exist staffing current hospital stroke services • Both Lincoln County Hospital and Pilgrim Hospital, Boston stroke services have struggled to consistently perform well in national audit of service quality and performance, despite skills and dedication of staff	• Evidence that consolidating hyper-acute and acute stroke services on a smaller number of sites where specialised staff and equipment can be concentrated means patients are: ➢ More likely to survive and recover more quickly. ➢ More likely to have a reduced length of stay in hospital ➢ More likely to continue to lead more fulfilling lives in the future, such as being able to return to work • Consolidating hospital stroke services helps address the significant workforce shortages and challenges experienced in these services by: ➢ Concentrating specialist skills and expertise together to ensure clinical staff maintain and develop these to provide the safest and best possible care ➢ Making hospital stroke services more attractive to doctors, nurses and therapists to work in ➢ Reducing reliance on temporary, expensive staffing solutions • Consolidation of hospital stroke services on the Lincoln County Hospital site allows more patients to benefit from these services being located on the same hospital site as the highly successful Lincolnshire Heart Centre, which include: ➢ Increased access to important time critical interventions ➢ Increased access to acute imaging services, further reducing time to treatment • Consolidation of stroke services on the Lincoln County Hospital site ensures patients are closer to Nottingham's Queen's Medical Centre in the instance they require mechanical thrombectomy.

2.6.4 It should be noted that through the process and up to the stage of developing the PCBC numerous other options were considered and appraised. The change proposals described here are the ones that were identified as best addressing the challenges faced.

2.7 Independent expert advice and assurance

2.7.1 The four service change proposals contained within the PCBC had successfully passed through rigorous regional and national assurance processes.

Clinical

2.7.2 The East Midlands Clinical Senate is one of twelve Clinical Senates that were established across England in 2013. They were set up as a source of independent, objective and strategic advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

2.7.3 On 11 July 2018, the clinical review team was asked to consider whether there is a clear clinical evidence base underpinning Lincolnshire STP's proposals. Specifically, the clinical review team was asked whether it supported Lincolnshire STP's proposals based on clinical sustainability, workforce and clinical outcomes.

2.7.4 Following this meeting the panel recommended that the Lincolnshire STP proceeds with its proposals for orthopaedics and stroke, and the use of the word 'Plus' in UTC is dropped (which was agreed by the Lincolnshire system on the day at the end of the session.). The panel was of the opinion further work needed to be completed for the acute medical beds at Grantham Hospital.

2.7.5 A supplementary clinical review took place on 12 September 2018 in relation to the acute medical beds at Grantham Hospital. The panel were left with the impression that all system partners are joined up on the future of medicine for Grantham, and that the proposal had changed significantly in a short period.

2.7.6 All previous concerns were adequately addressed and the proposal was considered by the panel to be not only clinically acceptable but to represent an excellent example of the value of a team approach to finding solutions to the inevitable issues that result from service redesign.

NHS regulator

2.7.7 The PCBC met the requirements and regulatory processes of NHS England and Improvements (NHSEI), including:

- The NHSEI Regional Panel
- The NHSEI national assurance process

2.8 Decision to proceed to consultation

2.8.1 On 29 September 2021, following completion of the NHSEI assurance process outlined above, the PCBC was considered by the NHS Lincolnshire CCG Board, and the Board took the decision to proceed to public consultation.

3 Public Consultation

3.1 Overview of consultation

3.1.1 The consultation on the four proposed NHS service changes (orthopaedics, urgent and emergency care, acute medicine and stroke services) set out in the Pre Consultations Business case (and outlines in the previous chapter) was planned and delivered in line with national guidance, good practice and the statutory 'Duty to Involve'.

3.1.2 There is a legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:

- Section 242, of the NHS Act 2006, places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate
- Section 244 requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees)
- The NHS Act 2012, Section 14Z2 updated for Clinical Commissioning Groups places a duty on CCGs to make arrangements to ensure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):
    - In the planning of the commissioning arrangements by the group
    - In the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them
    - In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

3.1.3 NHS Lincolnshire Clinical Commissioning Group (CCG) was the NHS organisation legally responsible for approving the Pre Consultation Business Case (PCBC) and agreeing to proceed to a public consultation on the four Lincolnshire NHS service change proposals set out within it. Decision-making responsibility, through the Decision Making Business Case (DMBC) following the public consultation also falls solely with NHS Lincolnshire CCG.

3.1.4 Through public bodies giving an account of their plans or proposals and listening to feedback, public consultation promotes accountability and assists decision making.

3.1.5 To provide additional independent and external assurance, the NHS Lincolnshire CCG appointed the Consultation Institute to provide an assessment of the public consultation. The Consultation Institute provided a six stage Quality Assurance Assessment, which is a structured assurance programme designed to provide organisations undertaking a public consultation with a high level of assurance that their activities are in line with best-practice expectations. These are outlined in the Consultation Institutes Consultation Charter, the UK government's Consultation Principles and UK case law.

3.1.6 It should be noted, however, that consultations are not referenda or 'votes' in which the loudest voices or the greatest numbers automatically determine the outcome. The feedback received often reflects widely varied and sometimes polarised views, and it is important to report these concerns and contrary views robustly, in order for decision-makers to be able to conscientiously consider the issues raised.

3.1.7 To support this consideration NHS Lincolnshire CCG appointed an independent organisation, Opinion Research Services (ORS – a company that grew out of Swansea University with a UK-wide reputation for social research and major statutory consultations), to analyse and report the outcomes of the public consultation with members of the public, clinicians and other NHS staff, and other stakeholders.

3.1.8 It is also important to note that it is not ORS' role to 'make the case' for the proposals, or to make any recommendations as to how decision makers should use the reported results. It is for NHS Lincolnshire CCG to take decisions based on all of the evidence available, of which consultation feedback is one part.

3.1.9 NHS Lincolnshire CCG is also required to make sure the consultation activities meet the requirements of The Equality Act 2010, which requires a demonstration of how the Public Sector Equality Duty is being met.

3.1.10 An overview of the consultation process is provided below. More detail is available in Appendix A, which contains the Communications and Consultation Activity Report, and Appendix O (Consultation Plan) of the Pre Consultation Business Case (PCBC).

3.2 Overview of consultation process

3.2.1 The NHS Lincolnshire CCG launched the public consultation on 30 September 2021, and it ran for 12 weeks until 23 December 2021. The approach to consultation was underpinned by the Gunning principles which say consultations must have the following principles applied:

- When proposals are still at a formative stage
- Sufficient information to give 'intelligent consideration'
- Adequate time for consideration and response
- Must be 'conscientiously' taken into account

3.2.2 In line with the Consultation Plan, a suite of materials was produced, which included the main consultation document (which benefited from the input of patient representatives), a summary document, a leaflet and feedback questionnaire (all of which were translated into languages relevant to the local population), as well as supplementary information, including videos that described the process to date and the proposed changes.

3.2.3 It was agreed with the Health Scrutiny Committee for Lincolnshire that to further extend the reach of the consultation, Royal Mail would be commissioned to deliver consultation leaflets to all households in Lincolnshire.

3.2.4 During the consultation period, views were invited through:

- A consultation questionnaire for all residents, staff, stakeholders and organisations; the questionnaire was available online (hosted by ORS) and paper questionnaires were widely circulated and available on request. An easy read version and translated documents were also available
- Independently facilitated engagement designed and conducted by ORS:
  - A telephone residents survey; and
  - Independently-facilitated online focus groups and 1:1 in-depth interviews with members of the public (delivered by ORS)
- Engagement activities undertaken by NHS Lincolnshire CCG including:
  - Face-to-face and online public events, and a 'virtual' 24/7 event
  - Meetings with staff members, stakeholders and service users
  - 'Pop-up' engagement activities at market days across Lincolnshire
- Written or email submissions from residents, staff, stakeholders and organisations

3.2.5 In addition petitions were submitted by two local campaign groups to ORS.

3.2.6 The consultation methods reflected the government guidelines in force at the time relating to Covid-19, while continuing to ensure the needs of all communities were met.

3.2.7 The public consultation was supported by a comprehensive communication strategy:

- Consultation leaflets commissioned to be delivered to over 370,000 households across Lincolnshire (and some over the county border)
- 93 media articles appeared in over 300 separate locations across TV, radio, print and online
- 25 advertisements placed in county wide newspapers
- 431 NHS social media posts and tweets seen by over 260,000 people, of whom 7,700 directly engaged and 784 clicked through to the consultation questionnaire.

3.2.8 Consultation materials were made available in hard copy, as well as via a dedicated section of the CCG website. Material was also available in different formats and languages.

3.2.9 Consultation materials were also distributed through the network of the NHS organisation communications and engagement teams, including United Hospitals Lincolnshire NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS), and available in locations such as GP surgeries, libraries, clinics, food banks, Parish Councils and community venues.

3.2.10 A pack of consultation promotional materials was sent to all 84 GP surgeries in Lincolnshire. The total materials distributed were: 2,550 A5 flyers, 850 A4 posters and 425 questionnaires.

3.2.11 Partner organisations and key stakeholder groups were also asked to share these materials on our behalf via their online methods and extensive venue and distribution lists.

3.2.12 In addition to both the traditional and social media methods focussed work was also undertaken to ensure those from seldom heard groups and those with protected characteristics were able to consider the proposals from the perspective of the relevant characteristics.

3.2.13 Consultation materials were sent to groups aligned with the nine protected characteristics, as set out in the Equality Act 2010, requesting they consider the proposals from the perspective of those they support. An overview of the groups contacted is set out below.

Figure 11 – Overview of specific groups contacted during the public consultation

Audience	Consultation distribution
Age – Older	Document, questionnaire, leaflet, poster and link to website emailed directly 172 contacts: • Vitality (exercise groups for over 60s) • Senior Citizens club • Age UK • PPGs
Age - Young	39 young groups such as: • Children's Centres • Grantham Youth Centre • Homestart Lincolnshire • Action for Children • Schools and sixth forms
Disability - Physical	58 Groups including: • Grantham and District talking newspaper for the blind • MS Society • Deaf Society • Lincolnshire Sensory Services • Sickle Cell Society

Audience	Consultation distribution
Disability – Mental Impairment	37 groups including: • Lincoln Dementia Café • Lincolnshire Autism Society • Lincolnshire Neurological Alliance
Gender reassignment	8 Groups including: • University of Lincoln LGBT+ Society • Just Lincolnshire • Lincolnshire parents of LGBT+ children • Transhaven Boston
Pregnancy and Maternity	108 groups including: • Little SNapps (Boston premature baby group) • Better births and Lincolnshire Maternity Voices • Sleaford breastfeeding group • Parent and toddler groups
Race/ethnicity	30 groups including: • Lincolnshire Traveller Initiative • Just Lincolnshire • BME Inclusion Services • Factories with Eastern European workforce
Religion/belief	30 groups including: • Salvation Army • Churches Together in Grantham and District • Samaritans • Lincoln Mosque • Sleaford Islamic Centre
Gender	30 Groups including: • The Women's Institute • Dad's Saturday Club in Grantham • Active Lincolnshire
Sexual Orientation	15 groups including: • Gay Outdoor Club • LGBT+ Sleaford • University of Lincoln LGBT+ Society
Carers	• Carers First • EveryOne • Lincolnshire Parent Carer Forum
Economically deprived	• Towns identified from community profiling • Foodbanks • Job Centres • Citizens Advice • Homeless
Rurality	• Farming community • Parish Councils
Veterans	• Via CCG Involvement Champions

3.2.14 The consultation team offered to attend meetings on request from community groups and other organisations.

3.2.15 When the Consultation Plan was developed it was recognised it would need to be 'dynamic' in nature. There were a number of ways throughout the public consultation in which feedback from the public and other stakeholders allowed continuous adjustment to be made to improve delivery.

3.2.16 These included additional events, organising additional media coverage to further clarify details of service change proposals (such as a full page advertorial in Grantham Journal explaining better some frequent confusion we heard with regard to the acute medical beds proposal), and holding weekly staff meetings to ensure we shared best practise regarding the most common feedback themes and what elements of these need particular care and attention to discuss accurately and in a way that was most helpful to the public.

3.2.17 Examples of additional events covered include:

- Attendance at Skegness Town Council meeting on 1 December 2021 to present the public consultation as an agenda item
- Attendance at Boston Primary Care Network board meeting on 9 December 2021 to discuss as an agenda item at the request of a locality lead.
- Establishment of an additional consultation event in Louth on 14 December 2021 at the request of patient representatives and a local councillor

3.2.18 An independent Equality Review (see Appendix B) of the consultation process was completed to determine whether reasonable steps have been taken to ensure that the consultation was inclusive and met the requirements of the Public Sector Equality Duty as defined in the Equality Act 2010.

3.2.19 It found that the CCG made reasonable attempts in a variety of ways to reach the protected groups identified in the area, particularly those who would be affected by the options proposed and decisions taken. This included undertaking a midpoint review to identify and close any gaps in responses, more targeted communication to reach all groups and additional recruitment activities with LGB&T+ and BAME communities.

3.2.20 The CCG also responded to requests for involvement from different community groups by making adjustments throughout the process such as running additional events in certain geographies and providing information in different formats.

3.2.21 An overview of the public consultation responses is set out below.

Figure 12 – Overview of public consultation response

3.3 Lincolnshire Health Scrutiny Committee

3.3.1 In accordance with the National Health Service Act 2006 and Regulation 23 of The Local Authority Regulations 2013 the Lincolnshire Health Scrutiny Committee was requested to respond to the consultation.

3.3.2 The consultation team, including relevant clinicians, attended one informal and two formal meetings with the Lincolnshire Health Scrutiny Committee (HSC) during the consultation period to discuss the consultation process and change proposals:

- 13 October 2021 – Consultation process
- 10 November 2021 – Stroke and urgent and emergency care proposals
- 15 November 2021 – Orthopaedics and acute medicine proposals

3.3.3 Following these meetings, the Lincolnshire HSC wrote to the NHS Lincolnshire CCG with its response to the consultation proposals, which was based on the consultation questionnaire. The HSC's response together with the responses of the Lincolnshire health system is set out further in the next two chapters.

4 Overview of Public Consultation Findings

4.1 Introduction

4.1.1 The public consultation process on the change proposals set out in the Pre Consultation Business Case enabled a robust and detailed dialogue with an extensive range of stakeholders. The final full independent public consultation report provides detailed analysis and presentation of both quantitative and qualitative responses for all consultation proposals, including a selection of qualitative free text responses to illustrate the range of feedback received.

4.1.2 It is not the intention of this Decision Making Business Case (DMBC) to repeat all of this but rather to focus on specific issues that need to be highlighted to decision-makers and the responses of relevant subject matter experts. The full independent consultation report should be read in full and can be found in Appendix C, and an overview is provided in this chapter.

4.1.3 To support this consideration, for each of the four change proposals the feedback received through the public consultation has been themed and the type of feedback defined. These definitions are:

- In support of proposal (S)
- In opposition of proposal (O)
- Additional consideration (AC)
- Mitigation (M)
- Alternative option (AO)

4.1.4 It should be noted that feedback received through the consultation can fall into more than one of the types described above given they are not mutually exclusive.

4.1.5 The key findings identified in the independent report on the consultation feedback are set out in the remainder of this chapter by theme and type, and the responses are provided in the following chapter.

4.1.6 As part of The Consultation Institute's Quality Review, they undertook a review of the draft consultation feedback report from Opinion Research Services (ORS), and it was ensured they had early sight of the emerging themes and issues and were able to discuss with us how it was planned to consider and respond to these within the Decision Making Business Case.

4.1.7 A summary of the main findings from the consultation feedback report is set out below.

There was 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 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; and people with learning disabilities and neurodiverse people such as those with ASD.

Across the consultation, evidence suggests that individuals' views and feedback on the proposals were commonly informed most strongly by their area of residence, rather than in light of any protected or other demographic characteristics.

ORS Public Consultation Feedback Report May 2022

4.2 The need for change

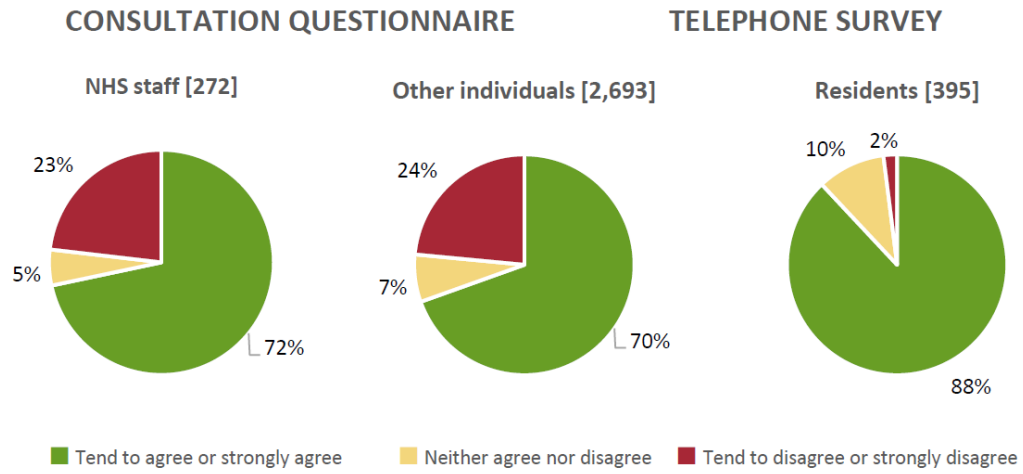
There was broad support for the overall need for change across all elements of the consultation

ORS Public Consultation Feedback Report May 2022

4.2.1 The consultation questionnaire identified that over two thirds of the individuals (72% of NHS staff and 70% of other individuals) who responded to the questionnaire either tended to agree or strongly agreed with the need for changes to be made in response to challenges facing NHS hospital services in Lincolnshire. Less than a quarter (23% and 24% respectively) either tended to disagree or strongly disagreed.

4.2.2 Support among the Lincolnshire population as a whole was overwhelming, with 88% of residents (+/- 6%) agreeing that changes should be made in principle, while just 2% disagreed.

Figure 13 – Views on the need for change to respond to challenges in delivering NHS services in Lincolnshire (from the consultation questionnaire and residents telephone survey, by stakeholder type)



BASE: Number of participants given in brackets (excludes 'don't know' responses)

4.2.3 Among the 16 organisations that submitted questionnaire responses, 13 agreed with the need for changes to be made to address challenges, 2 neither agreed nor disagreed, and 1 disagreed.

4.2.4 In the feedback received across the consultation programme, the issues most commonly raised in regard to the need for change were those of increasing pressure on NHS services in Lincolnshire, challenges related to recruitment and retention of staff, and waiting times for both hospital appointments and urgent and emergency care.

4.3 Orthopaedic surgery

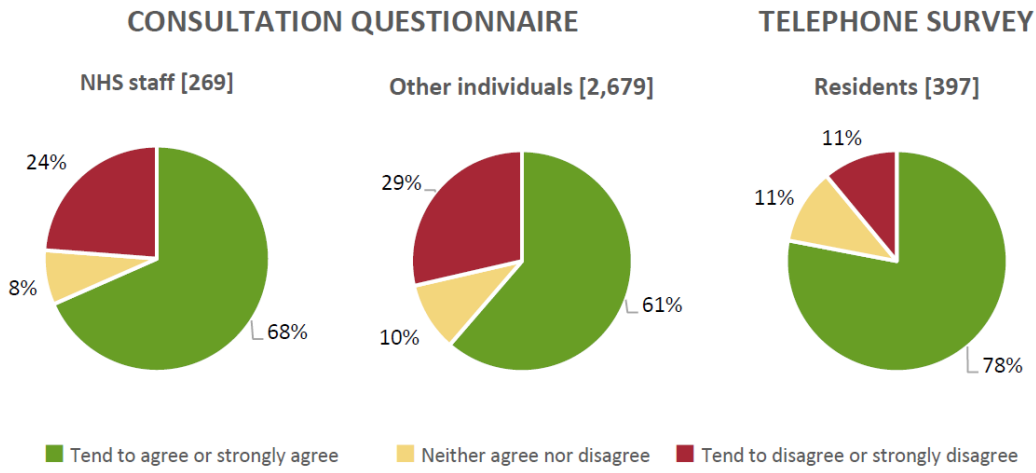
There was also broad support for the proposal to create a 'Centre of Excellence' at Grantham and District Hospital for Lincolnshire's patients to receive planned and day case orthopaedic surgery, with a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery, across all elements of the consultation.

ORS Public Consultation Feedback Report May 2022

4.3.1 The consultation questionnaire identified that over two thirds of NHS staff who responded (68%) and three fifths (61%) of other individual respondents either tended to agree or strongly agreed with the proposal for orthopaedic surgery in Lincolnshire. Around a quarter (24%) of NHS staff and three in ten (29%) of other respondents either tended to disagree or strongly disagreed.

4.3.2 Support for the proposal for orthopaedic surgery among the Lincolnshire population as a whole was even stronger, with over three quarters (78%) of residents (+/- 6%) agreeing with the proposed changes, while just over one in ten (11%) disagreed.

Figure 14 – Views on the proposal to create a 'Centre of Excellence' at Grantham and District Hospital for Lincolnshire's patients to receive planned and day care orthopaedic surgery, with a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery (from the consultation questionnaire and residents telephone survey, by stakeholder type)



BASE: Number of participants given in brackets (excludes 'don't know' responses)

4.3.3 Among the 16 organisations that submitted questionnaire responses, 9 agreed with the proposals for orthopaedic services, 2 neither agreed nor disagreed, and 4 disagreed.

4.3.4 In feedback, support for the proposal to create a Centre of Excellence for planned orthopaedic surgery at Grantham and District Hospital was often linked to the perceived benefits in terms of reduced waiting times and fewer cancellations of planned surgery.

4.3.5 Disagreement tended to focus on the loss of emergency orthopaedic surgery from Grantham and was linked to opponents to proposals to make changes to urgent and emergency care at Grantham and District Hospital.

4.3.6 Other concerns were also expressed, both by those who agreed with the proposal and those who disagreed; these included the implications for travel and access, staffing across two sites, and which services might be delivered locally in the community.

4.3.7 Several specific groups such as older people, people on low incomes, those without access to private vehicles, and people with disabilities were mentioned as being particularly vulnerable to impacts as a result of longer or more expensive journeys to hospitals. Patients with co-morbidities were also mentioned, including those who might require access to kidney dialysis while in hospital.

4.3.8 A number of mitigations, alternative suggestions and additional considerations around orthopaedic surgery in Lincolnshire were also put forward.

4.3.9 An overview of the themed consultation feedback relating to the orthopaedic proposals is set out below. The full break down of the comments and concerns put forward by respondents through all the public consultation engagement activities against each of these themes is included in Appendix D.

Figure 15 – Orthopaedics: Overview of the feedback on proposal

Theme / feedback	S	O	AC	M	AO
Quality / Workforce					
• Ongoing improvements in quality of care	✓				
• Ongoing improvements in staff recruitment and retention	✓				
• Could staffing 2 separate centres present challenges to recruitment	✓	✓			
• Negative impacts on quality/timeliness of emergency orthopaedic care		✓			
• Proposal will not address issues around staff recruitment and retention		✓			
• Short term plan to cope with deep rooted problems not addressed		✓			
• Confirmation best practice rehab would be put in place under changes			✓		
• Communication between care facilities needs to be addressed urgently			✓		
• NHS Lincolnshire should work with and learn from private hospitals			✓		
• Proposal includes no provision for unforeseen emergencies arising			✓		
• Concerns over metrics and factual inaccuracies in documentation			✓		
• Concerns Grantham will be able to cope with increased demand			✓		
• Ensure policies and pathways are robust			✓		
• Lack of evidence and information in relation to changes at Grantham.			✓		
• Not clear how many patients would choose to have surgery out of county			✓		
Access					
• Benefits of access to specialist centre would outweigh increased travel	✓				
• Reassurance about Pre-Op/Post-Op/fracture clinics still provided locally	✓	✓			
• All sites should be available for planned and unplanned care		✓			✓
Interdependency with Urgent and Emergency Care					
• Orthopaedic proposal linked to UEC change proposals		✓			
• Less serious fractures will be required to travel to other hospitals			✓		✓
• Emergency orthopaedics should be retained at Grantham			✓		✓
• Emergency orthopaedics should remain at hospitals with A&E/Intens.Care			✓		✓
• Grantham Hospital should be a centre of excellence for all services			✓		✓
Travel and transport					
• Concerns about travel and transport to Louth Hospital	✓	✓			
• Concerns about travel and transport to Grantham Hospital	✓	✓			
• Not LCC role to facilitate transport in response to NHS service changes			✓		
• Mitigations which might address challenges include: More patient transport services; working with LA to explore public transport improvements; more follow-up appointments in community				✓	
Equalities and health inequalities					
• Older people / people on low incomes / older people/people without private vehicles / people with disabilities identified as particularly vulnerable to proposed changes			✓		
• Review eligibility criteria for patient transport services			✓		
• Challenge of ensuring equitable access in large, rural county			✓		
• People with disabilities might not find same support elsewhere			✓		
• Ability of carers not being able to travel to Grantham			✓		
• Running down of Grantham/Louth is endangering people living a distance from Lincoln/Pilgrim			✓		
• Travellers/Gypsies being left behind as cannot access on-line/read letters			✓		
• Cost to NHS of patient transport outweighs benefits of proposal			✓		
• Concerns support to deaf people not available at other sites			✓		
Facilities					
• Grantham Hospital in poor state on maintenance / build a new centre			✓		✓

S = In support of proposal; O = In opposition of proposal; AC = Additional consideration; M = Mitigation; AO = Alternative option

4.3.10 In summary, the feedback on the orthopaedics change proposal identified:

- Support across both consultation questionnaire and telephone survey
- Recognition of benefits in terms of reduced waiting times and fewer cancellations
- Links made to reduction of Urgent and Emergency Care at Grantham and District Hospital
- Concerns around implications for travel and access and staffing
- Older people, people on low incomes, those without access to private vehicles, and people with disabilities in particular identified as being particularly vulnerable to impacts of change
- Mitigations for travel challenges put forward: more patient transport, working with the Local Authority to explore transport improvements, more follow up appointments in community

4.4 Urgent and emergency care

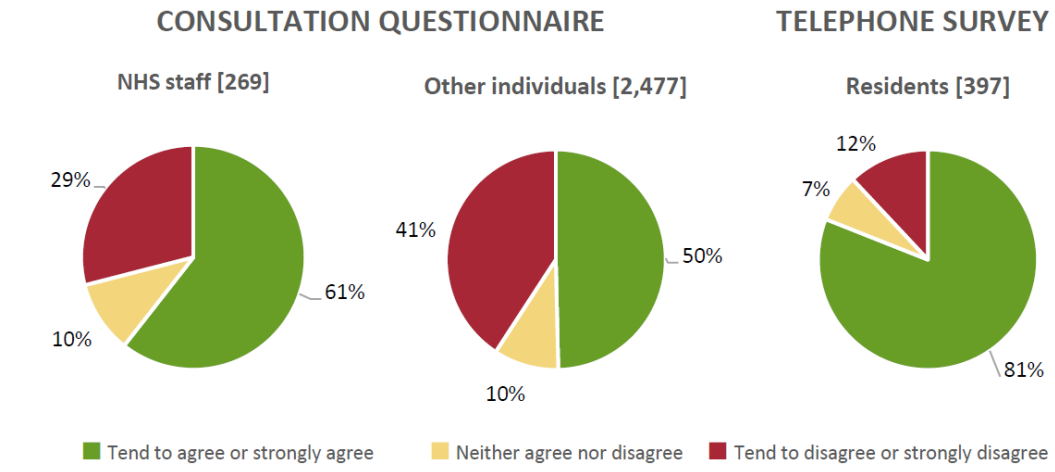
There was overall support for the proposal to provide 24/7 walk-in urgent care services in Grantham via an Urgent Treatment Centre (UTC) at Grantham and District Hospital

ORS Public Consultation Feedback Report May 2022

4.4.1 The consultation questionnaire identified that around three fifths of NHS staff who responded (61%) and half (50%) of other individual respondents either tended to agree or strongly agreed with the proposal to create a UTC at Grantham and District Hospital. Around three in ten (29%) of NHS staff and two fifths (41%) of other individual respondents either tended to disagree or strongly disagreed.

4.4.2 Support for the proposal for urgent and emergency care among the Lincolnshire population as a whole was much stronger, with over four fifths (81%) of residents (+/- 6%) agreeing with the proposed changes, while approximately one in eight (12%) disagreed.

Figure 16 – Views on the proposal to provide 24/7 walk-in urgent care services in Grantham via an Urgent Treatment Centre at Grantham and District Hospital (from the consultation questionnaire and residents telephone survey, by stakeholder type)



BASE: Number of participants given in brackets (excludes 'don't know' responses)

4.4.3 Among the 14 organisations that submitted questionnaire responses, 8 agreed with the proposals for urgent and emergency care in Grantham, 2 neither agreed nor disagreed, and 4 disagreed.

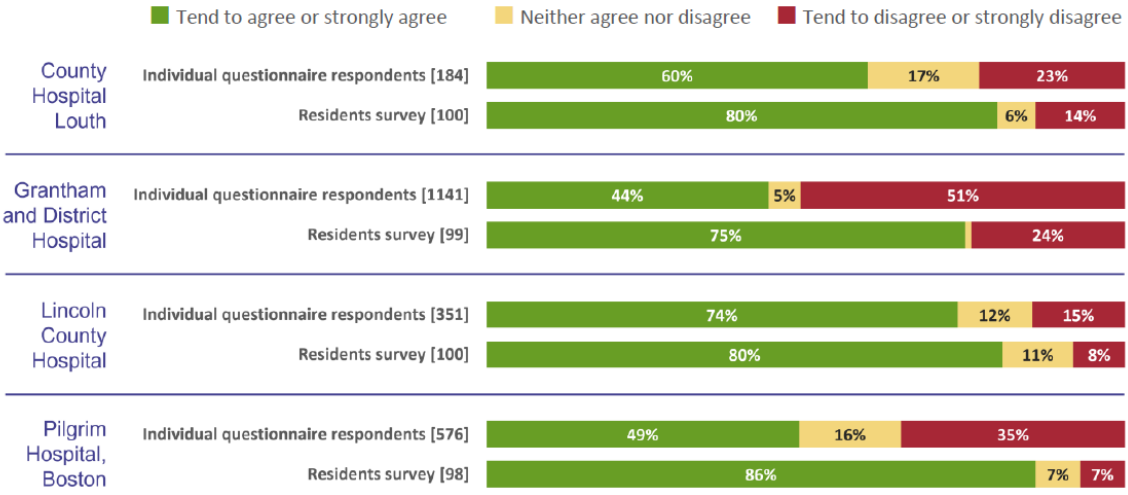
4.4.4 There was, however, evidence of differing views on the proposal between those living in different areas of Lincolnshire.

4.4.5 It is important to note that there is evidence that concerns about the proposals for urgent and emergency care are strongest among those living nearest to Grantham and District Hospital. This is most particularly marked in the questionnaire responses, in which just over half (51%) of all individual respondents living closest to Grantham and District Hospital expressed disagreement with the proposal, compared to 44% who agreed.

4.4.6 The residents telephone survey indicates that there is majority support among the resident population, including those living closest to Grantham and District Hospital, three quarters (75%) of whom agree with the proposals. There was nonetheless evidence of concern as well, with nearly a quarter (24%) of residents disagreeing with the proposals.

4.4.7 Just over a third of questionnaire respondents (35%) living closest to Pilgrim Hospital in Boston also expressed disagreement with the proposals for urgent and emergency care, with just under half (49%) expressing agreement. By contrast, the telephone survey indicated that the vast majority of residents (86%) living closest to Pilgrim Hospital either tended to agree or strongly agreed with the proposed changes.

Figure 17 – Views on the proposal to provide 24/7 walk-in urgent care services in Grantham via an Urgent Treatment Centre at Grantham and District Hospital (from the consultation questionnaire and residents telephone survey, by closest hospital)



BASE: Number of participants given in brackets (excludes 'don't know' responses)

4.4.8 Support for the proposal to provide 24/7 walk-in urgent care services at Grantham and District Hospital was most commonly based on the view that a local 24-hour UTC is preferable to a limited-hours A&E department that is not able to meet the needs of all patients.

4.4.9 Disagreement with the proposal for a new 24/7 walk-in Urgent Treatment Centre in Grantham was most commonly based on the view that anything less than a fully equipped and staffed Emergency Department at Grantham and District Hospital would be unacceptable, rather than a desire for services to remain unchanged.

4.4.10 Many of the concerns expressed about the proposal were shared by those who agreed and those who disagreed with the proposals; for the former, these were potential issues to be considered and mitigated against while, for those who disagreed, they were reasons to reject the proposals for a 24/7 UTC and increase service provision at Grantham and District Hospital.

4.4.11 Concerns around potential impacts of the proposals focused predominantly on travel and transport; there was also positive feedback about the benefits of 24-hour access to local urgent care services.

4.4.12 Analysis of questionnaire and survey responses did not indicate that there were any strong differences in views or specific concerns being expressed by respondents from groups with protected characteristics under the Equalities Act 2010 (e.g., age, ethnicity, gender). Instead, the evidence indicates that it is local concerns that account for differences in views, with members of different demographic or protected characteristics groups tending to share the views of others living in the same area.

4.4.13 Where concerns were raised in feedback about particular groups (e.g., older people, people with disabilities, those from more deprived communities or living in rural areas), the focus was predominantly on travel and transport, particularly for those with limited access to private transport. In consultation feedback from individuals' with protected characteristics or other key demographics, their views on the proposals were typically informed most strongly by their area of residence, regardless of any other demographic characteristics.

4.4.14 The one example of a slight difference was that, in the residents survey, there was evidence that residents with disabilities or long-term health conditions that limited their day-to-day activities a lot, were significantly less likely to agree (and more likely to disagree) with proposals around urgent and emergency care at Grantham and District Hospital than other residents (although there was still majority agreement); it should be noted that the feedback indicated that concerns about the proposal were again focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.

4.4.15 A number of mitigations, alternative suggestions and additional considerations around urgent and emergency care in Lincolnshire were also identified

4.4.16 An overview of the themed consultation feedback relating to the urgent and emergency care proposals is set out below. The full break down of the comments, messages and concerns put forward by respondents through all the public consultation engagement activities against each of these themes is included in Appendix D.

Figure 18 – Urgent and emergency care: Overview of feedback

Theme / feedback	S	O	AC	M	AO
Condition treated at 24/7 UTC at Grantham and District Hospital					
• High % of visitors to Lincoln/Peterborough A&Es could be treated locally	✓				
• 24hr access to walk in UTC might relieve pressure on Lincoln A&E	✓				
• Represents a reasonable 'real world' compromise	✓				
• Reassurance 24hr UTC appropriate for majority of patients OOH	✓	✓			
• Recognition most people requiring full A&E services travel by ambulance	✓	✓			
• Concerns about quality of A&Es at Lincoln and Boston	✓	✓			
• Statement Grantham did not have a Level 1 A&E from 2007 is incorrect		✓			
• Vital UTC at Grantham should always operate as a walk-in service			✓		
• Concerns opening times would drop later to 12hr opening from 24/7			✓		
• Assurance 111 refer to Grantham Hospital and they are on database			✓		
Full A&E and hospital service provision at Grantham and District Hospital					
• 24hr UTC viewed as preferrable to current limited service A&E	✓				
• Vast majority of those who rejected proposal did so because want a full 24/7 A&E department		✓			
• Additional Nurse ACPs be trained to compensate for shortage of consultants				✓	
• Offer A&E services during the day, with UTC in operation overnight only					✓
• Maintain A&E services at Grantham and provide dedicated separate walk-in service run by nurses					✓
Ambulance conveyance					
• Concerns to risk to life due to increased travel times	✓	✓			
• Concerns about services becoming more 'spread-out' given geography	✓	✓			
• NHS 111 needs to be informed this is being proposed			✓		
Workforce and organisational integration					
• Recruiting/retaining staff to proposed UTC will not be straightforward		✓	✓		
• Issue of staff recruitment is not specific to A&E doctors			✓		
• Need to ensure safeguarding and IT systems operate well in future model			✓		
Travel and transport					
• Impact on patients due to poor transport links	✓	✓			
• Impact on visitor's journeys and subsequent impact on patient recovery	✓	✓			
• Climate change implications when patients have to travel further			✓		
• More patient transport options be offered between hospital sites				✓	
• ULHT should provide emergency/non-emergency transfer to local A&Es				✓	
Equalities and health inequalities					
• Concerns raised in feedback about particular groups – older people, people with disabilities, those from more deprived communities, living in rural areas – focus predominantly on travel and transport, particularly those with limited access to private transport			✓		
• Travel and accessibility was a concern for multiple organisations, even for some who agreed with the proposals			✓		
Similar UTC provided at Stamford and Spalding					
• A similar urgent treatment service be provided at Stamford			✓		
• Run a pilot to see if 24hour cover should be provided at Spalding			✓		
New specialist hospital					
• Build a new specialist hospital near Sleaford for all emergency care					✓

S = In support of proposal; O = In opposition of proposal; AC = Additional consideration; M = Mitigation; AO = Alternative option

4.4.17 In summary, the feedback on the urgent and emergency care change proposal identified:

- Support across consultation questionnaire responses, particularly from staff, and the telephone survey
- Concerns about the proposals for urgent and emergency care are strongest among those living nearest to Grantham and District Hospital - this is most particularly marked in the questionnaire responses
- Residents telephone survey indicates majority support among the resident population, including those living closest to Grantham and District Hospital
- Support for proposal was most commonly based on the view that a local 24-hour UTC is preferable to a limited-hours A&E department that is not able to meet the needs of all patients.
- Disagreement with the proposal was most commonly based on the view that anything less than a fully equipped and staffed Emergency Department would be unacceptable - rather than a desire for services to remain unchanged.
- Where concerns were raised in feedback about particular groups (e.g., older people, people with disabilities, those from more deprived communities or living in rural areas), the focus was predominantly on travel and transport - particularly for those with limited access to private transport.
- Evidence that residents with disabilities or long-term health conditions that limited their day-to-day activities a lot, were significantly less likely to agree (and more likely to disagree) with proposals than other residents (although there was still majority agreement) – concerns were about travel and access to alternative sites and the need for local acute emergency services at all hospitals

4.5 Acute medical beds

There was broad agreement with the proposal for community/acute medical beds, seen by many as an opportunity to better integrate hospital and community services to benefit patients

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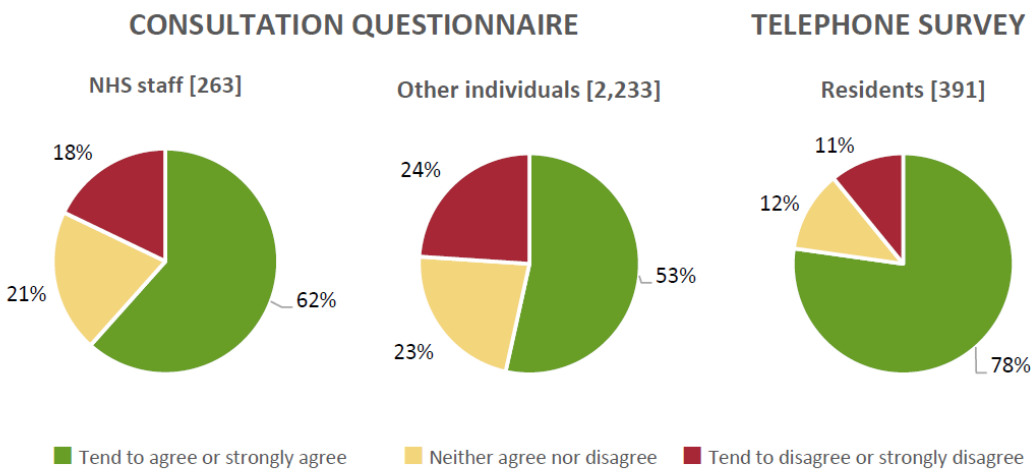
4.5.1 There was majority support for the proposals to provide integrated community/acute medical beds across all stakeholder and consultation strands. Of note, however, is evidence of a level of uncertainty about the proposal, with many consultation respondents indicating that they neither agreed nor disagreed with the proposals, or that they felt unable to provide a view. It is reasonable to assume that this may reflect a lack of familiarity with acute medical beds among respondents and residents compared to the other acute services addressed in the consultation.

4.5.2 Just over three fifths (62%) of NHS employees in the open questionnaire agreed with the proposals to provide integrated community/acute medical beds at Grantham and District Hospital, with fewer than one in five (18%) expressing disagreement.

4.5.3 There was also majority agreement from other individual questionnaire respondents (53%), with just under a quarter (24%) disagreeing. As noted above, among NHS staff and other individuals who took part in the questionnaire, between one fifth and a quarter of respondents neither agreed nor disagreed with this proposal.

4.5.4 Over three quarters (78%, +/- 6%) of Lincolnshire residents expressed support for the proposals, with around one in ten (11%) disagreeing and a similar proportion (12%) neither agreeing nor disagreeing.

Figure 19 – Views on the proposal to provide integrated community/acute medical beds at Grantham and District Hospital (from the consultation questionnaire and residents telephone survey, by stakeholder type)



BASE: Number of participants given in brackets (excludes 'don't know' responses)

4.5.5 Of the 12 organisations that submitted questionnaire responses, 7 agreed with the proposals, 2 neither agreed nor disagreed, and 3 disagreed.

4.5.6 Across consultation feedback, those who agreed with the proposal to provide integrated community/acute medical beds felt that it would provide benefits such as more efficient care, with patients being discharged more quickly while continuing to receive treatment and care in their communities. Indeed, staff and patient representatives said they would like to see this model replicated across the Trust.

4.5.7 Those disagreeing with the proposal felt that Grantham and District Hospital should be a fully serviced hospital with acute medical beds (as opposed to integrated medical beds), especially given the need to account for the area's growing and ageing population. There were also concerns around negative impacts on quality of care, and the potential for increased pressure on other hospital sites.

4.5.8 Other concerns expressed were around overall bed numbers, costs, staff shortages, and capacity within primary and social care services. Further clarity was sought on the impact of the proposals on overall bed space at Grantham and District Hospital, and concerns were expressed about capacity within the other services that are essential in facilitating change - adult social care and primary care for example.

4.5.9 Other worries focused on the cost of implementing the changes and the anticipated increase in staff workloads. Moreover, the latter would, it was felt, be compounded by shortages among community- and hospital-based staff, both of whom are crucial to the successful implementation of this proposal.

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

4.5.11 In feedback from individuals' with protected characteristics or other key demographics, their views on the proposals were typically informed most strongly by their area of residence, regardless of any other demographic characteristics.

4.5.12 One exception was that evidence suggested that residents with the most limiting disabilities or long-term health conditions were significantly less likely to agree (and more likely than other residents to disagree) with proposals around acute medical beds at Grantham and District Hospital (although there was still majority agreement); it should be noted that the feedback indicated that their concerns were focused on loss of acute services and travel and access to alternative sites.

4.5.13 A number of mitigations, alternative suggestions and additional considerations around acute medical beds in Lincolnshire were also identified.

4.5.14 An overview of the themed consultation feedback relating to the acute medical beds proposals is set out below. The full break down of the comments, messages and concerns put forward by respondents through all the public consultation engagement activities against each of these themes is included in Appendix D.

Figure 20 – Acute medicine: Overview of feedback

Theme / feedback	S	O	AC	M	AO
Quality / Workforce					
• Provide benefits: more efficient care, quicker discharge, local care	✓				
• Likely improve recruitment and retention	✓				
• Need to make sure staff are available to support whole pathway	✓				
• Other services need to be involved to enable change	✓	✓			
• Cost of implementing changes and increased workload	✓	✓			
• Community staff in short supply as well as hospital staff	✓	✓			
• CCG proposed to place patients with complex needs out of hospital		✓			
• No reference to Grantham hospital as a training hospital		✓			
• Adequate staffing/resource required for 7-day service			✓		
• Difficulty accessing GPs means minor illnesses not treated			✓		
• Huge recruitment drive is needed for all staff groups			✓		
Condition treated at 24/7 UTC at Grantham and District Hospital					
• Concerns if proposed UTC is developed with extended range of services compared to other similar centres, there is a risk withdrawing any of these would impact on arrangements for proposal			✓		
• NHS 111 needs to be fully informed of who can be sent to Grantham				✓	
Full A&E and hospital service provision at Grantham and District Hospital					
• Grantham Hospital should be fully serviced hospital with acute medical beds		✓			
• Proposal does not take into account growing/ageing Grantham population		✓			
• Concerns about negative impact on quality of care		✓			
Acute Care Unit (ACU)					
• What happened to ACU? Why has ACU been closed?		✓			
• Propose not to replace Acute Service Unit		✓			
• Specific concerns about lack of provision of Level 2 respiratory beds			✓		✓
Ambulance conveyance					
• Will be additional impact put onto EMAS to transfer patients			✓		
Facilities					
• Further clarity sought on impact on bed space at Grantham hospital	✓	✓			
Equalities and health inequalities					
• Patients seen quicker and discharged quicker, particularly elderly/frail			✓		
• Reduces pressure on acute hospital sites at Lincoln and Boston			✓		
Travel and transport					
• Non urgent hospital transfer may also be affected			✓		
Alternative suggestions					
• Blood tests should be available					✓
• Establish acute and rehab pathways					✓
• Provide ‘half way house’ care wards					✓
• Acute medical beds should not be provided at Grantham					✓
• Hospital and ongoing social care should be staffed by integrated MDTs					✓
• Develop district nurse type role to go into people’s homes					✓

Theme / feedback	S	O	AC	M	AO
Criticism over lack of detailed information					
• Criticism over lack of detailed information on the integrated model in consultation document			✓		
Additional considerations					
• Staff / PPG representatives would like to see model replicated elsewhere • Mental health beds should be treated as a priority in future planning • Develop research and development linked to university • Patients with chronic health conditions / co-morbidities should be centralised			✓ ✓ ✓ ✓		

S = In support of proposal; O = In opposition of proposal; AC = Additional consideration; M = Mitigation; AO = Alternative option

4.5.15 In summary, the feedback on the acute medical bed change proposal identified:

- Support across staff consultation questionnaire responses and telephone survey – still 53% of 'other individual' questionnaire responses supported
- Recognition of benefits such as patients seen quicker, more efficient care, with patients being discharged more quickly while continuing to receive treatment and care in their communities – particularly for frail/elderly people
- Concerns expressed around overall bed numbers, costs, staff shortages, capacity within primary and social care services and cost to implement

4.6 Stroke services

There was also majority support for the proposal to create a Centre of Excellence for acute and hyper-acute stroke at Lincoln County Hospital, supported by an enhanced community stroke rehabilitation service across the consultation as a whole, however views did vary somewhat across different areas in Lincolnshire

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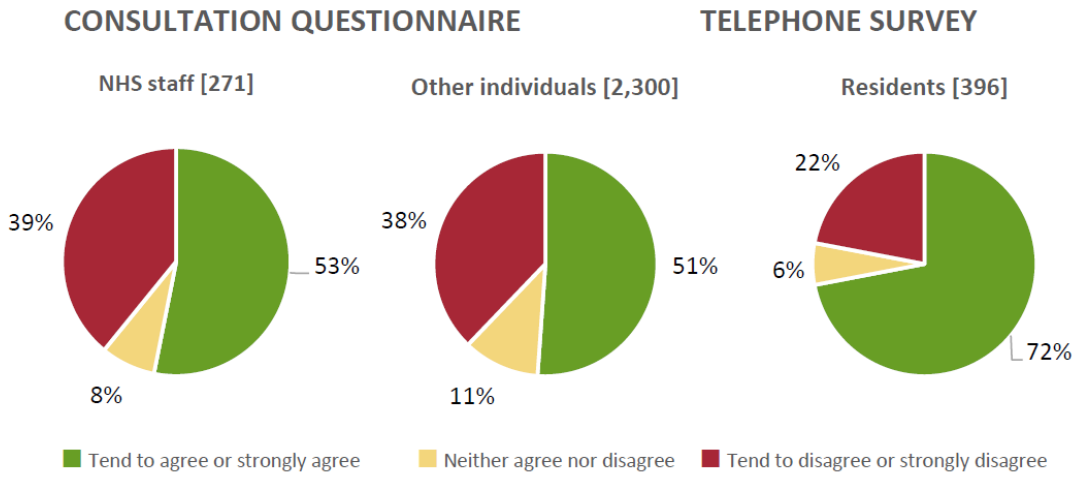
4.6.1 More than half (53%) of NHS staff responding to the consultation questionnaire agreed with the proposal for stroke services, while approximately two fifths (39%) disagreed. This was also the case with other individual respondents to the questionnaire, half of whom expressed agreement (51%) and just over a third (38%) disagreed.

