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**
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Appendix A

Communications and Consultation Activity Report

NHS Lincolnshire

Lincolnshire NHS public consultation on proposed changes to four services

Orthopaedic surgery in Lincolnshire
Urgent and emergency care at Grantham and District Hospital
Acute medical beds at Grantham and District Hospital
Stroke services in Lincolnshire





Communications and Consultation Activity Report May 2022

30 September—23 December 2021

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1. Introduction

For full details of the results of this public consultation, please see the report by ORS: NHS Lincolnshire Public Consultation 2021 Feedback- ORS Report May 2022

The purpose of this report is to provide an overview of the comprehensive public consultation and communications activities undertaken to promote and provide various opportunities to get involved and share views on the proposed services changes.

NHS Lincolnshire CCG undertook a 12-week public consultation between 30 September 2021 and 23 December 2021 on the future of four hospital services:

- **Orthopaedic surgery services in Lincolnshire**
- **Urgent and emergency care at Grantham and District Hospital**
- **Integrated community/acute medical beds at Grantham and District Hospital**
- **Stroke services in Lincolnshire**

Public consultation promotes accountability and assists decision making; public bodies give an account of their plans or proposals and listen to feedback. Consultation has therefore been described as a dialogue, based on a genuine and purposeful exchange of views. It should be noted that consultations are not referenda or 'votes' in which the loudest voices or the greatest numbers automatically determine the outcome.

NHS Lincolnshire CCG undertook a vast range of activities to proactively gather as much feedback on our proposals as possible, and in particular, from those usually less likely to get involved. Our consultation was guided by our commitment to inform and listen, ensuring that our methods and approaches were inclusive and tailored to the people we want to reach so that they could have their say.

The purpose of the consultation's communications and engagement activity was to:

- Raise awareness of and provide information on the changes being proposed
- Involve all stakeholders in the consultation about the proposed changes, ensuring they have enough knowledge to make an informed contribution
- Gather feedback which will inform the decision making about the future hospital services within the consultation
- Ensure we meet our statutory duties set out in the Health and Social Care Act 2006
- Ensure we pay due regard to our equality duty in our decision making with stakeholders to consider potential solutions to any issues raised.

For full details of the results of this public consultation, please see the report by ORS: NHS Lincolnshire Public Consultation 2021 Feedback- ORS Report May 2022

The feedback we have received will inform the CCG's decision-making. No final decisions will be taken until all of the results have been collated, independently analysed, and reported to the CCG Board.

Opinion Research Services (ORS), a company from Swansea University with a positive UK-wide reputation for social research and major statutory consultations, was appointed by NHS Lincolnshire to support consultation activities, and to independently analyse and report the outcomes of this public consultation programme with members of the public, clinicians and other NHS staff, and other stakeholders.



2. Summary of activities

The twelve-week consultation was widely promoted via stakeholder organisations, leaflet deliveries to households across Lincolnshire, posters and leaflets in GP practices and public locations, online and traditional media coverage and advertisement, and to United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Community Health Services NHS Trust (LCHS) service users and Lincolnshire Partnership NHS Foundation Trust (LPFT), among others.

This consultation was widely supported by our patient groups and Involvement Champions.

During the consultation period, stakeholders were invited to provide feedback through:

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 NHS staff members, stakeholders and services users; and
- 'Pop-up' engagement activities at market days across Lincolnshire;

At or following these opportunities, we received feedback via:

- A consultation questionnaire for all residents, 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;
- Verbal comments made at events;
- Written or email submissions from residents, stakeholders and organisations; and
- Petitions (organised by two local campaign groups and submitted to ORS).

Feedback from all activities have been reported in the ORS report **NHS Lincolnshire Public Consultation 2021 Feedback- ORS Report May 2022.** This report outlines the consultation and communication activities undertaken by NHS Lincolnshire.

2.1 Summary of consultation activities

Seldom Heard Groups

- Working with local organisations and key delivery partners to promote involvement opportunities and to support their groups and contacts to take part in our consultation via attendance at existing meetings
- Promotion of ways to get involved displayed in specialist food shops, Polish cafes, factories and large employers across Lincolnshire. Translated materials and alternative formats were available.

Public and online events

- Public events held across Lincolnshire including presentations from NHS Executives and clinicians and panel Q&As
- Online events held on various days and times to suit all as well as a virtual event available 24/7
- Market stalls and public stands at supermarkets, highstreets and shopping centres to promote the consultation and questionnaire

Involvement Champions

- Recruitment and development of our own Involvement Champions to support the consultation by promoting and gathering views from seldom heard groups and those within their communities

Digital Engagement

- One central website created that housed all communications and engagement activity and background information, the pre consultation business case, FAQs, full consultation document, questionnaire etc. that was easily accessed by members of the public
- 24/7 online event held on the website via Slido, providing the public the opportunity to hear the same information that was given at the main public/virtual events.
- Regular messages and updates shared via social media such as Nextdoor, Facebook, Twitter and Instagram

Public Consultation

Relating to four of Lincolnshire's NHS Services

Have **your** say

Patients and public

- Telephone surveys and in-depth interviews carried out by ORS
- Updates and information sent to PPGs, and attendance at patient group meetings including presentations given to ULHT patient panel
- Leaflets, surveys, posters and summary documents displayed in clinics and receptions

Staff Engagement

- Virtual staff engagement events held for all staff across ULHT, CCG, LCHS and LPFT. Additional events were also held by ULHT Clinical Support Services Division
- Surveys, posters, leaflets and summary documents displayed in staff areas, as well as displayed on screens across the hospitals
- Built on existing platforms across organisations to increase staff involvement via intranet, social media, and detailed staff briefings