4.6.2 Among Lincolnshire residents, there was more support for the proposed changes; approximately three quarters (72%, +/- 6%) of residents agreed with the proposal, with a little over one in five (22%) expressing disagreement.

Figure 21 – Views on the proposal to a Centre of Excellence at Lincoln County Hospital offering both a hyper-acute stroke unit and an acute stroke unit to deliver care for the county's patients, supported by an enhanced community stroke rehabilitation service (from the consultation questionnaire and residents telephone survey, by stakeholder type)



BASE: Number of participants given in brackets (excludes 'don't know' responses)

4.6.3 Among the 14 organisations that submitted valid responses to this question, 10 agreed with the proposal for stroke services in Lincolnshire and 4 disagreed.

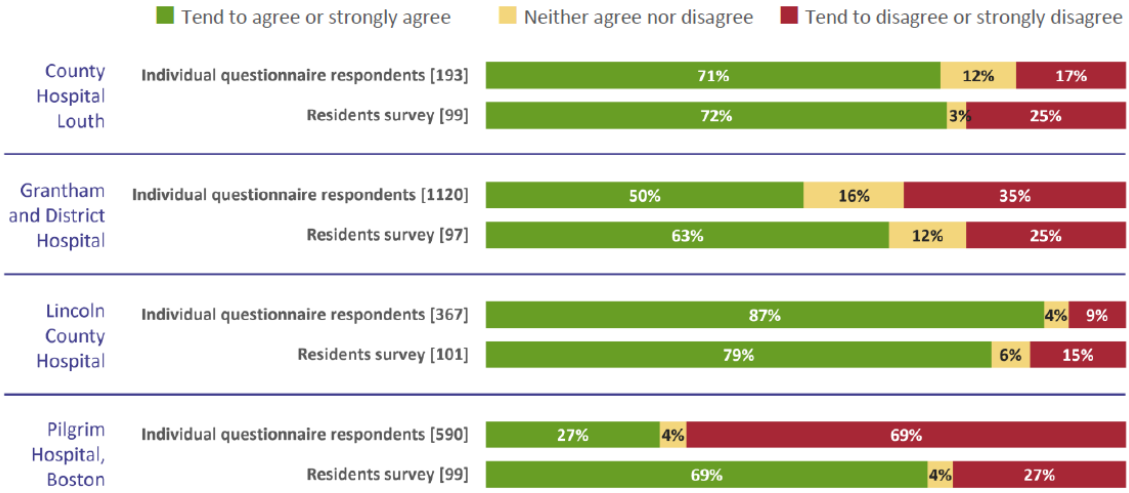
4.6.4 There is evidence that concerns about the proposals for stroke services are strongest among those living nearest to Pilgrim Hospital in Boston. This is most particularly marked in the questionnaire responses, in which more than two thirds (69%) of all individual respondents living closest to Pilgrim Hospital expressed disagreement with the proposal, compared to just over a quarter (27%) who agreed.

4.6.5 The residents telephone survey indicates that there is majority support among the resident population, including among those living closest to Pilgrim Hospital Boston, more than two thirds (69%) of whom agree with the proposals. There was nonetheless evidence of concern, with more than a quarter (27%) of Boston residents disagreeing with the proposal to provide a Centre of Excellence for acute and hyper-acute stroke services at Lincoln County Hospital with Pilgrim Hospital no longer delivering specialist stroke services.

4.6.6 Just over a third of questionnaire respondents (35%) living closest to Grantham and District Hospital also expressed disagreement with the proposals for stroke services, with half (50%) expressing agreement.

4.6.7 The residents survey indicated that a quarter of residents (25%) living closest to Grantham and District Hospital disagreed with the proposal, compared to the nearly two thirds (63%) who agreed.

Figure 22 – Views on the proposal to a centre of Excellence at Lincoln County Hospital offering both a hyper-acute stroke unit and an acute stroke unit to deliver care for the county's patients, supported by an enhanced community stroke rehabilitation service (from the consultation questionnaire and residents telephone survey, by closest hospital)



BASE: Number of participants given in brackets (excludes 'don't know' responses)

4.6.8 There was some agreement with the proposals for stroke services on the grounds of increasing expertise and improving quality of care

4.6.9 Supporters of developing a specialist centre for hyper-acute and acute stroke services at Lincoln County Hospital felt that increasing expertise in this area would inevitably improve patient care and outcomes, and likely tackle many of the challenges faced by NHS Lincolnshire. It was also said that the centre could be a catalyst for further future investment into the area's healthcare infrastructure.

4.6.10 Those who disagreed (mostly residents of the Boston area) did so mainly for fear of a lack of local services and longer travel times, and a concern that it could lead to poorer patient outcomes

4.6.11 Disagreement with the proposals for stroke services came largely from Boston residents, who worried that the removal of "life-saving" local services would be to the detriment and disadvantage of the area and suggested that if the population of Boston continues to increase at its current trajectory, acute stroke services will be required in future. There was also worry that the removal of stroke services would pose a threat to other services at Pilgrim Hospital.

4.6.12 Travel times, including by ambulance, to reach Lincoln were said to be too long, particularly in stroke cases when 'time is of the essence'. It was said that people living in places outside the 'golden hour' of travel time to Lincoln will be disadvantaged by these proposals. Moreover, travelling to Lincoln to visit patients would be difficult for many families and carers, especially as the county's travel infrastructure is poor.

4.6.13 It was argued that, until 18 months ago, Pilgrim ran a safe and high-quality stroke service achieving higher targets than Lincoln; it was alleged that basing data on the last two years is inaccurate as, prior to COVID-19, Pilgrim Hospital saw spikes in admissions over the summer months due to increased holiday makers at the coast. Having only one specialist stroke unit across the whole of Lincolnshire, it was felt, would lead to patients being on wards without access to specialist nurses or therapists.

4.6.14 Moreover, the proposed changes would, it was felt, lead to worsened rehabilitation outcomes, as more complex patients requiring longer periods of inpatient specialist rehabilitation will not receive it due to the lack of specialist stroke management staff and facilities in existing community settings.

4.6.15 It was argued that stroke services should be available at all hospitals, and that the delay in thrombolysis delivery for patients in the South/South East of the county is unacceptable. A centralised model of care was thought to be a particular risk in such a large county with infrastructure issues, especially when treatment time is so crucial for stroke patients.

4.6.16 Other concerns centred around: a lack of ambulance availability in Boston as a result of more frequent journeys to Lincoln and lengthy handovers; whether Lincoln County Hospital has the capacity and infrastructure to deal with increased patient demand; the lack of additional specialist staffing proposed for the Lincoln site; and the presumption that specialist stroke staff will be able to easily relocate from Boston to Lincoln owing to personal circumstances and a lack of transport.

4.6.17 The proposal could, some felt, widen health inequalities and negatively impact patient access as services would be removed from a deprived area. Furthermore, the stroke figures for the area served by Pilgrim Hospital are higher owing to an ageing population. It was thought to make more sense, therefore, to have a centre of excellence in Boston to reduce travel times for the majority.

4.6.18 The impact on patients' loved ones was also noted, particularly elderly spouses/family who may be unable to visit due to the increased travel distance. The impact of this on patients' mental health and recovery may, it was said, have been overlooked.

4.6.19 As with the other proposals, feedback from members of protected characteristics groups and other key demographics tended to express some concerns about travel and transport along the same lines as other respondents.

4.6.20 In the consultation questionnaire data, slightly more respondents from the most deprived communities disagreed with proposal for stroke services than agreed. It should be noted, however, that further analysis indicated that this was almost certainly a result of the majority of questionnaire respondents from deprived communities living in Boston and East Lindsey, closest to Pilgrim Hospital in Boston.

4.6.21 Boston and East Lindsey are geographic areas in which the views among respondents from both deprived and more affluent communities were more negative than elsewhere; the implication, therefore, is that it is shared concerns about loss of local services in Boston driving disagreement, rather than a particular or separate concern from those experiencing deprivation.

4.6.22 In the residents survey there was some indication (at a 90% confidence level) that residents with disabilities that limit their activities a lot were also less likely to agree, and more likely to disagree with this proposal, compared to other residents (although there was still majority agreement).

4.6.23 A number of mitigations, alternative suggestions and additional considerations around stroke services in Lincolnshire were also identified.

4.6.24 An overview of the themed consultation feedback relating to the stroke proposal is set out below. The full break down of the comments, messages and concerns put forward by respondents through all the public consultation engagement activities against each of these themes is included in Appendix D.

Figure 23 – Summary of the feedback themes for the stroke proposal

Theme / feedback	S	O	AC	M	AO
Outcomes / Quality					
• Agree with principles of specialist centre for hyper-acute / acute stroke	✓				
• Proposals likely tackle many of the challenges stroke services face	✓				
• Increased expertise and quality of care	✓				
• Could lead to future investment into NHS Lincolnshire as a result	✓				
• Examples such as Heart Centre at Lincoln show benefit of centralisation	✓				
• If pop. of Boston increases in line with trajectory, stroke unit required		✓			
• Basing figures on last 2 years will provide false data		✓			
• Until 18 months ago Pilgrim ran a safe high quality service		✓			
• Proposal will lead to worsened rehabilitation outcomes		✓			
• Removal of life-saving local services		✓			
• Integrated pathways of care should start from day 1 of condition			✓		

Theme / feedback	S	O	AC	M	AO
• Clarification of pre-hospital treatment of stroke			✓		
• Social care provision needs to be strengthened to reduce LoS				✓	
Workforce					
• Presumption specialist stroke staff will move to Pilgrim is unrealistic	✓	✓	✓		
• Concerns around increase in no. of patients, lack of additional specialist staff at Lincoln, increase in outliers, more complex patients requires more intensive support, lack of community beds/specialist management in community hospitals	✓	✓	✓		
• Proposals will not improve recruitment and retention		✓			
• Improve recruitment with higher wages/benefits			✓		
• Increase staff numbers/staff with thrombolysis training			✓		
• Introduce telemedicine system			✓		
• Stroke unit requires sufficient qualified therapy staff			✓		
Travel Time / Ambulance Conveyance					
• Increased travel times for Boston residents to travel to Lincoln	✓	✓			
• Concerns about centralising model is a risk given size of county	✓	✓			
• Less availability of ambulances in Boston	✓	✓			
• Travel times, including by ambulance, to reach Lincoln are too long		✓			
• People of Grantham and Boston severely disadvantaged		✓			
• Air ambulance to cover east of the county would be supported				✓	
• Provision of a mobile stroke unit				✓	
Travel and transport					
• Travelling to Lincoln to visit patients would be difficult for many families and carers	✓	✓			
Facilities					
• Concern over capacity and infrastructure at Lincoln County Hospital	✓	✓			
Equalities and health inequalities					
• Proposals could widen health inequalities / patient access taken away from deprived areas			✓		
• Patients have elderly spouses / family who won't be able to visit			✓		
• Stroke figures for area served by Pilgrim are higher due to ageing population			✓		
• Concerns around lack of familiarity with 'new' or different locations			✓		
• Needs of people with sensory disabilities will need consideration			✓		
Alternative suggestions: hyper-acute and acute wards					
• Both Lincoln and Pilgrim should be centres of excellence					✓
• Locating stroke service in Boston seem to better suit needs of population					✓
• Train teams stepping into hyper-acute care in a timely way					✓
• If there is a second ward at Lincoln should be a small hyper-acute ward					✓
• Keep hyper-acute at site; make consultants and ACPs work pan-trust					✓
• Standard operating procedure should be in place that allows thrombolysis to be given in ED					✓
• Concern over lack of capacity					✓
• Develop centre of excellence at Peterborough, Grimsby or Nottingham and don't have anything in Lincolnshire at all					✓

Theme / feedback	S	O	AC	M	AO
Alternative suggestions: rehabilitation					
• Grantham should have rehabilitation service, but only have an A&E					✓
• Ringfence specialist beds at Boston to create a hub and spoke service					✓
• An appropriate stroke rehab ward would ensure throughput sufficient to allow new patients to be admitted and longer term patients supported					✓
• Community rehab need to be in place for stroke & neuro conditions					✓
• Provide step down beds in Pilgrim and Grantham and District Hospital					✓
• There is no mention / link to community rehab beds within care homes					✓
• Why are brain and head injury rehab kept separate					✓
• Funding is maintained for the number of beds at Pilgrim Hospital					✓
Additional consideration					
• Need to consider prevention: smoking, high blood pressures, diabetes, heavy drinking			✓		

S = In support of proposal; O = In opposition of proposal; AC = Additional consideration; M = Mitigation; AO = Alternative option

4.6.25 In summary, the feedback on the stroke service change proposal identified:

- Support across consultation questionnaire responses and telephone survey
- Concerns about proposals are strongest among those living nearest to Pilgrim Hospital in Boston - this is most particularly marked in the questionnaire responses
- Residents telephone survey indicates that there is majority support among the resident population, including among those living closest to Pilgrim Hospital Boston.
- Agreement with the proposals for stroke services on grounds of increasing expertise, improving quality of care and outcomes and likely tackle many of the challenges faced.
- Disagreement with the proposals comes largely from Boston residents, with concerns about loss of 'life-saving' services and concerns about time to get to other stroke units
- Concerns the proposal could widen health inequalities and negatively impact patient access as services would be removed from a deprived area.
- Some indication that residents with disabilities that limit their activities a lot were also less likely to agree, and more likely to disagree. with this proposal, compared to other residents (although there was still majority agreement).

4.7 Lincolnshire Health Scrutiny Committee

4.7.1 The consultation team, including relevant clinicians, attended one informal and two formal meetings with the Lincolnshire Health Scrutiny Committee (HSC) during the consultation period to discuss the consultation process and change proposals:

- 13 October 2021 – Consultation process
- 10 November 2021 – Stroke and urgent and emergency care proposals
- 15 November 2021 – Orthopaedics and acute medicine proposals

4.7.2 The approach adopted by the HSC for its response was to use the consultation questionnaire, an overview of its response is set out below, together with how and where the points raised are considered and responded to in the Decision Making Business Case (and its appendices). The full HSC response is included in Appendix E.

4.7.3 In its response the HSC said it was "*grateful to the NHS in Lincolnshire for providing an introduction and presentation on each element of the Lincolnshire Acute Services Review at meetings on 13 October, 10 November and 15 December 2021, which included clinicians".*

4.7.4 The response went on to *say, "The Committee would also like to record its thanks to the Clinical Commissioning Group (CCG) for allowing its response to be submitted to the NHS in Lincolnshire by 31 January 2022, after the closing date for submissions from members of the public and organisations".*

The need for change

4.7.5 The HSC 'Strongly Agree' with the need for change put forward in the public consultation.

4.7.6 However, as indicated in the following answers on each specifical proposal, the Committee did not agree in three instances out of four that the proposal, as detailed, is right for the people of Lincolnshire.

Orthopaedic surgery

4.7.7 The HSC 'Tend to Disagree' with the orthopaedic proposal put forward in the public consultation.

4.7.8 The HSC indicated it understood the intention to reduced cancelled operations, however tends to disagree for the following reasons:

- Concerns on overall accessibility of Grantham and District Hospital for patients across Lincolnshire, but particularly for residents in the east of the county where they rely on public transport *[Consultation feedback response: Quality and workforce, Travel and Transport, Equalities and Health Inequalities]*
- Not convinced that the proposal would necessarily improve recruitment and retention of staff *[Consultation feedback response: Quality and workforce + provider statements of support]*
- Patient choice remains and it is not clear how many patients would choose to have their elective orthopaedic surgery at a hospital outside Lincolnshire. This would potentially impact on neighbouring healthcare systems and continued use of the independent sector. These in turn have funding impacts on the Lincolnshire healthcare system. *[Consultation feedback response: Quality and workforce]*

4.7.9 The Committee reported it strongly supports the continuation and expansion of day case orthopaedic surgery at County Hospital Louth.

Urgent and Emergency Care

4.7.10 The HSC 'Strongly Disagree' with the urgent and emergency care proposal put forward in the public consultation.

4.7.11 The HSC stated:

- The A&E department at Grantham and District Hospital has been a major concern for the Health Scrutiny Committee for Lincolnshire since August 2016, when it was closed overnight on a 'temporary basis'. Since that time two referrals have been made by the Committee to the Secretary of State for Health and Social Care. In each case, these referrals have in effect led to the outcome that the future of Grantham A&E would only be resolved by the NHS in Lincolnshire bringing forward proposals for its future as part a consultation exercise. *[Consultation feedback response: Full A&E and hospital service provision at Grantham and District Hospital]*
- Since 2016 many residents in Grantham have been campaigning to restore an overnight A&E service at Grantham. After six years, many residents in Grantham have concluded that their views have been overlooked. *[Consultation feedback response: Full A&E and hospital service provision at Grantham and District Hospital]*

- The Committee acknowledges that services such as gynaecology; obstetrics; acute surgery; acute orthopaedics; ear, nose and throat; stroke medicine and acute interventionalist cardiology are generally required in any general hospital offering a level one A&E service. These services are no longer provided at Grantham and District Hospital, and it is understood that they have been gradually removed or downgraded. The Committee is not re-assured that further changes to the service provided at Grantham will be avoided. *[Consultation feedback response: Full A&E and hospital service provision at Grantham and District Hospital]*

4.7.12 In view of the long-standing concerns of residents and in addition to the above, the Committee strongly disagrees with the proposal for the following reasons:

- Not convinced that the proposal would necessarily improve recruitment and retention of staff and there may be circumstances in the future where staff are re-allocated from the urgent treatment centre to support A&E departments, thus reducing the ability of the proposed urgent treatment centre to treat 97% of its patients. Where a temporary change in provision occurs, there is a risk that this might become more permanent *[Consultation feedback response: Workforce and organisational integration + provider statements of support]*
- The Committee understands that only 3% of patients could not be treated at the proposed urgent treatment centre. The Committee is not reassured that these patients will be discharged from another A&E department, without transport or a means of returning home at times when public transport is unavailable. The role of any support from the non-emergency patient transport service would need to be clarified. *[Consultation feedback response: Travel and transport]*

4.7.13 In its response the Committee stated that if the proposal for an urgent treatment centre at Grantham and District Hospital is implemented by NHS Lincolnshire CCG, the Committee would make the following recommendations:

- There should be clear publicity in Grantham and the surrounding area on what services are provided at the Grantham urgent treatment centre, as the term 'urgent treatment centre' is a relatively new concept within the NHS. *[Consultation feedback response: Conditions that would be treated at a 24/7 Grantham and District Hospital UTC]*
- The modest capital investment for the expansion of the proposed urgent treatment centre into unused parts of the hospital should be identified, planned and implemented immediately. *[To be considered further through implementation phase if change proposal is agreed]*

Acute medicine

4.7.14 The HSC 'Tend to Agree' with the acute medicine proposal put forward in the public consultation.

4.7.15 The HSC indicated the following reasons for this:

- The Committee accepts the argument put forward by the NHS in Lincolnshire and supported by the East Midlands Clinical Senate that the proposal is likely to improve the recruitment and retention of middle grade doctors *[Consultation feedback response: Quality and workforce]*
- The Committee supports the concept of integration of health and social care services as part of this proposal, and the potential for this to become a centre of excellence for multi-disciplinary care. *[Consultation feedback response: Quality and workforce]*

4.7.16 The Committee also put forward the following additional comments:

- There are concerns that if the proposed urgent treatment centre is implemented, with an extended range of services compared to other urgent treatment centres, there will be a risk that withdrawal of any of these services would impact on the arrangements for medical and community beds. *[Consultation feedback response: Conditions that would be treated at a 24/7 Grantham and District Hospital UTC]*

- This service is NHS-funded, but as the integration agenda develops, there may be discussions on where funding for such services is held. If the budgets were to be held by local authorities, as opposed to the NHS, the Committee would wish to see the County Council receiving adequate funding to ensure high quality service provision; and would not wish to see it becoming a burden on the County Council's finances. *[Consultation feedback response: Conditions that would be treated at a 24/7 Grantham and District Hospital UTC]*

- The Committee notes that a full description of the proposed community bed provision is detailed in chapter 11 of the pre-consultation business case. The Committee would wish to be made aware of any changes to that provision, as the initiative develops. *[See implementation chapter and role of proposed Implementation Oversight Group to link in with wider system partners including the Health Scrutiny Committee for Lincolnshire]*

Stroke services

4.7.17 The HSC 'Tend to Disagree' with the stroke services proposal put forward in the public consultation.

4.7.18 The HSC indicated it is not convinced by all the arguments put forward in support of this proposal, and tends to disagree for the following reasons:

- The proposal represents another example of services being consolidated at Lincoln County Hospital; and the removal of a service from Pilgrim Hospital, Boston and in this case the displacement of 497 patients each year currently treated there. Irrespective of the clinical arguments in favour, this leads to a perception in the Boston area that the services provided at Pilgrim are gradually being downgraded. *[Consultation feedback response: Quality and outcomes]*

- Further to the above, the east coast of Lincolnshire has high areas of deprivation, and a higher proportion of residents, who rely heavily on acute hospital services. Where a service is withdrawn it is likely to have a significant impact on their wellbeing. *[Consultation feedback response: Quality and outcomes, Ambulance conveyance]*

- As stated in the pre-consultation business case approximately 50% of the 497 displaced patients would be taken to Peterborough City Hospital. Whilst the pre-consultation case models the impact of this on patient travel times, it is silent on the capacity of North West Anglia NHS Foundation Trust to treat as many as an extra 250 stroke patients each year. *[Consultation feedback response: Ambulance conveyance]*

- Although the pre-consultation business case models the impact on the timings for patients between the arrival of the ambulance and treatment, it is important to recognise any impact on the East Midlands Ambulance Service, where longer journey times, for example from Boston and the surrounding area to Peterborough City Hospital, affect the availability of ambulances. These do not appear to have been addressed in the pre-consultation business case. *[Consultation feedback theme: Quality and outcomes, Ambulance conveyance]*

- The Committee is not completely convinced that the proposals will lead to improvements in the recruitment and retention of both medical and nursing staff. *[Consultation feedback response: Workforce]*

4.7.19 The Committee also put forward the following additional comments:

- During the discussion with the HSC reference was made to the possibility of introducing a mobile stroke unit, which would be able to support, in particular, people in the east of the county. The Committee was advised this suggestion would be considered in further detail. *[Consultation feedback response: Ambulance conveyance]*

- The Committee was advised that clinics for the treatment and follow-up of transient ischaemic attacks would continue at Pilgrim Hospital, Boston and would urge this to continue. *[This is included in the change proposal description]*

4.7.20 In addition to the feedback provided on the four service change proposals, the HSC provided feedback on a number of other areas. An overview of this is provided in the table below.

Figure 24 – Overview of feedback from Lincolnshire Health Scrutiny Committee

Area	Overview of HSC feedback
Equalities impact	The HSC urged the NHS Lincolnshire to take full account of the ageing population, rural geography and areas of high socio-economic deprivation prior to making a decision on any service changes. *[Consultation feedback response: Equalities and Health Inequalities]*
Travel and transport	The Committee does not believe that it is the County Council's role to facilitate changes to public transport provision, solely and directly in response to changes to services provided by the NHS. Furthermore, public transport in Lincolnshire tends not to operate in the evening and overnight, so when people are discharged without their own transport, there is an additional challenge. It is important that patient transport not only continues to be offered to lessen the impacts of any service changes, but also any revisions arising from the implementation of the national criteria, including any flexibilities in those criteria, are used to the full for the benefit of patients in Lincolnshire. *[Consultation feedback response: Travel and transport]*
Recruitment and retention	There is an argument in each of the four proposals that there would be improvements to the recruitment and retention of staff, which has been a long-standing challenge in Lincolnshire, even prior to the Covid-19 pandemic. The supply of medical and nursing staff is a national issue, and thus not solely the responsibility of the NHS in Lincolnshire. The Committee is not convinced that these service changes alone will necessarily address the particular staffing challenges, which have led to the development of the four proposals. The Committee recognises that one of the difficulties is that many medical and nursing staff are more attracted to the agency style of working, where they can choose the days that they work, without detriment to their overall salary levels. *[Consultation feedback response: Workforce and quality + provider statements of support]*
Links to neighbouring health system	<u>Impact on Other Health Systems</u> These four proposals will impact on neighbouring health systems, as acknowledged by the detail in the pre-consultation business case. The Committee would like to be re-assured that neighbouring health systems would be able to cope with any increased demand placed on their services from patients being displaced in Lincolnshire. <u>Impact of Other Health Systems on Lincolnshire</u> Although the Humber Acute Services Programme is at an earlier stage in its development, with its public consultation planned for the summer of 2022 at the earliest, there is concern that there may be proposals to withdraw certain acute hospital services from either Diana Princess of Wales Hospital in Grimsby or Scunthorpe General Hospital, which would in turn lead to increased pressures on the acute hospital services provided by United Lincolnshire Hospitals NHS Trust. *[See implementation chapter]*
Consultation arrangements	The Committee was advised that leaflets on the consultation would be delivered to every household, as a mean of eliciting a high rate of response. The Committee would like to see the full consultation report provide an assessment on how well this approach worked, as anecdotal evidence suggests that many households did not receive a consultation leaflet. The Committee does not support the approach whereby pre-booking was required for attendance at the in-person consultation events. The Committee understands that there have been some very low attendances at these events, and feels that pre-booking might have deterred people coming forward with their views.

Area	Overview of HSC feedback
	The Committee recognises that promoting a consultation exercise in a county as large and rural as Lincolnshire represents a challenge, with several local media outlets and various forms of engagement required to reach the public. However, the Committee feels that although there were 2,495 online responses, the reach of the consultation could have been more extensive and elicited more responses. The Committee believes that the reach of the consultation has been constrained in part by the Covid-19 pandemic. For example, it has not always been possible to access any consultation leaflets in GP surgeries, as visits to these surgeries have been limited. *[Consultation feedback response: Consultation arrangements + Communication and Consultation Activity Report in Appendices]*

5 Addressing the themes from consultation

5.1 Introduction

5.1.1 Following the end of the public consultation there has been an extensive programme of work to review the findings of the public consultation and ensure conscientious consideration of the feedback, ahead of final decision-making on the change proposals.

5.1.2 Central to this review process has been the theming of the feedback received through the public consultation for each of the four change proposals (as set out in the previous chapter), and the establishment of subject matter expert working groups to consider and respond to each theme.

5.1.3 Over the remainder of this chapter the key conclusions and actions identified by the working groups for each theme of feedback for each of the four change proposals is presented, and the full consideration is included in Appendix F, G and H:

- Appendix F1 – Orthopaedics consultation feedback responses
- Appendix F2 – Urgent and emergency care consultation feedback responses
- Appendix F3 – Acute medicine consultation feedback responses
- Appendix F4 – Stroke consultation feedback responses
- Appendix G – Quality Impact Assessments (QIAs)
- Appendix H – Equality Impact Assessments (EIAs)

5.1.4 In many cases, the responses to feedback from the consultation include reference to completed, current or proposed activities if the change proposals are agreed that seek to address the issues identified, including the completion of additional analysis. These have been highlighted in the following way **ACTION**.

5.1.5 Where conclusions and actions specifically relate to the feedback received from the Health Scrutiny Committee for Lincolnshire this is highlighted in the following way **HSC**.

5.1.6 In addition to responses to the specific change proposal feedback, at the end of this chapter consideration is given to feedback received on the overall consultation arrangements, as well as the overall conclusions on the change proposals consulted on following consideration of the feedback.

5.1.7 It should also be noted that the NHS Lincolnshire CCG Involvement Champions were integral to the review of the consultation findings and emerging themes. In order for them to undertake a confidential review, they were provided with the full draft independent report on the consultation findings from ORS together with the themed feedback.

5.1.8 A subsequent meeting was held to enable the Involvement Champions to share their thoughts on whether the feedback theming included everything in the report that they would expect to see, identified all of the key pieces of feedback or information that they would expect to be responded to and if there was anything they felt had been missed.

5.1.9 Discussions also included their thoughts on the consultation report in general and suggestions for how we could communicate the findings of the consultation and CCG Board decision extensively. Healthwatch Lincolnshire were also involved in reviewing the full draft independent report on the consultation findings from ORS. Healthwatch circulated this to their volunteers to undertake a readability and 'plain English' review of the document and to their steering group to gain an organisational perspective on the draft findings.

5.1.10 All feedback was taken into consideration during discussions with ORS and development of the final report.

5.2 Orthopaedic proposal

Quality and workforce

5.2.1 At the beginning of the orthopaedic pilot success factors were agreed to ensure it could be evidenced whether the changes implemented had the desired impact and drive performance improvements in terms of quality, safety, patient experience and use of resources.

5.2.2 Performance against these key indicators has been regularly monitored and been used to report progress to the ULHT Board. Moving forward the intention is to present them in the form of a reporting dashboard. ACTION

5.2.3 The orthopaedic pilot showed very positive results including high patient satisfaction, reduced lengths of stay and increased day case rates with performance outperforming peers. If the change proposal is agreed and the pilot made permanent, key performance indicators would continue to be used to regularly monitor performance, including patient satisfaction. ACTION

5.2.4 At the start of the orthopaedic pilot weekend trauma lists and weekday trauma slots lists were put in place at the Grantham hospital site; however, it became clear that these were significantly underutilised and that the emergency patients were best cared for at the Lincoln and Pilgrim hospital sites. Minor trauma cases that could be appropriately discharged home to have a semi-planned operative procedure on a later day could be scheduled to take place at Grantham.

5.2.5 There is already agreed investment for an additional physiotherapy support post and a business case has been developed for additional physiotherapy and occupational therapy staff to provide these services over the weekend period to improve patient recovery, facilitate protocol led nurse/physiotherapy discharge. ACTION

5.2.6 The orthopaedic pilot has demonstrated positive benefits in relation to establishing a sustainable orthopaedic workforce and it is not anticipated that a change to workforce is required. It is anticipated that if the proposed model of care is made permanent this will be a model that would allow for staff development and will improve recruitment and retention. HSC

5.2.7 Consultation groups were held with all staff prior to the pilot. Consultations have been held continually with the medical staff and although there were initial concerns raised, discussed and addressed, over the period of the pilot the medical workforce has not raised any additional concerns. Other consultations have been undertaken with other workforce groups and staff have voluntarily move their base to the Grantham site. There will be further formal engagement if the proposal is agreed. ACTION

5.2.8 Since the pilot, all of the health services are working more collaboratively and are communicating well and in a timely manner regarding patient care. Letters are sent out to all patients. All appropriate health professions can view clinical records and imaging reports. The information systems are linked through the care portal and primary care colleagues can view the records through SystmOne. ACTION

5.2.9 There is continuous learning from Private Hospitals as several the orthopaedic surgeons at ULHT also undertake work in the independent sector. The key learning is the separation of elective work from unplanned work and the medical cover required to support patients out of hours is a similar model to that used on the Grantham site. ACTION

5.2.10 Under the pilot the patient remains under the care of the operating consultant and there is a ward round every day in the morning by a senior orthopaedic doctor. This doctor liaises with the original operating consultant as required. The patient's follow-up is with the consultant who performed the operation/procedure. After 6:00 pm, all patients are under the care of the on-call consultant. On a Monday, Wednesday, Friday, and Sunday the Lincoln County Hospital consultant is in charge, the other days it is the Pilgrim Hospital consultant.

5.2.11 In the event of a deteriorating patient who requires a higher level of post-operative care, the nursing and medical team at Grantham liaise with the ITU/Outreach team at Lincoln or Pilgrim and arrange transfer as appropriately needed.

5.2.12 Under the pilot the on-call pattern at Grantham is hospital at night which looks after all patients. There is a middle-tier resident on call system to look after very unwell patients. Lincoln County Hospital and Pilgrim Hospital do 24hr orthopaedic on-call. The resident on-call at Grantham can contact the orthopaedics team on-call at these sites and a transfer can be arranged if required. A transfer may be required if there is a post-operative complication that requires to be treated on one of the acute sites. Since the commencement of the pilot, only one post-operative patient has been transferred from the Grantham site to the Lincoln site. This was a precautionary transfer of a patient with a suspected post-operative complication of a DVT following surgery. In the event the patient did not have a DVT.

5.2.13 Only suitable patients are listed for surgery at the Grantham Hospital Site. There is a Grantham and District Hospital admitting criteria which excludes patients with a number of medical co-morbidities. This has not changed during the pilot and is not planned to in the proposed model.

5.2.14 The orthopaedics change proposals have no impact on the continued right for patients being given a choice of provider at point of referral. However, through the proposed changes there is the expectation that over time more people will be able to and will want to choose to have their surgery in Lincolnshire as opposed to having to go to the independent sector, often outside of the county. **HSC**

5.2.15 Under the pilot available capacity is optimised with as much planned orthopaedic surgery as possible carried out at Grantham and District Hospital. If the temporary change proposal being delivered through the pilot is agreed to be formally implemented and more planned orthopaedic surgery capacity became available at Grantham and District Hospital and County Hospital Louth, more patients could be seen at these sites and would benefit. This includes seeing more of the patients who receive their planned care in the independent sector (much of which takes place outside of Lincolnshire). **HSC**

5.2.16 Through the pilot it has been shown that the consolidation of elective orthopaedic services at Grantham Hospital (together with a greater focus on day cases at Louth) can deliver a reduction in the amount of time people wait to have their surgery as well as the potential to increase the number of patients treated by ULHT. It has also shown people are prepared to travel to have their elective surgery if it means they will have their operation quicker. **HSC**

5.2.17 Supported by the current pilot model, United Hospitals Lincolnshire NHST Trust (ULHT) is one of the best performing trusts in the region in relation to waiting times for orthopaedics. **HSC**

5.2.18 The service uses a standard assessment of a patient's pre-anaesthesia medical comorbidities. A patient with no or minor comorbidities can be operated on the Grantham site. The Grantham site has eight acute surgical beds, therefore following anaesthetic review some patients with moderate co-morbidities may be listed at Grantham. Other patients with moderate or severe co-morbidities will have their operation planned for the Lincoln or Boston sites where there is suitable post-operative care and access to the ICU.

5.2.19 If the temporary change proposal being delivered through the pilot is agreed to be formally implemented and more planned orthopaedic surgery capacity became available at Grantham and District Hospital and County Hospital Louth, more patients could be seen at these sites and would benefit. **ACTION**

5.2.20 Analysis of hospital activity conducted as part of developing the service change proposal and reflecting the experience of the pilot, estimates that around one patient a day on average who would previously been admitted to Grantham and District Hospital for unplanned orthopaedic surgery would receive care at an alternative hospital. There was more pressure on the emergency orthopaedic care at Lincoln and Boston. However, this was balanced by the increases to the non-emergency orthopaedic operations going to Grantham and Louth.

5.2.21 The proposal is similar to the pilot and over the duration of the pilot this has proved to be successful with a minimal amount of trauma patient transfers. There are many patients who require a period of waiting prior to surgery. These will be typically limb fractures and in these cases patients from the Grantham area can be booked onto one of the elective lists and in this way orthopaedic trauma patient transfers are kept to a minimum. **ACTION**

5.2.22 Grantham and District Hospital urgent care services will continue to treat cases such as simple fractures and dislocations.

5.2.23 When the pilot started a dialogue was had with East Midlands Ambulance Services NHS Trust (EMAS) about patients with a fractured neck of femur and the need to transport them to Lincoln County Hospital. No concerns around these arrangements have been raised through the pilot and EMAS are fully aware of the exclusion criteria at Grantham and District Hospital. There have been no issues during the pilot.

5.2.24 The Quality Impact Assessment (QIA) for the orthopaedics change proposal developed for the Pre Consultation Business Case was also reviewed in light of the feedback from the public. This can be found in Appendix G.

Access

5.2.25 The orthopaedic pilot demonstrated the benefits of care being provided in a centre of excellence. This was underpinned by pilot key performance indicators. If the change proposal is agreed and the pilot made permanent key performance indicators would continue to be used to regularly monitor performance, including patient satisfaction. **ACTION**

5.2.26 It is recognised by GIRFT as 'best practice' to split elective and non-elective orthopaedic work onto different sites to drive improvements, and recognised that managing complex, urgent care on a separate hot site (emergency/unplanned non-elective care) allows improved trauma assessment and better access to specialist care, so patients have better access to the right expertise at the right time. Therefore, to provide the best quality sustainable care for patients it is not possible for all acute hospital services / orthopaedic surgery to be delivered close to patient's homes.

5.2.27 During the change proposal and appraisal process consideration was given to not changing the way orthopaedic surgery is provided across ULHT's, meaning its main three sites would continue to provide elective and non-elective surgery. Following a clinically led appraisal, this option did not progress to the short-list stage for further analysis as the group of clinical leaders did not see the current situation and challenges improving without change. **ACTION**

5.2.28 In light of the feedback received from the public consultation, alternating or rotating elective operating services between the sites to provide care for patients closer to their homes has been considered by the orthopaedic service. However, the view is this would have a negative impact on the service that is currently being provided. It would spread the service and resources, including workforce too thin. The service would have to duplicate equipment on these sites, and therefore would not be able to provide the best quality of care at any of the sites. In addition, this would mean undertaking elective orthopaedic surgery on an acute site which has the disadvantage of high cancellation rates. The results of the pilot are testament to the view that the concentration of services on fewer sites supports the delivery of high quality services to the residents of Lincolnshire. **ACTION**

5.2.29 Under the change proposals outpatient clinics will remain across all sites they are currently provided from (ULHT and others). Opportunities also exist to support improved access pre-operative and post-operative through the increased use of digital support. ULHT are developing a traffic light pre assessment process which will reduce the number of face to face pre-operative assessments occurring on hospital sites. In addition, eConsultations and video consultations can support improved access. The Lincolnshire health system's capability in this has been accelerated through COVID-19 as more virtual clinics have been run. **ACTION**

5.2.30 The fracture clinic would continue to be provided from Grantham and District Hospital and at all of the current site locations if the proposed changes go ahead. There is increased opportunity for virtual fracture clinics and telemedicine to support access. E-Trauma and Virtual clinics will be taking place where possible to reduce the patient travel. **ACTION**

Interdependency with Urgent and Emergency Care

5.2.31 In relation to orthopaedics the proposed exclusion protocol identified that ambulances and GPs should not bring or send patient to Grantham and District Hospital in the following situations:

- All Major trauma is excluded from this site in line with the East Midlands Trauma Network Triage Tool, including all suspected femoral fractures.
  NOTE Major Trauma has always been part of the exclusion protocol
- Fractures/ dislocations with evidence of distal neurovascular compromise.
- Open lower limb fractures of femur, tibia/fibula, ankle or forefoot

5.2.32 The proposed exclusion protocol goes on to identify trauma that can be treated at the site:

- All suspected shoulder, arm, wrist and hand fractures
- All suspected closed tibial, ankle and foot fractures
- All suspected joint dislocations of the shoulder, elbow, wrist, patella
- All suspected peripheral soft tissue injuries, sprains, strains, lacerations, haematomas
- All hand injuries (may require transfer after assessment)
- Children's suspected fractures – if confined to one area and child is haemodynamically stable (may require subsequent transfer after assessment)

5.2.33 Following ongoing and further review, 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: **ACTION**

- 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 sustainably deliver this level of care.

Equalities and Health Inequalities **HSC**

5.2.34 Several specific groups such as older people, people on low incomes, those without access to private vehicles, and people with disabilities were mentioned as being particularly vulnerable to impacts as a result of longer or more expensive journeys to hospitals. Patients with co-morbidities were also mentioned, including those who might require access to kidney dialysis while in hospital.

5.2.35 A review of the eligibility criteria for patient transport services was suggested, to address any potential barriers to access - particularly for the most deprived communities in rural and inner city areas, or from frail or older people who might find travel stressful or difficult - so that additional support and transport can be provided according to need.

5.2.36 The challenge of ensuring equitable access in a large, rural county was raised, especially for localities (e.g., on the east coast) where health service and public transport provision were described as already being poor. Concern was also expressed that people with disabilities used to attending particular hospitals where additional support is available might find that the same support and assistance is not available elsewhere.

5.2.37 Others were concerned about the practicalities of travel for friends and family, those without access to their own vehicle, and those who might struggle to drive and/or otherwise get to/from hospital if they were unwell, in discomfort or were recovering from surgery. A small proportion were concerned about impacts on the ambulance service and on patient transport.

5.2.38 A deaf service user was appreciative of the additional support they had received when accessing care at Pilgrim Hospital in Boston and was concerned to know if similar support is or would be available at other hospital sites if services were to move.

5.2.39 Consideration of the potential positive impacts of the change proposal was given during the development of the Pre Consultation Business Case (PCBC), and further consideration was given following the public consultation. The potential positive impacts identified for the proposed service changes are the same for all patients, and are therefore equally relevant in the context of all groups with protected characteristics ACTION:

- Reduced waiting times
- Reduced cancellations
- Improved service quality
- Reduced lengths of stay in hospital
- Improved outcomes

5.2.40 A number of mitigations to the travel and access concerns have been identified and are set out in the Travel and Transport Report. An overview of these is provided in the Travel and Transport section at the end of this chapter. ACTION HSC

5.2.41 In addition to the mitigations set out in the Travel and Transport Report, if the changes are agreed all services will comply with the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support they need from health and care services. ACTION

5.2.42 It has also been identified that any service changes if agreed need to ensure services are accessible in respect of different races and ethnicity. ACTION

5.2.43 Specifically in response to the concerns of the deaf service user, the provision of additional support for deaf service users is the same at all of ULHT's hospitals.

5.2.44 The Equality Impact Assessment (EIA) for the orthopaedics change proposal developed for the Pre Consultation Business Case was also reviewed in light of the feedback from the public. This can be found in Appendix H. The EIA is a 'living document' and will continue to be updated if and when new information becomes available. If the change proposals are agreed it will continue to develop through the implementation phase.

Travel and Transport HSC

5.2.45 See Travel and Transport section at the end of this chapter

Facilities

5.2.46 The current estates strategy for the Grantham site is to enhance and maintain the buildings and estate to support the delivery of hospital services. There has been significant investment into the Grantham hospital site to maintain and improve the buildings and infrastructure. ACTION

5.2.47 For example, patient environment improvements such as decoration and flooring, two new modular theatres, which include laminar flow to ensure they are suitable for orthopaedic patients. These are due to open in July 2022 along with continued ward enhancement works. ACTION

5.3 Urgent and Emergency care proposal

Conditions that would be treated at 24/7 Grantham and District Hospital

5.3.1 Within the public consultation document the current situation in relation to orthopaedic provision by United Lincolnshire Hospitals NHS Trust (ULHT) is set out. This document highlights that since August 2018 the orthopaedic surgery service provided by United Lincolnshire Hospitals NHS Trust (ULHT) has been part of a national orthopaedic pilot to look at how service quality and patient outcomes could be improved.

5.3.2 It highlights that prior to the pilot beginning, planned and unplanned orthopaedic surgery was carried out at three hospital sites; Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital. In addition, planned orthopaedic surgery was provided from County Hospital Louth.

5.3.3 The public consultation document goes on to explain that under the pilot all unplanned orthopaedic surgery is now carried out at Lincoln County Hospital and Pilgrim Hospital, Boston, and as much planned orthopaedic surgery as possible is carried out at Grantham and District Hospital.

5.3.4 Within the public consultation document the proposal for orthopaedics was described as reflecting the pilot arrangements through the establishment of a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital, and a dedicated day case centre at County Hospital Louth. Outpatient clinics would be unaffected.

5.3.5 This document described that 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.

5.3.6 The PCBC that was made publicly available at the start of the public consultation described these changes in more detail and within the Appendix of that business case document the proposed exclusion protocol for Grantham and District Hospital in light of the proposed changes was included.

5.3.7 In relation to orthopaedics the proposed exclusion protocol identified that ambulances and GPs should not bring or send patient to Grantham and District Hospital in the following situations:

- All Major trauma is excluded from this site in line with the East Midlands Trauma Network Triage Tool, including all suspected femoral fractures.
  NOTE Major Trauma has always been part of the exclusion protocol – see next section for more information
- Fractures/ dislocations with evidence of distal neurovascular compromise.
- Open lower limb fractures of femur, tibia/fibula, ankle or forefoot

5.3.8 The proposed exclusion protocol goes on to identify trauma that can be treated at the site:

- All suspected shoulder, arm, wrist and hand fractures
- All suspected closed tibial, ankle and foot fractures
- All suspected joint dislocations of the shoulder, elbow, wrist, patella
- All suspected peripheral soft tissue injuries, sprains, strains, lacerations, haematomas
- All hand injuries (may require transfer after assessment)
- Children's suspected fractures – if confined to one area and child is haemodynamically stable (may require subsequent transfer after assessment)

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

5.3.10 The exclusion criteria have been 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 (Lincoln, Pilgrim, Nottingham or Peterborough) where more specialised services are located.

5.3.11 This exclusion list is well understood by the local healthcare system including primary care, community providers and the ambulance service. However, since the introduction of the exclusion criteria, the workforce at Grantham and District A&E has maintained the ability to manage all presentations, including those requiring stabilisation and transfer to an alternative hospital with the right skills and expertise. To ensure the safe care of all patients presenting at the hospital's A&E department.

5.3.12 The consultation document set this out: 'If patients do present at Grantham and District Hospital A&E department with conditions that the hospital is not able to deal with, the skills and experience are there to manage the patient whilst transfer is quickly arranged to a more specialist unit for the appropriate treatment', and the Pre Consultation Business Case (PCBC) that was made publicly available at the start of the public consultation described this situation in more detail.

5.3.13 This approach of Grantham and District Hospital having an exclusion criteria in place and also having the skills and capabilities to stabilise and transfer patients is reflected in the information shared by the member of the public. This information was shared as it was felt it showed statements in the public consultation that Grantham and District Hospital did not have a Level 1 A&E from 2007 as inaccurate, as every level of severity across a wide range of critical conditions were treated and stabilised at the hospital.

5.3.14 The information shared shows the National Early Warning Scores (NEWS) of patients attending the Grantham and District Hospital A&E in November 2017, plus information showing the diagnosis description of patients admitted to Grantham Hospital wards as an 'emergency.

5.3.15 Early warning scores (EWS) are forms of track and trigger scoring systems. These involve checking basic physiological signs at intervals (tracking) and responding to abnormal physiological parameters (triggers).

5.3.16 NEWS uses six physiological measurements: respiratory rate; oxygen saturation; temperature; systolic blood pressure; heart rate and level of consciousness. Each scores 0–3 and individual scores are added together for an overall score. An additional two points are added if the patient is receiving oxygen therapy. The total possible score ranges from 0 to 20. The higher the score the greater the clinical risk. Higher scores indicate the need for escalation, medical review and possible clinical intervention and more intensive monitoring.

5.3.17 The information shared identifies patients with NEWS as high as 14 were seen at the Grantham & District A&E department, which is in line with its capability to stabilise and transfer those patients the hospital is not able to directly deal with. **ACTION**

5.3.18 However, it is important to note that a 'Type 1 A&E' is not determined by the nature of complaints people present with, nor by having the skills and experience to manage patients who initially attend, or subsequently deteriorate after arrival, with a higher level of acuity. A 'Type 1 A&E' can only be categorised as such if it is a consultant-led, 24-hour service with full resuscitation facilities which has all the required clinical interdependent services co-located with it.

5.3.19 This means a 'Type 1 A&E' department that is able to maintain safe, sustainable 24/7 cover, is able to receive all patients (i.e. 'unselected') and is co-located with other specialties (Critical Care/Intensive Care, Acute Medicine (and specialties), General Surgery (and specialties), Paediatrics, Orthopaedics, Obstetrics and Gynaecology, Laboratory Services and Diagnostic Imaging) that are also delivered in a safe and sustainable way.

5.3.20 Further detail on the requirements for a 'Type 1 A&E' and its clinical dependencies is described in the system's response to the consultation feedback around 'why can't Grantham have a full A&E?'. This document also includes evidence from a number of external reviews of the services offered at Grantham & District Hospital, which also confirm it was not a Type 1 A&E service.

5.3.21 Within the public consultation document it was set out that under the proposals to establish a 24/7 walk-in UTC at Grantham and District Hospital and provide integrated acute/community medical beds, the exclusion criteria would be refined such that a small volume of higher acuity cases currently managed at Grantham and District Hospital would receive specialised treatment elsewhere. The service is planned to be 24/7 and walk-in following feedback during the pre-consultation engagement exercises.

5.3.22 The public consultation document also described 'existing doctors retained as part of the team and consultant (senior doctor) oversight provided to the unit. The multi-disciplinary workforce would have the ability to manage all presentations, including those requiring stabilisation and transfer to an alternative hospital with the right skills and expertise'. As the A&E department currently does.

5.3.23 The PCBC that was made publicly available at the start of the public consultation described these changes in more detail. Within this document it sets out that following a clinical audit of patients on the Grantham and District Hospital site that used a combination of National Early Warning Scores (NEWS) and Frailty Scores, recommendations from the audit were:

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

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

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

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

5.3.27 Within the PCBC the Grantham and District Hospital Acuity Model to underpin the proposed changes was outlined. This is set out below.

Figure 25 – Proposed Grantham and District Hospital acuity model

Outline Assessment Criteria for Suitability for Grantham Hospital

For individuals assessed by a healthcare professional, including ambulance arrivals

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

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

For walk-ins

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

5.3.28 This outline assessment criteria for suitability at Grantham and District Hospital was set out in more detail in the proposed exclusion criteria that was included as an Appendix of the PCBC.

5.3.29 If the proposed change goes ahead all relevant health and care providers including 111, East Midlands Ambulance Service Trust (EMAS), primary care and community providers will be engaged and information provided detailing the full list of exclusion criteria for Grantham and District Hospital under the change proposals. The current exclusion list is well understood by the local health and care system, and the adjustments made under the service change will be made explicit and clear. For 111 this will include making sure the Directory of Services (DOS) profile aligns so that patients are appropriately seen by the right service. **ACTION HSC**

5.3.30 In addition, if the service change proposals relating to Grantham and District Hospital are agreed, a comprehensive communication plan will 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. Including a public facing document that clearly lists conditions that can be managed at the proposed 24/7 UTC, is also 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. **ACTION HSC**

5.3.31 This communication plan will be rolled out using the NHS Lincolnshire CCG's well established communication channels as well as those of all local health and care providers, including United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust. **ACTION HSC**

5.3.32 Activity modelling completed to assess the service change estimated that with the proposed change and refinement of the exclusions criteria, around 3% of those patients currently attending the Grantham and District Hospital A&E would not under the proposed model. This is equivalent to two patients a day, on average. These are patients who require onward transfer for immediate specialist care. This was highlighted in the public consultation document and set out in detail in the Pre Consultation Business Case. **ACTION**

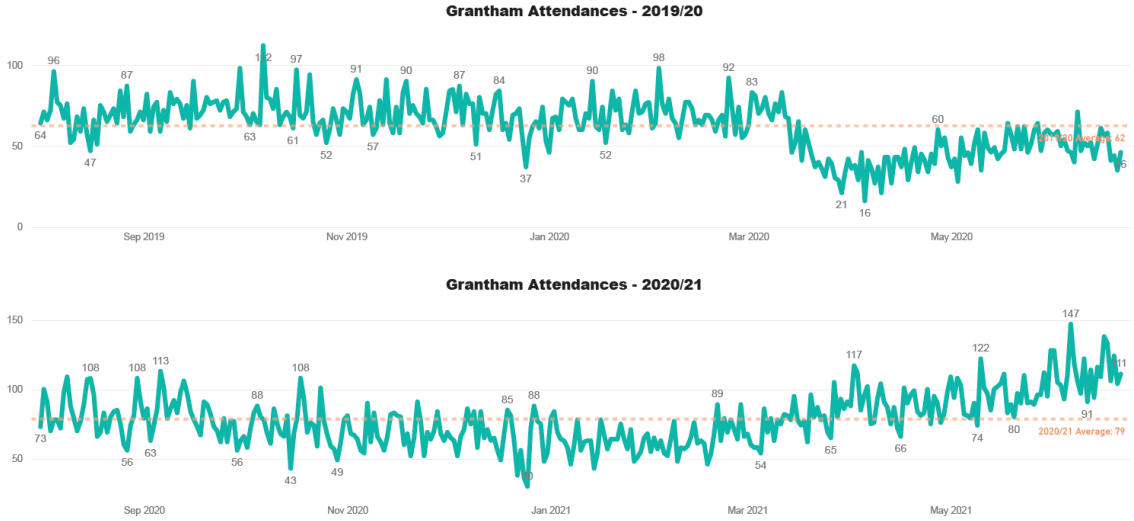
5.3.33 During the Covid-19 pandemic a temporary change was made to the Grantham and District Hospital site to make it a 'Green' site. This involved temporarily changing the Grantham A&E department to a 24/7 UTC between August 2020 and June 2021.

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

5.3.35 Of particular note when making this comparison is that the proposed 24/7 UTC at Grantham and District Hospital would be able to see and treat patients with a higher level of acuity and support additional pathways of attendance such as 111 appointments compared to the temporary UTC put in place during Covid.

5.3.36 Comparing the activity between the Grantham A&E and the temporary UTC shows the temporary UTC when it was open saw more patients a day on average compared to Grantham A&E for the same period the previous year.

Figure 26 – Comparison of activity between Grantham A&E and temporary UTC



5.3.37 A comparison of the performance of the temporary UTC at Grantham and District Hospital as part of the 'Green' site in August 2020 and June 2021 has also been carried out, although due to the length of time the temporary service was in place it is not possible to use comparable months. ACTION

5.3.38 However, there is an assumption that given similar levels of isolation and lockdown that overall performance should not differ between months:

- August 2020
  - 90% of patients seen within their 15 minute clinical triage, of those averaging around a 9 minute assessment
  - 98% of UTC attendances are discharged within the 4 hour target, of those averaging 102 minute attendance.
  - 5% referral rate to A&E
  - Friends and Family Test (FFT): 90% = recommend, 4% = not recommend
- June 2021
  - 84% of patients seen within their 15 minute clinical triage, of those averaging around a 16 minute assessment
  - 98% of UTC attendances are discharged within the 4 hour target, of those averaging 130 minute attendance.
  - 4% referral rate to A&E.
  - Friends and Family Test (FFT): 93% = recommend, 3% = not recommend

Full A&E and hospital service provision at Grantham and District Hospital

5.3.39 The consideration given by the working group in relation to this consultation feedback reflects and builds upon the significant scrutiny that has been placed upon the A&E department at Grantham and District Hospital over recent years, including that by the Independent Reconfiguration Panel (IRP) and the East of England Clinical Senate.

5.3.40 Work completed by the working group to consider this feedback included:

- Reviewing the definitions of A&E departments ACTION
- Reviewing national staffing guidelines ACTION
- Reviewing the independent clinical advice on the closure of Grantham and District Hospital A&E department overnight ACTION

- Reviewing the current position of ULHT A&E department staffing and requirements to operate three 'full' A&Es **ACTION**
- Considering A&E department clinical interdependencies and scale requirements **ACTION**
- Analysing the population growth forecasts for Grantham and South Kesteven **ACTION**
- Analysing the catchment populations for five A&E departments that have been reorganised and the rationale for change **ACTION**

5.3.41 An overview of the conclusions and outcomes of this work is set out below.

5.3.42 Definitions vary across the UK and in England A&E departments are defined by three 'types', these are:

- Type 1 departments – A consultant-led, 24-hour service with full resuscitation facilities and designated accommodation for the reception of emergency department patients.
- Type 2 departments – A consultant-led, single specialty emergency department service (e.g. ophthalmology or dental services) with designated accommodation for the reception of patients.
- Type 3 departments – May be doctor-led or nurse-led with designated accommodation for the reception of emergency department patients, treating at least minor injuries and illnesses (e.g. sprains) which patients can routinely access without an appointment. This also includes all NHS walk-in centres and other open access treatment services offering at least minor injury/illness services, whether located alongside a main emergency department or at another location.

5.3.43 However, it should be noted that this terminology of A&E type is generally used 'internally' by the NHS in the context of recording the activity being undertaken by these services, rather than a public facing description of services provided.

5.3.44 It is often the perception of the public that the NHS provides a single type of A&E department, which provides services and care in line with the type 1 description above. The terms minor injury unit, walk-in centres and urgent care centres are generally recognised by the public, however the scope of services provided at these can vary and may not always be fully understood.

5.3.45 The United Lincolnshire Hospitals NHS Trust (ULHT) operates three acute hospitals within the county of Lincolnshire, each of which has a service called an A&E department, however the services provided from each of these are not the same (note the number of attendances per year will include non-Lincolnshire residents e.g. people on holiday):

- Lincoln County Hospital – provides an A&E department with an 'unselected take' i.e. all patients can attend; it serves a population of c.300,000 and has c.75,000 attendances per year.
- Boston, Pilgrim Hospital – provides an A&E department with an 'unselected take' i.e. all patients can attend; it serves a population of c.215,000 and has c.55,000 attendances per year.
- Grantham and District Hospital – provides an A&E department with an exclusion criteria or 'selected take' i.e. not all patients can attend; it serves a population of c.100,000-120,000 (c.29,000 attendances per year prior to the temporary closure and c.23,000 per year after it).

5.3.46 Major trauma cases go to Queens Medical Centre in Nottingham.

5.3.47 Following the temporary closure the Independent Review Panel (IRP) responded to the Secretary of State in March 2017 with its view, which included:

- The changes agreed by the ULHT Board in August 2016 and implemented in relation to the temporary closure at Grantham and District Hospital were done so on the grounds of safety.
- The situation raised a number of questions in relation to the true nature of emergency care provision at Grantham and District Hospital.
- The A&E service at Grantham and District Hospital has for some time (since 2007/08) only dealt with a limited range of presenting emergency conditions.
- The level of emergency service provided from Grantham Hospital prior to August 2016 was already more akin to that of an urgent care centre. Yet description of the service as an A&E or ED by the NHS and Health Scrutiny Committee continues today.
- This is not just about the appropriate use of terminology or signage but that unrealistic expectations and misunderstanding may have been allowed to develop about the level of service that can and should be provided at Grantham and District Hospital.
- Genuine efforts to recruit and retain staff to work in ULHT's departments continue but, thus far, with limited success. The IRP agreed that after six months (to date at the time) the closure of the A&E service at Grantham and District Hospital can no longer be regarded as a temporary measure and considered that it is not in the interests of patients that future discussions be conducted on this basis.
- The Grantham A&E service is demonstrably the smallest of the three A&E services provided by ULHT and deals with a limited range of presenting conditions. Consequently, taking account of the low level of activity through the night, the actual numbers of patients affected in terms of accessing A&E elsewhere is relatively small.
- Even if it were possible to return to a 24/7 service, it has to be recognised that the service provided can never be (nor was it prior to the overnight closure) at the same level as that provided at Lincoln or Boston.

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

5.3.49 In a subsequent review by the East of England Clinical Senate, the report produced included a foreword from the Chair of the Senate Panel, Dr Bernard Brett. Within this forward, Dr Brett states that the unanimous view of the panel was that it was not in the interests of short term or longer-term patient safety to re-open the Emergency Department on Grantham and District Hospital on a 24/7 basis at this time. It was also the unanimous view that any changes to service provision on the Grantham site, should, if possible, be linked to the longer-term plans for urgent care across the Trust and that these plans should be developed with appropriate stakeholders and public consultation as soon as possible.

5.3.50 A&E departments nationally face longstanding challenges in recruiting and retaining sufficient staff. Although the Emergency Medicine (EM) Consultant workforce has grown over recent years (6.6% per year 2012-2016), this has not kept pace with the demand and complexity of work required to be delivered. This issue is exacerbated further given approximately 26% of advertised Consultant posts remain unfilled.

5.3.51 A range of national policies have been put in place over recent years to boost the numbers of clinical staff in A&E departments through increased recruitment and improved retention of existing staff. Over this time, other professional roles, such as advanced clinical practitioners and physician associates, have also been developed to play a greater role in delivering A&E services to relieve pressures on departments. However, despite all of these initiatives, it remains difficult to recruit and retain sufficient staff in emergency care and other key services.

5.3.52 Over the last decade, a number of Royal College of Emergency Medicine (RCEM) documents have been produced that describe in detail ways in which ED staffing requirements can be calculated, the most recent of which is 'RCEM Workforce Recommendations 2018 – Consultant Staffing in Emergency Departments in the UK'. The purpose of this most recent document is to describe the future requirements for A&E department senior staffing in medium and large emergency care systems, to allow for a clear definition of the ways in which these senior decision makers can perform to contribute to safe and effective patient care. The document is clear to point out though that the staffing requirements it sets out do not relate to smaller A&Es, these types of units have an additional set of challenges that are described later in this document.

5.3.53 In its latest publication the RCEM identifies it is not possible to describe a 'one size fits all' approach to A&E department Consultant staffing. Effective staffing is a function of capacity, capability, sustainable working and resilience.

5.3.54 Insufficient staff numbers deliver a vicious spiral of longer waits, crowding, compromises to safe practice, reduction in the quality of care and poor experience of patients and staff. This leads to an inability to recruit and retain staff, a reduction in system efficiency, an increase in staffing costs (increased locum staff numbers) and system costs (serious incidents, complaints and litigation). Larger systems require more staff, and far more hours, across the full range of professional groups.

5.3.55 For the purpose of describing senior staffing numbers required, the RCEM describes the size of systems in terms of annual new patient attendances to an Emergency Department (ED) as shown in the table below.

Figure 27 – Royal College of Emergency Medicine ED size definitions

Size of ED	New patient attendances per annum
Small ED	Less than 60,000 attendances (may be urban)
Remote and Rural ED	Typically less than 60,000 attendances (may be much lower)
Medium-Sized ED	60,000-100,000 attendances
Large ED	greater than 100,000 attendances
Very Large ED	greater than 150,000 attendances
Major Trauma Centre	Usually either a large or very large ED

5.3.56 The RCEM has defined that for 'Medium Sized' EDs and above (i.e. not Small or Remote and Rural) that there should be 1WTE Consultant to between 3,600-4,000 new attendances, depending upon complexity of workload and associated clinical services for which an ED is responsible.

5.3.57 In light of this the RCEM has identified the required numbers of Consultants and other senior decision makers (SDMs) required to support the various sizes of department (in a functional system – i.e. not exit blocks and crowding). The calculation takes into consideration numbers of new patient attendances, complexity, co-located services, rota design and sustainability for senior staff.

5.3.58 RCEM classifies clinical staffing into five tiers, with an increasing autonomy of practice from Tier 1 (F1 doctors, trainee practitioners) to Tier five (EM Consultants with FRCEM).

5.3.59 SDMs are made up of staff from tiers four and five. Although not all hold FRCEM, they are able to make key decisions regarding investigations, treatment and disposal at the point of first contact with the patients.

Figure 28 – Royal College of Emergency Medicine ED staffing guidelines

Size of department (attendances / year)	WTE Consultant numbers	WTE SDMs (minimum)
Medium-Sized ED (60,000-100,000)	18-25	30
Large ED (100,000-150,000)	25-36	42
Very Large ED (greater than 150,000)	34-48	60

5.3.60 ULHT has continued to work hard to improve medical staffing levels in its A&E departments over recent years, and had success with a wide range of initiatives, however recruitment continues to be a real challenge both locally and nationally.

5.3.61 The table below sets out the current position in relation to the A&E service at Grantham and District Hospital together with the increase in numbers that would be required to meet the most recently published Royal College of Emergency Medicine guidance on the numbers of medical consultants and senior decision makers required to maintain safe, sustainable 24/7 'full' A&E at Grantham and District Hospital.

Figure 29 – 'Full' Grantham and District Hospital A&E staffing based on RCEM guidelines

Staff grade	Current workforce numbers	No/% that are locums	No/% of vacancies	Additional required to provide full 24/7 A&E at GDH
WTE Consultants	2	1	0	10
WTE Senior decision makers	14	2	0	29

5.3.62 However, it is important to consider the outputs of this table in the context of the findings of:

- The IRP - "Even if it were possible to return to a 24/7 service, it has to be recognised that the service provided can never be (nor was it prior to the overnight closure) at the same level as that provided at Lincoln or Boston"
- The East Midlands Clinical Senate - "there was no evidence that any extended opening, over and above the current level of provision of the Accident and Emergency department at Grantham and District Hospital would improve outcomes for patients."

5.3.63 A key factor underpinning this is as well as having sufficient medical and practitioner staffing to maintain safe, sustainable 24/7 cover a 'type 1 A&E' that is able to receive all patients (i.e. 'unselected') needs to be co-located with other specialties.

5.3.64 A review of various publications and guidance on the need for A&E services to be co-located with other specialties, together with the view of local clinical leaders, identifies a core of specialties with A&E department clinical interdependencies: Critical Care/Intensive Care, Acute Medicine (and specialties), General Surgery (and specialties), Paediatrics, Orthopaedics, Obstetrics and Gynaecology, Laboratory Services and Diagnostic Imaging". HSC

5.3.65 Each of these specialties also needs to be provided at a sufficient scale to ensure they can deliver safe and sustainable services. HSC

5.3.66 Accident and Emergency (A&E) departments play a pivotal role in both the assessment and treatment of patients requiring emergency care, and in transferring patients to other specialties. HSC

5.3.67 The configuration of emergency and acute care has therefore been the focus of a number of publications by the Royal Colleges, medical associations, government departments and other organisations, which often takes the form of guidance, recommendations and/or good practice examples. HSC

5.3.68 As previously mentioned various publications and guidance has been produced regarding the need for A&E services to be co-located with other specialties. HSC

5.3.69 Having identified a core of specialties for co-location with A&E departments the Centre for Health Economics at the University of York identified that "whilst these are all seen as highly preferable for co-location, there is some debate about the degree to which a sub-set of this core is essential on-site or could be provided elsewhere subject to establishment of robust networks and patient pathways, albeit usually with a proviso that this would impact on the nature of the cases that should be admitted to A&E." Unselected medical take in units that cannot provide all the service on the same site would be unsafe. HSC

5.3.70 The Centre for Health Economics concluded that "it is clear that it will not always be feasible to have all services thought to be desirable to support A&E on a single site. The use of network arrangements as an alternative is a constant theme within the guidance and the documents … reviewed reflect some consistent themes in relation to the nature of the trade-offs – financial and non-financial - that may be involved in such arrangements. These include potential increased risks to health from transferring or directing patients elsewhere, balanced against the gains from specialist treatment; the financial costs of establishing and maintaining network arrangements and clear protocols for patient pathways; and the costs of establishing and maintaining adequate training opportunities for those working within and outside of the main services to fulfil the requirements of professional standards (i.e. ensuring that staff see the required volume and mix of cases). There also appears to be a consensus that where some specialties are located away from the emergency department, there is a need to ensure staff within the emergency department receives extra training that equips them to deal with emergencies." HSC

5.3.71 A Royal College of Surgeons report identifies "the preferred catchment population size, as recommended in previous reports, for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care would be 450,000–500,000". HSC

5.3.72 The report goes on to identify "it is estimated that hospitals of this size account for less than 10% of acute hospitals in England…the majority of acute hospitals currently have, and are likely to continue to have, a catchment population of approximately 300,000…hospitals serving a population of 150,000 or less are found in many geographically remote parts of England…advice offered regarding the organisations of services usually centres around the hospital working in close partnership with adjacent services to make use of those specialist services not available on site." HSC

5.3.73 This 'mixed model' of some acute hospitals (Lincoln County and Pilgrim, Boston) providing 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 working in close partnership with adjacent services to access specialist services not available on site is one currently deployed across Lincolnshire. HSC

5.3.74 The South Kesteven Local Plan seeks to plan positively and guide developments across the District up to 2036. This includes detailed plans on how the new homes and jobs needed for the plan period will be delivered throughout the duration of the plan, how retail, leisure and commercial development will be provided for, and what infrastructure is needed to support sustainable development and growth across the District.

5.3.75 The District Council's aim is to see the majority of growth and development focused in Grantham, with the town accommodating up to 55% of growth needs. The Area Action Plan for Grantham town will drive regeneration and growth for the town and will serve as a vehicle to deliver Grantham's status as a Growth Point.

5.3.76 The projected population change for the Grantham and South Kesteven District as a whole between 2016 and 2039 indicate that by 2039 the populations of Grantham and South Kesteven will be c.50,000 and c.164,000 respectively.

Figure 30 – Grantham and South Kesteven population projections

Grantham

Age Band	2016			2039		
	Male	Female	Total	Male	Female	Total
1-10	2,821	2,718	5,539	2,821	2,718	5,539
11-20	2,531	2,517	5,048	2,847	2,832	5,679
21-30	2,692	2,694	5,386	2,899	2,901	5,800
31-40	2,605	2,781	5,386	2,977	3,178	6,155
41-50	2,999	3,063	6,062	2,713	2,771	5,484
51-60	2,837	2,951	5,788	2,837	2,851	5,688
61-70	2,369	2,538	4,907	2,778	2,672	5,450
71-80	1,536	1,713	3,249	2,513	2,998	5,511
80+	765	1,257	2,022	1,817	2,985	4,802
Total	21,158	22,232	43,390	24,202	25,906	50,108

South Kesteven

Age Band	2016			2039		
	Male	Female	Total	Male	Female	Total
1-10	8,047	7,793	15,840	8,047	7,793	15,840
11-20	7,959	7,779	15,738	8,755	8,557	17,312
21-30	6,607	6,757	13,364	7,268	7,433	14,700
31-40	6,959	7,871	14,830	7,655	8,658	16,313
41-50	9,580	10,257	19,837	8,622	9,231	17,853
51-60	9,887	10,535	20,422	9,887	10,535	20,422
61-70	8,997	9,582	18,579	9,897	10,540	2-,437
71-80	6,060	6,553	12,613	10,908	11,795	22,703
80+	3,032	4,654	7,686	7,277	11,170	18,446
Total	67,128	71,781	138,909	78,315	85,712	164,027

ONS Population Projections

5.3.77 It should be noted that Grantham and District Hospital does not serve the whole population of South Kesteven. The areas towards the south of the District are closer to Peterborough Hospital and therefore the residents of these parts tend to head south to Peterborough for care. There are also areas outside of South Kesteven to the north-east of Grantham that fall within the catchment area of Grantham and District Hospital.

5.3.78 The current catchment population of Grantham and District hospital is estimated to be c.100,000-120,000 people. Based on the growth forecasts for Grantham and South Kesteven it is estimated this could increase to c.120,000-140,000 people by 2039 (this takes the higher growth rate of 18% forecast in South Kesteven between 2016-2039).

5.3.79 If this level of growth is realised, this would still mean a population catchment area that is well below the 300,000 identified by the Royal College of Surgeons required for an acute hospital providing a full range of facilities, and even below the 150,000 identified as the size below which hospitals would need to utilise network arrangements for specialist services that cannot be provided on site.

5.3.80 To put the challenges faced by Lincolnshire in the provision of A&E services at Grantham and District Hospital in relation to scale and interdependencies into a wider national context, consideration was given to the catchment population, rationale for reorganisation, the 'new' service and year of change for the reorganisation of five Accident and Emergency departments in England. This was done through a review of research paper looking at these issues.

5.3.81 This identified all five of the A&E departments that reorganised the way care was provided had a catchment population larger than the current estimate of the Grantham and District Hospital catchment population, which is c.100,000-120,000.

5.3.82 Based on the forecast estimate of the catchment population of Grantham and District Hospital being c.120,000-140,000 by 2039, of the five A&E departments reorganised:

- One had a catchment population within the range of the Grantham and District Hospital catchment population forecast (Newark);
- Three had a catchment population larger than the forecast for Grantham and District Hospital (Bishop Auckland, Rochdale and Hartlepool); and
- One had a catchment population substantially larger than the forecast (Hemel Hempstead)

5.3.83 What is also clear from the table is that all five of these A&E departments, even those with catchment populations of over 140,000, faced a common set of sustainability risks and challenges that could not be resolved, namely:

- The ongoing provision of safe care
- Insufficient staffing numbers
- Maintenance of skills amongst doctors
- Services are unattractive to clinical staff

5.3.84 The experience of these five health systems in terms of the challenges faced and solutions found align to the views of the Royal College of Surgeons “hospitals serving a population of 150,000 or less are found in many geographically remote parts of England…advice offered regarding the organisations of services usually centres around the hospital working in close partnership with adjacent services to make use of those specialist services not available on site.”

5.3.85 The conclusions of this work that looked to understand the impact of Emergency Department reorganisations on populations and emergency care provision were there was no statistically reliable evidence that the changes were associated with an increase in population mortality. This suggests that any negative effects caused by increased journey time to the Emergency Department can be offset by other factored; for example, if other new services are introduced and care becomes more effective than it used to be, or if the care received at the now-nearest hospital is more effective that the care that was received at the hospital where the Emergency Department was reorganised.

5.3.86 Following the completion of the analysis highlighted above the findings of the working group were:

- There 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.

5.3.87 The proposed service change is in line with clinical guidance i.e. network arrangements where some acute hospitals (Lincoln County and Pilgrim, 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.

5.3.88 Other health systems have faced the same challenges, including those with a bigger catchment population than that forecast for Grantham and the surrounding area, and could only solve them by reorganising the way care was delivered.

Ambulance Conveyance

5.3.89 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.

5.3.90 This exclusion list is well understood by the local healthcare system including primary care, community providers and the ambulance service. If patients do present at Grantham A&E with conditions that are listed within the criteria, the staff have the capabilities to stabilise the patient pending transfer to a bigger unit.

5.3.91 However, since the introduction of the exclusion criteria, the workforce at Grantham and District A&E has maintained the ability to manage all presentations, including those requiring stabilisation and transfer to an alternative hospital with the right skills and expertise. To ensure the safe care of all patients presenting at the hospital's A&E department.

5.3.92 To support these transfers United Lincolnshire Hospitals NHS Trust (ULHT), as do all other NHS provider organisations, has written protocols for transfers from Grantham and District Hospital to Lincoln County Hospital. These protocols ensure all patients are given emergency transfers relevant to their condition, regardless of their origin.

5.3.93 More recently, to support further consideration of the proposed service change in the context of ambulance travel times, independent analysis was commissioned by the NHS Lincolnshire CCG from Operational Research in Health Limited (ORH). **ACTION**

5.3.94 As part of this analysis ORH looked at ambulance travel times for the wards closest to Grantham and District Hospital (defined as those wards with a quicker average travel time to GDH than to other hospitals) between January 2019 and June 2020.

5.3.95 The reason the analysis only went up to June 2020 is because in this month the Grantham and District Hospital A&E department became a 24/7 Urgent Treatment Centre as part of Lincolnshire's response to the Covid-19 pandemic. The output of this analysis is set out below.

Figure 31 – Ambulance travel times for wards closest to Grantham and District Hospital

Wards closest to GDH	Average travel time
Travel to GDH	0:15:46
Travel to Other Hospital	0:41:29
Average	0:37:27

5.3.96 This analysis identified that the average ambulance travel time to Grantham and District Hospital, other hospitals and the average for all hospitals was below 45 minutes, the travel time threshold set by the local health system for this type of activity.

5.3.97 Of the 52 wards that are closest to Grantham, this analysis identified that:

- None had an average travel time of over 45 minutes to GDH
- 13 had an average travel time of over 45 minutes to another hospital (highest was 00:50:58)
- 1 had an average travel time of over 45 minutes to any hospital (00:45:38)

5.3.98 In addition to looking at the ambulance travel times, the ORH analysis also looked at the number of ambulance transfers originating from Grantham and District Hospital. This identified, on average, there were 733 patients per year requiring transfer by the ambulance service to another hospital. As highlighted above, these would happen in line with ULHT's written transfer protocols.

5.3.99 Under the proposed model of a 24/7 UTC at Grantham and District Hospital the exclusion criterion for the Grantham and District Hospital site would be refined, meaning a relatively small number of patients (two 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 and therefore their travel time could be less than 45 minutes.

5.3.100 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.

5.3.101 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.

5.3.102 If the proposed change goes ahead all relevant health and care providers including 111, East Midlands Ambulance Service Trust (EMAS), primary care and community providers will be engaged and information provided detailing the full list of exclusion criteria for Grantham and District Hospital under the change proposals. For 111 this will include making sure the Directory of Services (DOS) profile aligns so that patients are appropriately seen by the right service. **ACTION**

5.3.103 As well as analysing the ambulance travel time, ORH modelled the performance changes on the ambulance service from the proposed service changes. This identified that in order to mitigate any reduction in performance two additional weekly DCA vehicle hours would be required, which could be delivered through extending a shift length. **ACTION**

5.3.104 If the change proposal is implemented the additional ambulance hours required to maintain current performance levels will be reflected in the ambulance provider contract. **ACTION**

5.3.105 Although not explicitly raised in the consultation feedback, the Lincolnshire health system is fully aware and acknowledges current challenges in relation to ambulance Category 2 response times. The current Category 2 performance is a mean response time of 1 hour and 03 minutes against an 18 minute standard in March 22.

5.3.106 This challenge is not specific to Lincolnshire, it is an issue that impacts across all health systems nationally. The regional and national performance stands at 1 hour and 1 hour and 1 minute respectively in March 22.

5.3.107 A significant under lying issue across the country is the delayed handover of ambulances at hospitals Emergency Departments.

5.3.108 Significant work is underway across Lincolnshire, as it is in other parts of the country, to tackle this issue including dedicated Ambulance submits with NHS England and Improvement at a regional and national level. This has included a review of protocols for ambulance handovers in ULHT and an agreed action plan to improve ambulance availability has been agreed.

5.3.109 Putting this challenge in the context of the four service change proposals, this is particularly relevant to the urgent and emergency care proposals.

5.3.110 A key foundation to this proposed care models is ensuring patients get to the definitive treatment, first time at a site that has a skilled and dedicated workforce than can provide high level care sustainably.

5.3.111 These challenges in relation to ambulance response times are not seen as a reason to not proceed with the urgent and emergency care change proposal given the benefits they will bring in terms of improved patient outcomes, care quality and service sustainability. In fact to some degree the change proposal even provides some level of mitigation to the challenges faced by ensuring when patients arrive at hospital diagnosis and treatment happens as efficiently and effectively as possible.

5.3.112 However, as described above, tackling current ambulance response times is an absolute priority for the NHS in Lincolnshire to ensure patients receive the best possible care.

Workforce and Organisational Integration

5.3.113 Building on the workforce modelling in the Pre Consultation Business Case (PCBC), the workforce modelling for the new provider would need to be mapped to cover a new 24/7 UTC. ACTION

5.3.114 There is recognition that a staged transfer from an A&E to a UTC would be required to ensure a safe and smooth service delivery. ACTION

5.3.115 It is not expected that staff would re-allocate between a UTC and A&E due to the difference required in skillset. ACTION HSC

5.3.116 It would be a requirement for the new provider to ensure they have full accountability and governance for the delivery and performance of the service. ACTION

5.3.117 The new provider would continue to host their own electronic health records and would align to the standards of a UTC. The new provider would need to work closely with the current organisation to manage any issues or complications with new IT solutions. ACTION

Equalities and Health Inequalities HSC

5.3.118 Analysis of questionnaire and survey responses did not indicate that there were any strong differences in views or specific concerns being expressed by respondents from groups with protected characteristics under the Equalities Act 2010 (e.g., age, ethnicity, gender). Instead, the evidence indicates that it is local concerns that account for differences in views, with members of different demographic or protected characteristics groups tending to share the views of others living in the same area.

5.3.119 Where concerns were raised in feedback about particular groups (e.g., older people, people with disabilities, those from more deprived communities or living in rural areas), the focus was predominantly on travel and transport, particularly for those with limited access to private transport.

5.3.120 The one example of a slight difference was that, in the residents survey, there was evidence that residents with disabilities or long-term health conditions that limited their day-to-day a lot, were significantly less likely to agree (and more likely to disagree) with proposals around urgent and emergency care at Grantham and District Hospital than other residents (although there was still majority agreement); it should be noted that the feedback indicated that concerns about the proposal were as again focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.

5.3.121 There were concerns about accessibility for specific groups including: people without personal access to a vehicle, people visiting friends/family, people needing to get home after treatment (including those who are too unwell to drive, and/or experiencing pain/discomfort), the elderly, people with disabilities, children, and those from low-income backgrounds.

5.3.122 Consideration of the potential positive impacts of the change proposal was given during the development of the Pre Consultation Business Case (PCBC), and further consideration was given following the public consultation. The potential positive impacts identified for the proposed service changes are the same for all patients, and are therefore equally relevant in the context of all groups with protected characteristics ACTION:

- 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 (estimated to be around 97%) seen at the Grantham and District Hospital A&E department would continue to be seen and treated at the 24/7 Urgent Treatment Centre (UTC)
- For some patients there may be longer travel times, but this is balanced against ensuring those patients receive treatment in the right place first time.
- Given the serious nature of the conditions that would not be seen at Grantham and District Hospital under the change proposal, those patients displaced are most likely to travel by ambulance. This is what happens now for those patients requiring a level of emergency care that cannot be met by Grantham and District Hospital A&E.

5.3.123 A number of mitigations to the travel and access concerns have been identified and are set out in the Travel and Transport Report. An overview of these is provided in the Travel and Transport section at the end of this chapter. ACTION

5.3.124 In addition to the mitigations set out in the Travel and Transport Report, if the changes are agreed all services will comply with the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support they need from health and care services. ACTION

5.3.125 It has also been identified that any service changes if agreed need to ensure services are accessible in respect of different races and ethnicity. ACTION

5.3.126 The Equality Impact Assessment (EIA) for the urgent and emergency care change proposal developed for the Pre Consultation Business Case was also reviewed in light of the feedback from the public. This can be found in Appendix H. The EIA is a 'living document' and will continue to be updated if and when new information becomes available. If the change proposals are agreed it will continue to develop through the implementation phase.

Travel and Transport HSC

5.3.127 See Travel and Transport section at the end of this chapter

Similar UTC provided at Stamford and Spalding

5.3.128 The national Urgent Care Strategy set out the need for transformational change in service provision to sustainably support current and future generations.

5.3.129 A local Lincolnshire Urgent Care Strategy has been developed in line with the national strategy and is already delivering system transformation.

5.3.130 The provision of urgent care services at Stamford and Spalding, as they are across the whole county, are informed by the Lincolnshire Urgent Care Strategy.

5.3.131 The Lincolnshire Urgent Care Strategy is under constant review and development to ensure urgent care services best meet the needs of all Lincolnshire residents. ACTION

5.3.132 The Urgent Care proposal consulted on with the public, which was developed in the context of the Lincolnshire Urgent Care strategy and aligns to it, solely focused on the provision from Grantham and District Hospital.

5.3.133 Services provided at Stamford and Spalding were not part of the public consultation.

5.3.134 At present, there are no additional plans to replicate or pilot this model in other locations across the county.

New Specialist Hospital

5.3.135 To develop and consider potential solutions for improving the prioritised hospital services within the scope of the Acute Services Review (ASR) programme, the Lincolnshire health system followed a process that started with identifying an initial full range of possible solutions, this was in 2017/18. The health system then carried out a thorough analysis on each of them and identified a preferred proposal for change to be taken to public consultation.

5.3.136 One of the nine overarching scenario-based options was a new build scenario which closed Lincoln County Hospital, Pilgrim Hospital Boston and Grantham & District Hospital and a new hospital site established in Sleaford (known as NG34).

5.3.137 In light of the immediate quality, financial and workforce challenges, the Lincolnshire health system concluded not to progress further work on this single site new build scenario and to revisit this decision in three years.

5.3.138 Further work was carried out in 2019/20 to look at the acute hospital site and configurations. This exercise considered several options including i) a new central site plus three satellites and ii) a new central site and three new satellites.

5.3.139 Following discussions by the health system it was agreed any future work would focus on three acute hospitals in Lincoln, Boston and Grantham for the following reasons:

- A new building NG34 would still require investment in the three other sites due to their current state.
- It would not address the backlog maintenance issues
- Workforce availability and issues would impact on the operational deliverability of the scheme.

5.4 Acute Medicine proposal

Quality and Workforce

5.4.1 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.

5.4.2 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 one 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.

5.4.3 The change proposal would deliver a more comprehensive local service provision at Grantham and District Hospital, specifically in relation to the 'frail' population, thereby reducing pressure on acute hospital sites at Lincoln and Boston. It would enable Grantham and District Hospital to build a centre of excellence for integrated multi-disciplinary care (particularly for frail patients), which supports improved community-based management of long term conditions. **HSC**

5.4.4 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 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. **ACTION**

5.4.5 An increase in financial cost of the service has been modelled and this includes an increase in staff numbers. **ACTION**

5.4.6 Following the public consultation further consideration has been given to the clinical/workforce model and no changes are being proposed. However, general challenges in recruitment both locally and indeed nationally are noted. However, they do not stop the need for the new proposed model. **ACTION** **HSC**

5.4.7 There is constant engagement with the Lincolnshire neighbourhood teams when implementing new initiatives across Lincolnshire, and they have been extremely positive for current system improvement programmes. Ensuring engagement with the local health and social care community within early implementations will be crucial to ensure the successful delivery. **ACTION** **HSC**

5.4.8 If the service change were agreed and implemented, changes would be completed through a sequence of changes to clinical practice and the workforce. Throughout this process, there would be ongoing monitoring of the clinical outcomes of patients. **ACTION** **HSC**

5.4.9 Staff will be fully supported in terms of recruitment where required. **ACTION** **HSC**

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

5.4.11 Grantham and District Hospital remaining a training hospital is very much part of the plans, and this is set out in the Pre Consultation Business Case (PCBC). Trainee roles offer significant value to the medical establishment, both financially and in terms of care delivery. With the exception of the withdrawal of cardiology and gastroenterology trainee posts, there are no plans at present to further reduce training posts at Grantham as part of the transition to the new model; indeed, it is hoped that improved opportunities for training support at Grantham could be offered. **ACTION** **HSC**

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

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

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

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

Conditions that would be treated at 24/7 Grantham and District Hospital UTC

5.4.16 See response with same name above in Urgent and Emergency Care section above **HSC**

Full A&E and hospital service provision

5.4.17 See response with same name above in Urgent and Emergency Care section above

Acute Care Unit (ACU)

5.4.18 The acute medicine change proposals relate to the way care is delivered on the acute medicine wards at Grantham and District hospital:

- Emergency Assessment Unit / Short Stay Assessment Unit
- Medical wards – high acuity and low acuity

5.4.19 In addition to the bed elements, two further components of the proposed model are:

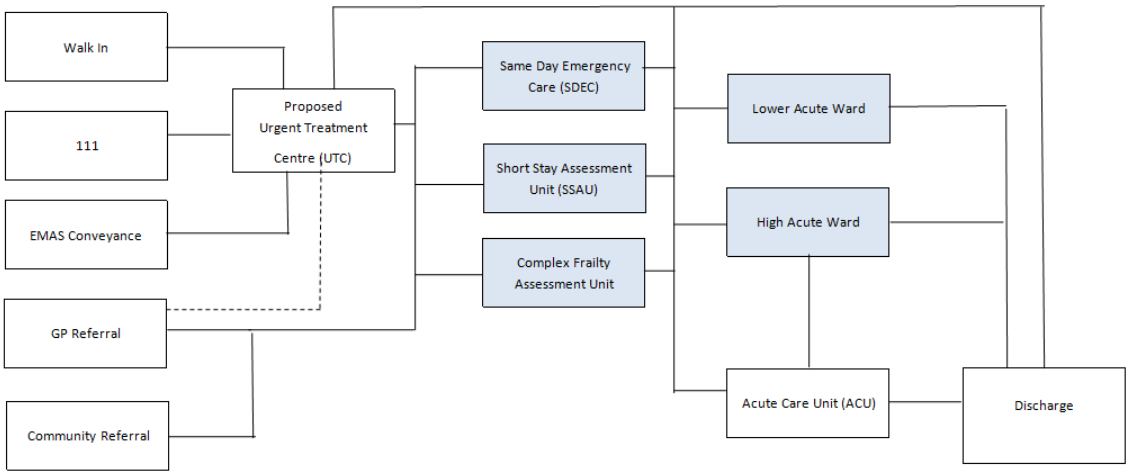
- Same Day Emergency Care (SDEC)
- Complex Frailty Assessment Service

5.4.20 The change proposal being consulted upon focus on these elements, retaining acute specialists and strengthening it through greater integration with community and primary care providers.

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

5.4.22 This is set out in the Pre Consultation Business Case in the following way.

Figure 32 – Proposed Grantham and District Hospital acute medicine service



5.4.23 The Acute Care Unit is identified in the Pre Consultation Business Case (PCBC) as potentially being part of some care pathways.

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

5.4.25 Prior to the changes made on the Grantham hospital site in response to the Covid-19 pandemic, the Acute Care Unit (ACU) (also known as L1 beds) was provided from 12 beds in a single location.

5.4.26 When the Grantham hospital site moved to a 'green model' in response to Covid-19 the ACU was split into eight surgical and four medical beds on the specialist wards to support IPC requirements.

5.4.27 This approach has been kept in place when the Grantham hospital site reverted back and no longer operated under the 'green model' as the surgical and medical patients are better cared for by being in the relevant specialties.

5.4.28 The L1 beds will remain in place as currently provided, regardless of the outcome of the ASR. This is not done in any way to pre-empt agreement on the service change proposal and has no impact on the deliverable care for patients.

5.4.29 The working group confirmed the split of the ACU beds does not alter the proposed model except that the patients will be cared for in the two distinct areas. **ACTION**

5.4.30 Feedback from the public consultation also included specific concerns about a lack of provision of Level 2 respiratory beds at Grantham and District Hospital and suggested that respiratory Advanced Care Practitioners could manage respiratory beds with support from anaesthetists and additional funding for recruitment and training.

5.4.31 Consideration of this feedback by the working group confirmed: **ACTION**

- There are not and have not been critically care trained consultants at Grantham and District Hospital. There have not been nor are there any anaesthetists based at Grantham and District Hospital on the critical care specialist register. The anaesthetists at Grantham and District Hospital are not trained to deliver or supervise NIV as per BTS national guidelines. Therefore, in addition the ACP's do not have the right skillset to deliver this.

- The last time any form of L2 beds were provided at the Grantham site was five years ago. These were part of the HDU unit at the time. National guidance meant that the HDU unit was removed from Grantham as it did not meet the criteria for the service and how it should fit into accompanying ICU support. At present there are no HDU units on any site in ULHT.

Ambulance Conveyance

5.4.32 Independent analysis identified that in order to mitigate any reduction in current performance two additional weekly DCA vehicle hours would be required to respond to all the change proposals relating to Grantham and District Hospital, which could be delivered through extending a shift length.

5.4.33 If the change proposal is implemented the additional ambulance hours required to maintain current performance levels will be reflected in the ambulance provider contract.

Facilities

5.4.34 Bed demand and capacity modelling formed a key part of the underpinning analysis to assess the proposed service change.

5.4.35 The modelled bed requirement by 2023/24 is comfortably within the current acute medicine bed capacity at Grantham and District Hospital, however there are no intentions to reduce the number of acute medicine beds at Grantham and District Hospital.

5.4.36 Retaining current provision is essential to supporting stabilisation of the wider system. However, ensuring only those that require an admission and reducing length of stay and delayed transfers of care will be a priority, thereby supporting a greater patient cohort.

5.4.37 It is noted that currently Grantham also has only one acute ward open. Presently it is not possible to safely staff the second ward due to lack of both nurses and medical staff. The site is able to function without the second ward at present but having it in place will support the wider system with the required lower acuity beds. Certainty of the ASR model could help support refreshed recruitment plans for the site. **ACTION**

Equalities and Health Inequalities **HSC**

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

5.4.39 In feedback from individuals with protected characteristics or other key demographics, their views on the proposals were typically informed most strongly by their area of residence, regardless of any other demographic characteristics.

5.4.40 One exception was that evidence suggested that residents with the most limiting disabilities or long-term health conditions were significantly less likely to agree (and more likely than other residents to disagree) with proposals around acute medical beds at Grantham and District Hospital (although there was still majority agreement); it should be noted that the feedback indicated that their concerns were focused on loss of acute services and travel and access to alternative sites.

5.4.41 Skegness Town Council stated that acute medical beds would be lost from Grantham and District Hospital, placing additional pressure on hospitals elsewhere. It also reiterated others' concerns around the potential demand impact on EMAS and raised worries around the ability of patients' loved ones to visit them, potentially impacting their recovery. The Council was also of the view that removing local services would most impact vulnerable residents.

5.4.42 Consideration of the potential positive impacts of the change proposal was given during the development of the Pre Consultation Business Case (PCBC), and further consideration was given following the public consultation. The potential positive impacts identified for the proposed service changes are the same for all patients, and are therefore equally relevant in the context of all groups with protected characteristics ACTION:

- The majority of patients (estimated to be around 90%) cared for in the acute medical beds at Grantham and District Hospital would continue to be cared for in the integrated community/acute medical beds
- The proposal for change would deliver a more comprehensive local service provision at Grantham and District Hospital, specifically in relation to the 'frail' population.
- For some patients there may be longer travel times, but this is balanced against ensuring those patients receive treatment in the right place first time.
- Given the serious nature of the conditions that would not be seen at Grantham and District Hospital under the change proposal, those patients displaced are most likely to travel by ambulance. This is what happens now for those patients requiring a level of emergency care that cannot be met by Grantham and District Hospital A&E.

5.4.43 A number of mitigations to the travel and access concerns have been identified and are set out in the Travel and Transport Report. An overview of these is provided in the Travel and Transport section at the end of this chapter. ACTION

5.4.44 In addition to the mitigations set out in the Travel and Transport Report, if the changes are agreed all services will comply with the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support they need from health and care services. ACTION

5.4.45 It has also been identified that any service changes if agreed need to ensure services are accessible in respect of different races and ethnicity. ACTION

5.4.46 The Equality Impact Assessment (EIA) for the urgent and emergency care change proposal developed for the Pre Consultation Business Case was also reviewed in light of the feedback from the public. This can be found in Appendix H. The EIA is a 'living document' and will continue to be updated if and when new information becomes available. If the change proposals are agreed it will continue to develop through the implementation phase.

Travel and Transport HSC

5.4.47 See Travel and Transport section at the end of this chapter

Alternative Suggestions

5.4.48 Bloods are currently taken by the ward nurse/medical staff and processed on site or sent to other sites if specific analysis is required. This model will be replicated post ASR.

5.4.49 The feedback received through the public consultation that described the establishment of acute and rehab pathways and wards for those who are medially well but unable to cope with going home and 'half way house' wards is very much in line with the proposed model.

5.4.50 The model will also support the concept of step up beds that GPs will be able to admit patients to rather than sending them to ED / full admission to acute bed, although the full acute bed offer is still provided. This also sits alongside the new SDEC and frailty unit that aim to treat patients in the best, appropriate setting.

5.4.51 Establishing fully integrated multidisciplinary teams is at the heart of the change proposal. This innovative integrated community/acute model has been developed through extensive discussions by local clinicians, commissioners and provider organisations and reflects feedback received from the East Midlands Clinical Senate and takes into consideration feedback received during the various ASR public engagement activities.

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

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

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

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

5.4.56 Grantham Care Coordinators have been pivotal in supporting PCN and Neighbourhood Team activities, and will continue throughout the duration of the proposals. The Care Coordinators are able to ensure that the Neighbourhood Teams are there to support the patient needs, ensuring that the community actively gets the support it requires.

5.4.57 In response to the consultation feedback that Grantham hospital should have no acute medical beds; The proposed service changes were identified following a clinically led options appraisal process. At the short-list stage of this process there were two options for the provision of acute medical beds at Grantham and District Hospital:

- No acute medical beds at Grantham and District Hospital; and
- Integrated community/acute medical beds at Grantham and District Hospital

5.4.58 A key part of the process to evaluate the shortlist of options and identify a preferred option was a stakeholder options evaluation workshop. This was held on 4 October 2018 and attended by over 60 stakeholders from across the Lincolnshire health system. Attendees represented a broad range of stakeholder groups including general practitioners, acute hospital clinicians, nurses, hospital managers, mangers from clinical commissioning groups, and the third sector.

5.4.59 Attendees were asked to consider the service change proposals at a specialty level. Each specialty area discussed was introduced by a lead clinician for that area who set out the case for change and described the proposals.

5.4.60 Where there was more than one alternative option attendees were asked to think about the 'advantages and disadvantages of the two proposals against each of the four criteria, to what extent do you consider that either Proposal 1 or Proposal 2 would satisfy the criteria better, or do you consider that both proposals would satisfy the criteria equally well?'.

5.4.61 There was majority support for integrated community/acute beds at Grantham and District Hospital:

- Overall 85% of participants thought this proposal satisfied the criteria significantly better or somewhat better than no medical beds at Grantham and District Hospital
- There was a strong preference across all criteria.
- Particularly strong preference against the access (86%), affordability (88%) and deliverability (87%) criteria.

Criticism over a lack of detail

5.4.62 At the heart of the public consultation approach developed by the NHS Lincolnshire CCG was a real desire for people across Lincolnshire to get involved and have their say.

5.4.63 The consultation document that was published as part of the consultation process was only one of a number of components to the public consultation strategy and plan to enable this to happen.

5.4.64 It is acknowledged that the way the NHS operates and provides services may sometimes appear complicated, especially to those not working in it. Therefore the aim of the consultation document was to describe the proposed changes in a way that is understandable for all and enables people to get involved.

5.4.65 Because of the technical nature of the service change proposal detail, a number of simplified ways of sharing the key points about the proposal were created. These were made available on the consultation website, as well as promoted through social media and at events. They included:

- Summary films featuring the relevant clinicians and subject matter experts, talking through the case for change, service change proposals, and risks and benefits, in plain English
- A summary consultation document, acknowledging that not everybody wished to read a complex, longer set of information, whilst we ensured that as many people as possible were informed about the service change proposals

5.4.66 As well as this accessible, plain English information, it was also recognised that some people may want more information, and therefore a number of approaches were deployed through the public consultation to support this. These were all set out in the 'How to get involved' section on page 6 of the public consultation document.

5.4.67 This section of the consultation document *stated 'This consultation will run for 12 weeks from 30 September until 23 December. There are lots of ways you can find out more about it:*

- *Visit our website for further detail about all sections of this document, films, FAQs and much more at www.lincolnshire.nhs.uk*
- *The website also has the full Pre Consultation Business Case document that contains the full detail behind the proposals and their selection*
- *Look through the consultation materials distributed to local outlets e.g. consultation booklet, Easy Read booklet, awareness flyer to local households*
- *Attend one of our events, either online or face-to-face. If you can't make one of the events listed on our schedule, you can watch our event film to learn what is discussed at www.lincolnshire.nhs.uk*
- *Talk to us when you see us out and about in market places, supermarkets and community venues*
- *NHS staff can attend one of our staff engagement events to learn what this might mean for them. Your line manager will have more information*

5.4.68 The detailed public consultation strategy and plan, as well as full event listings and contact information, was also made publicly available on the NHS Lincolnshire CCG website. This was made clear in the consultation document and the website address was provided.

5.4.69 In addition, during the consultation period additional material was made available and published through various channels, such as the Grantham Journal, to provide responses to some of the common requests for clarity received. This included the acute medical bed proposals.

Additional Consideration

5.4.70 At present, there are no additional plans to increase or replicate this model across the Trust, however there are developments of virtual wards to sit alongside acute and community beds.

5.4.71 Following the deliverability of the proposals for ASR, there may be future scoping or opportunities for this model to be replicated across Lincolnshire. This would be dependent on the realisation of the benefits associated to ASR and would consider a full review of the successes or any lessons learnt.

5.4.72 Models, can and may, be put in place to be able to nurse medical patients in community beds where the patient has enhanced mental health needs. This would require future scoping as it is not included in the original proposals but may be a future option with the mental health provider in Lincolnshire.

5.4.73 The Trust is committed to become a University hospital with links to Lincoln University and the medical school, to attract the graduates, in turn this will lead to enhanced research and related activities. Providers within Lincolnshire continue to work closely together in academic research and continue to share knowledge and expertise in this area. This work is linked into the research development plans for Lincoln University Medical School.

5.4.74 The proposed model of integrated community / acute medical beds will allow patients with multi-morbidity to be treated locally and closer to home where appropriate. Where specialist care is needed that cannot be provided at Grantham, that care will be (and already is) centralised to allow staff to develop that specialist knowledge e.g. cardiology, stroke.

5.4.75 Full assessment of chronic health conditions and co-morbidities would be required to warrant whether centralised or specialist centres would suit the needs of the Lincolnshire population. A lot of these long term conditions are currently managed within Primary Care and Neighbourhood Team areas.

5.5 Stroke proposal

Outcomes and Quality

5.5.1 ULHT has continually strived to improve the Sentinel Stroke National Audit Programme (SSNAP) performance at Lincoln County Hospital and Boston Pilgrim Hospital, however this has been difficult due to:

- The comparatively small size of each of the stroke units; and
- Ongoing medical and nursing workforce recruitment and retention challenges.

5.5.2 National evidence shows centralising hyper-acute stroke treatment on a smaller number of sites, that meet the recommended critical mass, has considerable benefits including reduced mortality, faster recovery, shorter length of stay and improved workforce sustainability

5.5.3 Evidence shows patients treated in dedicated hyper-acute stroke units are more likely to survive and recover more quickly as these units are fully staffed and equipped and set up to deliver specialist care 24/7.

5.5.4 When the model for consolidating hyper-acute and acute stroke services at Lincoln County Hospital was presented to the East Midlands Clinical Senate it was praised by the panel and deemed to be well led clinically and from the evidence provided well researched. It was acknowledged that the proposed reconfiguration would reduce unwarranted variation in outcomes and would ensure a more consistent achievement of clinical standards and national guidelines.

5.5.5 Feedback on the stroke proposals received from the Lincolnshire Local Medical Committee during the public consultation was ‘Examples such as the Heart Centre at Lincoln illustrate that having specialist services concentrated leads to better outcomes’.

5.5.6 Since April 2020, in light of the pressures of Covid-19 on hyper-acute and acute stroke service sustainability, a temporary service change of consolidating these services on the Lincoln County Hospital site.

5.5.7 However, it is important to note the purpose of the change as well as the similarities and differences between the temporary change and the proposed model when considering performance data during the temporary change:

- The purpose of the temporary change was to support the fragility of the medical and nursing workforce.
- As well as similarities with the proposed model (i.e. consolidation of hyper-acute and acute stroke on the Lincoln site) there are also some key differences, namely the continuation of acute based stroke rehabilitation trust-wide (i.e. across both the Lincoln and Pilgrim Hospital sites).

5.5.8 It is also vital to recognise that even though the temporary change was made to improve the stroke services sustainability and resilience it was still working under intense pressure. For example during this time only two substantive stroke consultants were working in the service.

5.5.9 Analysis of SSNAP data conducted by the working group in light of the feedback received through the pilot consultation shows that the experience of the temporary change made has demonstrated that even though the service was still operating under immense pressure, the benefit of faster access to diagnosis and treatment once at the acute site offsets the longer travel times for some patients: ACTION HSC

- On average patient's diagnosis and treatment times were improved. In the quarter July to September 2021 Lincoln County Hospital achieved a median time of 6hrs 11mins between clock start and being assessed by a stroke consultant compared to 10hrs 04mins nationally.
- In the four quarters between October 2020 and September 2021 apart from one quarter (93.8%) all patients who were eligible for thrombolysis received this within the four hour window from onset of symptoms. In the quarter July to September 2021 Lincoln County Hospital achieved 100% of eligible patients receiving thrombolysis compared to 85.8% nationally. Thrombolysis delay was because of a small number of patients called an ambulance after the available time window for thrombolysis.
- When comparing national performance at site level, out of a total of 157 sites Lincoln County Hospital was one of only six sites that achieved eight Key Indicators. Only one site achieved nine Key Indicators and no site achieved ten. All the remaining sites achieved less than eight Key Indicators.

5.5.10 The Lincoln County Hospital stroke service was able to deliver this improved performance compared to the national average whilst it was under a huge amount of pressure.

5.5.11 It also needs to be recognised that other aspects of the stroke service had limited improved outcomes during the temporary consolidation, and these relate to the areas of the service that were not consolidated such as the staff involved in rehabilitation given the need to maintain a stroke service trust-wide. Under the proposed service change all hospital based stroke rehabilitation would be provided on a single site at Lincoln County Hospital.

5.5.12 The rehabilitation of the stroke patients was maintained on the Pilgrim and Lincoln hospital sites. This is different to the proposed model for stroke services which, if agreed, would see all hospital based services provided from the Lincoln County Hospital supported by an enhanced community rehabilitation stroke team. It is envisaged that if the proposed changes are implemented the outcomes relating to hospital based stroke rehabilitation services would improve.

5.5.13 SSNAP is a nationally recognised performance and benchmarking data and would continue to be used following the implementation of any changes to stroke service provision if they are agreed, to support ongoing improvements. ACTION

5.5.14 Lincoln County Hospital site was performing better than Pilgrim, Boston in terms of the SSNAP data in the two quarters prior to the temporary change being made due to Covid-19 pressures.

5.5.15 The consolidation of hyper acute stroke services at Lincoln County Hospital has also brought closer alignment with other co-specialities such as cardiology, which is also based on the site:

- The majority of stroke (87%) are caused by blockage to a blood vessel causing disability or death. Of these strokes around 25% are due to a cardiac cause like irregular heartbeat, clots or defects, whereas carotid disease causes around 8% of all strokes.
- When investigating strokes, availability, speed and access to cardiac tests are vital to acute as well as long term stroke treatment, but carotid surgery is only recommended for those with no or minor disability, and with a two week period to surgery.
- More than two thirds of stroke patients require echocardiography, and over a third will need cardiac rhythm monitoring, as well as other specialist cardiac consultations, which are made easier if the cardiac team are based at the same hospital. On the other hand, out of over a thousand strokes seen in 2021 in ULHT, only 99 patients were referred to the vascular surgeons, and only 52 of them underwent the required operation.
- Moreover, cardiac patients undergoing interventional procedures have a small risk of acute stroke during these procedures, which need immediate intervention by the stroke team.

- The availability of the heart centre facilities to stroke patients at Lincoln County Hospital provide a valuable resource in improving access and bypassing A&E for the “direct to CT” pilot. Thus speeding door to CT scan time and door to needle/angio time. Analysis by the working group identified: ACTION
    - With practice, the Lincoln County Hospital site has reduced its average door to angiogram time from 67 minutes in 2019 to 34 minutes in 2021.

5.5.16 The stroke team at Lincoln County 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. Analysis by the working group identified: ACTION

- Since the service started in 2018 and up to April 2020, Lincoln County 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, 19 patients from the Lincoln County Hospital catchment area and 14 patients from the Pilgrim Hospital catchment were sent to QMC for thrombectomy, again demonstrating the net benefit to all patients going to a single, better staffed site.

5.5.17 Using the experience of the temporary service change of consolidating hyper-acute and acute stroke services on the Lincoln County Hospital site a comparison of certain aspects of access to stroke care has been made for stroke patients from the Pilgrim, Boston Hospital catchment area before and after the change.

5.5.18 Data has been compared for a similar six month period in 2019 and 2021. However, not all data is comparable due to collection methodology. 2019 data is from SSNAP, whereas 2021 data is from actual patient notes and Advanced Care Practitioner (ACP) sheets. ACTION

5.5.19 This analysis shows that following the introduction of the temporary change, patients from the Pilgrim, Boston Hospital catchment area get seen and scanned quicker, have more access to thrombectomy and were, on average, discharged sooner. HSC

5.5.20 One area where the data is less strong following the temporary change is access to a bed on the stroke unit. However, the key contributing factor to this is during the second wave of Covid-19 was the hyper-acute stroke unit at Lincoln County Hospital was moved from its normal location to manage trust-wide operational pressures.

Figure 33 – Comparison of outcomes for patients from Pilgrim, Boston Hospital before and after the temporary change to consolidate hyper-acute stroke services at Lincoln County Hospital

Stroke patients from Boston Hospital catchment	Jan – Jun 2019*	Jan – Jun 2021*
Location where stroke care received:	Boston	Lincoln
Total number confirmed strokes	226	226
Onset to first arrival (hr:mm)	10.06 (average)	-
Referral by EMAS to arrival (hr:min)	-	01:01 (average)
Arrival to stroke review (hr:min)	01:27 (average)	00:36 (average)
Arrival to CT (hr:min)	00:46 (average)	00:39 (average)
Arrival to Stroke Unit (hr:min)	03:00 (average)	05:18 (average)**
Number of patients for Mechanical Thrombectomy	1	6
Number of Thrombolysis	29	22
Average LoS	12 (average)	9 (average)

** Data is not 100% comparable due to collection methodology: 2019 data is from SSNAP, whereas 2021 data is from actual patients and ACP sheets*

*** During second wave of Covid-19 the HASU at Lincoln was moved from its normal location to manage trust-wide operational pressures*

5.5.21 Given the evidence of the impact of centralising hyper-acute stroke care and the experience of ULHT during the temporary change it has been concluded the clinical benefits and outcomes outweigh the impact of increased geographical distance. Lincolnshire has experience of this through the consolidation of heart services on the Lincoln County Hospital site. **HSC**

5.5.22 As well as the demonstrable benefits of co-locating stroke services with cardiology services at Lincolns County Hospital, experience has shown it is easier to recruit to Lincoln County Hospital compared to Pilgrim Hospital, and therefore the current and future feasibility of the service would be better protected if services were consolidated on the Lincoln site.

5.5.23 More Lincolnshire residents would also receive their care out of the county if stroke services were consolidated on the Pilgrim Hospital site rather than at Lincoln County Hospital. Based on stroke patients attending their nearest hospital it is estimated c.150 more patients per year would be treated outside of Lincolnshire if stroke services were consolidated at Pilgrim Hospital rather than Lincoln County Hospital (this reduces to c.65 patients if a 15-minute travel time preference for Pilgrim hospital is applied). Lincoln County Hospital is therefore a better solution for more of Lincolnshire's population on that basis.

5.5.24 It should also be noted that through the establishment of the Lincoln Heart Centre, the Lincolnshire health system has first-hand experience of making a change to time critical services such as stroke and improving outcomes for all the residents of Lincolnshire, and not to the detriment of the people in certain geographies.

5.5.25 The NHS in Lincolnshire has a collective and integrated ambition for health and care services in the east of the county, with Pilgrim Hospital, Boston playing a full, relevant and dynamic role in the provision of care for the local population and wider local economy. The hospital has received substantial investment in recent years, with further investment planned in the years to come. **ACTION** **HSC**

5.5.26 The health system's recognition that continued investment is necessary to support the hospital's value to its patients is again highlighted through our most recent request for additional capital funding via the national Health Infrastructure Plan (HIP) funding scheme to improve the estates and services of the county's hospitals. **ACTION** **HSC**

5.5.27 The activity baseline data used in the Pre Consultation Business Case (PCBC) that set out the analysis and recommendations for the proposed service changes used was 2019/20 (i.e. pre temporary Covid changes). This was forecast to 2023/24 in line with the local five-year strategic plan using the average annual growth rate as it was felt this was most likely to reflect future demand.

5.5.28 Sensitivity analysis was completed for the PCBC based on ONS population projections (all age and 65+), these showed Pilgrim Hospital, Boston would not achieve 600 stroke admissions per annum by 2023/24. ONS population growth estimates (all age and 65+) were reviewed again by the working group, which showed Pilgrim Hospital Boston was unlikely to achieve 600 admissions by 2030. **ACTION**

5.5.29 It should also be noted, as set out in the considerations of the working group, that reaching the minimum recommended admissions each year is only part of the challenge as all stroke units also need to be staffed in a safe and sustainable way to ensure the best outcomes.

5.5.30 The enhanced community service will support all stroke survivors across Lincolnshire to receive their rehabilitation within their local community wherever possible. This will be supported by investment in the capacity and capability of the community stroke team. **ACTION**

5.5.31 The service will link in closely with the Neighbourhood Teams, who will provide the requisite nursing, social care support and on-going 'self-care' options and support for stroke survivors. **ACTION**

5.5.32 The service will support community hospitals, which will be health and wellbeing hubs providing different levels of care under one roof, making the most effective use of inpatient and ambulatory services offered locally, including rehabilitation, reablement and palliative care services. **ACTION**

5.5.33 At present between four and six stroke survivors per week are discharged into a community bed, which is expected to continue. However, the overriding principle for this work is 'home first' and as the enhanced community stroke service embeds and integrates into Neighbourhood working the ability to support complex survivors at home is expected to increase. ACTION

5.5.34 A centre of excellence on the Lincoln site should improve recruitment and retention issues. This will increase the capacity and capability to be able to manage patient pathways more effectively by being able to concentrate staff into covering one area, coupled with the increased provision in the community supporting patient rehabilitation closer to home.

5.5.35 Given the provision of acute based rehabilitation services in the temporary service model differ to those in the proposed model if implemented, it is not possible to use rehabilitation data during these temporary changes to draw any conclusions on rehabilitation outcomes in the proposed model. ACTION

5.5.36 As part of the 100 day challenge previously completed with LCHS and ULHT, a joint MDT process was completed that showed a smooth discharge process and reduction of LOS through collaborative working for the benefit of the patients for them receiving care closer to home. This included making the most effective use of inpatient and ambulatory services offered locally, including rehabilitation, reablement and palliative care services. ACTION

5.5.37 As part of the temporary change of consolidating hyper-acute and acute stroke services on the Lincoln County Hospital site due to service sustainability challenges, standard operating procedures (SOPs) have been put in place to ensure communication between ambulances and the receiving stroke team at Lincoln County Hospital is managed through the ACP team with integrated pathways either onto thrombolysis and admission to our Hyper Acute Stroke Unit beds or with transfer to our tertiary surgical centre. ACTION

5.5.38 Once the patient is admitted a clear plan is put in place in the acute setting and then with onward care for the patient.

5.5.39 The stroke service work with social care once the patient is admitted from day 1 to resolve and support care packages for the patient when they are discharged. ACTION

5.5.40 Pilgrim Hospital, Boston is one of the major acute hospitals in the county. It serves thousands of Lincolnshire residents in the east of the county as a lead provider of acute and specialist care. Pilgrim Hospital will continue to be an essential part of the NHS in Lincolnshire for years to come.

Workforce

5.5.41 There are currently 28 stroke beds in the Lincoln County Hospital stroke unit. To manage the expected increase in activity at Lincoln Hospital under the change proposal an increase of seven beds is planned.

5.5.42 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 Lincoln County Hospital, and ensure the unit is staffed according to agreed national guidelines for medical, nursing and allied health professional staff.

5.5.43 The proposed future model of acute stroke services supports a more sustainable and resilient workforce, particularly in the medical consultant and nursing groups. HSC

5.5.44 The proposed future model of acute stroke services supports a more sustainable and resilient workforce, particularly in the medical consultant and nursing groups, by: HSC

- A reduction in a heavy reliance on locum and agency staff;
- Increases the chances of recruiting to substantive roles if the service is based at Lincoln Hospital alongside other specialist services;
- Avoids having to spread 6.0 consultants across two sites; and
- Supports a concentration (through service consolidation and the provision of fewer beds) of nursing staff at the Lincoln site, where there are currently fewer vacancies than at the Pilgrim site

5.5.45 Over the past few years, and in line with the proposed workforce model, the hospital based stroke service has recruited 5.8wte Advanced Care Practitioners (ACPs). This was not done in a pre-emptive manner of the proposed change being agreed, but rather as part of finding operational solutions to tackle the challenges faced in recruiting stroke consultants and support the service to deliver high quality care. ACTION HSC

5.5.46 The recruitment of more ACPs provide further mitigation to the stroke consultant recruitment challenges in the short and medium term. ACTION HSC

5.5.47 At present between four and six stroke survivors per week are discharged into a community bed, which is expected to continue. In addition the community stroke rehabilitation team's capacity and capability will be expanded by 14 wte under the change proposal. ACTION

5.5.48 Staff engagement is ongoing and ULHT are happy to engage with any flexible working and requirements of staff going forward. It is acknowledged that a number of staff do not wish to move to the Lincoln site. ACTION

5.5.49 If the change proposal is agreed, a full formal management of change consultation would need to take place with all staff from the Pilgrim Stroke Department to ascertain their future employment options. For any stroke staff that do not wish to be relocated they would receive support and training in competencies to allow successful relocation to another area. Agency and Bank work will play a part in workforce as required, to meet the service need, as they do in all Trusts in Lincolnshire currently. ACTION

5.5.50 ULHT's stroke services are working within the NHS framework that is nationally agreed. The Trust is always looking at ways in which it can support the retention of existing staff, recognising their hard work and dedication to the stroke service. ACTION

5.5.51 The model supports the consolidated number of nursing and medical staff that will then be appropriately trained in thrombolysis. ACTION

5.5.52 ULHT is working within a regional Integrated Stroke Delivery Network group exploring and moving forward on plans to provide a telemedicine service within Lincolnshire. ACTION

5.5.53 The ability to support the change proposal from a workforce perspective is set out further in the provider statement of support (Appendix L). HSC

Travel Time / Ambulance Conveyance

5.5.54 During the development of the stroke change proposals and Pre Consultation Business Case (PCBC) a substantial amount of travel analysis was conducted. This is set out in detail in the PCBC and its appendices, and an overview is provided below. The activity analysis in the PCBC was based on the 2019/20 year, the last 'normal' year before Covid-19.

5.5.55 In 2019/20 Pilgrim Hospital, Boston treated 497 strokes, those patients transported to Pilgrim Hospital by ambulance generally originate from Boston, Mablethorpe on the east coast and Spalding to the south.

5.5.56 If fully implemented the change proposal to consolidate stroke services at Lincoln County Hospital would displace all 497 stroke patients currently seen at Pilgrim Hospital, Boston. In the proposed model of consolidated hyper-acute and acute stroke services at Lincoln County Hospital, the patient pathway will see patients with FAST positive symptoms who would have previously gone to Pilgrim Hospital, Boston taken directly to the nearest A&E Department by the ambulance service.

5.5.57 For patients who self-present at the Pilgrim Hospital A&E department, they will be assessed and transferred to Lincoln County Hospital by ambulance for treatment if their symptoms indicate a diagnosis of stroke.

5.5.58 Independent analysis and modelling conducted by Operational Research in Health Ltd. (ORH) on potential changes to stroke services at Pilgrim Hospital, Boston in 2018, identified approximately 50% of the Pilgrim Hospital, Boston patients would be taken to Lincoln County Hospital and the others would be transported out of county, mostly to Peterborough, based on attending the nearest hospital.

5.5.59 ORH used a combination of East Midlands Ambulance Trust data and data on FAST-positive stroke patients from Lincolnshire. Travel time analysis was undertaken to quantify the base position for Pilgrim Hospital patients and how travel times would be expected to change if changes to services occur. Travel times were based on blue-light speeds.

5.5.60 Under the proposal of consolidating acute stroke services at Lincoln Hospital, it was estimated the average travel time by ambulance to an acute stroke unit for stroke patients who would have gone to Pilgrim Hospital, Boston will increase from 23m58s to 44m28s (increase of 20m30s on average). This is based on the assumption patients attend their nearest unit.

5.5.61 In 2015 the predecessor programme to ASR, LHAC, prescribed and agreed the level of activity which should be accessible within three different time thresholds. The three thresholds were 45 minutes (A&E, maternity and non-elective paediatrics), 60 minutes (all other non-electives and outpatients) and 75 minutes (elective paediatrics, day case surgery and elective surgery).

5.5.62 Stroke services fall into the 60-minute threshold, as other non-elective services, and the travel time analysis conducted estimated that under the proposal where stroke services are consolidated at Lincoln County Hospital no patients would travel over 60-minutes.

5.5.63 A sensitivity analysis was also conducted on the number of patients travelling over 60-minutes if stroke services were consolidated at Lincoln County Hospital. This estimated that even with patients travelling to their nearest acute stroke unit plus a 15-miunte threshold preference for Lincoln County Hospital, no patients would travel over 60-minutes (increase in average travel time of 22m53s). It was estimated around 75% of Pilgrim Hospital, Boston patients would attend Lincoln County Hospital under this scenario. HSC

5.5.64 The sensitivity analysis estimated patients would still not travel more than 60-minutes when the threshold was increased to 20-minutes. Under this scenario the average increase in travel time to hospital is 23m07s, compared to 20m30s if there is no preference.

5.5.65 The table below is from the PCBC and provides a summary of the estimated impact on the number of patients displaced and associated travel times by ambulance when the preferred option is fully implemented (based on 19/20 activity and forecast 23/24 activity). This includes a sensitivity analysis relating to patients not attending the nearest hospital with a preference for Lincoln County Hospital of up to 15 minutes.

Figure 34 – PCBC modelling - Displaced stroke activity and impact on travel times

	Lincoln Hospital		Pilgrim Hospital		Peterborough Hospital		QE Kings Lyn Hospital	
	19/20	23/24	19/20	23/24	19/20	23/24	19/20	23/24
Patients attend nearest hospital								
Stroke Activity	+236	+246	-497	-517	+226	+235	+35	+36
Travelling +60 mins.	0	0	0	0	0	0	0	0
Sensitivity Analysis – nearest hospital +5mins								
Stroke Activity	+277	+289	-497	-517	+185	+192	+35	+36
Travelling +60 mins.	0	0	0	0	0	0	0	0
Sensitivity Analysis – nearest hospital +10mins								
Stroke Activity	+338	+352	-497	-517	+124	+129	+35	+36
Travelling +60 mins.	0	0	0	0	0	0	0	0
Sensitivity Analysis – nearest hospital +15mins								
Stroke Activity	+376	+392	-497	-517	+86	+89	+35	+36
Travelling +60 mins.	0	0	0	0	0	0	0	0

NOTE: Forecast is based on average annual growth rate of 0.97% p.a.

5.5.66 Within the PCBC, the proposed hyper-acute and acute stroke service change proposal was based on a 15-minute site preference for Lincoln County Hospital. HSC

5.5.67 A number of stroke patients transferred to Pilgrim Hospital, Boston are from the most deprived wards, as defined by the Index of Multiple Deprivation (IMD), around Skegness and some areas of Boston. There are also pockets of demand in less deprived wards around Coningsby and Woodhall Spa.

5.5.68 The ORH modelling analysis data showed the majority of wards which account for the highest 10% of IMD scores in Lincolnshire currently have travel times of over 30-minutes, with an average of c.35m32s. ORH also modelled the scenario of Pilgrim Hospital, Boston stroke services being consolidated at Lincoln County Hospital, which estimated all of these wards experience an increase in average travel time to hospital, with an average increase of c.21m39s (based on attending nearest hospital).

5.5.69 The ORH modelling identified that under the scenario where Pilgrim Hospital, Boston stroke services are consolidated at Lincoln County Hospital, the change in travel time is generally similar regardless of the IMD group. But the most deprived wards still have the longest travel time.

5.5.70 The analysis and modelling completed by ORH on potential changes to stroke services at Pilgrim Hospital, Boston in 2018 (based on 2015/16 data) was re-run in 2021 with more recent data (2019/20). The findings were very similar to the original analysis, including the modelling identifying no patients would travel over 60 minutes by ambulance (including when a threshold preference of 20 minutes is set for Lincoln County Hospital). A summary of the analysis output of the original analysis and that re-run is set out below, and the full reports completed by ORH were included in the appendices of the PCBC and made publicly available.

Figure 35 – PCBC: Pilgrim Hospital, Boston Stroke Summary 2015/16 vs 2019/20 comparison

Scenario	Average Time to BPH		Difference
	2015/16	2019/20	
Base Model Position	***23:58***	***23:43***	**-0:15**

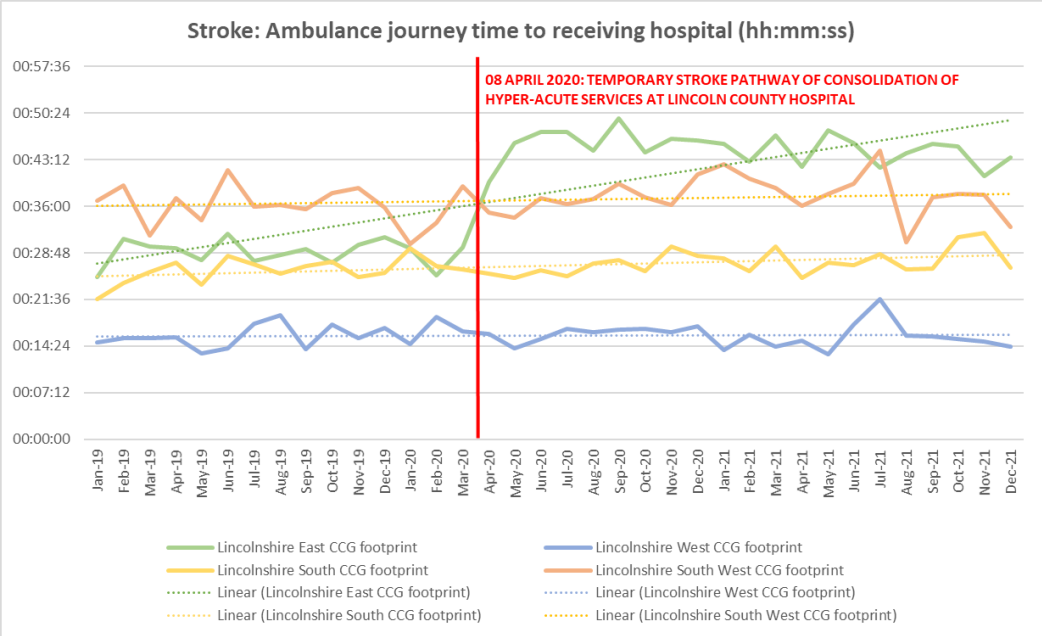
Scenario	Average Time to Hospital Impact		Difference
	2015/16	2019/20	
Close BPH, no HASU preference	+20:29	+20:32	+0:02
Close BPH, Lincoln preferred (5min)	+20:36	+20:52	+0:16
Close BPH, Lincoln preferred (10min)	+22:10	+21:44	-0:26
Close BPH, Lincoln preferred (15min)	+22:53	+22:12	-0:41
Close BPH, Lincoln preferred (20min)	+23:07	+22:24	-0:44

5.5.71 The temporary consolidation of hyper-acute and acute stroke services on the Lincoln County Hospital site (at the start of April 2020) provides some additional insights into the travel times for the proposed stroke changes, given under the proposed model for stroke services, if agreed, hyper-acute and acute stroke will be consolidated on the Lincoln County Hospital site.

5.5.72 Following completion of the public consultation, an analysis of East Midlands Ambulance Service journey times for stroke patients was conducted based on the four old Lincolnshire CCG footprints – using the Lincolnshire East CCG footprint as a proxy for those patients who would have gone to Pilgrim Hospital, Boston prior to the temporary change made by ULHT to consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site. ACTION

5.5.73 Following the temporary change the average ambulance journey time to receiving hospital for those stroke patients from the old Lincolnshire East CCG footprint was around 45 minutes, which is very much in line with the modelling completed for the PCBC.

Figure 36 – Ambulance journey time to receiving hospital by old Lincolnshire CCG footprints



5.5.74 As would be expected, this analysis showed that after the temporary change to the stroke pathway of consolidating hyper-acute stroke services at Lincoln County Hospital the average ambulance journey time to receiving hospital for those stroke patients from the old Lincolnshire East CCG footprint increased.

5.5.75 Following the temporary change the average ambulance journey time to receiving hospital for those stroke patients from the old Lincolnshire East CCG footprint was around 45 minutes, which is very much in line with the modelling completed for the PCBC.

5.5.76 Building on the above analysis, to develop a more granular understanding of the ambulance travel times during the temporary change (consolidation of hyper-acute and acute stroke services on the Lincoln County Hospital site) further independent analysis and modelling was conducted by Operational Research in Health Ltd. (ORH) using actual ambulance service data. **ACTION**

5.5.77 This analysis identified that based on all ambulance journeys between 1st May 2020 and 31st December 2021 for those patients who live in the wards closest to Pilgrim Hospital, Boston the average travel time by ambulance (time left scene to arriving at hospital) was 46 minutes and 31 seconds. This aligns to the analysis based on the old Lincolnshire East CCG footprint and the activity modelling conducted by ORH for the Pre Consultation Business Case. The map below shows the most frequent destination hospital by Ward.

5.5.78 The analysis conducted by ORH also identified the average travel time by ambulance by wards within the Pilgrim Hospital, Boston catchment area for patients going to Lincoln County Hospital. This identified that out of 48 wards within the Pilgrim Hospital, Boston catchment area, eight had an average ambulance transfer time of more than 60 minutes, the threshold set for this type of activity by the Lincolnshire health system in previous system wide service change programmes.

5.5.79 With the exception of one ward the average travel time was below 64 minutes. The one ward with an average travel time above this had an average time of just under 70 minutes, however it should be noted that the activity volume was low and therefore the average could be skewed by one or two incidents. The average annual patients from all of these wards was 128.

5.5.80 This analysis is set out in the table below together with a comparison of the average travel time to Pilgrim Hospital, Boston for these wards prior to the temporary change, which was over 30 minutes for six of them.

Figure 37 – Average 'time left scene to arriving at hospital' and 'call connect to handover' – based on all journeys between 01 May 2020 and 31 December 2021 to Lincoln County Hospital

District name	Ward Name	Average Annual Patient (2020/21)	Av. Travel Time to Lincoln Hospital (2020/21)	*Av. Travel Time to Boston Hospital (2019/20)*
East Lindsey	Wainfleet	6.0	69:39	*23:49*
East Lindsey	Sutton on Sea	18.0	63:38	*41:06*
Boston	Old Leake and Wrangle	2.4	63:23	*11:45*
East Lindsey	Mablethorpe	31.2	61:59	*43:25*
East Lindsey	Ingoldmells	14.4	61:08	*36:03*
East Lindsey	Scarborough & Seacroft	24.0	61:00	*30:34*
East Lindsey	Chapel St Leonards	15.0	60:55	*39:57*
East Lindsey	Winthorpe	17.4	60:24	*31:45*

5.5.81 However, when considering access to services it is not just about the travel time, it is also about access to the appropriate treatment and intervention, and delivering good patient outcomes.

5.5.82 It is the overall time from event to treatment that is most important and improves outcomes. The temporary service changes have demonstrated reductions in the time taken for patients to receive diagnosis and treatment at hospital, which makes up for any increases in travel time. HSC

5.5.83 In this context it should also be noted that in terms of on scene time for conveyed stroke patients, the Lincolnshire Division of EMAS had the most efficient on scene time of all East Midlands divisions/counties helping to reduce overall call to definitive treatment timescales (FY 2019/20 & 2020/21 & 2021/22). Independent analysis identified that between May 2020 and December 2021 the average time on scene for expected stroke patients from the Pilgrim Hospital, Boston catchment area was c.45 minutes.

5.5.84 It also needs to be recognised 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 County Hospital to review previous medical history and decision for treatment commences as soon as patients arrives at hospital.

5.5.85 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.

5.5.86 This analysis of ambulance activity during the temporary change due to Covid-19 (consolidation of hyper-acute and acute stroke services on the Lincoln County Hospital site) also allowed further testing of the assumptions in relation to the destination hospitals outside of Lincolnshire for stroke patients from the Pilgrim Hospital catchment area.

5.5.87 The table below shows a comparison between the modelled destination hospital in the PCBC (based on 15-minute preference for Lincoln County Hospital) and the actual destination hospital during the temporary change to ULHT's stroke services. For Peterborough City Hospital, which would see the largest increase in stroke patients from Lincolnshire under the change proposal, the actual number seen was between 15 and 18 patients a year higher than identified through the modelling. This is the equivalent of around 1.5 patients a month. HSC

Figure 38 – Comparison of modelled destination hospital in PCBC and actual destination hospital during temporary change

Destination Hospital	PCBC modelling baseline 2019/20	PCBC modelling forecast to 2022/23	During temporary change 2020/21
Peterborough City Hospital	86	89	104
Queen Elizabeth Kings Lynn	35	36	21
Grimsby Diana Princess of Wales	-	-	3
Scunthorpe General Hospital	-	-	1
Total	121	125	129

5.5.88 This analysis also showed that none of the average travel times by ambulance for wards within the Pilgrim Hospital, Boston catchment area that are within the South Holland District Council area were greater than 60 minutes. It is the patients from these areas are likely to go to Peterborough City Hospital or Queen Elizabeth Kings Lynn. HSC

5.5.89 It should be noted that prior to the temporary changes to hyper-acute and acute stroke services in Lincolnshire stroke patients from the south of Lincolnshire already went to Peterborough City Hospital as it is geographically closer. So relationships already existed between the hospital and health care commissioners and providers in Lincolnshire. Including the Lincolnshire community stroke rehabilitation team which supports discharges back from Peterborough City Hospital. HSC

5.5.90 Throughout the temporary service change to Lincolnshire stroke services discussions have been ongoing between Lincolnshire's health care commissioners and providers and Peterborough City Hospital to ensure the arrangements were safe and sustainable. HSC

5.5.91 If the proposed stroke changes went ahead, the impact on travel times would be kept under constant review. ACTION

5.5.92 During the various public engagement exercises that have taken place a number of people, particularly in the Boston area, raised some concern about travel time for people with symptoms of a suspected stroke if the service was no longer provided at Pilgrim Hospital, Boston.

5.5.93 Something in particular that was raised was the 'golden hour'. The conversations highlighted there were differing views amongst the public about what the 'golden hour' referred to, with many thinking of it in the context of the core principle of rapid intervention in trauma cases, rather than the specific golden hour for administering thrombolysis treatment.

5.5.94 The golden hour is often used to refer to the period of time following a traumatic injury during which there is the highest likelihood that prompt medical and surgical treatment will prevent death. While initially defined as an hour the exact time period depends on the nature of the injury and can be more than or less than this duration. It is well established that the person's chances of survival are greatest if they receive care within a short period of time after a severe injury; however, there is no evidence to suggest that survival rates drop off after 60 minutes.

5.5.95 The golden hour for stroke services refers to the door to needle time i.e. from the patient arriving in hospital to administering the thrombolysis treatment. It is a target and has no clinical significance to outcome. The sooner the treatment is given, the better the chance of a better outcome for those who are going to benefit from the treatment. Not everybody can have the treatment as it depends on the type of stroke, around 15% of all patients can receive this treatment and of these one third (5% of total) will benefit.

5.5.96 There is a 4.5-hour limit in the national clinical stroke guidance that refers to the time within which thrombolysis treatment can be administered with the current licence. This is more relevant to clinical practice, but it starts from the time of onset of stroke symptoms or from when the last time the patient was seen well. When discussing the preferred option for stroke services with the public this was explained.

5.5.97 In this context of the ’60-minute door to needle time’ and ‘4.5-hour limit for the time in which thrombolysis can be administered’ it is important to note the local experience of consolidating heart services on to the Lincoln County Hospital site to create the Lincolnshire Heart Centre and what can be achieved:

- On average it takes the specialist team in Lincoln County Hospital just 32 minutes from the moment a patient arrives in the ambulance at hospital to open the artery – national average is 40 minutes.
- The national target is 2.5 hours for all patients to receive angioplasty from first 999 call to when the balloon is inflated. Nationally, 75% of patients are treated within this window. In Lincolnshire, despite the large geographical area and road network, 85% of patients are treated within the timeframe.

5.5.98 The experience of the temporary change has demonstrated the benefit of faster access to diagnosis and treatment once at the acute site offsets the longer travel times for some patients.

5.5.99 Analysis conducted by the working group in light of the feedback received through the pilot consultation shows that the experience of the temporary change made has demonstrated that even though the service was still operating under immense pressure, the benefit of faster access to diagnosis and treatment once at the acute site offsets the longer travel times for some patients: **ACTION**

- On average patient’s diagnosis and treatment times were improved. In the quarter July to September 2021 Lincoln County Hospital achieved a median time of 6hrs 11mins between clock start and being assessed by a stroke consultant compared to 10hrs 04mins nationally.
- In the four quarters between October 2020 and September 2021 apart from one quarter (93.8%) all patients who were eligible for thrombolysis received this within the four hour window from onset of symptoms. In the quarter July to September 2021 Lincoln County Hospital achieved 100% of eligible patients receiving thrombolysis compared to 85.8% nationally.
- When comparing national performance at site level, out of a total of 157 sites Lincoln County Hospital was one of only six sites that achieved eight Key Indicators. Only one site achieved nine Key Indicators and no site achieved ten. All the remaining sites achieved less than eight Key Indicators.

5.5.100 Using the experience of the temporary service change of consolidating hyper-acute and acute stroke services on the Lincoln County Hospital site a comparison of certain aspects of access to stroke care has been made for stroke patients from the Pilgrim Hospital, Boston catchment area before and after the change.

5.5.101 Data has been compared for a similar six month period in 2019 and 2021. However, not all data is comparable due to collection methodology. 2019 data is from SSNAP, whereas 2021 data is from actual patient notes and Advanced Care Practitioner (ACP) sheets. **ACTION**

5.5.102 This analysis shows that following the introduction of the temporary change, patients from the Pilgrim Hospital, Boston catchment area get seen and scanned quicker, have more access to thrombectomy and were, on average, discharged sooner.

5.5.103 One area where the data is less strong following the temporary change is access to a bed on the stroke unit. However, the key contributing factor to this is during the second wave of Covid-19 the hyper-acute stroke unit at Lincoln County Hospital was moved from its normal location to manage trust-wide operational pressures.

Figure 39 – Comparison of outcomes for patients from Pilgrim Hospital, Boston before and after the temporary change to consolidate hyper-acute stroke services at Lincoln County Hospital

Stroke patients from Boston Hospital catchment	Jan – Jun 2019*	Jan – Jun 2021*
Location where stroke care received:	Boston	Lincoln
Total number confirmed strokes	226	226
Onset to first arrival (hr:mm)	10.06 (average)	-
Referral by EMAS to arrival (hr:min)	-	01:01 (average)
Arrival to stroke review (hr:min)	01:27 (average)	00:36 (average)
Arrival to CT (hr:min)	00:46 (average)	00:39 (average)
Arrival to Stroke Unit (hr:min)	03:00 (average)	05:18 (average)**
Number of patients for Mechanical Thrombectomy	1	6
Number of Thrombolysis	29	22
Average LoS	12 (average)	9 (average)

**** Data is not 100% comparable due to collection methodology: 2019 data is from SSNAP, whereas 2021 data is from actual patients and ACP sheets***

***** During second wave of Covid-19 the HASU at Lincoln was moved from its normal location to manage trust-wide operational pressures***

5.5.104 Given the evidence of the impact of centralising hyper-acute stroke care and the experience of ULHT during the temporary change it has been concluded the clinical benefits and outcomes outweigh the impact of increased geographical distance. Lincolnshire has experience of this through the consolidation of heart services on the Lincoln County Hospital site.

5.5.105 The NHS Lincolnshire CCG fully recognises its duty to reduce inequalities in respect of access to health services and that the proposals will have an adverse impact on travel times for some people from areas of high deprivation. However, increases in travel time are not isolated to areas of high deprivation and the health system's view is the clinical benefits and outcomes outweigh the impact of increased geographical distance.

5.5.106 Modelling has identified the number of additional shifts that would need to be introduced to restore the base position performance and utilisation across Lincolnshire. This identified a requirement for an additional 12 ambulance hours per week. If the proposed change went ahead the additional ambulance hours required to restore the base position performance would be reflected in the EMAS contract. ACTION HSC

5.5.107 The suggestion of an air ambulance being used to cover residents in the east of the county was considered as part of the Travel and Transport Report and will not been taken forward as the air ambulance does not respond to stroke patients.

5.5.108 Given the geography of Lincolnshire, the health system will be exploring the option of a mobile stroke unit option as part of further improvement to the provision of hyper-acute stroke care. ACTION HSC

Facilities

5.5.109 Stroke activity demand and hospital bed capacity modelling formed a key part of the underpinning analysis to assess the proposed service change.

5.5.110 Currently there are 28 stroke beds in the Lincoln County Hospital stroke unit. Following the demand and capacity modelling a requirement of 35 beds for the proposed model to consolidate acute stroke services on the Lincoln County Hospital site was identified.

5.5.111 During the development of the stroke service change proposal a broad range of options were identified to support delivery of the service solution, to consolidate hyper-acute and acute stroke services at Lincoln County Hospital.

5.5.112 The preferred option identified at that stage was to build an extension to the existing unit. The identified cost for this was £7.5m (at the time of producing the Pre Consultation Business Case).

5.5.113 If the change proposal is agreed, a more detailed and fuller analysis will be required at Outline Business Case and then Full Business Case stage for the capital spend. ACTION

Equalities and Health Inequalities HSC

5.5.114 The proposal could, some felt, widen health inequalities and negatively impact patient access as services would be removed from a deprived area. Furthermore, there was a view that the stroke figures for the area served by Pilgrim Hospital, Boston are higher owing to an ageing population. It was thought to make more sense, therefore, to have a centre of excellence in Boston to reduce travel times for the majority.

5.5.115 The impact on patients' loved ones was also noted, particularly elderly spouses/family who may be unable to visit due to the increased travel distance. The impact of this on patients' mental health and recovery may, it was said, have been overlooked.

5.5.116 Feedback from members of protected characteristics groups and other key demographics tended to express some concerns about travel and transport along the same lines as other respondents.

5.5.117 In the consultation questionnaire data, slightly more respondents from the most deprived communities disagreed with proposals for stroke services than agreed. It should be noted, however, that further analysis indicated that this was almost certainly a result of the majority of questionnaire respondents from deprived communities living in Boston and East Lindsey, closest to Pilgrim Hospital in Boston.

5.5.118 Boston and East Lindsey are geographic areas in which the views among respondents from both deprived and more affluent communities were more negative than elsewhere; the implication, therefore, is that it is shared concerns about loss of local services in Boston driving disagreement, rather than a particular or separate concern from those experiencing deprivation.

5.5.119 In the residents survey there was some indication that residents with disabilities that limit their activities a lot were also less likely to agree, and more likely to disagree. with this proposal, compared to other residents (although there was still majority agreement).

5.5.120 Consideration of the potential positive impacts of the change proposal was given during the development of the Pre Consultation Business Case (PCBC), and further consideration was given following the public consultation. The potential positive impacts identified for the proposed service changes are the same for all patients, and are therefore equally relevant in the context of all groups with protected characteristics ACTION:

- Hospital stroke service provision would be based on national clinical evidence, which has demonstrated stroke patients are more likely to survive, recover more quickly and spend less time in hospital.
- Hospital stroke services in Lincolnshire would be in a stronger position to attract and retain talented staff through building a strong, high quality and successful service – making it sustainable for the long term.
- More patients would benefit from hospital stroke services being located on the same hospital site as the highly successful Lincolnshire Heart Centre, with benefits including increased access to important time critical interventions and acute imaging services, further reducing time to treatment.
- Stroke patients would spend the minimum time necessary in a hospital bed, by ensuring enhanced community services have the right skills and capacity to provide high quality rehabilitation to stroke patients as they return home, or as close to home as possible.
- For some patients there may be longer travel times, but this is balanced against ensuring those patients receive treatment in the right place first time.
- Given the serious nature of a stroke, the vast majority of patients displaced are likely to travel by ambulance. This is what happens now for those patients.

5.5.121 A number of mitigations to the travel and access concerns have been identified and are set out in the Travel and Transport Report. An overview of these is provided in the Travel and Transport section at the end of this chapter. ACTION

5.5.122 In addition to the mitigations set out in the Travel and Transport Report, if the changes are agreed all services will comply with the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support they need from health and care services. ACTION

5.5.123 It has also been identified that any service changes if agreed need to ensure services are accessible in respect of different races and ethnicity. ACTION

5.5.124 The Equality Impact Assessment (EIA) for the urgent and emergency care change proposal developed for the Pre Consultation Business Case was also reviewed in light of the feedback from the public. This can be found in Appendix H. The EIA is a 'living document' and will continue to be updated if and when new information becomes available. If the change proposals are agreed it will continue to develop through the implementation phase.

Travel and Transport HSC

5.5.125 See Travel and Transport section at the end of this chapter

Alternative Suggestions – Hyper Acute and Acute Wards

5.5.126 The proposed stroke service changes were identified following a clinically led options appraisal process. At the short-list stage of this process there were two options for the provision of stroke services:

- Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service; and
- Provide hyper-acute and acute stroke services from Lincoln County Hospital and Pilgrim Hospital, Boston supported by a combined medical on-call rota

5.5.127 At an evaluation workshop attended by over 60 stakeholders from across the Lincolnshire health system, the consensus was the preferred option was to consolidate services on the Lincoln County Hospital site.

5.5.128 The major drive for moving to a single site is because the hospital based stroke service does not have enough doctors or nurses. The national standards state you cannot rely on ACPs to deliver the service it is not possible to run a rota with just consultant nurses, even if there were ten of them.

5.5.129 Locating a single hyper-acute and acute stroke unit at Lincoln County Hospital rather than Pilgrim Hospital, Boston has a number of advantages including:

- 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 Practitioner (ACP) service and pathway that was noted as a regional example of excellence by a Getting It Right First Time (GIRFT) review.
- Provides an increased opportunity for the Lincoln site to provide mechanical thrombectomy in the future
- 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 County Hospital.

5.5.130 Within ULHT opportunities exist for people to improve their skills. ULHT have a Stroke Improvement Lead who has arranged a training package for those staff that currently work on the stroke unit. There is an active training package in place for all Advanced Care Practitioners (ACPs) ending in them ultimately obtaining their Master's degree and qualifications. ACTION

5.5.131 Following an initial appraisal, the emerging preferred estates option for Stroke Services is to design and build an extension to the existing unit to provide a consolidated service at Lincoln County Hospital. If the change proposal is agreed, a more detailed and fuller analysis will be required at Outline Business Case and then Full Business Case stage for the capital spend. This will include considering in greater detail, by clinical and operational leads, what the best use for a new build next to the current stroke unit is and what the optimum configuration for the stroke services would be. This could include the second ward at Lincoln being a small hyper-acute ward close to the stoke unit and using the current stroke unit for acute/rehab. **ACTION**

5.5.132 Since the introduction of the temporary change to consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, the process for patients attending the emergency department at Pilgrim Hospital, Boston who require thrombolysis is for the patient to be 'blue-lighted to Lincoln County Hospital by ambulance. The process has been in place since the start of the temporary change and there have been no issues. This model would continue if the proposed change is agreed. **ACTION**

5.5.133 The proposal for developing a centre of excellence at Peterborough, Grimsby and Nottingham does not allow for the National standard for patient care, given the travel times. Having a centre at Lincoln provides the balance of travel against delivery.

5.5.134 Although not explicitly raised in the consultation feedback, the Lincolnshire health system is fully aware and acknowledges current challenges in relation to ambulance Category 2 response times. The current Category 2 performance is a mean response time of 1 hour and 03 minutes against an 18 minute standard in March 22. Stroke is responded to as a Category 2 response.

5.5.135 This challenge is not specific to Lincolnshire, it is an issue that impacts across all health systems nationally. The regional and national performance stands at 1 hour and 1 hour and 1 minute respectively in March 22.

5.5.136 A significant under lying issue across the country is the delayed handover of ambulances at hospitals Emergency Departments.

5.5.137 Significant work is underway across Lincolnshire, as it is in other parts of the country, to tackle this issue including dedicated Ambulance submits with NHS England and Improvement at a regional and national level. This has included a review of protocols for ambulance handovers in ULHT and an agreed action plan to improve ambulance availability has been agreed.

5.5.138 Putting this challenge in the context of the four service change proposals, this is particularly relevant to the stroke proposal.

5.5.139 A key foundation to this proposed care models is ensuring patients get to the definitive treatment, first time at a site that has a skilled and dedicated workforce than can provide high level care sustainably.

5.5.140 These challenges in relation to ambulance response times are not seen as a reason to not proceed with the stroke change proposal given the benefits they will bring in terms of improved patient outcomes, care quality and service sustainability. In fact to some degree the change proposal even provides some level of mitigation to the challenges faced by ensuring when patients arrive at hospital diagnosis and treatment happens as efficiently and effectively as possible.

5.5.141 However, as described above, tackling current ambulance response times is an absolute priority for the NHS in Lincolnshire to ensure patients receive the best possible care.

Alternative Suggestions - Rehabilitation

5.5.142 The service change proposal does not look at providing rehabilitation in an acute setting. A key factor being it is not sustainable with the medical / nursing staffing shortages to maintain safe patient care on multiple acute hospital sites.

5.5.143 The proposed model sets out enhanced rehabilitation being provided in the community being supported by an increased workforce, that shall provide patients with support closer to, or in their home setting.

5.5.144 During 2019 significant work took place to re-define and agree how an enhanced stroke rehabilitation service should function and what resources would be required. This aligned to the national recommendations regarding enhanced community stroke services set out in the NHS Long Term Plan.

5.5.145 From the outset it was agreed that there should be an integrated stroke rehabilitation service that worked across both community and acute care with a multi-organisational/multi-professional project group established to drive the work forward.

5.5.146 The service will link in closely with the Neighbourhood Teams, who will provide the requisite nursing, social care support and on-going 'self-care' options and support for stroke survivors.

5.5.147 The service will support community hospitals, which will be health and wellbeing hubs providing different levels of care under one roof, making the most effective use of inpatient and ambulatory services offered locally, including rehabilitation, reablement and palliative care services.

5.5.148 At present between four and six stroke survivors per week are discharged into a community bed, which is expected to continue. However, the overriding principle for this work is 'home first' and as the enhanced community stroke service embeds and integrates into Neighbourhood working the ability to support complex survivors at home is expected to increase.

5.5.149 Appropriate training will be given to specific care homes to enable the small number of patients with complex needs to be discharged in a timely manner and forms part of the discharge process for these complex patients.

5.5.150 Neurological conditions and a step up/down inpatient/outpatient unit were not part of the change proposals consulted on.

5.5.151 Brain and head injury and stroke rehabilitation are kept separate as the Acute function is managed very differently. For example, head injury/trauma is managed by either orthopaedics or neurosurgery. Whilst stroke is managed separately by the stroke team. The treatments for stroke and head injury are generally very different.

Additional Consideration

5.5.152 One You Lincolnshire (OYL) was commissioned in 2019 as the Integrated Lifestyle Service (ILS) for the county. This is a county wide offer.

5.5.153 The four key pillars of support for One You service offers are as follows:

- Go Smoke Free
- Move More
- East Well and Lose Weight
- Drink Less

5.5.154 One You Lincolnshire have a high-level partnership with the Office for Health Improvement and Disparities 'Healthy Weight' Lead for Midlands

5.5.155 Public Health: Key areas of focus:

- Hypertension case finding
- Making Every Contact Count (MECC)
- Substance Misuse Treatment service
- Pilot child and family weight management service

5.6 Travel and transport

5.6.1 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.

5.6.2 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.

5.6.3 The estimate of the number of patients that would be impacted if the proposed changes if they are agreed is relatively small (around 9 a day) in comparison with the daily attendances and admissions across ULHT's hospital sites. The NHS Lincolnshire CCG fully acknowledges and understand the concerns and recognises the impact on patients and their family/carers is important.

5.6.4 A Travel and Transport Report has been given extensive consideration by both the CCG Executive and Board (included in Appendix I). This report 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

5.6.5 The key points arising in the report are provided below.

Emergency and Urgent Transport

5.6.6 EMAS have confirmed they are able to accommodate the additional small demand on their services. ACTION HSC

5.6.7 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. However, and as stated above, 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. ACTION HSC

Non-emergency Patient Transport

5.6.8 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.

5.6.9 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. ACTION HSC

5.6.10 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. ACTION HSC

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

Other Transport

5.6.12 This 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.

5.6.13 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. ACTION HSC

5.6.14 Opportunities to strengthen current arrangements include: ACTION HSC

- 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

5.6.15 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. ACTION HSC

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

5.6.2 Lincolnshire County Council are also currently running a 'County Views' exercise which should also provide valuable inputs and insights from the public in relation to travel and transport across the county.

5.6.3 In addition, work to date with stakeholders have identified a number of proposals to improve support to patients with regards to travel in the broadest sense, these include: ACTION HSC

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

5.6.4 Irrespective of whether the four 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. ACTION HSC

5.6.5 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. ACTION

All Transport

5.6.6 The transport impact overall as well on those groups with protected characteristics would continue to be monitored during the implementation and 'go live' period of any agreed change, through the service implementation groups. Key areas of focus will be: ACTION

- Ambulance utilisation, performance and response times
- Non-emergency patients transport utilisation and complaints
- Patient complaints in relation to accessing services

5.6.7 It is proposed these implementation groups will feed into an Implementation Oversight Group (IOG) which will oversee the implementation and link in with other system forums, partners and stakeholders and programmes as necessary. ACTION HSC

5.6.8 The Lincolnshire health system is committed to tackling the impact of travel on air pollution through investment and engagement with staff, patients and the local authority. It will give special consideration to the air quality across Lincolnshire and aim to mitigate the impacts whilst contributing to a reduction in air pollution across the region. All the mitigations set out above will be developed and implemented in the context of this air pollution commitment and aim. ACTION HSC

Health inequalities

5.6.9 It is acknowledged that travel and transport is a particular concern for those who suffer from health inequalities. Through the Equality Impact Assessments (EIAs) that have been completed for each of the proposed service changes (See Appendix H) this has been careful consideration.

5.6.10 The EIAs have identified that all of the change proposals provide benefits and reduce health inequalities in terms of improved outcomes and experience for patients.

5.6.11 However, that is not to say this is not recognised and acknowledged as an important issue. As set out above the NHS in Lincolnshire is committed to working with all partners, particularly the Lincolnshire County Council, to improve access where possible.

5.6.12 In addition as part of its wider system strategies, and in line with national policy, the NHS in Lincolnshire continually looking at how health services can be provided more locally where it is clinically safe to do so in a sustainable way.

5.7 Consultation arrangements

5.7.1 Royal Mail's Door to Door service was procured with the brief to include the A5 consultation flyer alongside mail delivered to every consenting residential address in Lincolnshire (374,193). HSC

5.7.2 This activity was commissioned to further boost efforts to inform every household in the county about the public consultation. On 28/01/22, Royal Mail provided confirmation that 99% of the commissioned mailing was completed, with delays in delivery confirmation from Royal Mail's courier being responsible for them being unable to fully confirm that 1% of the total flyers were available for distribution from its Swindon bundling centre. HSC

5.7.3 A mixed media approach was adopted to raising awareness of the consultation to alert as many people as possible, and also minimise the impact of the pandemic, which meant less footfall in NHS buildings than usual. Despite this, and alongside the numerous digital and promotional activities employed elsewhere, it was felt worthwhile to undertake the following, to maximise the number of people who engaged with the process: HSC

- NHS Lincolnshire Clinical Commissioning Group, United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust and Lincolnshire Community Health Service NHS Trust received and displayed 400 consultation posters across their locations and properties for display in public and staff locations of high footfall.
- A pack of consultation promotional materials was sent to all GP surgeries in Lincolnshire. The total materials distributed were: 2,550 A5 flyers, 850 A4 posters and 425 questionnaires.

- Public consultation packs, containing posters, flyers, key information documents, and questionnaires were distributed to 21 libraries across Lincolnshire.
- 510 A5 leaflets and 240 A4 posters were sent to the Lincolnshire NHS CCG Involvement Champions to distribute and display in their communities.

5.7.4 Face to face events were bookable using Eventbrite or by contacting the NHS Lincolnshire CCG directly via the dedicated email address and telephone number. Booking on events was essential to ensure management of numbers and social distancing during the Covid pandemic. HSC

5.7.5 This enabled monitoring of numbers attending to enable social distancing and the safe delivery of public events. Where it was Covid safe to do admissions were allowed for those who hadn't pre-booked events, such as at the first event held in Grantham. Throughout the consultation nobody was turned away from an event. HSC

5.7.6 NHS Lincolnshire CCG agrees that the higher the number of respondents, the better, however the delivery of the consultation also needed to be proportionate to the simultaneous demands upon NHS staff and resources of simultaneous activities, including covid and national level four pressures. HSC

5.7.7 The total respondents is not equivalent to the total number of people aware of the consultation, but it is accepted that for some members of the public, competing pressures for their time mean that responding to a public consultation is not always prioritised.

5.8 Conclusion

5.8.1 Following the 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 were the change proposals consulted on were still supported.

5.8.2 However, as set out in this chapter, through the review and consideration of the feedback by the working groups a number of actions have been identified for implementation across all four services if the change proposals are agreed.

5.8.3 All the conclusions and actions identified by the working groups following consideration of the consultation feedback were tested further through the approach to decision making following consultation.

5.8.4 The approach to decision making on the service change proposals and associated analysis is set out further in the following chapters.

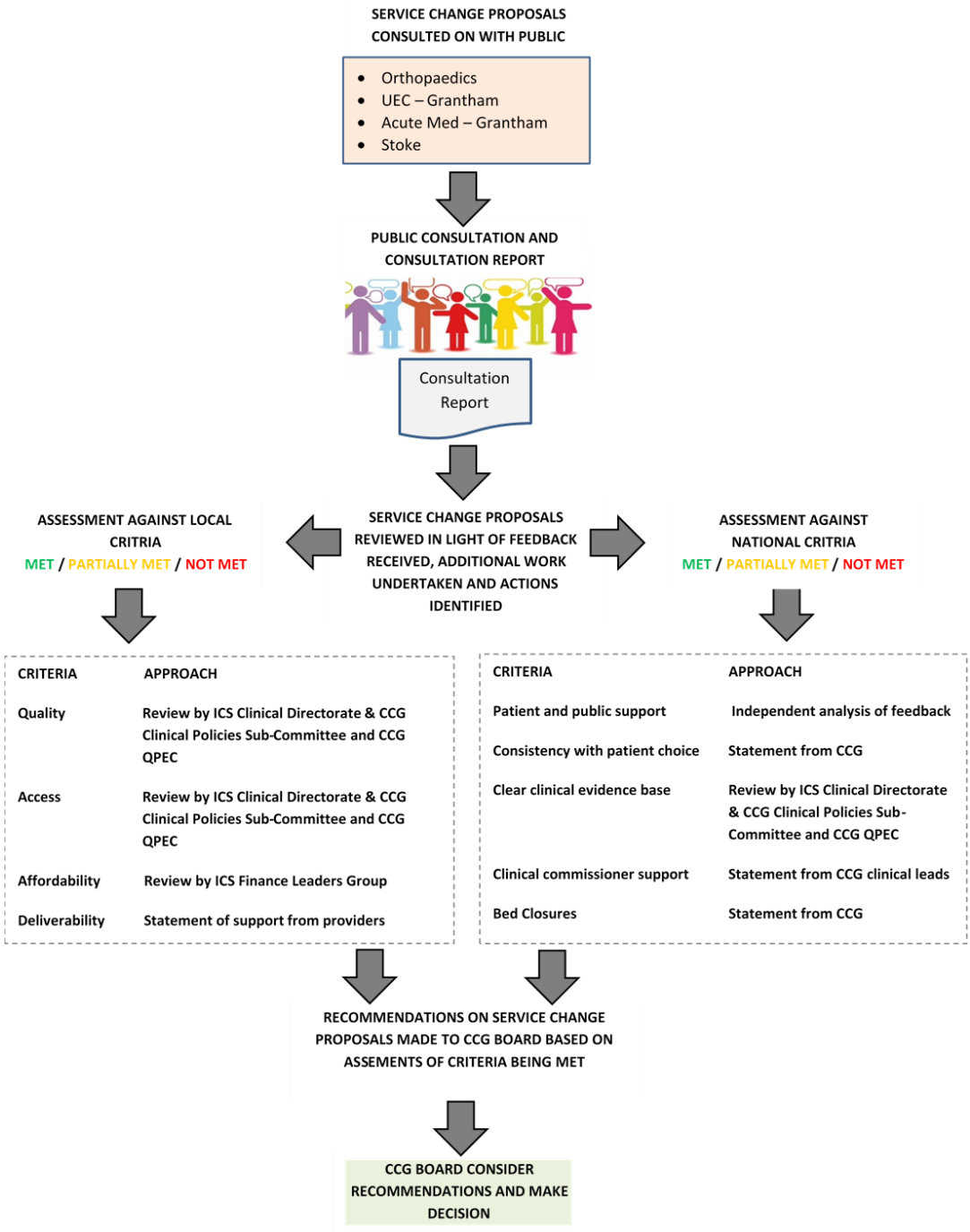
6 Approach to decision making on service change proposals following consultation

6.1 Overview

6.1.1 Following the public consultation the four change proposals have been reviewed in light of the feedback received and the work undertaken by the working groups to consider it (the previous chapter set out the key conclusions and actions and Appendix F has the full outputs).

6.1.2 This review has been carried out against local criteria for service change (as defined in the Pre Consultation Business Case (PCBC) for the four service change proposals) and the prescribed national tests for reconfiguration. An overview of this process is set out in the diagram below.

Figure 40 – Overview of analysis to inform DMBC recommendations



6.1.3 This assessment framework for the service change proposals following consultation is described below and encompasses a range of information and approaches to support decision-making.

6.2 Local considerations for service reconfiguration

6.2.1 In the pre-consultation phase, options for service change were assessed against four criteria. This DMBC uses the same criteria against which to judge proposals and make recommendations.

6.2.2 The table below describes the local criteria and the evidence that has been reviewed to support decision-making and the development of recommendations being placed before the NHS Lincolnshire CCG Board.

Figure 41 – Local criteria for Acute Services Review (ASR)

Local Criteria	Evidence considered pre-consultation	Evidence considered post-consultation
Quality • **Does option maintain or improve clinical quality and outcomes?** • **Does option maintain or improve patient experience?**	• Work completed by local clinical teams, with support from regional and national clinical leads • Recommendations of the East Midlands Independent Clinical Senate Review Panels • Quality Impact Assessments (QIAs) led by local clinical leads	• Recommendations of the East Midlands Independent Clinical Senate Review Panels – see Appendix J • Responses to proposals through public consultation – see Appendix C • Responses to public consultation feedback by working groups – see Appendix F • Review of Clinical Senate recommendations, QIAs and working group considerations by ICS Clinical and Care Directorate &CCG Clinical Policies Sub-Group and CCG QPEC – see Appendix K
Access • **Does option maintain or improve equality of access to care?** • **Does option minimise activity seen or treated at a different site or provider?**	• Stage 1 and Stage 2 Equality Impact Assessments (EIA) • Activity displacement analysis	• Outputs of Transport Working Group – see Appendix I • Independent Equality Impact Assessment (EIA) and action plans arising – see Appendix H • Responses to proposals through public consultation – see Appendix C • Responses to public consultation feedback by working groups – see Appendix F • Review of Clinical Senate recommendations, EIAs and working group considerations by ICS Clinical and Care Directorate &CCG Clinical Policies Sub-Group and CCG QPEC – see Appendix K
Affordability • **Does the option minimise the requirement for capital?** • **Is the implementation of the option achievable?**	• Local work in developing the PCBC • Regional and National NHSEI assurance processes	• Review of financial plans by ICS Finance Leaders Group – see Finance chapter
Deliverability • **Does option have an achievable workforce requirement?**	• Local work in developing PCBC	• Statement of support from providers – see Appendix L

6.3 National tests for reconfiguration

6.3.1 In 2010, the NHS set four key tests for service reconfiguration:

- Strong public and patient involvement
- Consistency with current and prospective need for patient choice
- Clear evidence base
- Support from clinical commissioners

6.3.2 In 2017 a further test was added in relation to proposed bed closures.

6.3.3 The table below describes the national tests for reconfiguration and the evidence that has been reviewed to support decision-making and the development of recommendations being placed before the CCG Board.

Figure 42 – National tests for service reconfiguration

National Criteria	Evidence considered pre-consultation	Evidence considered post-consultation
Patient and Public Support ***Strong public and patient involvement***	• Pre-consultation engagement • Options appraisal • Regional and National NHSEI assurance process	• Independent analysis of public consultation – see Chapter 3 and Appendix C
Consistency with current and prospective need for patient choice	• Local work in developing the PCBC • Regional and National NHSEI assurance process	• Choice statement from CCG – see Appendix M
Clear clinical evidence base	• Work completed by local clinical teams, with support from regional and national clinical leads • Recommendations of the East Midlands Independent Clinical Senate Review Panels • Regional and National NHSEI assurance process	• Recommendations of the East Midlands Independent Clinical Senate Review Panels – see Appendix J • Responses to proposals through public consultation – see Appendix C • Responses to public consultation feedback by working groups – see Appendix F • Review of Clinical Senate recommendations, QIAs and working group considerations by ICS Clinical and Care Directorate &CCG Clinical Policies Sub-Group and CCG QPEC – see Appendix K
Support for proposals by clinical commissioners	• PCBC approved by CCG Board • Pre-consultation activities led by CCG • Regional and National NHSEI assurance process	• Statement of support from CCG clinical leads – see analysis of proposals chapters
Bed closures	Non-applicable, no beds being closed	Not-applicable, no beds being closed – see Appendix M

6.4 Service change proposal assessment

6.4.1 Each of the four service change proposals that were consulted with the public has been assessed against the post-consultation evidence base described above.

6.4.2 For the local criteria, this has been done using the methodology set out in the table below.

Figure 43 – Methodology for assessment against local criteria for reconfiguration

Local Criteria			
Criteria	**Source of Evidence**	**Methodology**	
Quality	Recommendations of the East Midlands Independent Clinical Senate Review Panels in relation to proposals AND Review of Clinical Senate recommendations and QIAs by ICS Clinical Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in context of public feedback on proposals	EM Clinical Senate and/or ICS Clinical Directorate & CCG Clinical Policies Sub-Group and/or CCG QPEC do not continue to support the proposed service change	Not Met
		EM Clinical Senate and/or ICS Clinical Directorate & CCG Clinical Policies Sub-Group and/or CCG QPEC understand principle of proposed service change but cannot continue to offer full support without further information/review.	Partially Met
		EM Clinical Senate and ICS Clinical Directorate & CCG Clinical Policies Sub-Group and CCG QPEC continue to support proposed service changes (incl. if have minor suggestions for further work)	Met
		Service change proposal not put forward for review	Not Applied
Access	Review of final independent EIAs by ICS Clinical Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in context of public feedback	ICS Clinical Directorate & CCG Clinical Policies Sub-Group and/or CCG QPEC identify the final independent EIA revealed overall negative impact of the proposed changes	Not Met
		ICS Clinical Directorate & CCG Clinical Policies Sub-Group and/or CCG QPEC identify the final independent EIA revealed some negative impacts of the proposed changes; however, the overall impact was considered low. Mitigating actions were identified.	Partially Met
		ICS Clinical Directorate & CCG Clinical Policies Sub-Group and CCG QPEC identify the final independent EIA revealed that the impact of the proposed service changes was positive	Met
		Service change proposal not put forward for final independent EIA	Not Applied
Affordability	Review by ICS Finance Leaders Group	The ICS Finance Leaders Group considered the proposed service changes are not achievable and financially sustainable and/or are best use of capital resources	Not Met
		The ICS Finance Leaders Group considered the proposed service changes have some achievability and financial sustainability and/or are best use of capital resources, however the overall impact was considered to be low. Mitigation actions were identified.	Partially Met
		The ICS Finance Leaders Group considered the proposed service changes are achievable and financially sustainable and are best use of capital resources	Met
		Service change proposal not put forward for consideration by the ICS Finance Leaders Group	Not Applied
Deliverability	Statement of support from providers	The provider statement does not provide sufficient assurance that the proposed service change will be deliverable	Not Met
		The provider statement provides partial assurance that the service change will be deliverable, with some caveats and further work to be completed before full assurance can be provided	Partially Met
		The provider statement provides sufficient assurance that the proposed service change will be deliverable	Met
		Service change proposal not put forward for consideration of deliverability by providers	Not Applied

6.4.3 For the national criteria, the following methodology has been applied.

Figure 44 – Methodology for assessment against national criteria for reconfiguration

National Criteria			
Criteria	**Source of Evidence**	**Methodology**	
Patient and public support ***Strong public and patient involvement***	Independent analysis of public consultation feedback	The independent consultation report identifies the views of the public on the proposed service changes are negative overall	Not Met
		The independent consultation report identifies the views of the public on the proposed service changes are less positive overall	Partially Met
		The independent consultation report identifies the views of the public on the proposed service changes are positive overall	Met
		Service change proposals not put forward for public consultation	Not Applied
Consistency with need for patient choice	Choice statement from CCG	Review of proposed service changes identified that patient choice would be negatively impacted	Not Met
		Review of proposed service changes identified some negative impacts on patient choice, but overall the impact is considered to be low	Partially Met
		Review of proposed service changes identified that patient choice would be preserved.	Met
		Service change proposals not reviewed in context of patient choice	Not Applied
Clear clinical evidence base	Recommendations of the East Midlands Independent Clinical Senate Review Panels in relation to proposals AND Review of Clinical Senate recommendations and QIAs by ICS Clinical Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in context of public feedback on proposals	EM Clinical Senate and/or ICS Clinical Directorate & CCG Clinical Policies Sub-Group and/or CCG QPEC consider the clinical evidence base for the proposed service change is no longer clear	Not Met
		EM Clinical Senate and/or ICS Clinical Directorate & CCG Clinical Policies Sub-Group and/or CCG QPEC require more clinical evidence to be presented in order to continue to support the proposed service change	Partially Met
		EM Clinical Senate and ICS Clinical Directorate & CCG Clinical Policies Sub-Group and CCG QPEC consider the clinical evidence to support the proposed service change continues to be clear	Met
		Service change proposal not put forward for review	Not Applied
Support from clinical commissioners	Support statement from CCG clinical leads	Clinical commissioners do not support the proposed service change	Not Met
		Clinical commissioners offer partial support for the proposed service changes, but have some reservations	Partially Met
		Clinical commissioners support the proposed service change	Met
		Service change proposal not put forward for consideration by clinical commissioners	Not Applied
Bed closures	Statement in relation to bed closures	*The service changes proposed do not involve bed closures*	*N/A*

6.4.4 Following assessment using the criteria described above, each of the four change proposals was assigned a rating for each category of the local and national tests. The table below provides an overview of the ratings for the criteria.

Figure 45 – Overview of assessment against national and local criteria for service change proposal

	Orthopaedics	Urgent and Emergency Care	Acute Medical Beds	Stroke Services
Quality	***Met***	***Met***	***Met***	***Met***
Access	***Met***	***Partially Met***	***Met***	***Met***
Affordability	***Met***	***Met***	***Met***	***Met***
Deliverability	***Met***	***Met***	***Met***	***Met***
Patient and public support	***Met***	***Met***	***Met***	***Met***
Consistency with need for patient choice	***Met***	***Met***	***Met***	***Met***
Clear clinical evidence base	***Met***	***Met***	***Met***	***Met***
Support from clinical commissioners	***Met***	***Met***	***Met***	***Met***
Bed closures	***N/A***	***N/A***	***N/A***	***N/A***

6.4.5 The rationale for the assessment for each of the four service change proposals is set out in the following four chapters.

6.4.6 This takes into account a range of information to enable a balanced approach to decision-making.

7 Orthopaedics – analysis of proposal following consultation to inform decision-making

7.1 Overview

7.1.1 The change proposal consulted on was to establish a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital, along with a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery.

7.1.2 The table below provides an overview of the assessment of the orthopaedics proposal, following public consultation, against local and national criteria. The rationale for the assessment and subsequent recommendations are set out in the remainder of the chapter.

Figure 46 – Orthopaedics: Overview of assessment against criteria

Local Criteria		National Criteria	
Criteria	**Finding**	**Criteria**	**Finding**
Quality	***Met***	**Patient and public support**	***Met***
Access	***Met***	**Consistency with need for patient choice**	***Met***
Affordability	***Met***	**Clear clinical evidence base**	***Met***
Deliverability	***Met***	**Support from clinical commissioners**	***Met***
		Bed closures	***Not applicable***

7.2 Quality and Clear Clinical Evidence Base

7.2.1 The findings of the assessment of the orthopaedics proposal against the quality and clear clinical evidence base criterions is **Met.**

7.2.2 The evidence base for this is:

- Recommendations of the East Midlands Independent Clinical Senate Review Panels; and
- Review of East Midlands Clinical Senate recommendations and Quality Impact Assessments (QIA) by ICS Clinical and Care Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in context of public feedback on proposals and analysis of this by subject matter expert working groups

7.2.3 The East Midlands Clinical Senate review team was asked to consider whether there is a clear clinical evidence base underpinning the Lincolnshire health system's proposals. Specifically, the clinical review team was asked whether it supported the proposals based on clinical sustainability, workforce and clinical outcomes.

7.2.4 The proposed orthopaedic model was designed through a number of clinically led workshops directed by the clinical leads for orthopaedics at ULHT with contributions, support and advice from Professor Briggs, and input from local acute, primary and community based health professionals.

7.2.5 When this model was presented to the East Midlands Clinical Senate it reported the proposal for Grantham to become a centre of excellence for short stay elective work was understood and had been very clearly articulated. The clinical review team supported the proposal for Orthopaedic services and recommended the health system proceed with it.

7.2.6 The East Midlands Clinical Senate also made a number of recommendations. Responses to the clinical review team's recommendation were included in the Pre Consultation Business Case and reviewed as part of the NHS England and Improvement assurance process which was completed before starting the public consultation.

7.2.7 In parallel with the discussions with the East Midlands Clinical Senate, United Lincolnshire Hospitals NHS Trust (ULHT) volunteered to be involved with the national Getting It Right First Time (GIRFT) programme and to be one of a small number of trusts across England to pilot a 'hotter' (emergency/unplanned non-elective care) and 'colder' (elective/planned care) site plan for orthopaedic services.

7.2.8 The orthopaedics service was therefore able to draw on the experiences of the pilot to respond to the East Midlands Clinical Senate recommendations.

7.2.9 An evaluation of the pilot demonstrated that ULHT was performing substantially better than peer trusts when it came to length of stay, very positive results in the Friends and Family Test (FFT), a reduction in the amount of time people had to wait for surgery and the potential to increase the number of patients treated by ULHT.

7.2.10 Following completion of the public consultation there was an extensive programme of work to review the findings and ensure consideration of the feedback, ahead of final decision-making on the change proposals.

7.2.11 Central to this review process was the theming of the feedback received through the public consultation for each of the four change proposals (see Chapter 3), and the establishment of subject matter expert working groups to consider the feedback for each theme (see Chapter 4).

7.2.12 On 28 April 2022 a joint meeting of the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group was held to review the conclusions of the working groups and consider if the information presented continued to support the establishment of:

- A 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital, along with
- A dedicated day case centre at County Hospital Louth for planned orthopaedic surgery

7.2.13 The group considered all the information presented including the Pre Consultation Business Case (PCBC), feedback themes and data from the public consultation, an updated Quality Impact Assessment (QIA), and further analysis and consideration of the proposal undertaken by the subject matter expert working groups in relation to the consultation feedback.

7.2.14 Following its considerations, the Lincolnshire ICS Clinical & Care Directorate and CCG Clinical Policies Sub-Group confirmed its continued support for the change proposal and considered the:

- Quality criterion to be met; and
- Clear clinical evidence criterion to be met

7.2.15 Building on the conclusions and actions identified by the working groups in response to the public feedback (Appendix F) and the actions identified in the updated QIA (Appendix G) key comments made by the group in relation to the quality criterion and clear clinical evidence base criterion are set out in the table below.

Figure 47 – Orthopaedics: Quality criterion and clear clinical evidence base criterion - Key comments from the joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group

Criterion	Comments
Quality ***Criteria Met***	Improvements in patient outcomes have been proven by the pilot Supported by the current pilot model, United Lincolnshire Hospitals NHS Trust (ULHT) is one of the best performing trusts in the region in relation to waiting times for orthopaedics ULHT is providing 'mutual aid' to neighbouring trusts to support delivery of elective orthopaedic waiting lists From an elective procedure perspective since the pilot started in August 2018 there has been only one patient who required transfer due to a post operation complication to Lincoln with a suspected venous thrombolism – this demonstrates how robust the selection criteria for patients is At the start of the pilot trauma lists were kept as part of the model, however it was evidenced these were not utilised - minor trauma cases that can be appropriately discharged home to have a semi-planned operative procedure on a later day at Grantham are, therefore keeping orthopaedic trauma patient transfers to a minimum.
Clear clinical evidence base ***Criteria Met***	

7.2.16 The minutes of the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group are included in Appendix K.

7.2.17 Following the meeting of the ICS Clinical Directorate and CCG Clinical Policies Sub-Group the NHS Lincolnshire Quality and Patient Experience Committee (QPEC) reviewed the groups conclusions on the 12 May 2022 and supported them.

7.2.18 If the change proposals are agreed, as part of the implementation process continuous assessment against the actions identified by the subject matter expert working groups, including the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), as well as those identified by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group and CCG QPEC will be undertaken and reported to the Implementation Oversight Group (IOG). The IOG is described further in Chapter 15.

7.3 Access

7.3.1 The findings of the assessment of the orthopaedics proposal against the access criterion is **Met**.

7.3.2 This evidence base for this is:

- Recommendations of the East Midlands Independent Clinical Senate Review Panels; and
- Review of the East Midlands Clinical Senate recommendations and independent Equality Impact Assessments by a joint meeting of the ICS Clinical and Care Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in the context of the public feedback and the work completed by subject matter expert working groups to consider and respond to it

7.3.3 An Equality Impact Assessment (EIA) was completed for the proposed orthopaedic change prior to commencing the consultation with the public, this was included in the Pre Consultation Business Case.

7.3.4 Within this initial assessment it was identified that the impact of the proposed service change proposals on access, particularly on groups with protected characteristics would be continued to be explored and understood through consultation with the public and following a review of the feedback, and plans only finalised once that process is complete and a decision made.

7.3.5 In this initial assessment the groups with protected characteristics that were identified as potentially being impacted by the proposed service change were age, disability and economically disadvantaged.

7.3.6 In the public consultation feedback several specific groups such as older people, people on low incomes, those without access to private vehicles, and people with disabilities were mentioned as being particularly vulnerable to impacts as a result of longer or more expensive journeys to hospitals. Patients with co-morbidities were also mentioned, including those who might require access to kidney dialysis while in hospital.

7.3.7 A review of the eligibility criteria for patient transport services was also suggested in the consultation feedback to address any potential barriers to access - particularly for the most deprived communities in rural and inner city areas, or from frail or older people who might find travel stressful or difficult - so that additional support and transport can be provided according to need.

7.3.8 The challenge of ensuring equitable access in a large, rural county was raised, especially for localities (e.g., on the east coast) where health service and public transport provision were described as already being poor.

7.3.9 Concern was also expressed that people with disabilities used to attending particular hospitals where additional support is available might find that the same support and assistance is not available elsewhere.

7.3.10 Concerns by disabled and deaf person over potential loss of appointments and operations at valued local Pilgrim Hospital and belief this support would not be available elsewhere.

7.3.11 Others were concerned about the practicalities of travel for friends and family, those without access to their own vehicle, and those who might struggle to drive and/or otherwise get to/from hospital if they were unwell, in discomfort or were recovering from surgery.

7.3.12 A small proportion were concerned about impacts on the ambulance service and on patient transport.

7.3.13 Organisations representing particular communities, an Older People's Forum and a Lincolnshire Traveller Initiative Health Champion for example, also cited travel and transport issues as their main concern. The latter suggested that while the proposal is a positive one 'in theory', resulting patient transport costs could outweigh any benefits seen.

7.3.14 As planned, the impact of the proposed service change proposals on access, particularly on groups with protected characteristics, was explored further in light of the feedback received through the consultation and the EIAs produced for the PCBC were developed further, with independent support. An overview of these the considerations, actions and mitigations identified in the EIA for the orthopaedics proposals is set out below.

Figure 48 – Orthopaedics: Equality Impact Assessment (EIA) considerations, actions and mitigations

Groups	Considerations, actions and mitigations

Emergency Transport & Non-Emergency Transport
 	
For all patients in all groups (specifically those in age, disability and economically disadvantaged)
	• For some patients there may be longer travel times and a greater reliance on family and friends for transport.
	• However this is balanced against a number of potential positive impacts for all patients of the proposed changes, including:
	  ○ Improved service quality
	  ○ Reduced waiting times
	  ○ Reduced cancellations
	  ○ Reduced length of stay
	  ○ More coordinated care
	• Estimated that since the Orthopaedic Pilot started c.1,710 (c.825 EL, c.475 DC, c.410 NEL) patients per year have been displaced.
	  ○ Estimated that before the Orthopaedic Pilot c.70 patients travelled more than 75 minutes for day case and elective orthopaedic surgery and procedures within Lincolnshire, the threshold agreed through for this type of activity. However, this figure does not include the patients that currently go out of county to the independent sector.
	  ○ Analysis of Orthopaedic Pilot activity has estimated that under the current pilot arrangements an additional c.365 patient per annum travel more than 75 minutes by car for orthopaedic surgery and procedures within Lincolnshire.
	• EMAS have been fully engaged in the ASR and fully expect to be able to provide additional resources so that the impact of the proposed service changes on ambulance capacity is negligible.
	• It is fully expected that 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 assessment and treatment at hospitals that are further away from their home and for the discharge from these hospitals.
	• The patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternative transport providers

Other Transport **For all patients (specifically those in age, disability and economically disadvantaged) who are ineligible for non-emergency patient transport and transport for carers, relatives and visitors**	• This 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. • Solutions already exist such as voluntary care schemes and daily bus services between Lincoln County Hospital and Pilgrim Hospital, Boston and Lincoln County Hospital and Grantham and District Hospital; transport needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise. • The NHS in Lincolnshire is committed to working with 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, to strengthen current arrangements.
All Transport **For all patients in all groups (specifically those in age, disability and economically disadvantaged)**	• The transport impact overall as well as on those groups with protected characteristics would continue to be monitored during the implementation and 'go live' period of any agreed change. Including ensuring inequalities are not exacerbated. • The Lincolnshire health system is committed to tackling the impact of travel on air pollution through investment and engagement with staff, patients and the local authority. All the mitigations set out above will be developed and implemented in the context of this air pollution commitment and aim.

Groups	Considerations, actions and mitigations
Disability	• Ensuring all services, if the changes are agreed, comply with the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support they need from health and care services. • The provision of additional support for deaf service users is the same at all of ULHT's hospitals
Race (in particular travellers/gypsies)	• Support with reading letters and access to online support and care to be considered as part of accessible services provision.

7.3.15 On 21 April 2022 a joint meeting of the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group was held to review the conclusions of the working groups and consider if the information presented continued to support the establishment of:

- A 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital, along with
- A dedicated day case centre at County Hospital Louth for planned orthopaedic surgery

7.3.16 The group considered all the information presented including the Pre Consultation Business Case (PCBC), feedback themes and data from the public consultation, the updated Equality Impact Assessment (EIA), and further analysis and consideration of the proposal undertaken by the subject matter expert working groups in relation to the consultation feedback.

7.3.17 Following its considerations, the Lincolnshire ICS Clinical & Care Directorate and CCG Clinical Policies Sub-Group confirmed its continued support for the change proposal and considered the:

- Access criterion to be met

7.3.18 Building on the conclusions and actions identified by the working groups in response to the public feedback (Appendix F) and the actions identified in the updated EIA (Appendix H) the key comments made by the group in relation to the access criterion are set out in the table below.

Figure 49 – Orthopaedics access criterion: Key comments from the joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group

Criterion	Comments
Access ***Criteria Met***	It was highlighted that this could potentially not be fully met due to the travel and transport issues, however the criteria is met in terms of timeliness of access. No formal complaints have been made to United Lincolnshire Hospital Lincolnshire Hospital NHS Trust during the orthopaedics pilot in relation to travel and transport. Patients actively choose to travel to other providers out of the county, and the travel to the Grantham model is no different to the ones already in place and 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. The proposed model will enable more patients to receive their care in Lincolnshire. For a large proportion of patients this is seen as a better deal. The implementation of digital and virtual appointments will contribute to limiting the number of journeys.

7.3.19 The minutes of the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group are included in Appendix K.

7.3.20 Following the meeting of the ICS Clinical Directorate and CCG Clinical Policies Sub-Group the NHS Lincolnshire Quality and Patient Experience Committee (QPEC) reviewed the groups conclusions on the 12 May 2022 and supported them.

7.3.21 If the change proposals are agreed, as part of the implementation process continuous assessment and updates against the actions identified by the subject matter expert working groups, including the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), as well as those identified by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group and CCG QPEC will be undertaken and reported to the Implementation Oversight Group (IOG). The IOG is described further in Chapter 15.

7.3.22 A particular area of focus would be the opportunities to work with partners to strengthen current travel arrangements including:

- 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

7.3.23 If the change proposals are agreed, this ongoing work 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.

7.4 Affordability

7.4.1 The findings of the assessment of the orthopaedics proposal against the affordability criterion is **Met**.

7.4.2 This evidence base for this is:

- Review by ICS Finance Leaders Group

7.4.3 On 18 May 2022 the ICS Finance Leaders Group (FLG) met to consider the financial case and affordability of the four service change proposals.

7.4.4 Consideration was given to the affordability of the four change proposals and focused on two questions:

- Is the implementation of the option achievable and financially sustainable?
- Does the proposed option make best use of capital resources?

7.4.5 With regards to the first question in relation to ‘achievable and financially sustainable’ the view of FLG was this was ‘met’. Since preparing the Pre Consultation Business Case there has been no material change in the assumptions underpinning financial sustainability of the proposal. Therefore the proposal is seen to be achievable and financially sustainable. The FLG acknowledged a risk in recruiting substantive workforce to replace interim and agency staff, and this is referred to in the risk section of the finance chapter.

7.4.6 There is no capital requirement for this change proposal so the second question does not arise.

7.5 Deliverability

7.5.1 The findings of the assessment of the orthopaedics proposal against the deliverability criterion is **Met**.

7.5.2 This evidence base for this is:

- Statement of support from providers

7.5.3 The United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) supports the change proposal to develop a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital, along with a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery.

7.5.4 An overview of the key benefits to patients identified by ULHT and LCHS in relation to this change proposal are:

- Quality of care:
  - The evaluation of the orthopaedics pilot showed very positive results. The experience of the pilot has reaffirmed the proposed model for orthopaedic services.
  - Achieves a balance between access and ensuring the long term sustainability of services
  - The reconfiguration of services is highly likely to repatriate care back into Lincolnshire which in turn helps both patients and healthcare staff.
  - As an example - reduction in the average length of stay for elective orthopaedics at Grantham and District Hospital from 2.7 days to 1.7 days, demonstrating strong operational performance. A reduction in the Trust-wide orthopaedic elective length of stay has been achieved from 2.9 days to 2.3 days.
- Access to care:
  - Patients are more likely to receive timely assessment, treatment and diagnosis when they arrive at hospital.
  - Improve support to patients with regards to travel in the broadest sense across Lincolnshire.
  - Reduced cancellations for elective patients as following this reconfiguration as hot and cold activity are split.

7.5.5 The prosed model for orthopaedics in Lincolnshire is seen to support a more sustainable and resilient workforce:

- A reduction in a heavy reliance on locum and agency staff
- Increases the chances to recruiting to substantive roles
- The pilot workforce model has successfully removed all agency doctor usage within orthopaedics across ULHT. Before the pilot, agency doctors were used to cover one consultant post, a number of junior doctor posts and a number of middle grade posts.
- Helps staff maintain their skills working in a specialist elective centre with negligible patient cancellations

7.5.6 Key risks to delivery and their mitigations are included in the implementation chapter. If the change proposals are agreed, an implementation risk log would be established and managed by each service change proposal implementation group.

7.6 Patient and Public Support (*strong public and patient involvement*)

7.6.1 The findings of the assessment of the orthopaedics proposal against the patient and public support criterion is **Met**.

7.6.2 This evidence base for this is:

- Independent analysis of public consultation feedback

7.6.3 The overarching conclusion in the independent consultation report is *'There was also broad support for the proposal to create a 'Centre of Excellence' at Grantham and District Hospital for Lincolnshire's patients to receive planned and day case orthopaedic surgery, with a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery, across all elements of the consultation'.*

7.6.4 The consultation questionnaire identified that over two thirds of NHS staff who responded (68%) and three fifths (61%) of other individual respondents either tended to agree or strongly agreed with the proposal for orthopaedic surgery in Lincolnshire.

7.6.5 Support for the proposal for orthopaedic surgery among the Lincolnshire population as a whole (telephone survey) was even stronger, with over three quarters (78%) of residents (+/- 6%) agreeing with the proposed changes.

7.6.6 In feedback, support for the proposal to create a Centre of Excellence for planned orthopaedic surgery at Grantham and District Hospital was often linked to the perceived benefits in terms of reduced waiting times and fewer cancellations of planned surgery.

7.6.7 Disagreement tended to focus on the loss of emergency orthopaedic surgery from Grantham, which some opponents linked to the proposal to make changes to urgent and emergency care

7.6.8 Other concerns were also expressed, both by those who agreed with the proposal and those who disagreed; these included the implications for travel and access, staffing across two sites, and which services might be delivered locally or in the community

7.7 Consistency with need for patient choice

7.7.1 The findings of the assessment of the orthopaedics proposal against the consistency with need for patient choice criterion is **Met**.

7.7.2 This evidence base for this is:

- Choice statement from CCG

7.7.3 One of the national tests for service reconfiguration in the NHS is that the proposed changes are consistent with the current and prospective need for patient choice, as enshrined in the NHS Constitution.

7.7.4 The NHS Constitution states that individuals (subject to certain exclusions) have the right to choose the organisation or team that provides them with NHS care when referred for a first outpatient appointment with a service led by a consultant or by a named health care professional. There are certain exceptions including:

- Where speed of access to diagnosis and treatment is particularly important, for example in an emergency
- Attendance at cancer services under the two-week maximum waiting time.

7.7.5 Having assessed the proposals it is considered that patients will continue to be able to exercise choice in line with the NHS Constitution. See Appendix M for statement from NHS Lincolnshire CCG.

7.8 Support from clinical commissioners

7.8.1 The findings of the assessment of the orthopaedics proposal against the support from clinical commissioners criterion is **Met**.

7.8.2 The evidence base for this is:

- Support statement from CCG clinical leads

7.8.3 In developing the Pre-Consultation Business Case there was significant clinical discussion around the production of the options, including with clinical commissioners, but also counterparts from across the clinical workforce.

7.8.4 There has been clear and robust clinical commissioner input throughout the process, including in options development and appraisal and in the planning and execution of the public consultation, including development of the public consultation material.

7.8.5 NHS Lincolnshire CCG clinical leads have been present at public meetings as part of the public consultation sharing information and hearing first-hand the views of the public and issues that need careful consideration.

7.8.6 Since the completion of the public consultation NHS Lincolnshire CCG clinical leads:

- Have been part of the joint meetings of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group where the quality, clear clinical evidence base and access criterion were considered.
- Have been part of the NHS Lincolnshire CCG Executive discussions that have considered the change proposals against the whole criteria and informed the recommendations set out in this DMBC.

7.8.7 The NHS Lincolnshire CCG clinical leads also met as a group to explicitly discuss their support for the orthopaedics proposal. The conclusion of this was *'support the proposed service change'*.

7.8.8 In addition to support a number of points were made relating to implementation if the change is agreed:

- A roadmap needs to be developed to ensure a real 'centre of excellence' is established that optimises opportunities such as academic and multi-disciplinary training
- Opportunities should be identified to increase the volume of activity as this will support the development of a 'centre of excellence'.
- Need to make sure don't get a distillation of skills at different sites

7.9 Bed closures

7.9.1 The findings of the assessment of the orthopaedics proposal against the bed closure criterion is **Not Applicable**.

7.9.2 This evidence base for this is:

- A statement in relation to bed closures

7.9.3 One of the national tests for service reconfiguration is the consideration of bed closures. None of the changes described in the public consultation will require hospital bed closures. See Appendix M for statement from NHS Lincolnshire CCG.

8 Urgent and Emergency Care – analysis of proposal following consultation to inform decision making

8.1 Overview

8.1.1 The change proposal consulted on was for the Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre (UTC).

8.1.2 The table below provides an overview of the assessment of the urgent and emergency care proposal following public consultation, against local and national criteria. The rationale for the assessment and subsequent recommendations are set out in the remainder of this chapter.

Figure 50 – Urgent and emergency care: Overview of assessment against criteria

Local Criteria		National Criteria	
Criteria	**Finding**	**Criteria**	**Finding**
Quality	***Met***	**Patient and public support**	***Met***
Access	***Partially Met***	**Consistency with need for patient choice**	***Met***
Affordability	***Met***	**Clear clinical evidence base**	***Met***
Deliverability	***Met***	**Support from clinical commissioners**	***Met***
		Bed closures	***Not applicable***

8.2 Quality and Clear Clinical Evidence Base

8.2.1 The findings of the assessment of the urgent and emergency care proposal against the quality and clear clinical evidence base criterions is **Met**.

8.2.2 The evidence base for this is:

- Recommendations of the East Midlands Independent Clinical Senate Review Panels; and
- Review of East Midlands Clinical Senate recommendations and Quality Impact Assessments (QIA) by ICS Clinical and Care Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in context of public feedback on proposals and analysis of this by subject matter expert working groups

8.2.3 The East Midlands Clinical Senate review team was asked to consider whether there is a clear clinical evidence base underpinning the Lincolnshire health system's proposals. Specifically, the clinical review team was asked whether it supported the proposals based on clinical sustainability, workforce and clinical outcomes.

8.2.4 The development of the case for change and preferred option for urgent and emergency care has had substantial clinical consideration and input from across the Lincolnshire health system over a number of years, prior to review by the East Midlands Clinical Senate:

- 2016: Concerns regarding sustainability of three 24/7 A&E services at each of ULHT's hospital sites expressed by clinical leads at Lincoln County Hospital and Pilgrim Hospital, Boston which led to:
  - The development of options to address challenges faced in sustainability of A&E services led by ULHT Medical Director, supported by ULHT lead clinicians
  - The implementation of the overnight closure of Grantham and District Hospital A&E

- 2017: Review (2017) by the Independent Reconfiguration Panel (IRP), which is supported by clinical experts:
  - Identified the A&E service at Grantham Hospital has for some time (since 2007/08) only dealt with a limited range or presenting emergency conditions and that the level of emergency service provided from Grantham and District Hospital is more akin to that of an urgent care centre.
  - Confirmed this is not just about the appropriate use of terminology or signage but that unrealistic expectations and misunderstanding may have been allowed to develop about the level of service that can and should be provided at Grantham and District Hospital.
  - Concluded that in the interests of safety the A&E service at Grantham and District Hospital should not re-open 24/7 unless sufficient staff defined by the threshold can be recruited and retained.
- 2017: The East of England Clinical Senate review recommendations included:
  - Not support the reopening of the 24/7 A&E department at Grantham and District Hospital on the grounds of potential adverse impact on patient safety at A&E Departments at all three United Lincolnshire NHS Trust Hospitals.
  - In order to make it clear for patients and the public the type of service available at Grantham and District Hospital A&E, the Trust look to re-labelling or re-naming the department, and ensure that it communicates that widely. The panel further recommended that the terminology 'A&E Centre' is not applied to Grantham and District Hospital in any further model.

8.2.5 The presentation of the preferred option for urgent and emergency care services to the East Midlands Clinical Senate was led by local lead clinicians.

8.2.6 The East Midlands Clinical Senate only made one recommendation in relation to the proposed service model, which was the word 'Plus' in UTC is dropped. This was agreed on the day of the session. The East Midlands Clinical Senate panel considered the proposed exclusion criteria to be 'clear, comprehensive and excellent'.

8.2.7 On 21 April 2022 a joint meeting of the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group was held to review the conclusions of the working groups and consider if the information presented continued to support the establishment of:

- A 24/7 Urgent Treatment Centre (UTC) at Grantham and District Hospital, in place of the A&E department

8.2.8 The group considered all the information presented including the Pre Consultation Business Case (PCBC), feedback themes and data from the public consultation, an updated Quality Impact Assessment (QIA), and further analysis and consideration of the proposal undertaken by the subject matter expert working groups in relation to the consultation feedback.

8.2.9 Following its considerations, the Lincolnshire ICS Clinical & Care Directorate and CCG Clinical Policies Sub-Group confirmed its continued support for the change proposal and considered the:

- Quality criterion to be met; and
- Clear clinical evidence criterion to be met

8.2.10 Building on the conclusions and actions identified by the working groups in response to the public feedback (Appendix F) and the actions identified in the updated QIA (Appendix G) key comments made by the group in relation to the quality criterion and clear clinical evidence base criterion are set out in the table below.

Figure 51 – Urgent and emergency care: Quality and clear clinical evidence base criterion - Key comments from the joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group

Criterion	Comments
Quality ***Criteria Met***	Criterion met, however if service change is agreed key requirements for implementation and delivery are: • A comprehensive communication plan will 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. • All relevant health and care providers including 111, East Midlands Ambulance Service Trust (EMAS), primary care and community providers to be engaged and information provided detailing the full list of exclusion criteria for Grantham and District Hospital under the change proposals. • Detailed staffing model developed, and ongoing review and alignment of staffing model and ambulance conveyance arrangements for Grantham and District Hospital site • Detailed staffing model developed, and ongoing review of staffing model to ensure right staff skill mix is available and competent to stabilise and transfer patients whatever the condition that presents • Ongoing review of ambulance transfer protocols and ensure clear process is in place, including risk assessment and mitigations
Clear clinical evidence base ***Criteria Met***	From a clinical view the population has access to the services in the County and implementing a Type 1 A&E in Grantham may harm more people than save, and splitting limited resources across multiple sites/services is not appropriate, here is a need for specialisms to be concentrated in certain areas

8.2.11 The minutes of the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group are included in Appendix K.

8.2.12 Following the meeting of the ICS Clinical Directorate and CCG Clinical Policies Sub-Group the NHS Lincolnshire Quality and Patient Experience Committee (QPEC) reviewed the groups conclusions on the 12 May 2022 and supported them.

8.2.13 If the change proposals are agreed, as part of the implementation process continuous assessment against the actions identified by the subject matter expert working groups, including the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), as well as those identified by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group and CCG QPEC will be undertaken and reported to the Implementation Oversight Group (IOG). The IOG is described further in Chapter 15.

8.3 Access

8.3.1 The findings of the assessment of the urgent and emergency care proposal against the access criterion is **Partially Met**.

8.3.2 This evidence base for this is:

- Recommendations of the East Midlands Independent Clinical Senate Review Panels; and
- Review of the East Midlands Clinical Senate recommendations and independent Equality Impact Assessments by a joint meeting of the ICS Clinical and Care Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in the context of the public feedback and the work completed by subject matter expert working groups to consider and respond to it

8.3.3 An Equality Impact Assessment (EIA) was completed for the proposed urgent and emergency care change prior to commencing the consultation with the public, this was included in the Pre Consultation Business Case.

8.3.4 Within this initial assessment it was identified that the impact of the proposed service change proposals on access, particularly on groups with protected characteristics would be continued to be explored and understood through consultation with the public and following a review of the feedback and plans only finalised once that process is complete and decision made.

8.3.5 In this initial assessment the groups with protected characteristics that were identified as potentially being impacted by the proposed service change were age, disability and economically disadvantaged.

8.3.6 Following the completion of the public consultation, analysis of questionnaire and survey responses did not indicate that there were any strong differences in views or specific concerns being expressed by respondents from groups with protected characteristics under the Equalities Act 2010 (e.g., age, ethnicity, gender). Instead, the evidence indicates that it is local concerns that account for differences in views, with members of different demographic or protected characteristics groups tending to share the views of others living in the same area.

8.3.7 Where concerns were raised in feedback about particular groups (e.g., older people, people with disabilities, those from more deprived communities or living in rural areas), the focus was predominantly on travel and transport, particularly for those with limited access to private transport.

8.3.8 The one example of a slight difference was that, in the residents survey, there was evidence that residents with disabilities or long-term health conditions that limited their day-to-day activities a lot were significantly less likely to agree (and more likely to disagree) with proposals around urgent and emergency care Grantham and District Hospital than other residents (although there was still majority agreement); it should be noted that the feedback indicated that concerns about the proposal were again focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.

8.3.9 There were concerns about accessibility for specific groups including: people without personal access to a vehicle, people visiting friends/family, people needing to get home after treatment (including those who are too unwell to drive, and/or experiencing pain/discomfort), the elderly, people with disabilities, children, and those from low-income backgrounds.

8.3.10 As planned, the impact of the proposed service change proposals on access, particularly on groups with protected characteristics, was explored further in light of the feedback received through the consultation and the EIAs produced for the PCBC developed further, with independent support. An overview of these considerations, actions and mitigations identified in the EIA is set out below.

Figure 52 – Urgent and emergency care: Equality Impact Assessment (EIA) considerations, actions and mitigations

Groups	Considerations, actions and mitigations

Emergency Transport & Non-Emergency Transport
 	
For all patients in all groups (specifically those in age, disability and economically disadvantaged)
	• 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 (estimated to be around 97%) seen at the Grantham and District Hospital A&E department would continue to be seen and treated at the 24/7 Urgent Treatment Centre (UTC).
	
	• Estimated c.600 patients per year who are currently seen at Grantham A&E will be displaced to an alternative site:
	  ○ This is equivalent to c3.0% of the current activity, and the displacement is due to their care needs being better met in a more specialised service at an alternative hospital.
	  ○ Under the proposed changes it is estimated that of these displaced patients c.375 (based on 19/20 activity) will travel over 45 minutes by car for A&E services, the travel time threshold set by the local health system for this type of activity. It is estimated that currently c. 21,500 people in Lincolnshire travel over 45 minutes to access A&E by car.
	  ○ Given the acuity of patients who would no longer be seen at Grantham and District Hospital many are likely to travel by ambulance to an alternative site and therefore travel time could be less than 45 min.
	
	• EMAS have been fully engaged in the ASR and fully expect to be able to provide additional resources so that the impact of the proposed service changes on ambulance capacity is negligible.
	
	• It is fully expected that 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 assessment and treatment at hospitals that are further away from their home and for the discharge from these hospitals.
	
	• The patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers.

Other Transport **For all patients (specifically those in age, disability and economically disadvantaged) who are ineligible for non-emergency patient transport and transport for carers, relatives and visitors**	• This 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. • Solutions already exist such as voluntary care schemes and daily bus services between Lincoln County Hospital and Pilgrim Hospital, Boston and Lincoln County Hospital and Grantham and District Hospital; transport needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise. • The NHS in Lincolnshire is committed to working with 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, to strengthen current arrangements.
All Transport **For all patients in all groups (specifically those in age, disability and economically disadvantaged)**	• The transport impact overall as well as on those groups with protected characteristics would continue to be monitored during the implementation and 'go live' period of any agreed change. Including ensuring inequalities are not exacerbated. • The Lincolnshire health system is committed to tackling the impact of travel on air pollution through investment and engagement with staff, patients and the local authority. All the mitigations set out above will be developed and implemented in the context of this air pollution commitment and aim.
Disability	• Ensuring all services, if the changes are agreed, comply with the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support they need from health and care services.

Groups	Considerations, actions and mitigations
Race (in particular travellers/gypsies)	• Support with reading letters and access to online support and care to be considered as part of accessible services provision

8.3.11 On 21 April 2022 a joint meeting of the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group was held to review the conclusions of the working groups and consider if the information presented continued to support the establishment of:

- A 24/7 Urgent Treatment Centre (UTC) at Grantham and District Hospital, in place of the A&E department

8.3.12 The group considered all the information presented including the Pre Consultation Business Case (PCBC), feedback themes and data from the public consultation, the updated Equality Impact Assessment (EIA), and further analysis and consideration of the proposal undertaken by the subject matter expert working groups in relation to the consultation feedback.

8.3.13 Following its considerations, the Lincolnshire ICS Clinical & Care Directorate and CCG Clinical Policies Sub-Group confirmed its continued support for the change proposal and considered the:

- Access criterion to be partially met

8.3.14 Building on the conclusions and actions identified by the working groups in response to the public feedback (Appendix F) and the actions identified in the updated EIA (Appendix H) the key comments made by the group in relation to the Access criterion are set out in the table below.

Figure 53 – Urgent and emergency care access criterion: key comments from the joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group

Criterion	Comments
Access ***Criteria Partially Met***	Criterion partially met due to current county wide infrastructure Key mitigations identified are: • Ongoing joint working with Lincolnshire County Council on transport plans • Ensure a clear and comprehensive communication plan in terms of access routes and conditions treated by the service

8.3.15 The minutes of the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group are included in Appendix K.

8.3.16 Following the meeting of the ICS Clinical Directorate and CCG Clinical Policies Sub-Group the NHS Lincolnshire Quality and Patient Experience Committee (QPEC) reviewed the groups conclusions on the 12 May 2022 and supported them.

8.3.17 If the change proposals are agreed, as part of the implementation process continuous assessment and updates against the actions identified by the subject matter expert working groups, including the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), as well as those identified by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group and CCG QPEC will be undertaken and reported to the Implementation Oversight Group (IOG). The IOG is described further in Chapter 15.

8.3.18 A particular area of focus would be the opportunities to work with partners to strengthen current travel arrangements including:

- 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

8.3.19 If the change proposals are agreed, this ongoing work 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.

8.4 Affordability

8.4.1 The findings of the assessment of the urgent and emergency care proposal against the affordability criterion is **Met**.

8.4.2 This evidence base for this is:

- Review by ICS Finance Leaders Group

8.4.3 On 18 May 2022 the ICS Finance Leaders Group (FLG) met to consider the financial case and affordability of the four service change proposals.

8.4.4 Consideration was given to the affordability of the four change proposals and focused on two questions:

- Is the implementation of the option achievable and financially sustainable?
- Does the proposed option make best use of capital resources?

8.4.5 With regards to the first question in relation to 'achievable and financially sustainable' the view of FLG was this was 'met'. Since preparing the Pre Consultation Business Case there has been no material change in the assumptions underpinning financial sustainability of the proposal. Therefore the proposal is seen to be achievable and financially sustainable.

8.4.6 There is no capital requirement for this change proposal so the second question does not arise.

8.5 Deliverability

8.5.1 The findings of the assessment of the urgent and emergency care proposal against the deliverability criterion is **Met**.

8.5.2 This evidence base for this is:

- Statements of support from providers

8.5.3 The United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) supports the change proposal to re-designate the Grantham A&E service as an Urgent Treatment Centre (UTC) and maintain 24/7 A&E services provided from Lincoln County Hospital and Pilgrim Hospital, Boston and consider it deliverable and sustainable.

8.5.4 An overview of the key benefits to patients identified by ULHT and LCHS in relation to this change proposal are:

- Quality of care:
  - Reduce the number of intra hospital transfers to another site, so demonstrating that the patient was getting to the definitive treatment site, first time.
  - Support a more consistent achievement of clinical standards, i.e. the NHS constitutional four-hour standard, time to triage at the Lincoln County Hospital and Pilgrim Hospital, Boston sites and time to treatment across all three ULHT hospital sites.
  - Ensuring Grantham Hospital receives an appropriate mix of patient acuity in line with its capabilities.

- Aligns with NHS England and Improvements vision for urgent and emergency care patients.
- Encourages integrated service delivery between primary care, community care and acute care providers.
- Given the medical workforce challenges and heavy reliance on locum doctors who are likely to represent a less stable workforce, will minimise additional pressures across the A&E system in Lincolnshire and patient risk.
- Minimise the pressure on ULHT's nursing staff, where there are already significant vacancies, and therefore impact on the quality and safety of care provided

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

8.5.5 Consideration by ULHT and LCHS identifies the proposed model supports a more sustainable workforce by:

- The Consultant workforce will be ULHT employed and will undertake sessions at Grantham and District Hospital Urgent Treatment Centre on a rotational basis. This will support the likelihood of recruiting to substantive ED Consultant posts by linking the service to the remaining Type 1 EDs.
- Initially a total of ten sessions of Emergency Medicine Consultant cover will be provided (equivalent to 40 hours a week). This will be reviewed at three, six and 12 months.
- The proposed model being led by a community provider should also minimise the pressure on ULHT's nursing staff, where there are already significant vacancies.
- By implementing the proposed model of an Urgent Treatment Centre at Grantham and District Hospital it is believed the optimum balance of patient volumes, acuity, outcomes and resource will be achieved. Medical middle grades will support the UTC between 08.00 and midnight when activity is known to be at its highest and will not need to staff an on-call rota at night. When the A&E operated as a 24/7 service on average 11 patients a day attended between 23.00 and 07.00.

8.5.6 By implementing the proposed model of an Urgent Treatment Centre at Grantham Hospital it is believed the optimum balance between patient volumes, acuity outcomes and resources will be achieved.

8.5.7 Key risks to delivery and their mitigations are included in the implementation chapter. If the change proposals are agreed, an implementation risk log would be established and managed by each service change proposal implementation group.

8.6 Patient and Public Support (*strong public and patient involvement*)

8.6.1 The findings of the assessment of the urgent and emergency care proposal against the patient and public support criterion is **Met**.

8.6.2 This evidence base for this is:

- Independent analysis of public consultation feedback

8.6.3 The overarching conclusion in the independent consultation report is *'There was overall support for the proposal to provide 24/7 walk-in urgent care services in Grantham via an Urgent Treatment Centre (UTC) at Grantham and District Hospital'*.

8.6.4 The consultation questionnaire identified that around three fifths of NHS staff who responded (61%) and half (50%) of other individual respondents either tended to agree or strongly agreed with the proposal to create a UTC at Grantham and District Hospital.

8.6.5 Support for the proposal among the Lincolnshire population as a whole (telephone survey) was much stronger, with over four fifths (81%) of residents (+/- 6%) agreeing with the proposed changes.

8.6.6 There was, however, evidence of differing views on the proposal for a 24-hour UTC at Grantham and District Hospital between those living in different areas of Lincolnshire. There is evidence that concerns about the proposals for urgent and emergency care are strongest among those living nearest to Grantham and District Hospital.

8.6.7 This is most particularly marked in the questionnaire responses, in which just over half (51%) of all individual respondents living closest to Grantham and District Hospital expressed disagreement with the proposal, compared to 44% who agreed.

8.6.8 Support for the proposal to provide 24/7 walk-in urgent care services at Grantham and District Hospital was most commonly based on the view that a local 24-hour UTC is preferable to a limited-hours A&E department that is not able to meet the needs of all patients.

8.6.9 Disagreement with the proposal for a new 24/7 walk-in Urgent Treatment Centre in Grantham was most commonly based on the view that anything less than a fully equipped and staffed Emergency Department at Grantham and District Hospital would be unacceptable, rather than a desire for services to remain unchanged.

8.6.10 Many of the concerns expressed about the proposal were shared by those who agreed and those who disagreed with the proposals; for the former, these were potential issues to be considered and mitigated against while, for those who disagreed, they were reasons to reject the proposals for a 24/7 UTC and increase service provision at Grantham and District Hospital.

8.6.11 Concerns around potential impacts of the proposals focused predominantly on travel and transport; there was also positive feedback about the benefits of 24-hour access to local urgent care services.

8.7 Consistency with need for patient choice

8.7.1 The findings of the assessment of the urgent and emergency care proposal against the consistency with need for patient choice criterion is **Met**.

8.7.2 This evidence base for this is:

- Choice statement from CCG

8.7.3 One of the national tests for service reconfiguration in the NHS is that the proposed changes are consistent with the current and prospective need for patient choice, as enshrined in the NHS Constitution.

8.7.4 The NHS Constitution states that individuals (subject to certain exclusions) have the right to choose the organisation or team that provides them with NHS care when referred for a first outpatient appointment with a service led by a consultant or by a named health care professional. There are certain exceptions including:

- Where speed of access to diagnosis and treatment is particularly important, for example in an emergency
- Attendance at cancer services under the two-week maximum waiting time.

8.7.5 Having assessed the proposals it is considered that patients will continue to be able to exercise choice in line with the NHS Constitution. See Appendix M for statement from NHS Lincolnshire CCG.

8.8 Support from clinical commissioners

8.8.1 The findings of the assessment of the orthopaedics proposal against the support from clinical commissioners criterion is **Met.**

8.8.2 This evidence base for this is:

- Support statement from CCG clinical leads

8.8.3 In developing the Pre-Consultation Business Case there was significant clinical discussion around the production of the options, including with clinical commissioners, but also counterparts from across the clinical workforce.

8.8.4 There has been clear and robust clinical commissioner input throughout the process, including in options development and appraisal and in the planning and execution of the public consultation, including development of the public consultation material.

8.8.5 NHS Lincolnshire CCG clinical leads have been present at public meetings as part of the public consultation sharing information and hearing first-hand the views of the public and issues that need careful consideration.

8.8.6 Since the completion of the public consultation the NHS Lincolnshire CCG clinical leads:

- Have been part of the joint meetings of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group where the quality, clear clinical evidence base and access criteria were considered.
- Have been part of the NHS Lincolnshire CCG Executive discussions that have considered the change proposals against the criteria and informed the recommendations set out in this DMBC.

8.8.7 The NHS Lincolnshire CCG clinical leads also met as a group to explicitly discuss their support for the urgent and emergency care proposal. The conclusion of this was *'support the proposed service change'*.

8.8.8 In addition to support a number of points were made relating to implementation if the change 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.
- It is only the most acutely ill patients that will be treated at an alternative site, which is clinically appropriate and where their needs will be best met.
- If the service change is agreed, 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.

8.9 Bed closures

8.9.1 The findings of the assessment of the urgent and emergency care proposal against the bed closure criterion is **Not Applicable**.

8.9.2 This evidence base for this is:

- A statement in relation to bed closures

8.9.3 One of the national tests for service reconfiguration is the consideration of bed closures. None of the changes described in the public consultation will require acute hospital bed closures. See Appendix M for statement from NHS Lincolnshire CCG.

9 Acute Medicine – analysis of proposal following consultation to inform decision making

9.1 Overview

9.1.1 The change proposal consulted on was to develop integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.

9.1.2 The table below provides an overview of the assessment of the acute medicine proposal, following public consultation, against local and national criteria. The rationale for the assessment and subsequent recommendations are set out in the remainder of the chapter.

Figure 54 – Acute medicine: Overview of assessment against criteria

Local Criteria		National Criteria	
Criteria	**Finding**	**Criteria**	**Finding**
Quality	***Met***	**Patient and public support**	***Met***
Access	***Met***	**Consistency with need for patient choice**	***Met***
Affordability	***Met***	**Clear clinical evidence base**	***Met***
Deliverability	***Met***	**Support from clinical commissioners**	***Met***
		Bed closures	***Not applicable***

9.2 Quality and Clear Clinical Evidence Base

9.2.1 The findings of the assessment of the acute medicine proposal against the quality and clear clinical evidence base criterions is **Met**.

9.2.2 The evidence base for this is:

- Recommendations of the East Midlands Independent Clinical Senate Review Panels; and
- Review of East Midlands Clinical Senate recommendations and Quality Impact Assessments (QIA) by ICS Clinical and Care Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in context of public feedback on proposals and analysis of this by subject matter expert working groups

9.2.3 The East Midlands Clinical Senate review team was asked to consider whether there is a clear clinical evidence base underpinning the Lincolnshire health system's proposals. Specifically, the clinical review team was asked whether it supported the proposals based on clinical sustainability, workforce and clinical outcomes.

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

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

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

9.2.7 On 21 April 2022 a joint meeting of the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group was held to review the conclusions of the working groups and consider if the information presented continued to support the establishment of:

- Integrated community/acute medical beds at Grantham and District Hospital

9.2.8 The group considered all the information presented including the Pre Consultation Business Case (PCBC), feedback themes and data from the public consultation, an updated Quality Impact Assessment (QIA), and further analysis and consideration of the proposal undertaken by the subject matter expert working groups in relation to the consultation feedback.

9.2.9 Following its considerations, the Lincolnshire ICS Clinical & Care Directorate and CCG Clinical Policies Sub-Group confirmed its continued support for the change proposal and considered the:

- Quality criterion to be met; and
- Clear clinical evidence criterion to be met

Figure 55 – Acute medicine: quality and clear clinical evidence base criterion - key comments from the joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group

Criterion	Comments
Quality ***Criteria Met***	Challenge: Given this is an innovative model should it be partially met as not in receipt of all the detail recognising that there is further work to do. Need further understanding of how the model will work such as workforce, accountability and where the responsibilities sit and does not detract from quality of care.
Clear clinical evidence base ***Criteria Met***	Response: There is strong clinical evidence base for the model, ICS and advent of PCNs about integration which makes it stronger. As work progresses this will require oversight. Criteria met, however if service change is agreed key requirements for implementation and delivery are: • Detailed workforce planning to ensure the model attracts in and retains workforce, and governance and accountability arrangements ae clear between partners delivering the service. • Existing bed capacity is optimised and cohorts extended in line with detailed workforce planning

9.2.10 The minutes of the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group are included in Appendix K.

9.2.11 Following the meeting of the ICS Clinical Directorate and CCG Clinical Policies Sub-Group the NHS Lincolnshire Quality and Patient Experience Committee (QPEC) reviewed the groups conclusions on the 12 May 2022 and supported them.

9.2.12 If the change proposals are agreed, as part of the implementation process continuous assessment against the actions identified by the subject matter expert working groups, including the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), as well as those identified by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group and CCG QPEC will be undertaken and reported to the Implementation Oversight Group (IOG). The IOG is described further in Chapter 15.

9.3 Access

9.3.1 The findings of the assessment of the urgent and emergency care proposal against the access criterion is **Met**.

9.3.2 This evidence base for this is:

- Recommendations of the East Midlands Independent Clinical Senate Review Panels; and
- Review of the East Midlands Clinical Senate recommendations and independent Equality Impact Assessments by a joint meeting of the ICS Clinical and Care Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in the context of the public feedback and the work completed by subject matter expert working groups to consider and respond to it

9.3.3 An Equality Impact Assessment (EIA) was completed for the proposed urgent and emergency care change prior to commencing the consultation with the public, this was included in the Pre Consultation Business Case.

9.3.4 Within this initial assessment it was identified that the impact of the proposed service change proposals on access, particularly on groups with protected characteristics would be continued to be explored and understood through consultation with the public and following a review of the feedback and plans only finalised once that process is complete and decision made.

9.3.5 In this initial assessment the groups with protected characteristics that were identified as potentially being impacted by the proposed service change were age and economically disadvantaged.

9.3.6 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 previously stated concerns about travel and access for groups without access to private transport.

9.3.7 Several respondents, including some NHS staff members, felt that the proposed move to 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.

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

9.3.9 In feedback from individuals with protected characteristics or other key demographics, their views on the proposals were typically informed most strongly by their area of residence, regardless of any other demographic characteristics.

9.3.10 One exception was that evidence suggested that residents with the most limiting disabilities or long-term health conditions were significantly less likely to agree (and more likely than other residents to disagree) with proposals around acute medical beds at Grantham and District Hospital (although there was still majority agreement); it should be noted that the feedback indicated that their concerns were focused on loss of acute services and travel and access to alternative sites.

9.3.11 As planned, the impact of the proposed service change proposals on access, particularly on groups with protected characteristics, was explored further in light of the feedback received through the consultation and the EIAs produced for the PCBC developed further, with independent support. An overview of these the considerations, actions and mitigations identified in the EIA is set out below.

Figure 56 – Acute medicine: Equality Impact Assessment (EIA) considerations, actions and mitigations

Groups	Considerations, actions and mitigations
Emergency Transport & Non-Emergency Transport **For all patients in all groups (specifically those in age, disability and economically disadvantaged)**	• The majority of patients (estimated to be around 90%) cared for in the acute medical beds at Grantham and District Hospital would continue to be cared for in the integrated community/acute medical beds • The proposal for change would deliver a more comprehensive local service provision at Grantham and District Hospital, specifically in relation to the 'frail' population. • Estimated c.385 patients per year who are currently seen by the medical service at Grantham and District Hospital will be displaced to an alternative site. o This is equivalent to c10% of the current activity, and the displacement is due to their care needs being better met in a more specialised service at an alternative hospital. o Under the proposed changes it is estimated that there will be no increase in the number of patients travelling more than 60 minutes by car, the threshold agreed for this type of activity o However, in reality given the existing exclusion criteria and current usage of the Grantham and District Hospital site many of the patients who would no longer attend Grantham and District Hospital would actually travel by ambulance and therefore their travel time would likely to be less than 60 minutes. • EMAS have been fully engaged in the ASR and fully expect to be able to provide additional resources so that the impact of the proposed service changes on ambulance capacity is negligible. • It is fully expected that 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 assessment and treatment at hospitals that are further away from their home and for the discharge from these hospitals. • The patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers.
Other Transport **For all patients (specifically those in age, disability and economically disadvantaged) who are ineligible for non-emergency patient transport and transport for carers, relatives and visitors**	• This 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. • Solutions already exist such as voluntary care schemes and daily bus services between Lincoln County Hospital and Pilgrim Hospital, Boston and Lincoln County Hospital and Grantham and District Hospital; transport needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise. • The NHS in Lincolnshire is committed to working with 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, to strengthen current arrangements.
All Transport **For all patients in all groups (specifically those in age, disability and economically disadvantaged)**	• The transport impact overall as well as on those groups with protected characteristics would continue to be monitored during the implementation and 'go live' period of any agreed change. Including ensuring inequalities are not exacerbated. • The Lincolnshire health system is committed to tackling the impact of travel on air pollution through investment and engagement with staff, patients and the local authority. All the mitigations set out above will be developed and implemented in the context of this air pollution commitment and aim.

Groups	Considerations, actions and mitigations
Disability	• Ensuring all services, if the changes are agreed, comply with the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support they need from health and care services.

9.3.12 On 21 April 2022 a joint meeting of the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group was held to review the conclusions of the working groups and consider if the information presented continued to support the establishment of:

- Integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds

9.3.13 The group considered all the information presented including the Pre Consultation Business Case (PCBC), feedback themes and data from the public consultation, the updated Equality Impact Assessment (EIA), and further analysis and consideration of the proposal undertaken by the subject matter expert working groups in relation to the consultation feedback.

9.3.14 Following its considerations, the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group confirmed its continued support for the change proposal and considered the:

- Access criterion to be met

9.3.15 Building on the conclusions and actions identified by the working groups in response to the public feedback (Appendix F) and the actions identified in the updated EIA (Appendix H) the key comments made by the group in relation to the Access criterion are set out in the table below.

Figure 57 – Acute medicine access criterion: key comments from the joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group

Criterion	Comments
Access ***Criteria Met***	• Distinction needs to be drawn between these proposals and the Urgent and Emergency Care proposal as these are based on admitted patients. • Supports repatriation of patients from Grantham and the surrounding areas so they can receive care closer to home • Ensure alignment with wider system strategies that are addressing digital poverty whilst exploring opportunities such as virtual wards and telemonitoring

9.3.16 The minutes of the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group are included in Appendix K.

9.3.17 Following the meeting of the ICS Clinical Directorate and CCG Clinical Policies Sub-Group the NHS Lincolnshire Quality and Patient Experience Committee (QPEC) reviewed the groups conclusions on the 12 May 2022 and supported them.

9.3.18 If the change proposals are agreed, as part of the implementation process continuous assessment and updates against the actions identified by the subject matter expert working groups, including the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), as well as those identified by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group and CCG QPEC will be undertaken and reported to the Implementation Oversight Group (IOG). The IOG is described further in Chapter 15.

9.3.19 A particular area of focus would be the opportunities to work with partners to strengthen current travel arrangements including:

- 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

9.3.20 If the change proposals are agreed, this ongoing work 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.

9.4 Affordability

9.4.1 The findings of the assessment of the acute medicine proposal against the affordability criterion is **Met**.

9.4.2 This evidence base for this is:

- Review by ICS Finance Leaders Group

9.4.3 On 18 May 2022 the ICS Finance Leaders Group (FLG) met to consider the financial case and affordability of the four service change proposals.

9.4.4 Consideration was given to the affordability of the four change proposals and focused on two questions:

- Is the implementation of the option achievable and financially sustainable?
- Does the proposed option make best use of capital resources?

9.4.5 With regards to the first question in relation to 'achievable and financially sustainable' the view of FLG was this was 'met'. Since preparing the Pre Consultation Business Case there has been no material change in the assumptions underpinning financial sustainability of the proposal. Therefore the proposal is seen to be achievable and financially sustainable.

9.4.6 There is no capital requirement for this change proposal so the second question does not arise.

9.5 Deliverability

9.5.1 The findings of the assessment of the acute medicine proposal against the deliverability criterion is **Met**.

9.5.2 This evidence base for this is:

- Statements of support from providers

9.5.3 The United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) supports the change proposal to provide integrated community/acute beds at Grantham and District Hospital.

9.5.4 An overview of the key benefits to patients identified by ULHT and LCHS in relation to this change proposal are:

- Quality of care:
  - Providing an excellent balance between access and sustainable long term outcomes.
  - Achieving a balance between access and ensuring the long term sustainability of services.
  - Grantham Hospital will become a hub for supporting community teams and community services across the county (including existing inpatient community hospital beds), reducing acute medicine admissions not just at Grantham Hospital but potentially across the county.

- The Same Day Emergency Care (SDEC) unit will offer an expansion of the current Ambulatory Assessment Unit (AAU), which is to be re-named in line with the national shift to 'Same Day Emergency Care'. The unit would receive referrals directly from the UTC, EMAS and primary / community care teams. The SDEC unit will be led by an Acute Physician team.
- Complex Frailty Service will offer specialist care and support for elderly and frail patients, including those with complex needs. The team will offer a day assessment and care service, supporting frail/complex patients who require diagnostics, multi-disciplinary assessment, medical review, therapy and social service assessments.
- The proposal would enable 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

- Access to care:
  - It is estimated that no more patients than currently do now will be travelling over 60 minutes for non-elective care, the travel time threshold set by the local health system for activity of this type.
  - Patients are more likely to receive timely assessment, treatment and diagnosis when they arrive at hospital.
  - Patients are more likely to see the right specialist, first time, 24/7 and receive the best possible care.
  - More patients going to the right place for care first time and minimising subsequent transfers.

9.5.5 Consideration by ULHT and LCHS identifies the proposed model supports a more sustainable workforce by:

- Introducing exposure to community-based services for the medical teams, particularly trainee roles, developing new specialists for the future with a more detailed understanding of the capabilities of community teams and the growing capacity for higher acuity care in the community.
- Reduce medical workload reliance and increase consistency of provision.
- Supports a concentration (through service consolidation and the provision of fewer beds) of nursing staff at the Lincoln site, where there are currently fewer vacancies than at the Pilgrim site.
- ULHT and the community provider would work together closely to establish the employment arrangements for the consultants and middle grades.
- Recruitment and retention of medical staff has been a long-standing concern for ULHT, although Grantham and District Hospital has not had as many issues as Lincoln County Hospital and Pilgrim Hospitals, Boston. At Grantham Hospital the majority of consultant posts are held by permanent Trust employees offering a consistency of service and training provision. Though there has been an increase in agency cover for some specialties more recently.

9.5.6 Key risks to delivery and their mitigations are included in the implementation chapter. If the change proposals are agreed, an implementation risk log would be established and managed by each service change proposal implementation group.

9.6 Patient and Public Support (*strong public and patient involvement*)

9.6.1 The findings of the assessment of the acute medicine proposal against the patient and public support criterion is **Met**.

9.6.2 This evidence base for this is:

- Independent analysis of public consultation feedback

9.6.3 The overarching conclusion in the independent consultation report *is 'There was broad agreement with the proposal for community/acute medical beds, seen by many as an opportunity to better integrate hospital and community services to the benefits of patients'*.

9.6.4 There was majority support for the proposals to provide integrated community/acute medical beds across all stakeholder and consultation strands. Of note, however, is evidence of a level of uncertainty about the proposal, with many consultation respondents indicating that they neither agreed nor disagreed with the proposals, or that they felt unable to provide a view.

9.6.5 Just over three fifths (62%) of NHS employees in the open questionnaire agreed with the proposal to provide integrated community/acute medical beds at Grantham and District Hospital. There was also majority agreement from other individual questionnaire respondents (53%).

9.6.6 Over three quarters (78%, +/- 6%) of Lincolnshire residents (telephone survey) expressed support for the proposals.

9.6.7 Across consultation feedback, those who agreed with the proposal to provide integrated community/acute medical beds felt that it would provide benefits such as more efficient care, with patients being discharged more quickly while continuing to receive treatment and care in their communities. Indeed, staff and patient representatives said they would like to see this model replicated across the Trust.

9.6.8 Those disagreeing with the proposal felt that Grantham and District Hospital should be a fully serviced hospital with acute medical beds (as opposed to integrated medical beds), especially given the need to account for the area's growing and ageing population. There were also concerns around negative impacts on quality of care, and the potential for increased pressure on other hospital sites.

9.6.9 Other concerns expressed were around overall bed numbers, costs, staff shortages, and capacity within primary and social care services. Further clarity was sought on the impact of the proposals on overall bed space at Grantham and District Hospital, and concerns were expressed about capacity within the other services that are essential in facilitating change - adult social care and primary care for example.

9.6.10 Other worries focused on the cost of implementing the changes and the anticipated increase in staff workloads. Moreover, the latter would, it was felt, be compounded by shortages among community- and hospital-based staff, both of whom are crucial to the successful implementation of this proposal.

9.7 Consistency with need for patient choice

9.7.1 The findings of the assessment of the acute medicine proposal against the consistency with need for patient choice criterion is **Met**.

9.7.2 This evidence base for this is:

- Choice statement from CCG

9.7.3 One of the national tests for service reconfiguration in the NHS is that the proposed changes are consistent with the current and prospective need for patient choice, as enshrined in the NHS Constitution.

9.7.4 The NHS Constitution states that individuals (subject to certain exclusions) have the right to choose the organisation or team that provides them with NHS care when referred for a first outpatient appointment with a service led by a consultant or by a named health care professional. There are certain exceptions including:

- Where speed of access to diagnosis and treatment is particularly important, for example in an emergency
- Attendance at cancer services under the two-week maximum waiting time.

9.7.5 Having assessed the proposals it is considered that patients will continue to be able to exercise choice in line with the NHS Constitution. See Appendix M for statement from NHS Lincolnshire CCG.

9.8 Support from clinical commissioners

9.8.1 The findings of the assessment of the acute medicine proposal against the support from clinical commissioners criterion is **Met**.

9.8.2 This evidence base for this is:

- Support statement from CCG clinical leads

9.8.3 In developing the Pre-Consultation Business Case there was significant clinical discussion around the production of the options, including with clinical commissioners, but also counterparts from across the clinical workforce.

9.8.4 There has been clear and robust clinical input throughout the process, including in options development and appraisal and in the planning and execution of the public consultation, including development of the public consultation material.

9.8.5 NHS Lincolnshire CCG clinical leads have been present at public meetings as part of the public consultation sharing information and hearing first-hand the views of the public and issues that need careful consideration.

9.8.6 Since the completion of the public consultation the NHS Lincolnshire CCG clinical leads:

- Have been part of the joint meetings of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group where the quality, clear clinical evidence base and access criteria were considered.
- Have been part of the NHS Lincolnshire CCG Executive discussions that have considered the change proposals against the criteria and informed the recommendations set out in this DMBC.

9.8.7 The NHS Lincolnshire CCG clinical leads also met as a group to explicitly discuss their support for the acute medicine proposal. The conclusion of this was *'support the proposed service change'*.

9.8.8 In addition to support a number of points were made relating to implementation if the change is agreed:

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

9.9 Bed closures

9.9.1 The findings of the assessment of the urgent and emergency care proposal against the bed closure criterion is **Not Applicable**.

9.9.2 This evidence base for this is:

- A statement in relation to bed closures

9.9.3 One of the national tests for service reconfiguration is the consideration of bed closures. None of the changes described in the public consultation will require hospital bed closures. See Appendix M for statement from NHS Lincolnshire CCG.

10 Stroke – analysis of proposal following consultation to inform decision making

10.1 Overview

10.1.1 The change proposal consulted on was to consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation team.

10.1.2 The table below provides an overview of the assessment of the stroke proposal, following public consultation, against local and national criteria. The rationale for the assessment and subsequent recommendations are set out in the remainder of the chapter.

Figure 58 – Stroke: Overview of assessment against criteria

Local Criteria		National Criteria	
Criteria	**Finding**	**Criteria**	**Finding**
Quality	***Met***	**Patient and public support**	***Met***
Access	***Met***	**Consistency with need for patient choice**	***Met***
Affordability	***Met***	**Clear clinical evidence base**	***Met***
Deliverability	***Met***	**Support from clinical commissioners**	***Met***
		Bed closures	***Not applicable***

10.2 Quality and Clear Clinical Evidence Base

10.2.1 The findings of the assessment of the stroke proposal against the quality and clear clinical evidence base criterions is **Met**.

10.2.2 This evidence base for this is:

- Recommendations of the East Midlands Independent Clinical Senate Review Panels; and
- Review of East Midlands Clinical Senate recommendations and Quality Impact Assessments (QIA) by ICS Clinical and Care Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in context of public feedback on proposals and analysis of this by subject matter expert working groups

10.2.3 The East Midlands Clinical Senate review team was asked to consider whether there is a clear clinical evidence base underpinning the Lincolnshire health system's proposals. Specifically, the clinical review team was asked whether it supported the proposals based on clinical sustainability, workforce and clinical outcomes.

10.2.4 The proposal to consolidate hyper-acute and acute stroke services at Lincoln County Hospital was designed through a number of clinically led workshops headed by the Stroke Consultants at ULHT with support and contributions from Professor Rudd (the National Clinical Director for Stroke Services), and local acute, primary and community based health professional.

10.2.5 When this model was presented to the East Midlands Clinical Senate they praised that it seemed to be well led clinically, and from the evidence provided to the panel, appeared it had been well researched.

10.2.6 The East Midlands Clinical Sente reported that the proposed reconfiguration would reduce unwarranted variation in outcomes and would ensure a more consistent achievement of clinical standards and national guidelines.

10.2.7 The clinical review team supported the proposal for stroke services and recommended the health system proceed with it.

10.2.8 The East Midlands Clinical Senate also made a number of recommendations. Responses to the clinical review team's recommendation were included in the Pre Consultation Business Case and reviewed as part of the NHS England and Improvement assurance process which was completed before starting the public consultation.

10.2.9 On 28 April 2022 a joint meeting of the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group was held to review the conclusions of the working groups and consider if the information presented continued to support the establishment of:

- Hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation team.

10.2.10 The group considered all the information presented including the Pre Consultation Business Case (PCBC), feedback themes and data from the public consultation, an updated Quality Impact Assessment (QIA), and further analysis and consideration of the proposal undertaken by the subject matter expert working groups in relation to the consultation feedback.

10.2.11 Following its considerations, the Lincolnshire ICS Clinical & Care Directorate and CCG Clinical Policies Sub-Group confirmed its continued support for the change proposal and considered the:

- Quality criterion to be met; and
- Clear clinical evidence criterion to be met

10.2.12 Building on the conclusions and actions identified by the working groups in response to the public feedback (Appendix F) and the actions identified in the updated QIA (Appendix G) key comments made by the group in relation to the quality criterion and clear clinical evidence base criterion are set out in the table below.

Figure 59 – Stroke: quality criterion and clear clinical evidence base criterion: Key comments from the joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group

Criterion	Comments
Quality ***Criteria Met***	There is not enough work for two stroke centres in Lincolnshire and if there is not the critical mass of patients they are unlikely to be attractive to recruit and retain staff – c.50% vacancy rate across England for stroke doctors. Trying to operate a parallel service on two sites when there is already a stretched workforce both nationally and locally can lead to disservice and it is crucial that a high level 7-day service is provided from the one site. The temporary change has shown reduced times to diagnosis and treatment.
Clear clinical evidence base ***Criteria Met***	The temporary change 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. Mechanical thrombectomy pathway between Lincoln County Hospital and Queen's Medical Centre in Nottingham is straight forward and there are no delays - the thrombectomy time frame has been extended to anything between 16 and 24 hours depending on the centre that takes the patient. However the proposed service change is not just about thrombolysis (which accounts for approximately 10% of strokes) but for all stroke patients – if these patients are admitted to a well-staffed unit their outcomes overall are much better. It is not only the thrombolysis and the mechanical element but having the skilled and dedicated workforce that can provide the high-level Consultant led 7-day provision that augments the patient journey and improves outcomes. Proposals mirror the cardiology model and the way that organisations have consolidated services based on syndromes/diseases that need the 7-day Consultant led service.

Criterion	Comments
	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 is an important part of the whole process and the proposed Centre of Excellence is crucial to the development of community services – rotational posts for stroke rehabilitation between acute and community setting are being explored. The proposal will attract staff bringing in a higher skilled workforce which will ultimately improve the patient outcomes and develop the MDT approach.

10.2.13 The minutes of the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group are included in Appendix K.

10.2.14 Following the meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group the NHS Lincolnshire Quality and Patient Experience Committee (QPEC) reviewed the groups conclusions on 12 May 2022 and supported them.

10.2.15 If the change proposals are agreed, as part of the implementation process continuous assessment against the actions identified by the subject matter expert working groups, including the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), as well as those identified by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group and CCG QPEC will be undertaken and reported to the Implementation Oversight Group (IOG). The IOG is described further in Chapter 15.

10.3 Access

10.3.1 The findings of the assessment of the urgent and emergency care proposal against the access criterion is **Met**.

10.3.2 This evidence base for this is:

- Recommendations of the East Midlands Independent Clinical Senate Review Panels; and
- Review of the East Midlands Clinical Senate recommendations and independent Equality Impact Assessments by a joint meeting of the ICS Clinical and Care Directorate & CCG Clinical Policies Sub-Group and CCG QPEC in the context of the public feedback and the work completed by subject matter expert working groups to consider and respond to it

10.3.3 An Equality Impact Assessment (EIA) was completed for the proposed urgent and emergency care change prior to commencing the consultation with the public, this was included in the Pre Consultation Business Case.

10.3.4 Within this initial assessment it was identified that the impact of the proposed service change proposals on access, particularly on groups with protected characteristics would be continued to be explored and understood through consultation with the public and following a review of the feedback and plans only finalised once that process is complete and decision made.

10.3.5 In this initial assessment the groups with protected characteristics that were identified as potentially being impacted by the proposed service change were age and economically disadvantaged.

10.3.6 Feedback to the public consultation included the view from some people that the proposal could widen health inequalities and negatively impact patient access as services would be removed from a deprived area.

10.3.7 Consultation feedback also suggested the stroke figures for the area served by Pilgrim Hospital, Boston are higher owing to an ageing population. It was thought to make more sense, therefore, to have a centre of excellence in Boston to reduce travel times for the majority.

10.3.8 The impact on patients' loved ones was also noted, particularly elderly spouses/family who may be unable to visit due to the increased travel distance. The impact of this on patients' mental health and recovery may, it was said, have been overlooked.

10.3.9 Feedback from members of protected characteristics groups and other key demographics tended to express some concerns about travel and transport along the same lines as other respondents.

10.3.10 In the consultation questionnaire data, slightly more respondents from the most deprived communities disagreed with proposals for stroke services than agreed. It should be noted, however, that further analysis indicated that this was almost certainly a result of the majority of questionnaire respondents from deprived communities living in Boston and East Lindsey, closest to Pilgrim Hospital, Boston.

10.3.11 Boston and East Lindsey are geographic areas in which the views among respondents from both deprived and more affluent communities were more negative than elsewhere; the implication, therefore, is that it is shared concerns about loss of local services in Boston driving disagreement, rather than a particular or separate concern from those experiencing deprivation.

10.3.12 In the residents survey there was some indication (at a 90% confidence level) that residents with disabilities that limit their activities a lot were also less likely to agree, and more likely to disagree. with this proposal, compared to other residents (although there was still majority agreement).

10.3.13 As planned, the impact of the proposed service change proposals on access, particularly on groups with protected characteristics, was explored further in light of the feedback received through the consultation and the EIAs produced for the PCBC developed further, with independent support. An overview of these the considerations, actions and mitigations identified in the EIA is set out below.

Figure 60 – Stroke: Equality Impact Assessment (EIA) considerations, actions and mitigations

Groups	Considerations, actions and mitigations
Emergency Transport & Non-Emergency Transport **For all patients in all groups (specifically those in age, disability and economically disadvantaged)**	• Hospital stroke services would be based on national clinical evidence, which has demonstrated stroke patients are more likely to survive, recover more quickly and spend less time in hospital • Hospital stroke services in Lincolnshire would be in a stronger position to attract and retain talented staff through building a strong, high quality and successful service – making it sustainable for the long term • More patients would benefit from hospital stroke services being located on the same hospital site as the highly successful Lincolnshire Heart Centre, with benefits including increased access to important time critical interventions and acute imaging services, further reducing time to treatment • Stroke patients would spend the minimum time necessary in a hospital bed, by ensuring enhanced community services have the right skills and capacity to provide high quality rehabilitation to stroke patients as they return home, or as close to home as possible • The experience of the temporary change made due to the pressures of Covid-19 on the services sustainability has demonstrated that even though the service was still operating under immense pressure, the benefit of faster access to diagnosis and treatment once at the acute site offsets the longer travel times for some patients. • Estimated c.500 patients per year who would have gone to Boston Pilgrim Hospital will be displaced to an alternative site: o Based on modelling completed for PCBC, estimated no patient would travel over 60 minutes for care.

Groups	Considerations, actions and mitigations
	○ Following temporary change to consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, the average travel time for patients from the old Lincolnshire East CCG footprint to receiving hospital was c.45minutes. • EMAS have been fully engaged in the ASR and fully expect to be able to provide additional resources so that the impact of the proposed service changes on ambulance capacity is negligible. • It is fully expected that 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 assessment and treatment at hospitals that are further away from their home and for the discharge from these hospitals. • The patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers.
Other Transport **For all patients (specifically those in age, disability and economically disadvantaged) who are ineligible for non-emergency patient transport and transport for carers, relatives and visitors**	• This 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. • Solutions already exist such as voluntary care schemes and daily bus services between Lincoln County Hospital and Pilgrim Hospital, Boston and Lincoln County Hospital and Grantham and District Hospital; transport needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise. • The NHS in Lincolnshire is committed to working with 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, to strengthen current arrangements.
All Transport **For all patients in all groups (specifically those in age, disability and economically disadvantaged)**	• The transport impact overall as well as on those groups with protected characteristics would continue to be monitored during the implementation and 'go live' period of any agreed change. Including ensuring inequalities are not exacerbated. • The Lincolnshire health system is committed to tackling the impact of travel on air pollution through investment and engagement with staff, patients and the local authority. All the mitigations set out above will be developed and implemented in the context of this air pollution commitment and aim.
Disability	• Ensuring all services, if the changes are agreed, comply with the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support they need from health and care services.
Race	• During engagement exercises, not having English as a second language was identified as a possible barrier to engagement. • This needs to be considered as part of accessible services provision

10.3.14 Following completion of the public consultation, a joint meeting of the Lincolnshire ICS Clinical and Care Directorate and CCG Clinical Policies Sub-Group was held on 28 April 2022 to consider if the information and evidence presented in light of and in response to the public consultation continued to support the consolidation hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation team.

10.3.15 The group considered all the evidence presented including the Pre Consultation Business Case (PCBC), feedback themes and data from the public consultation, an updated Equality Impact Assessment (EIA) and further analysis and consideration of the proposal undertaken by the subject matter expert working groups in relation to the consultation feedback.

10.3.16 Following its considerations, the Lincolnshire ICS Clinical & Care Directorate and CCG Clinical Policies Sub-Group confirmed its continued support for the change proposal and considered the:

- Access criterion to be met

10.3.17 Building on the conclusions and actions identified by the working groups in response to the public feedback (Appendix K) and the actions identified in the updated EIA (Appendix H) the key comments made by the group in relation to the Access criterion are set out in the table below.

Figure 61 – Stroke access criterion: Key comments from the joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group

Criterion	Comments
Access ***Criteria Met***	• It needs to be made clear that access is not just about the travel time, it is also about access to the appropriate treatment and intervention and delivering good patient outcomes • It is the overall time from event to treatment that is most important and improves outcomes – the temporary changes have demonstrated reductions in the time taken for patients receive diagnosis and treatment at hospital, which makes up for any increases in travel time • Since the start of the temporary model, a good joint working model has been established between ambulance paramedics and stroke ACPs at Lincoln County Hospital to review previous medical history and decision for treatment commences as soon as patients arrives at hospital • 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 • Consolidation of cardiology services on the Lincoln County Hospital site to concentrate capacity, skills and expertise has demonstrated improvements in outcomes for all Lincolnshire residents. • 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 need to be put in place • A targeted, local bespoke communication and education strategy on the proposal, how to recognise stroke symptoms and how to access care, with a specific focus on the deprived areas with the longest travel times is required • The additional analysis presented on patient outcomes should be included in the evidence together with the additional granular analysis on travel times that has been completed

10.3.18 The minutes of the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group are included in Appendix K.

10.3.19 Following the meeting of the ICS Clinical Directorate and CCG Clinical Policies Sub-Group the NHS Lincolnshire Quality and Patient Experience Committee (QPEC) reviewed the groups conclusions on the 12 May 2022 and supported them.

10.3.20 If the change proposals are agreed, as part of the implementation process continuous assessment and updates against the actions identified by the subject matter expert working groups, including the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs), as well as those identified by the joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group and CCG QPEC will be undertaken and reported to the Implementation Oversight Group (IOG). The IOG is described further in Chapter 15.

10.3.21 A particular area of focus would be the opportunities to work with partners to strengthen current travel arrangements including:

- 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

10.3.22 If the change proposals are agreed, this ongoing work 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.

10.4 Affordability

10.4.1 The findings of the assessment of the stroke proposal against the affordability criterion is **Met**.

10.4.2 This evidence base for this is:

- Review by ICS Finance Leaders Group

10.4.3 On 18 May 2022 the ICS Finance Leaders Group (FLG) met to consider the financial case and affordability of the four service change proposals.

10.4.4 Consideration was given to the affordability of the four change proposals and focused on two questions:

- Is the implementation of the option achievable and financially sustainable?
- Does the proposed option make best use of capital resources?

10.4.5 With regards to the first question in relation to 'achievable and financially sustainable' the view of FLG was this was 'met'. Since preparing the Pre Consultation Business Case there has been no material change in the assumptions underpinning financial sustainability of the proposal. Therefore the proposal is seen to be achievable and financially sustainable.

10.4.6 At the PCBC stage a number of estates solutions were considered for the proposed care model. The preferred estates solution identified was to design and build an extension to the existing unit to provide a consolidated service at Lincoln County Hospital. The FLG assessed whether this proposal made best use of capital resources and determined that there was no material change in the assumptions underpinning the capital requirement. The FLG acknowledged a risk for potential cost escalations, and this is referred to in the risk section of the finance chapter.

10.5 Deliverability

10.5.1 The findings of the assessment of the stroke proposal against the deliverability criterion is **Met**.

10.5.2 This evidence base for this is:

- Statements of support from providers

10.5.3 The United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services Trusts (LCHS) support the change proposal to develop a sustainable stroke service in Lincolnshire for hyper acute and acute stroke services at Lincoln County Hospital. This will be supported by a community stroke rehabilitation service across the county. This will support earlier discharge for patients to have their rehabilitation and care closer to home.

10.5.4 An overview of the key benefits to patients identified by ULHT and LCHS in relation to this change proposal are:

- Quality of care:
  - Ensuring hospital stroke services are based on national clinical evidence
  - The benefit of faster access to diagnosis and treatment once at the acute site offsets the longer travel times for some patients. The evidence of the temporary consolidation of hyper-acute stroke services demonstrated that on average patient's diagnosis and treatment times were improved and all patients who were eligible for thrombolysis received this within the four hour window from onset of symptoms.
  - Hospital stroke services receive over 600 (over 1000 across the county) stroke patients a year so that our doctors and nurses here in Lincolnshire maintain and develop their specialist skills and expertise
  - Improving the ability of hospital stroke services to attract and retain talented and substantive staff by building a strong, high quality and successful service, reducing our reliance on agency locum staffing
  - Stroke patients spend the minimum time necessary in a hospital bed, by ensuring community services have the right skills and capacity to support stroke patients at home, or as close to home as possible
- Access to care:
  - The benefit of faster access to diagnosis and treatment once at the acute site offsets the longer travel times for some patients. The evidence of the temporary consolidation of hyper-acute stroke services demonstrated that on average patient's diagnosis and treatment times were improved and all patients who were eligible for thrombolysis received this within the four hour window from onset of symptoms.
  - Patients are more likely to see the right specialist, first time and receive the best possible care upon arrival to the single site due to better staffing levels

10.5.5 Providers stated it is not possible to provide a robust stroke service across two acute hospitals. It is difficult to recruit stroke consultants nationally, with over 50% of posts remaining unfilled. The current model where the on-call cover is spilt by three consultants on each site makes recruitment very difficult and results in a service that is vulnerable in the event of sickness or absence. This has resulted in many of the posts being covered by agency staff. Currently, there is only one substantive accredited consultant in stroke medicine in ULHT.

10.5.6 ULHT and LCHS have identified that the proposed future model of acute stroke services supports a more sustainable and resilient workforce, particularly in the medical consultant and nursing groups, by:

- Increases the chances of recruiting to substantive roles (and the retention) if the service is based at Lincoln County Hospital alongside other specialist services
- Avoids having to spread 6.0 consultants across two sites which are covered mainly by locum consultants at present.
- A reduction in a heavy reliance on locum and agency staff
- Supports a concentration (through service consolidation and the provision of fewer beds) of nursing staff at the Lincoln site, where there are currently fewer vacancies than at the Boston site
- Supports the services ambition to provide posts with an academic element which again would make these posts more attractive and potentially sub-specialist interests
- There are gaps in the workforce at all levels. A consolidated model facilitates increase specialisation and by concentrating, the workforce on one site allows a rota with greater coverage over the working day/week.

- Supports skill mix and facilitates Advanced Nurse, therapist and consultant Practitioners who can provide a site presence to reduce the demands on the medical workforce and support patients by facilitating faster access to diagnostics and workup so that the consultant can commence treatment faster.

10.5.7 Key risks to delivery and their mitigations are included in the implementation chapter. If the change proposals are agreed, an implementation risk log would be established and managed by each service change proposal implementation group.

10.6 Patient and Public Support

10.6.1 The findings of the assessment of the stroke proposal against the patient and public support criterion is **Met**.

10.6.2 This evidence base for this is:

- Independent analysis of public consultation feedback

10.6.3 The overarching conclusion in the independent consultation report is *'There was also majority support across the consultation as a whole for the proposal to create a Centre of Excellence for acute and hyper-acute stroke at Lincoln County Hospital, supported by an enhanced community stroke rehabilitation service; however views did vary somewhat across different areas within Lincolnshire'*.

10.6.4 More than half (53%) of NHS staff responding to the consultation questionnaire agreed with the proposal for stroke services. This was also the case with other individual respondents to the questionnaire, just over half of whom expressed agreement (51%).

10.6.5 Among Lincolnshire residents (telephone survey), there was more support for the proposed changes; approximately three quarters (72%, +/- 6%) of residents agreed with the proposal.

10.6.6 There was evidence across the different consultation strands of differing views on the proposal for stroke services based on geography, with greater levels of concern expressed from those living closest to Pilgrim Hospital, Boston.

10.6.7 There is evidence that concerns about the proposals for stroke services are strongest among those living nearest to Pilgrim Hospital, Boston. This is most particularly marked in the questionnaire responses, in which more than two thirds (69%) of all individual respondents living closest to Pilgrim Hospital, Boston expressed disagreement with the proposal, compared to just over a quarter (27%) who agreed.

10.6.8 The residents telephone survey, by contrast, indicates that there is majority support from the overall resident population, including among living closest to Pilgrim Hospital, Boston where more than two thirds (69%) agree with the proposals. There was nonetheless also evidence of concern; more than a quarter (27%) of Boston residents disagreed with the proposals to provide a Centre of Excellence for stroke services at Lincoln County Hospital with Pilgrim Hospital, Boston no longer delivering specialist stroke services.

10.6.9 Supporters of developing a specialist centre for hyper-acute and acute stroke services at Lincoln County Hospital felt that increasing expertise in this area would inevitably improve patient care and outcomes, and likely tackle many of the challenges faced by NHS Lincolnshire. It was also said that the centre could be a catalyst for further future investment into the area's healthcare infrastructure.

10.6.10 Those who disagreed (mostly residents of the Boston area) did so mainly for fear of a lack of local services and longer travel times, and a concern that it could lead to poorer patient outcomes

10.6.11 Disagreement with the proposals for stroke services came largely from Boston residents, who worried that the removal of "life-saving" local services would be to the detriment and disadvantage of the area and suggested that if the population of Boston continues to increase at its current trajectory, acute stroke services will be required in future. There was also worry that the removal of stroke services would pose a threat to other services at Pilgrim Hospital.

10.6.12 Travel times, including by ambulance, to reach Lincoln were said to be too long, particularly in stroke cases when 'time is of the essence'. It was said that people living in places outside the 'golden hour' of travel time to Lincoln will be disadvantaged by these proposals. Moreover, travelling to Lincoln to visit patients would be difficult for many families and carers, especially as the county's travel infrastructure is poor.

10.6.13 Other concerns centred around: a lack of ambulance availability in Boston as a result of more frequent journeys to Lincoln and lengthy handovers; whether Lincoln County Hospital has the capacity and infrastructure to deal with increased patient demand; the lack of additional specialist staffing proposed for the Lincoln site; and the presumption that specialist stroke staff will be able to easily relocate from Boston to Lincoln owing to personal circumstances and a lack of transport.

10.7 Consistency with need for patient choice

10.7.1 The findings of the assessment of the stroke services proposal against the consistency with need for patient choice criterion is **Met**.

10.7.2 This evidence base for this is:

- Choice statement from CCG

10.7.3 One of the national tests for service reconfiguration in the NHS is that the proposed changes are consistent with the current and prospective need for patient choice, as enshrined in the NHS Constitution.

10.7.4 The NHS Constitution states that individuals (subject to certain exclusions) have the right to choose the organisation or team that provides them with NHS care when referred for a first outpatient appointment with a service led by a consultant or by a named health care professional. There are certain exceptions including:

- Where speed of access to diagnosis and treatment is particularly important, for example in an emergency
- Attendance at cancer services under the two-week maximum waiting time.

10.7.5 Having assessed the proposals it is considered that patients will continue to be able to exercise choice in line with the NHS Constitution. See Appendix M for statement from NHS Lincolnshire CCG.

10.8 Support from clinical commissioners

10.8.1 The findings of the assessment of the stroke services proposal against the support from clinical commissioners criterion is **Met**.

10.8.2 This evidence base for this is:

- Support statement from CCG clinical leads

10.8.3 In developing the Pre-Consultation Business Case there was significant clinical discussion around the production of the options, including with clinical commissioners, but also counterparts from across the clinical workforce.

10.8.4 There has been clear and robust clinical input throughout the process, including in options development and appraisal and in the planning and execution of the public consultation, including development of the public consultation material.

10.8.5 NHS Lincolnshire CCG clinical leads have been present at public meetings as part of the public consultation sharing information and hearing first-hand the views of the public and issues that need careful consideration.

10.8.6 Since the completion of the public consultation the NHS Lincolnshire CCG clinical leads:

- Have been part of the joint meetings of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub Group where the quality, clear clinical evidence base and access criteria were considered.
- Have been part of the NHS Lincolnshire CCG Executive discussions that have considered the change proposals against the criteria and informed the recommendations set out in this DMBC.

10.8.7 The NHS Lincolnshire CCG clinical leads also met as a group to explicitly discuss their support for the stroke proposal. The conclusion of this was *'support the proposed service change'*.

10.8.8 In addition to support a number of points were made relating to implementation if the change is agreed:

- Need to ensure there is a robust and effective needs assessment prior to discharge that identified 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

10.9 Bed closures

10.9.1 The findings of the assessment of the stroke services proposal against the bed closure criterion *is Not Applicable*.

10.9.2 This evidence base for this is:

- A statement in relation to bed closures

10.9.3 One of the national tests for service reconfiguration is the consideration of bed closures. None of the changes described in the public consultation will require hospital bed closures. See Appendix M for statement from NHS Lincolnshire CCG.

11 Economic and financial analysis

11.1 Introduction and background

11.1.1 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).

11.1.2 Full details of the methodology and approach can be found in the Pre Consultation Business Case (PCBC). Since the production of the PCBC, the following activities have been undertaken:

- Update 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

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

11.1.4 It should also be noted that there is an ongoing 'cost' of doing nothing, services will become more fragile and unstable that could not only result in additional cost to the health system but also directly impact on patient care and outcomes.

11.1.5 This section articulates the financial impact of each of the four proposed service changes in detail. The basis for calculating savings is to compare the cost of the service once changes have been implemented against the cost of the services pre-change. The cost of the service pre-change is based on actual costs and wte not planned.

11.1.6 Key headline assumptions which have been made in calculating the financial impact of the four proposed service changes are:

- All posts currently being filled by interim/agency staff will be replaced with substantive appointments, given the proposed care models being more attractive to work in;
- The service that has the potential to experience the largest proportion of its current activity flowing out of the county is stroke; and
- Capital Investment necessary to facilitate any of the proposed service changes will be sourced from within Capital Allocation resources.

11.2 System financial context

11.2.1 The Lincolnshire Health System has been in severe financial deficit for a number of years. In the most recent completed financial year pre-COVID (2019/20) the system reported a deficit of circa £100m. The majority of this deficit sat within ULHT.

11.2.2 The Coronavirus global pandemic and its associated impact on the delivery of NHS services resulted in the introduction of a fundamentally different financial regime for 2020/21. For the first six months of the financial year all systems were provided with enough financial resource to break-even irrespective of the level of expenditure. For the latter 6 months of 2020/21 systems were provided with set allocations based on expenditure and income projections derived from recently posted financial submissions. This meant that there was closer alignment between the cost of providing healthcare services and the resource allocation provided to fund them.

11.2.3 Throughout all of 21/22 allocation based resourcing based on fair shares was re-introduced with additional allocations provided to support the delivery of healthcare services throughout the continued pandemic. It was always understood that these additional allocations were temporary and would be withdrawn once the effect of the pandemic subsided and infection and prevention control measures returned to pre-pandemic levels.

11.2.4 Throughout the period of the pandemic the Lincolnshire Healthcare system has, with the support of additional non-recurrent funding, managed to deliver a balanced financial position. 2022/23 has seen the financial regime mover much closer to that which operated pre-pandemic. This has resulted in a significant element of financial resource provided to the Lincolnshire Healthcare system non-recurrently over the last two years being removed. That together with growth in costs associated with high levels of inflation and the need to deliver significant levels of elective activity which, was paused throughout the pandemic, has returned the Lincolnshire Healthcare system to a more challenged financial position.

11.2.5 Significant work will be required to ensure the Lincolnshire Healthcare system can continue to live within the resources it has been provided with. This will prove to be a significant challenge. Arguably too many patients non-elective needs are treated within an acute hospital setting. This maintains Lincolnshire's over-reliance on interim/agency staff which incur a premium cost. Also, too much acute elective activity either leaves the county or is delivered by the Independent Sector. This means a significant element of Lincolnshire's financial resource leaves the county or the NHS. Improving productivity and efficiency would allow the repatriation of elective activity back to ULHT and make a significant contribution to meeting the fixed and semi-fixed costs associated with delivering hospital services over multiple sites.

11.2.6 The abandonment of Payments by Results between Lincolnshire CCG and ULHT in 2019/20 has brought with it a reduction in transactional costs but also eliminated the need to flex payments up and down based on the volume of activity performed. The contract value paid to ULHT by Lincolnshire CCG is now based on the cost of delivery rather than an activity x price mechanism. On this principle, activity movements to other providers as a result of consolidation of services onto one site are unlikely to affect the payments ULHT receive. There are a number of providers outside of Lincolnshire to whom significant levels of activity flow.

11.2.7 With regards to the four services under the ASR scope it is not anticipated that there will be any significant alterations to patient flow to any of the acute providers external to Lincolnshire. The service that has the potential to experience the largest proportion of its current activity flowing external to United Lincolnshire Hospitals NHS Trust is stroke. Modelling on travel tolerances suggests that up to 261 spells of stroke activity would transfer to other hospitals. The impact of this can be seen later in this chapter.

11.3 Orthopaedics

11.3.1 Through the current orthopaedics pilot all appropriate elective orthopaedic cases are being undertaken at Grantham and District Hospital with dedicated ring fenced beds on site and County Hospital Louth has become a dedicated day case centre.

11.3.2 The pilot has been running since August 2018 and as well as delivering improved quality of care and patient outcomes has delivered a number of efficiency and productivity benefits, including:

- The reliance on interim locum medics across the four sites has been reduced to zero reducing the average employment cost of medics from £108.5k to £105.8k. This results in a cost reduction of £247k;
- Improvements in productivity in theatre throughput has allowed the medical workforce to be reduced to 86.11 wte from 90 wte resulting in a saving of £412k;
- Elimination in the use of agency nursing staff has resulted in saving of £918k;
- A reduction in cancelled procedures on the day from 9.4 to 4.6 (Trust wide);
- Reduction in utilisation of theatres so that two theatres (one at Lincoln County and one at Boston/Pilgrim) could now be relinquished;

- A reduction to zero “On the day” cancellations at Grantham and District Hospital;
- Reduction in LOS at Grantham and District Hospital from 2.7 to 1.7 days; and
- A movement of all non-complex elective activity from Lincoln County Hospital to Grantham and District Hospital.

11.3.3 The financial impact of the orthopaedic pilot across ULHT sites are set out below.

Figure 62 – Financial impact of Orthopaedic services change - Grantham and District Hospital

Orthopaedic Service – Grantham and District Hospital						
Cost Category	Establishment Pre-Pilot		Service Model Post-Pilot		Difference	
	WTE	Cost £k	WTE	Cost £k	WTE	Cost £k
Medical Staffing	19.00	2,261	17.11	1,712	-1.89	549
Nursing	36.83	1,310	34.38	815	-2.45	495
Administration	7.61	167	7.09	175	-0.52	-8
Non-Pay/Recharges	-	3,572	-	2,974	-	598
Totals	**63.44**	**7,310**	**58.58**	**5,676**	**-4.86**	**1,634**

Figure 63 – Financial impact of Orthopaedic services change – County Hospital Louth

Orthopaedic Service – County Hospital Louth						
Cost Category	Establishment Pre-Pilot		Service Model Post-Pilot		Difference	
	WTE	Cost £k	WTE	Cost £k	WTE	Cost £k
Medical Staffing	3.00	238	3.00	217	0.00	21
Nursing	0.00	0	0.00	0	0.00	0
Administration	3.00	59	0.00	0	-3.00	59
Non-Pay/Recharges	-	970	-	1,259	-	-289
Totals	**6.00**	**1,267**	**3.00**	**1,476**	**-3.00**	**-209**

Figure 64 – Financial impact of Orthopaedic services change – Pilgrim Hospital, Boston

Orthopaedic Service – Pilgrim Hospital, Boston						
Cost Category	Establishment Pre-Pilot		Service Model Post-Pilot		Difference	
	WTE	Cost £k	WTE	Cost £k	WTE	Cost £k
Medical Staffing	34.00	3,126	34.00	3,424	0.00	-298
Nursing	68.88	2,865	59.88	2,202	-9.00	663
Administration	12.45	287	15.14	393	2.69	-106
Non-Pay/Recharges	-	4,692	-	3,867	-	825
Totals	**115.33**	**10,970**	**109.02**	**9,886**	**-6.31**	**1,084**

Figure 65 – Financial impact of Orthopaedic services change – Lincoln County Hospital

Orthopaedic Service – Lincoln County Hospital						
Cost Category	Establishment Pre-Pilot		Service Model Post-Pilot		Difference	
	WTE	Cost £k	WTE	Cost £k	WTE	Cost £k
Medical Staffing	34.00	4,140	35.00	3,760	1.00	380
Nursing	74.36	3,040	82.08	3,280	7.72	-246
Administration	18.26	439	19.79	429	1.53	10
Non-Pay/Recharges	-	5,192	-	3,813	-	1,379
Totals	**126.62**	**12,811**	**136.87**	**11,282**	**10.25**	**1,529**

11.3.4 The financial impact as a result of the total Orthopaedics service changes is a savings of £4.04m and is set out in the table below.

Figure 66 – Financial impact of total Orthopaedic services changes

Orthopaedic Service – Overall Summary						
Cost Category	Establishment Pre-Pilot		Service Model Post-Pilot		Difference	
	WTE	Cost £k	WTE	Cost £k	WTE	Cost £k
Medical Staffing	90.00	9,765	89.11	9,113	-0.89	652
Nursing	180.07	7,215	176.34	6,297	-3.73	918
Administration	41.32	952	42.02	997	0.70	-45
Non-Pay/Recharges	-	14,426	-	11,913	-	2,513
Totals	**311.39**	**32,358**	**307.47**	**28,320**	**--3.92**	**4,038**

11.3.5 Within the £4m savings quantum there is an element relating to recharges of £2.5m. These covered the cost of services charged to Orthopaedics relating to their utilisation of Theatres. Through efficiencies in waiting list management, scheduling and the reduction in cancellations the Orthopaedics service has been able to relinquish two theatres (one at Pilgrim Hospital, Boston and one at Lincoln County Hospital). This has reduced the charge to orthopaedics for support services and overheads as the orthopaedic service now consumes less theatre space.

11.3.6 The improved theatre productivity enables the orthopaedic service to repatriate activity currently delivered by the Independent Sector or other NHS providers. Assuming this is achieved additional income will flow into the Lincolnshire health system and contribute to fixed costs.

11.3.7 The working groups considering the public feedback did not identify any requirement to adjust the proposed clinical model workforce.

11.4 Urgent and Emergency Care

11.4.1 The current A&E facility at Grantham and District Hospital which currently operates with a reduced service of 8.00am -18.30pm 7 days a week (from a 24/7 service) will be re-designated to an Urgent Treatment Centre open 24hrs 7 days a week. The financial comparison set out below is against the reduced hours A&E service and not the full 24/7 A&E service that previously operated out of Grantham.

11.4.2 As part of the cost comparison work, a review of the A&E cost base, when it was operating as a 24/7 service, was undertaken to establish whether the cost of delivery (uplifted to current year prices) was materially different from the cost as a reduced hours facility. The conclusion was there was no material difference and therefore the A&E reduced hours service vs the UTC 24/7 service was chosen as base for comparison.

11.4.3 The financial impact of this proposed service change is based on:

- A reduction in consultant cover from 80 hours a week to 40 hours with no evening or weekend on call service;
- A reduction in agency and locum spend; and
- Rationalisation of Out of Hours Service.

Figure 67 – A&E/UTC existing service model Vs proposed service model

Cost Category	Current Establishment		Proposed Service Model		Difference	
	WTE	Cost £'k	WTE	Cost £	WTE	Cost £'k
GPs	1.32	86	3.30	215	1.98	-129
Medical Staffing	14.00*	1,766	12.20	1,304	-1.80	462
Nursing	27.47	1,316	40.50	1,645	13.03	-329
ACP's	4.00	226	4.00	226	0	0
Administration	3.11	108	3.11	108	0	0
Non-Pay/Recharges	-	380	-	380	-	0
UTC/A&E Sub-Total	**49.90**	**3,882**	**63.11**	**3,878**	**13.21**	**4**
GP's	1.98	129	0.00	0.00	-1.98	129
Nursing	6.49	305	0.00	0.00	-6.49	305
Non-Registered Nursing	6.44	138	0.00	0.00	-6.44	138
Non-Pay/Recharges	-	86	-	0.00	-	86
Out of Hours Sub-Total	**14.91**	**658**	**0.00**	**0.00**	**-14.91**	**658**
Totals	**64.81**	**4,540**	**63.11**	**3,878**	**-1.70**	**662**

***Includes 1 wte agency coverage**

11.4.4 The working groups considering the public feedback did not identify any requirement to adjust the proposed clinical model workforce. However it was identified that if the proposed service change is agreed detailed workforce planning, including rota development, will be required as part of the implementation process.

11.5 Acute Medicine

11.5.1 The Grantham Acute Medicine Service will adopt an integrated acute/community bed base model based on patient acuity and admission criteria.

11.5.2 The financial impact of this proposed service change is based on:

- A dedicated medical establishment for Grantham based on the preferred clinical model;
- A substantive medical and nursing establishment which eliminates the reliance on locums and agency nursing; and
- Over time a reduction in consultant cover on-call.

Figure 68 – Acute medical beds existing service model vs proposed service model

Cost Category	Current Establishment		Future Establishment		Difference	
	WTE	Cost £k	WTE	Cost £k	WTE	Cost £k
Medical Staffing	23.15	3,109	27.00	3,396	3.85	-287
- General	*10.00*	*1,568*	*11.00*	*1,355*	*1.00*	*213*
- Cardiology	*1.00*	*95*	*0.0*	*0*	*-1.00*	*95*
- Gastroenterology	*2.00*	*142*	*0.0*	*0*	*-2.00*	*142*
- CoE	*7.00*	*812*	*8.00*	*861*	*1.00*	*-49*
- Respiratory	*3.15*	*492*	*8.00*	*1,180*	*4.85*	*-688*
Nursing	75.02	3,701	94.00	3,549	18.98	152
Administration	13.17	346	19.26	466	6.09	-120
Non-Pay/Recharges	-	1,464	-	1,464	-	-
Totals	**111.34**	**8,620**	**140.26**	**8,875**	**28.92**	**-255**

11.5.3 The working groups considering the public feedback did not identify any requirement to adjust the proposed clinical model workforce. However it was identified that if the proposed service change is agreed detailed workforce planning, including rota development, will be required as part of the implementation process.

11.6 Stroke services

11.6.1 The proposal for stroke services is to consolidate the hyper-acute and acute stroke services on the Lincoln County site from its current configuration of two sites at Lincoln County Hospital and Pilgrim Hospital, Boston.

11.6.2 The financial impact of this proposed service change is based on:

- The closure of the 28-bed facility at Pilgrim Hospital, Boston and an increase in the Lincoln County Hospital facility from 28 to 35 beds;
- A significant increase in the Community Stroke Rehab Team of 15.29 wte;
- A change in skill mix with a greater focus on Advanced Care Practitioners;
- Capital Investment of £7.5m (assumed to be treasury funded) in the Lincoln County Hospital facility to increase the number of beds to 35;
- A move to get the average length of stay down to 10 days; and
- A requirement to purchase two extra stroke beds at North West Anglia NHS Foundation Trust (NWAFT) and one extra bed at Queen Elizabeth Hospital (Kings Lynn) NHS Foundation Trust (QEH).

11.6.3 The consolidation of the hyper-acute and acute stroke facilities results in the potential displacement of up to 261 spells of stroke activity out of Lincolnshire. Of the 261 spells of activity which could leave the county the consolidated Stroke service at Lincoln County Hospital would have the capacity to deal with all but 121 (86 to North West Anglia NHS Foundation Trust and 35 to Queen Elizabeth Hospital NHS Foundation Trust). If this movement of spells occurred, it would result in additional capacity being required at both Trusts. The estimated capacity would be two additional beds at NWAFT and one additional bed at QEH. The patient flow analysis is set out in detail in the Stroke Services chapter.

11.6.4 The £7.5m of capital necessary to reconfigure stroke services will be found from within capital allocations over the next two years. Whilst the stroke reconfiguration is a priority a confirmed list of capital schemes over the next three years is still to be signed off by the system. Currently the values attributable to the list of proposed schemes exceeds the capital resource available. A process of prioritisation undertaken by the Lincolnshire Infrastructure and Investment Group will take place throughout the year to determine the schemes that will be progressed in 22/23 – 24/25 as part of the systems signed off Capital Plan. It is anticipated that the Stroke reconfiguration will be included in the list of confirmed schemes.

11.6.5 The financial impact of the stroke activity leaving the county plus the other proposed service changes are reflected in the table below.

Figure 69 – Stroke service existing service model vs proposed service model

Cost Category	Current Establishment		Proposed Service Model		Difference	
	WTE	Cost £	WTE	Cost £	WTE	Cost £
Medical Staffing	19.66	1,632	19.66	1,632	0.00	0
Nursing	85.72	3,471	73.52	3,137	-12.20	333
AHP's	39.36	1,527	33.67	1,220	-5.69	307
ACP's	0.00	0	5.80	447	5.80	-447
Non-Pay/Recharges	-	2,612	-	2,409	-	203
Acute Sub-Totals	**144.74**	**9,242**	**132.65**	**8,845**	**-12.09**	**397**
Therapists	45.95	1,608	58.24	2,034	12.29	-426
Dieticians	0.00	0	1.00	47	1.00	-47
Psychologists	0.00	0	1.00	56	1.00	-56
Assistant Psychologists	0.00	0	1.00	30	1.00	-30
Non-Pay/Recharges	-	812	-	919	-	-107
Community Sub-Totals	**45.95**	**2,420**	**61.24**	**3,086**	**15.29**	**-666**
NWAFT/QEH Capacity	-	-	-	758	-	-758
Cost of Capital (Revenue)	-	-	-	530		-530
Total Cost	**190.69**	**11,662**	**193.89**	**13,219**	**3.20**	**-1,557**

11.6.6 The working groups considering the public feedback did not identify any requirement to adjust the proposed clinical model workforce. However it was identified that if the proposed service change is agreed detailed workforce planning, including rota development, will be required as part of the implementation process.

11.6.7 Analysis was also conducted by the working groups to compare the modelled destination hospital in the PCBC (based on 15-minute preference for Lincoln County Hospital) and the actual destination hospital during the temporary change to ULHT's stroke services (consolidation on the Lincoln County Hospital site).

11.6.8 This demonstrated very close alignment between the modelled activity in the PCBC for the overall number of stroke patients going to hospitals outside of Lincolnshire compared to the actual numbers during the temporary change.

Figure 70 – Comparison of modelled destination hospital in PCBC and actual destination hospital during temporary change

Destination Hospital	PCBC modelling baseline 2019/20	PCBC modelling forecast to 2022/23	During temporary change 2020/21
Peterborough City Hospital	86	89	104
Queen Elizabeth Kings Lynn	35	36	21
Grimsby Diana Princess of Wales	-	-	3
Scunthorpe General Hospital	-	-	1
Total	121	125	129

11.7 ASR financial summary

11.7.1 The previous sections outlined the financial Impact of the four proposed service changes under the scope of the ASR once all proposed service changes are implemented. The overall financial impact across the four proposed service changes following completion of full implementation will be c.£1.9m.

11.7.2 One of the four service change proposals, stroke services, requires capital funding to enable its implementation. The current cost estimate of the estates solution that is the preferred way forward at this stage is £7.5m. The revenue consequences of this are included in the overall financial impact.

11.7.3 In addition to the financial impact attributable to the four service change proposals a contingency of £1m has been set aside to cover the cost of additional Emergency Ambulance journeys and Patient Transport Services (PTS). This will help reduce the impact on patients who may be required to travel to different ULHT sites for their services. Current estimates of the aforementioned costs are £349.5k for Emergency Ambulance services and £277.6k for PTS (Total cost estimate £627.1k). A breakdown of the financial impact summary by service is set out below.

Figure 71 – Financial impact of ASR following full impact of service changes

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 ASR Financial Impact	**57,180**	**55,292**	**1,888**

Figure 72 – Breakdown of future savings by category

Service	Impact due to WTE/Skill Mix Movement £k	Impact due to Interim/Agency saving £k	Impact due to Non-Pay £k	Total Impact £k
UTC/A&E	-20	596	86	662
Acute Medicine	-386	131	0	-255
Stroke	-365	0	-1,192	-1,557
Total	**-771**	**727**	**-1,106**	**-1,150**

11.7.4 In the case of orthopaedics, the savings identified are reflected in the 2022/23 position as the service changes have already been made as part of the Orthopaedics Pilot. As the three remaining services under scope have not yet commenced their service change the financial impact attributable to these changes won't start to be realised until the latter half of 2022/23.

11.7.5 The Lincolnshire System recognises the importance of progressing the agreed changes identified as part of the Acute Services Review. The revenue consequences resulting from the proposed changes in the four service areas have been communicated clearly to finance and planning leads within Lincolnshire's four constituent organisations.

11.7.6 In some circumstances these costs are already being incurred where there was a pre-22/23 component. In examples where the cost will be incurred from 22/23 onwards the organisational impact is already being reflected in 22/23 financial baseline calculations and will be provided for from within the financial allocations the Lincolnshire System has received as part of the 22/23 resource allocation. This is in accordance with the investment principles Lincolnshire ICS applies to all its service transformation priorities.

11.8 Financial Projections 2022/23 – 2025/26

11.8.1 The changes within the four proposed service changes will not be immediate. If the changes are agreed, due to implementation timeframes, it is unlikely that any changes will take place until the latter half of 2022/23 at the earliest. The only exception to this is orthopaedics. The following table compares the cost of each service to its pre-change position.

Figure 73 – Profiled financial impact of service changes

Service	Cost Pre ASR Change £k	Estimated 22/23 Cost £k	Difference £k	Estimated 23/24 Cost £k	Difference £k	Estimated 24/25 Cost £k	Difference £k	Estimated 25/26 Cost £k	Difference £k
- Orthopaedics	32,358	28,320	4,038	28,320	4,038	28,320	4,038	28,320	4,038
- A&E/UTC	4,540	4,540	0	3,878	662	3,878	662	3,878	662
- Acute Medical Beds	8,620	8,620	0	8,875	-255	8,875	-255	8,875	-255
- Stroke Pathway	11,662	11,729	-67	11,797	-135	13,219	-1,557	13,219	-1,557
- Patient Transport Contingency	0	500	-500	1,000	-1,000	1,000	-1,000	1,000	-1,000
Totals	**57,180**	**53,709**	**3,471**	**53,870**	**3,311**	**55,292**	**1,888**	**55,292**	**1,888**

11.8.2 The 2022/23 financial impacts are as follows:

- 0% of the Cost of Capital - Stroke
- 0% of the Out of County impact for Stroke
- 25% of all Stroke Service Changes costs - £0.07m
- 100% savings impact from the Orthopaedic Service Changes - £4.04m
- 50% of the Patient Transport Contingency cost - £0.5m
- 0% of all Acute Medical Bed Service Changes costs
- 0% of all A&E/UTC Service Changes savings

11.8.3 The 2023/24 financial impacts are as follows:

- 0% of the Cost of Capital - Stroke
- 0% of the Out of County impact for Stroke
- 50% of all Stroke Service Changes costs - £0.13m
- 100% savings impact from the Orthopaedic Service Changes - £4.04m
- 100% of the Patient Transport Contingency cost - £1.0m
- 100% of all Acute Medical Bed Service Changes costs - £0.26m
- 100% of all A&E/UTC Service Changes savings - £0.67m

11.8.4 The 2024/25 financial impacts are as follows:

- 100% of all Stroke Service Changes costs £1.6m
- 100% savings impact from the Orthopaedic Service Changes - £4.04m
- 100% of the Patient Transport Contingency cost - £1.0m
- 100% of all Acute Medical Bed Service Changes costs - £0.26m

100% of all A&E/UTC Service Changes savings - £0.67m

11.8.5 The 2025/26 financial impacts are as follows:

- 100% of all Stroke Service Changes costs £1.6m
- 100% savings impact from the Orthopaedic Service Changes - £4.04m
- 100% of the Patient Transport Contingency cost - £1.0m
- 100% of all Acute Medical Bed Service Changes costs - £0.26m
- 100% of all A&E/UTC Service Changes savings - £0.67m

11.9 Financial risks

11.9.1 There are three financial risks presented within the financial case which warrant further explanation. The first relates to the potential savings identified as part of the service changes in Acute Medicine and A&E/UTC at Grantham and District Hospital. With respect to both these services there is an amount attributable to the replacement of interim/agency staff with substantive staff (£131k in Acute Medicine and £596k in A&E/UTC). United Lincolnshire Hospitals NHS Trust has a long established over-reliance on interim/agency staff for which is has become dependent to operate services. Whilst concerns exist that the reliance on interim/agency staff will continue post the service changes it is important to point out that the management of both Acute Medicine and A&E/UTC will include a role for a community services provider as part of the proposed service changes. We would expect that this change will help break the reliance on interim/agency staff.

11.9.2 In recognition of this risk the table below sets out the impact of the sensitivity analysis performed on the potential savings associated with the replacement of interim/agency staff. Three scenarios have been included to demonstrate the impact both on the individual services and the overall ASR saving.

Figure 74 – Interim/Agency savings sensitivity analysis

Service	Identified Savings £k	75% Saving Delivery	50% Saving Delivery	25% Saving Delivery
A&E/UTC	596	447	298	149
Acute Medicine	131	98.25	65.5	32.75
Total	**727**	**545.25**	**363.5**	**181.75**
Revised Total ASR Savings	**1,888**	**1,706**	**1,525**	**1,343**

11.9.3 The second risk relates to the theatre productivity gains in orthopaedics. Included within the Orthopaedics savings is a number (£2,513k) associated with the reduction in overhead recharges attributable to orthopaedics. This results from efficiency improvements in theatre utilisation which allows the orthopaedics service to relinquish two theatres. The improved theatre productivity enables the orthopaedic service to repatriate activity currently delivered by the Independent Sector or other NHS providers. Assuming this is achieved additional income will flow into the Lincolnshire health system and contribute to fixed costs.

11.9.4 In 2019/20 Lincolnshire CCG commissioned £13.6m of Orthopaedic activity from the Independent Sector. Of this £4.3m related to Day Case activity and £9.2m related to Inpatient. Of these values £2.3m of Day Case activity and £6.8m of Inpatient activity was leaving to Independent Sector providers outside of Lincolnshire. This activity cohort was identified as the 1st cohort to be repatriated under the systems elective activity repatriation plan, the 2nd cohort to be addressed was those patients attending an Independent Sector provider in a neighbouring healthcare system, with the final cohort being those patients attending an Independent Sector provider within Lincolnshire. Due to the required NHS response to the COVID pandemic and the resulting impact on elective waiting times the plan to repatriate activity back to ULHT from the Independent Sector needs to be refreshed and new timeframes implemented to address the respective prioritised activity cohorts highlighted above.

11.9.5 The third risk relates to the cost of capital projects. Due to the significant rise in inflation the cost of capital projects are exceeding previous estimates. At the PCBC stage the cost of the stroke capital project was estimated at £7.5m. Assuming an 8% increase in the costs of the project would see a rise of £0.6m to £8.1m. This is currently an estimate and as the costs of the stroke capital project have not yet been revisited these estimated costs increases cannot be confirmed. Due to the uncertainty around the cost rises and the immateriality with regards to the revenue consequences mean that the overall impact of the ASR changes have not been adjusted as a result of this identified risk.

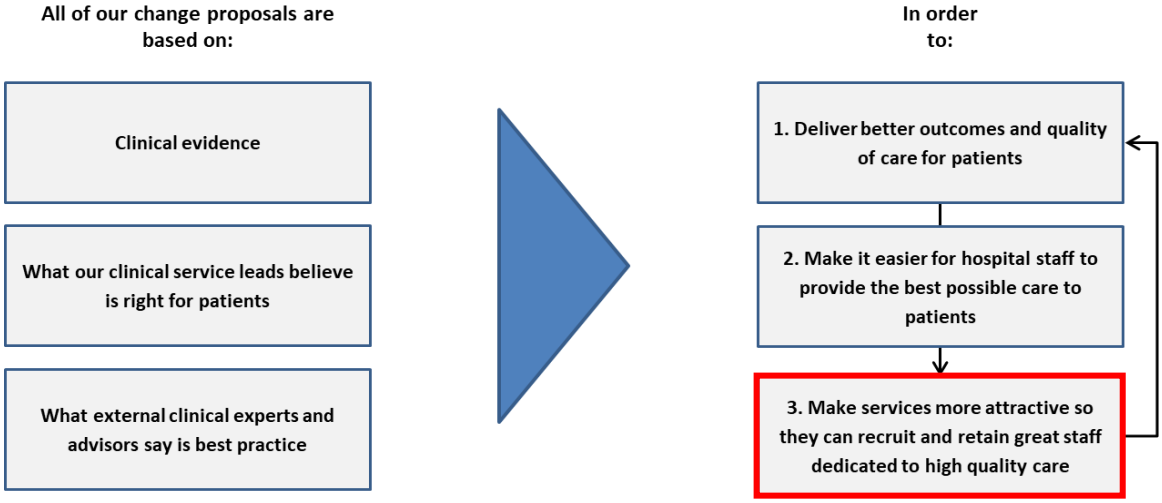
12 Workforce

12.1 Introduction

12.1.1 Making services more attractive so they can recruit and retain great staff dedicated to high quality care is one of three key interdependent aims for all the change proposals set out in this Decision Making Business Case.

12.1.2 These three aims and how they relate is set out in the diagram below.

Figure 75 – Key aims of change proposals



12.1.3 As set out in the Pre Consultation Business Case (PCBC) and detailed through the consideration of the feedback received through the public consultation by the working groups (Chapter 5 of this DMBC and Appendix F), workforce is a key focus of all four of the change proposals.

12.1.4 An overview of the key workforce considerations relating to the four proposed clinical models, if they are agreed, is set out below.

12.2 Retention

12.2.1 Retention initiatives and reviews of workforce pressures will be considered across whole pathways in all four areas to ensure that specific actions (e.g. recruitment and retention plans, employee experience in all care settings) are undertaken in a coordinated manner to avoid damaging recruitment and retention in differing settings or parts of the pathways. This is particularly important for the urgent and emergency care, acute medicine and stroke proposals given the increased integration they bring across organisational boundaries.

12.2.2 Development of relevant apprenticeship posts, rotations, new roles for internal development (e.g. Advanced Care Practitioners) will provide a greater opportunity for staff to develop and maintain skills across pathways which will also support staff retention in all four service areas.

12.2.3 Prior to formal organisational change processes, a series of communication briefings and engagement workshops will be held to ensure all relevant staff are well sighted on the details of the future state plans and service specifications. This is aimed at supporting staff in understanding how the future of the four services will work and to mitigate turnover.

12.3 Rotations

12.3.1 As part of the implementation of the four service change proposals, it is recognised that to achieve the best outcomes for patients services will need to work differently across the pathway.

12.3.2 A key feature of this will be more collaborative working as part of developing 'one workforce' in each of the four service areas. The impact of this for doctors, nurses and therapists will be the ability to bolster and further develop service specific competencies to support patients. One of the routes for this will be inter organisational rotations across the pathway for all professions.

12.3.3 Rotations already happen in certain areas in the Lincolnshire health system to support the various professions achieve the right skill set, for example in musculoskeletal (MSK) medicine.

12.3.4 The proposals for rotation would include all professions involved in delivering the four services where there would be an identified benefit for patients and staff to develop a rotation across the pathway.

12.3.5 The key benefits would include:

- Development and maintenance of service specific competencies
- Maintaining and improving staff retention
- Attracting and recruiting staff into Lincolnshire
- Providing increased consistency of practice and patient experience.

12.4 Role consistency and standardisation

12.4.1 Roles will be developed across the pathways to provide a consistent and standardised approach where appropriate and with the principle of avoiding unwarranted variation. This will enable a greater level of flexibility and support staff retention.

12.4.2 The approach to staffing will be to meet the appropriate standards as set out in the relevant guidance documentation relating to the services. Staff deployed to support the services will be determined in line with national standards and associated aligned staffing requirements (i.e. 'Safe Staffing levels').

12.4.3 Where appropriate consideration will be given to the standardisation of Terms and Conditions across employing organisations under national terms and conditions or alignment against these where employers are non-NHS.

12.4.4 Organisationally specific policies will however remain relevant to the organisations in which individuals are employed.

12.5 Clinical and management governance

12.5.1 Professions will be led by the clinically appropriate lead responsible within each of the services. Clinical leads for the service will oversee the patient pathways with clinical governance covered for the respective organisation in which the patient is treated.

12.5.2 Overall performance of the four service will be monitored through measures and metrics including nationally recognised audits (such as the Sentinel Stroke National Audit Programme (SSNAP)). This will identify if particular aspects of the pathway are giving cause for concern and can be escalated appropriately.

12.6 Workforce implementation

12.6.1 If the service change proposals are agreed, a key part of the implementation will be to develop the detailed staffing models and rota arrangements for the change proposals, building on the workforce models developed for the Pre Consultation Business Case.

12.6.2 Another key element of the implementation will be a series of engagement workshops held to support the socialisation of the service changes. These will provide opportunities for staff who have not had direct involvement in the work to better understand the future service delivery. Where required, formal organisational change processes will be put in place.

13 Digital

13.1 Overview

13.1.1 Lincolnshire has the vision for an integrated health and care system that has all the data and information it needs, delivered in an accessible and timely way, to enable it to support health and care services to achieve the best possible outcomes for the population of Lincolnshire.

13.1.2 People use digital technology to access services every day, and the health and care system needs to support and enable the population to access health and care services this way too. Digital tools can support people to have more choice and control over the way care is planned and delivered. It can enable people to access and contribute to their own care record, be cared for safely at home for longer and reduce unnecessary travel for face to face appointments.

13.1.3 To care for the local population a digitally enabled workforce is required, with the right tools so they can work flexibly, reducing the burden of bureaucracy. The power of the data already held needs to be harnessed to not only support direct care, but also plan for the future by supporting a better understand of the local population and its health and care needs; shifting the emphasis from treatment to prevention.

13.2 Future state

13.2.1 The role of digital will be a key factor in facilitating the benefits of the change proposals set out in this document, including supporting the further integration of care. The table below provides an overview of how it can support each of the four areas.

Figure 76 – Digital support to change proposals

Service Change Proposal	Digital enablers
Orthopaedics (elective and non-elective)	• Smart forms for pre-appointment and pre-op questionnaires to reduce requirement to attend hospitals ahead of surgery/procedures at Grantham and District Hospital. • Support eConsultations and video consultations between hospital sites and between specialists and the patients' home for follow-up care e.g. patient can attend their nearest hospital and the consultant can be in a different hospital. • Smart form algorithms to enable long term remote monitoring thus reducing the need to attend hospital. • Virtual fracture clinics and telemedicine to support access. e Trauma and Virtual clinics to reduce the patient travel. • Video calls to enable patients staying in hospital to talk to friends and family
Urgent & Emergency Care	• Use e Trauma software to support Grantham UTC obtain Trauma and Orthopaedic expertise, advice and guidance from Lincoln County Hospital and Pilgrim Hospital, Boston. • Support identification of undiagnosed disorders earlier thereby reducing demand for urgent and emergency care at Grantham and District Hospital. • Actively identify and manage the population using risk stratification and proactive management to reduce exacerbations and the need for urgent and emergency care at Grantham and District Hospital. • The roll out of '111 First' to support a reduction in A&E/UTC attendances

Acute Medicine	• Digital/video link between Grantham and District Hospital and Lincoln Hospital to provide remote on-call cover. • Notification function to Neighbourhood teams to flag when patients are admitted/discharged or have had an emergency admission to Grantham and District Hospital to provide integrated acute/community care pathway. • Virtual Wards to support early and safe discharge (step down) for with enhanced remote monitoring on the virtual ward (supervised from secondary care/community providers) with daily calls and hospital treatments for patients. • Video calls to enable patients staying in hospital to talk to friends and family
Stroke Services	• Support identification and management of those at risk of having a stroke. • Support self-management of those at risk of having a stroke and those who have had one including providing training, skills and confidence in technology that can support these patients – including the Lincolnshire Stroke YouTube Channel • Support eConsultations and video consultations between Lincoln County Hospital and other hospital sites and between specialists and the patients home for follow-up care e.g. patient can attend their nearest hospital and the consultant can be in a different hospital. • Enabled (hospital) WebV access for Social Care colleagues • Support a shared care record accessible by health (acute and community) and social care to optimise rehabilitation provide by the enhanced community team. • Video calls to enable patients staying in hospital to talk to friends and family • Work with regional Integrated Stroke Delivery Network to explore and move forward on plans for a telemedicine service within Lincolnshire • Mobile Stroke Unit (MSU) for Lincolnshire to be explored further

13.2.2 Several of these initiatives address directly the concerns raised through the public consultation. For example, concerns relating to access to pre and post-operative clinics and those relating to friends and family access for people admitted to hospital.

13.2.3 The last 12 months has seen rapid uptake and adoption of digital technologies across the health and care system as ways of working changed in response to the pandemic. The identified initiatives act as important enablers for the proposed future care models and will form a key element of quality of care and equity of access for people across Lincolnshire.

14 Governance and decision-making, and recommendations to the CCG Board

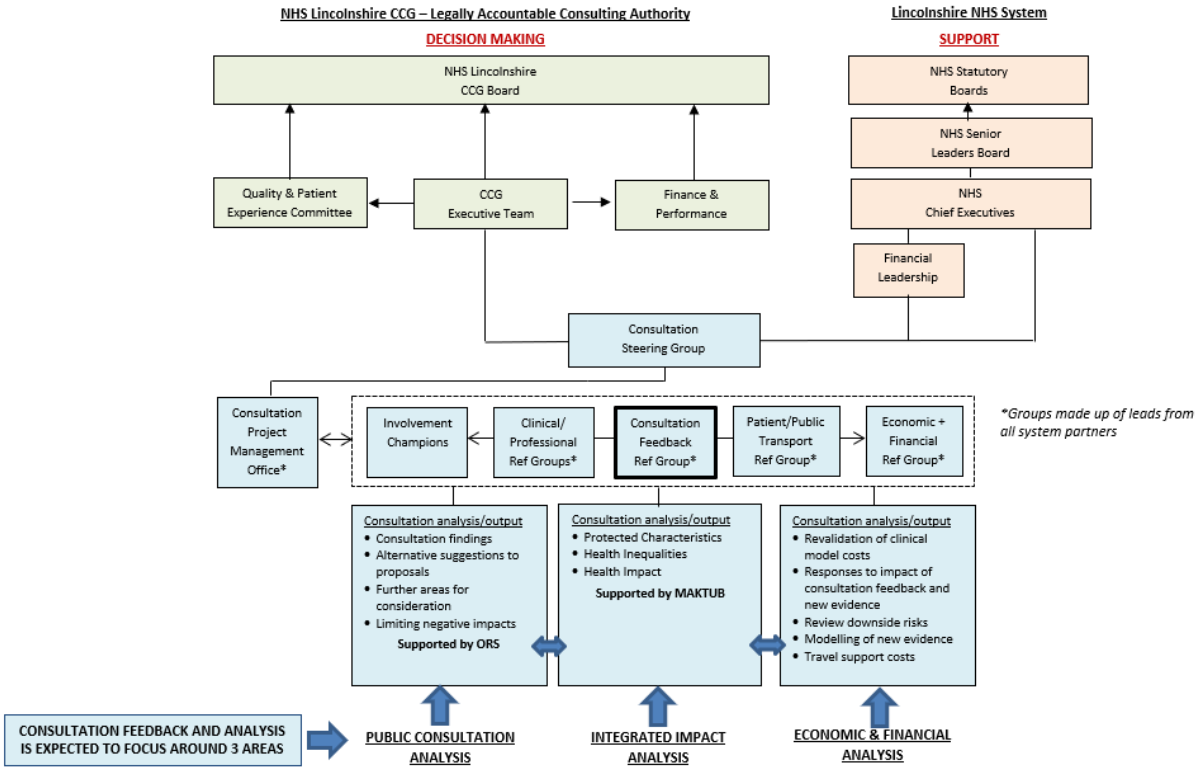
14.1 Overview

14.1.1 The Lincolnshire Integrated Care System (ICS), comprised of commissioning organisations and health and social care delivery partners, has provided the overarching governance and programme structure to the consideration of the public consultation feedback and development of the Decision Making Business Case (DMBC).

14.1.2 However, it is fully understood and acknowledged by ICS partners that it is the NHS Lincolnshire Clinical Commissioning Group (CCG) that is legally responsible for making any decisions on service change following the public consultation, through the DMBC.

14.1.3 This is set out in the diagram below.

Figure 77 – Overview of governance and decision making



14.2 Timeline

14.2.1 To enable this and facilitate the governance and assurance process, the programme has involved stakeholders from across the Lincolnshire health and care system to provide input and advice to the decision making process.

14.2.2 An overview of the governance and decision making timeline is set out in the table below.

Figure 78 – Overview of governance and decision making timeline

Date	Activity / Meeting	Meeting Purpose
23 Dec 2021	Consultation finished	
25 Feb 2022	First draft of independent consultation report	
07 Mar 2022	Consultation Steering Group	Oversight of consultation feedback, analysis and consideration
21 Mar 2022	Consultation Steering Group	Oversight of consultation feedback, analysis and consideration
30 March 2022	NHS Lincolnshire CCG Board - Closed	Receive independent consultation report (from ORS) and role of the CCG Board Receive update from the Consultation Institute (as part of assurance support put in place by NHS Lincolnshire CCG prior to commencing public consultation
04 April 2022	Consultation Steering Group	Oversight of consultation feedback, analysis and evaluation
07 April 2022	NHS Lincolnshire CCG Exec	Consider of Travel and Transport Report
13 April 2022	NHS Lincolnshire CCG Board - Closed	Discuss DMBC approach and timeline Discuss Travel and Transport Report Discuss draft Board agenda for May
19 April 2022	Consultation Steering Group	Oversight of consultation feedback, analysis and evaluation
21 April 2022	NHS Lincolnshire CCG Exec	Discuss approach to decision making
21 April 2022	Joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Committee	*Urgent and Emergency Care & Acute Medicine* Review of Clinical Senate recommendations, QIAs, EIAs and working group considerations of consultation feedback by ICS Clinical and Care Directorate & NHS Lincolnshire CCG Clinical Policies Sub-Group
25 April 2022	Consultation Steering Group	Oversight of consultation feedback, analysis and evaluation
27 April 2022	NHS Lincolnshire CCG Board - Closed	Discuss progress on responding to consultation feedback Discuss Board approach to decision making Update on outcome of clinical assessment of UEC and Stroke proposals Provide update on development of transport response to consultation feedback Highlight key information that will be circulated to board members to revie ahead of receiving DMBC
28 April 2022	Joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Committee	*Orthopaedics and Stroke* Review of Clinical Senate recommendations, EIAs and working group considerations of consultation feedback by ICS Clinical and Care Directorate & NHS Lincolnshire CCG Clinical Policies Sub-Group and CCG
03 May 2022	LCH Executive	Consider provider statements of support
05 May 2022	NHS Lincolnshire CCG Exec	Consider patient and public support criterion
06 May 2022	System Finance Committee	Review financial impact of proposals
09 May 2022	Consultation Steering Group	Oversight of consultation feedback, analysis and evaluation
10 May 2022	LCHS Board - Private	Consider provider statements of support
11 May 2022	NHS Lincolnshire CCG Board - Closed	Consider agenda structure to decision making Board meeting
12 May 2022	NHS Lincolnshire CCG Clinical Leads	Consider clinical commissioner support criterion
12 May 2022	NHS Lincolnshire CCG Quality and Patient Experience Committee	Consider and review conclusions of joint meetings of ICS Clinical Directorate and CCG Clinical Policies Sun Committee
12/13 May 2022	ULHT Executive/Board (private)	Consider provider statements of support
12 May 2022	NHS Lincolnshire CCG Executive	Consider deliverability, patient choice and bed closure criterion
19 May 2022	NHS Lincolnshire CCG Executive	Formation of DMBC recommendations to go to NHS Lincolnshire CCG Board for decision
25 May 2022	NHS Lincolnshire CCG Board - Open	DMBC for consideration and decision

15 Recommendations to the NHS Lincolnshire CCG Board

15.1 Overview

15.1.1 This document asks the Board of the NHS Lincolnshire CCG as the Consulting Authority for the four NHS service changes relating to orthopaedics, urgent and emergency care, acute medicine and stroke to **approve** key changes to the configuration of commissioned services.

15.1.2 These proposals have the full support of local senior clinicians and health providers across Lincolnshire.

15.2 Recommendation 1: Orthopaedics

15.2.1 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.

15.3 Recommendation 2: Urgent and emergency care

15.3.1 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.

15.4 Recommendation 3: Acute medicine

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

- This is in place of the current acute medicine beds.

15.5 Recommendation 4: Stroke services

15.5.1 Establish a 'centre of excellence' for hyper-acute and acute stroke services at the 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 stroke services would be consolidated at Lincoln County Hospital and no longer be provided from Pilgrim Hospital, Boston.
- Transient ischaemic attack (TIA) clinics would be unaffected at Pilgrim Hospital, Boston.

16 Implementation

16.1 Implementation governance

16.1.1 If the NHS Lincolnshire CCG Board approves the proposals, services will be commissioned through standard commissioning processes.

16.1.2 In this context CCGs are currently required to comply with two sets of regulations when awarding contracts for healthcare services:

- The Public Contracts Regulations 2015 ("PCR"); and
- The NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 ("NHS Procurement Regulations")

16.1.3 However, in 2022, in the context of awarding contracts for healthcare services, it is expected that the PCR and NHS Procurement Regulations will be replaced by the "Provider Selection Regime". The consultation on this is now closed but it is not expected that the regulations will be in force until at least October.

16.1.4 It is also recognised that the intent is for CCGs to be dissolved and replaced by an Integrated Care Board (ICB). Guidance from NHS England and Improvement issued in March 2022 sets out that the CCG should be ensuring that ICB designates are involved and consulted on commissioning decisions for healthcare services and contracting decisions for non-healthcare services from the date of this publication up to the point of transfer.

16.1.5 Both the PCR and NHS Procurement Regulations require CCGs to be transparent, treat providers equally and in a non-discriminatory manner and to act proportionately. If the decision is made to proceed with the proposals the relevant commissioning body will act in accordance with these existing regulations and any future regulations that may be brought in to replace them.

16.1.6 The implementation of the proposals for change will be provider led and delivered via a collaboration between NHS providers and where relevant Lincolnshire County Council and the voluntary sector.

16.1.7 If the recommendations set out in this document are approved, as the system moves from planning to implementation it is proposed a new system-wide co-ordination group is set up, the Implementation Oversight Group (IOG). As part of its establishment its relationship with existing Integrated Care System, commissioner and provider governance arrangements as well as wider stakeholders such as the Health Scrutiny Committee for Lincolnshire would be confirmed.

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

16.1.9 It is proposed there would be a dedicated implementation group for each of the four service change proposals that would ensure the project is delivered and embedded, reporting into the Implementation Oversight Group. These implementation groups will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues an manage risks
- Involve members of the whole health system such as acute trusts, community trusts, local GPs, commissioners and wider partners such as Lincolnshire County Council and the voluntary sector as required.
- Appoint a Senior Responsible Officer (SRO) for the project
- Agree and monitor performance metrics to track and manage progress against key metrics
- Align any other key programmes in place both within individual organisations but also the wider health and care system

16.1.10 It is anticipated that reporting into the implementation group for each of the four service change proposals would be clinical and non-clinical workstreams.

16.1.11 The clinical work streams would focus on areas such as:

- Agreeing pathways for patients
- Ensuring function of other aspects of ASR fit into the medical bed model, along with SDEC and frailty units and other system health / social care provision.
- Defining how service changes will be made, for example will there be double running / when will services start.
- Approach to management structures, workforce issues , governance including policies and protocols
- Approach to management of the deteriorating patient

16.1.12 The non-clinical work streams would include:

- Workforce
- Estates
- Equipment
- Communications and stakeholder management
- Finance

16.1.13 The organisations impacted by the changes and NHS Lincolnshire CCG will 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.

16.1.14 An overview of the high level implementation timelines and benefits plans for each of the four changes proposals is set out below.

16.1.15 The starting point for these high level plans is from agreeing to implement the changes following any necessary procurement process in line with regulations as outlined earlier in this chapter.

16.2 Orthopaedics

16.2.1 The proposed changes to orthopaedic services have been in place as part of a national pilot since August 2018.

16.2.2 Therefore if the proposed change was approved provisions would need to be made for this pilot to become a permanent change.

16.2.3 Key aspects of this would be the need to review internal governance around the programme and any necessary HR facets, such as staff consultation.

16.2.4 However, given the proposed service changes are currently being delivered through the pilot arrangements it is anticipated these shouldn't be a protracted timeframe.

16.2.5 The initial benefits plan for orthopaedics change proposal is set out below, if the proposed change is agreed this would be developed further through implementation.

16.2.6 The metrics would be included in a benefit log and then measured throughout the implementation stage of the project and post implementation to inform an evaluation report.

Figure 79 – Orthopaedics: Initial benefits plan

Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
This proposed change should improve patient safety. Patients will have improved access to elective and non-elective care, improving health outcomes.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
It is highly likely that the new model of care will be able to meet the needs of a significant majority of patients locally, through an integrated model of provision.	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
Reduced chance of post-op infection, extended use of enhanced recovery.	Length of Stay and current recorded incidents and patient quality indicators	Provider	PAS Data / Provider Datix / Complaints System	Monthly
Reduced cancellations for elective patients, as following this reconfiguration as hot and cold activity are split.	Monitor current recorded cancellations	Provider	PAS Data	Monthly
Reduced waiting times for surgery.	Monitor performance of the reduction	Provider	PAS Data	Monthly
Improve opportunities for staff to be developed in post. Staff will retain their base site and travelling between sites for the elective surgery which is part of Trust-wide working.	Current WTE and Vacancy Gap	Provider	Workforce Data / ESR	Monthly
The new model should make remaining in post more attractive, with more opportunities for development in the care of orthopaedic work.	Current WTE and Vacancy Gap	Provider	Workforce Data / ESR	Monthly

16.3 Urgent and emergency care

16.3.1 The high level implementation plan for the urgent and emergency care change proposal is set out below. If the proposed change is agreed this would be developed further through implementation.

Figure 80 – Urgent and emergency care: High level implementation plan

	Month											
UEC	1	2	3	4	5	6	7	8	9	10	11	12
Establishment of Operational & Governance Structures / Working Groups												
Staff Consultation												
Implementation												
Evaluation												

16.3.2 The initial benefits plan for orthopaedics change proposal is set out below, if the proposed change is agreed this would be developed further through implementation.

16.3.3 The metrics would be included in a benefit log and then measured throughout the implementation stage of the project and post implementation to inform an evaluation report.

Figure 81 – Urgent and emergency care: Initial benefits plan

Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
This service change may improve patient safety as it will ensure those patients with the highest acuity go to the right hospital first time.	Reduction in Incidents / Complaints	Provider	Provider Datix / Complaints System	Monthly
Positive impact related to greater accessibility (opening hours) and a direct link with Primary Care and Community services	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
Positive impact on time spent by patients within the department due to the UTC model of assessment and management versus the A&E model of care	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
Improve overall recruitment and retention due UTC changes that should make roles more attractive to some staff groups	WTE and Vacancy Fill	Provider	ESR	Monthly
Model sits alongside increased offer for SDEC / Frailty and medical beds	Utilisation of all units Complaints and compliments	Provide and commissioner	FFT / Complaints data. performance metrics	Monthly

16.4 Acute medicine

16.4.1 The high level implementation plan for the acute medicine change proposal is set out below. If the proposed change is agreed this would be developed further through implementation.

Figure 82 – Acute medicine: High level implementation plan

	Month							
Acute Medicine	1	2	3	4	5	6	7	8
Establishment of Operational & Governance Structures / Working Groups	■	■	■	■				
Staff Consultation	■	■	■	■	■	■	■	
Implementation	■	■	■	■	■	■	■	■
Evaluation							■	■

16.4.2 The initial benefits plan for orthopaedics change proposal is set out below, if the proposed change is agreed this would be developed further through implementation.

16.4.3 The metrics would be included in a benefit log and then measured throughout the implementation stage of the project and post implementation to inform an evaluation report.

Figure 83 – Acute medicine: Initial benefits plan

Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
This proposed changes should improve patient safety.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
The development of an integrated community/acute provision that safely meets patient's clinical needs and maintains access locally should address the workforce challenges.	Current WTE and Vacancy Gap	Provider	Workforce Data / ESR	Monthly
It is highly likely that the new model of care will be able to meet the needs of a significant majority of patients locally, through an integrated community/acute model of provision. It will build on the locality model of integrated neighbourhood working.	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
An integrated community/acute provision will allow for a service that safely meets patients' clinical needs and maintains access locally. The service will be aligned with the local Integrated Care Team that will support the management of the local bed base and be used to support people closer to home.	Results of national/local surveys, complaints, Family & Friends surveys	Commissioner	FFT Data	Monthly
The proposals may provide opportunity currently experienced by ULHT with significant workforce challenges in acute medicine. This will help to address the recruitment challenges faced by ULHT in this area.	Current WTE and Vacancy Gap	Provider	Workforce Data / ESR	Monthly
Greater integration with the Integrated Neighbourhood Team should support earlier discharge from the integrated community/acute beds	Length of Stay	Provider	PAS Data	Monthly
This program should improve overall performance against constitutional standards.	National Standards	Provider	PAS Data	Monthly
Following the implementation of multiple initiatives related to patient flow and care closer to home there has been significant change supporting acute and community care.	Monitor Performance of the impact from Care Closer to Home Initiatives and Patient flow Discharge Models.	Commissioner	PAS Data	Monthly

16.5 Stroke

16.5.1 The high level implementation plan for the stroke service change proposal is set out below. If the change proposal is agreed this would be developed further through implementation.

Figure 84 – Stroke: High level implementation plan

	Month											
Stroke	1	2	3	4	5	6	7	8	9	10	11	12
Review of start point/end model with current mitigation of service*												
Review of Implementation												
Business case development/Approval for capital/ revenue												
Impact Assessments												
Establishment / function of Operational & Governance Structures / Working Groups												
Recruitment of staff including LCHS therapy staff**												
Commencement of Build (if required)	18 months to completion once approved											
Implementation												
Staff Consultation												
Evaluation												

* Consultation has been on the service that existed before any current service mitigations were made. There will be an evaluation on the changes required to move to the new model, taking into account these required mitigations that are only in place as a temporary measure to keep the service safe.
** LCHS have already started recruitment outside of the ASR, on the need as a result of the ASR work. This has been driven by COVID and general recruitment challenges per say. However this recruitment does not reach the levels required for the complete Stroke ASR work.

16.5.2 The initial benefits plan for orthopaedics change proposal is set out below, if the proposed change is agreed this would be developed further through implementation.

16.5.3 The metrics would be included in a benefit log and then measured throughout the implementation stage of the project and post implementation to inform an evaluation report.

Figure 85 – Stroke: High level benefits plan

Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
Community slow stream rehab service would be in place which will support a reduction in LOS in the acute sector by increasing the availability of acute beds for patients with complex needs.	Length of Stay	Provider	PAS Data	Monthly
This proposed changes should improve patient safety.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
By creating a specialist centre of excellence for Stroke Services that safely meets patient's clinical needs and maintains access locally	National Standards	Provider	PAS Data	Monthly
This program should improve overall performance against constitutional standards.	National Standards	Provider	PAS Data	Monthly
By creating a specialist centre for Stroke Services, this should attract candidates from further afield	Vacancy rate	Provider	Workforce Data / ESR	Monthly
Impact could be both positive and negative. Staff who do not wish to transfer from Pilgrim site could increase turnover rate or absenteeism. Positive impact could be a more robust workforce at Lincoln improving retention rates and reducing sickness.	Turnover Rates Sickness Rates	Provider	Workforce Data / ESR	Monthly
Could be both positive and negative impact. Pilgrim Staff will potentially respond negatively and Lincoln Staff will potentially respond positively	Staff Survey	Provider	Workforce Data / ESR	Monthly

16.6 Implementation risks

16.6.1 Building on the work completed for the Pre Consultation Business Case and developed further through the provider statements of support a number of key implementations risks have been identified. These are set out in the table below.

Figure 86 – Key implementation risks

Service area	Risk	Mitigation
Orthopaedics	Patient's willingness to travel to Grantham and Louth for surgery	Through the pilot this has not proved to be an issue
	Recruitment and retention of staff	Has already improved since the commencement of the orthopaedic pilot, which has demonstrated positive benefits in relation to establishing a sustainable orthopaedic workforce It is anticipated that if the proposed model of care is made permanent this will be a model that would allow for staff development and will improve recruitment and retention
	More pressure on the emergency orthopaedic theatre list at Lincoln and Boston hospitals	As demonstrated through the pilot, this can be offset and more theatre time freed up by the elective orthopaedic care going to Grantham and District Hospital and County Hospital Louth.
Urgent and Emergency Care	Ability to recruit staff	Service stability and certainty along with general improvements in nursing and medical will mitigate the risk
	The workforce not being trained and hold the competencies in specific areas required in the UTC	This would need to be addressed by the new provider. The majority of staff working in the UTC would be required to have individualised training and development plans to support their confidence and competence in the care of minor injuries and illness. However, it could be expected that some of the current Emergency care staff already employed in the Grantham department transfer over to the UTC, along with their skills
	Public understanding of the changes – they may not attend the correct location for treatment or care initially	The provider would need to ensure that they complete a comprehensive communication plan and ensure that local residents are fully aware of the conditions that can be managed at the proposed 24/7 UTC. This communication plan would be developed in line with the national requirement of the 'NHS 111 First' initiative
Acute Medicine	The lower acuity ward cannot be staffed	Recruitment plan put in place and having certainty for the site will support this new community bed function
	The associated units that are part of the overall Grantham offer such as the Frailty assessment unit and the SDEC are not in place, weakening the delivery aims	The SDEC model at Grantham was delivered during the Green site as it was across all sites. Frailty services have also been successfully able to deliver their units so Grantham's risk needs to be seen in the context of these successes as a service as a whole.
	Staff leave Grantham as a result of all the changes made	Certainty of the ASR should see an increased ability to recruit staff when they see a developed plan for Grantham that aims to strength the offer for the site.
Stroke	Ability to recruit staff	Service stability and certainty along with general improvements in nursing and medical will mitigate the risk
	Securing funding for the proposed extension of the stroke unit at Lincoln Hospital	Discussed at system level and included within system capital process
	Patient activity rises above levels set out in business case	All activities will be monitored and mitigations considered as with any service.

16.6.2 If the change proposals are agreed, an implementation risk log would be established by each service change proposal implementation group, which would be overseen by the proposed Implementation Oversight Group (IOG).

16.6.3 In addition to the specific risk identified for each of the change proposals a further risk has been identified that is common to all. This is the risk of increasing health inequalities due to patients facing challenges in terms of accessing the services.

16.6.4 In response to this risk three mitigations have been identified:

- **Emergency transport:** 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:** 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.
- **Other transport:** 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.
    - 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.

16.7 Neighbouring health systems

16.7.1 The activity modelling for the Pre Consultation Business Case (PCBC) took into consideration the impact of the four change proposals on neighbouring health systems. This identified the one that would have the largest impact if implemented is stroke, and the impact would be on Peterborough City Hospital.

16.7.2 Following the temporary changes to Hyper Acute Stroke services at ULHT and the consolidation of these services on the Lincoln County Hospital site, the change in the pathway has already occurred which has resulted in an additional 108 patients being taken to Peterborough Hospital over a 12 month period, which is the equivalent of 2 patients a week. This is in line with the modelling carried out for the PCBC.

16.7.3 The NHS Lincolnshire CCG currently has monthly contract meetings with North West Anglia NHS Foundation Trust (NWAFT) to discuss quality and contract issues. When the temporary stroke changes were initially put in place NWAFT did identify concern, which led to changes to the ambulance protocols being made. Over the past 12 months the Trust have not identified any additional issue with the stroke pathway at the contract meetings and have been able to receive the additional patients.

16.7.4 In terms of potential service changes being made in neighbouring systems, the Lincolnshire NHS System have meetings with the Humber Acute Services Programme every six weeks to discuss the change proposals that are being developed.

16.7.5 This programme is considering a range of options to reconfigure their services some which will impact on surrounding systems but at this stage there are no confirmed proposals in place. These meetings will continue to take place and the Lincolnshire NHS will highlight any concerns to the Health Scrutiny Committee on the impact that may be felt at ULHT. The four proposals made by NHS Lincolnshire CCG do not impact trusts in North Lincolnshire.

17 Conclusion

17.1.1 This Decision Making Business Case has presented and summarised the extensive work undertaken on four NHS services as part of the Lincolnshire Acute Services Review.

17.1.2 This technical document follows the Pre Consultation Business Case and has described the proposals for reconfiguring orthopaedic, urgent and emergency care, acute medicine and stroke services across Lincolnshire, to enable decision makers to decide whether there is a case to implement the changes to these service areas.

17.1.3 The Acute Service Review has brought together stakeholders from all backgrounds and professions around a shared vision for the future of acute services in Lincolnshire.

17.1.4 The Acute Service Review has been underpinned by public involvement. If the change proposals are agreed further engagement will continue through the implementation phase to ensure that the changes to enable the Lincolnshire health service to better meet the needs of the local population to deliver improved outcomes and experience of care.

17.1.5 As set out at the start of this document, the clinical models put forward for each of the four area are aligned to the NHS Long Term Plan and centred around the needs of the Lincolnshire population.

17.1.6 Delivering the recommendations put forward in this document will result in real, meaningful clinical benefits for the people of Lincolnshire.

Glossary

#NOF	Fractured Neck of Femur
A&E	Accident and Emergency
AAC	Assessment and Ambulatory Care
ACP	Advanced Clinical Practitioner
AHP	Allied Health Practitioner
ASR	Acute Services Review
BBC	British Broadcasting Corporation
BM	Backlog Maintenance
BPPC	Better Payment Practice Code
BPT	Better Payment Tariff
CAS	Clinical Assessment Service
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CIP	Cost Improvement Plans
CIR	Critical Infrastructure Risk
CNST	Clinical Negligence Scheme for Trust
COIN	Community of Interest Network
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CSRR	Continuity of Service Risk Ratings
CT	Computer Tomography
CVD	Cardiovascular Disease
CYPAU	Children's and Young People Assessment Unit
D&B	Design and Build Construction Procurement
DASR	Directly Aged Standardised Rates
DBB	Design Bid Build construction procurement
DC	Day Case
DD	Digital Dictation
DHSC Procure 22	Department of Health ProCure 22 Framework
DMBC	Decision Making Business Case
DOS	Directory Of Service
DSN	Diabetes Specialist Nurse
DTOC	Delayed Transfer of Care
DTOC	Delayed Treatment of Care
DWP	Department of Work and Pensions
EAU	Emergency Assessment Unit
ED	Emergency Department
EFL	External Financing Limit
e-HR	E-health Record
EIA	Equality Impact Assessment
EL	Elective Care
EMAS	East Midlands Ambulance Service

ENT	Ear Nose Throat
ePMA	E-prescribing
ESD	Early Supported Discharge
EU	European Referendum
FEP	Financial Efficiency Plan
FM	Facilities Management
FOI	Freedom of Information
FRR	Financial Risk Rating
FT	Foundation Trust
FTE	Full Time Equivalent
GDH	Grantham District Hospital
GI	Gastrointestinal
GP	General Practitioner
GPFV	GP Forward View
Haem	Haematology
HART	Hospital Avoidance Response Team
HASU	Hyper-acute Stroke Unit
HBN	Health Building Note
HCE	Healthcare Educator
HCSW	Health Care Support Worker
HEE	Health Education England
HEI	Higher Education Institutions
HEY	Hull and East Yorkshire
HM	Her Majesty
HSC	Health Scrutiny Committee
HSE	Health and Safety Executive
I&E	Income and Expenditure
ICS	Integrated Care System
ICU	Intensive Care Unit
IMD	Index of Multiple Deprivation
IMTEG	IM&T Enabler Group
INW	Integrated Neighbourhood Working
IP	Internet Protocol
ISTC	Independent Sector Treatment Centre
IT	Information Technology
IUC	Integrated Urgent Care
IV	Intravenous
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LCB	Lincolnshire Co-ordinating Board
LCH	Lincoln County Hospital
LCHS	Lincolnshire Community Health Services NHS Trust
LDR	Local Digital Roadmap
LHAC	Lincolnshire Health and Care
LMC	Lincolnshire Medical Council
LMS	Local Maternity System

LNU	Local Neonatal Unit
LoS	Length of Stay
LPFT	Lincolnshire Partnership NHS Foundation Trust
LSOA	Lower Level Super Output Areas
LTC	Long Term Condition
LWAB	Lincolnshire Workforce Advisory Board
M&E	Mechanical and Electrical
MDT	Multi Disciplinary Teams
MIU	Minor Injury Unit
MLU	Midwifery Led Unit
MP	Member of Parliament
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
MSP	Managing Successful Projects
NED	Non Executive Director
NEL	Non-Elective Care
NEWS	National Early Warning Score
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NHSLA	NHS Litigation Authority
NICE	National Institute for Clinical Excellence
NIV	Non Invasive Ventilation
NLAG	North Lincolnshire and Goole
NT	Neighbourhood Team
OB	Outline Business Case
OBC	Outline Business Case
OMF	Oral Maxillofacial
Onc	Oncology
ONS	Office National Statistics
OP	Outpatient
OPA	Outpatient Appointment
OPD	Outpatient Department
OT	Occupational Therapy
P22	Department of Health ProCure 22 Framework
PA	Programmed Activities
PALS	Patient Advisory Liaison Service
PAU	Paediatric Assessment Unit
PCBC	Pre Consultation Business Case
PCDU	Psychiatric Clinical Decisions Unit
PDC	Public Dividend Capital
PF2	Private Finance 2
PFI	Private Finance Initiative
PHB	Pilgrim Hospital Boston
PHE	Public Health England

PHOF	Public Health Outcomes Framework
PLACE	Patient Led Assessments of the Care Environment
PMH	Perinatal Mental Health
PMO	Programme Management Office
POD	Point of Delivery
PSA	Prostate Specific Antigen
PT	Physiotherapy
Q&A	Question and Answer
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality Outcome Framework
RCHPH	Royal College of Paediatrics and Child Health
RCN	Royal College of Nursing
RDEL	Resource Departmental Expenditure Limit
RFS	Referral Facilitation Service
RTT	Referral to Treatment
SCBU	Special Care Baby Unit
SET	System Executive Team
SI	SystmOne
SLF	Senior Leadership Forum
SLR	Service Line Reporting
SLT	Speech & Language
SR	Speech Recognition
SRO	Senior Responsible Officer
SSNAP	Stroke National Audit Programme
SSPB	Shared Services Partnership Board
STP	Sustainability and Transformation Partnership
SWIPE	Strategic Workforce Planning Framework developed by Whole System Partnership
T&O	Trauma and Orthopaedics
TACC	Theatres and Critical Care
U&EC	Urgent and Emergency Care
U/S	Ultrasound
ULHT	United Lincolnshire Hospitals Trust
UTC	Urgent Treatment Centre
VAT	Value Added Tax
VC	Video Conferencing
VDI	Virtual Desktop Infrastructure
WTE	Whole Time Equivalent

Decision Making Business Case - Appendices

Lincolnshire Integrated Care System
Acute Services Review:

- **Orthopaedics (elective and non-elective)**
- **Urgent & Emergency Care**
- **Acute Medicine**
- **Stroke Services**

Appendix A	**Communication and Consultation Activity Report**
Appendix B	**Equality Review of consultation process**
Appendix C	**NHS Lincolnshire Public Consultation 2021 Feedback Report**
Appendix D	**Themed detailed consultation feedback**
Appendix E	**Health Scrutiny Committee for Lincolnshire response to public consultation**
Appendix F	**Consideration of public feedback by subject matter expert working groups**
Appendix G	**Quality Impact Assessments (QIAs)**
Appendix H	**Equality Impact Assessments (EIAs)**
Appendix I	**Travel and Transport Report**
Appendix J	**Recommendations of East Midlands Clinical Senate**
Appendix K	**Minutes of joint meeting of the ICS Clinical Directorate and CCG Clinical policies Sub-Group**
Appendix L	**Statements of support from providers**
Appendix M	**CCG statement on choice and bed closures**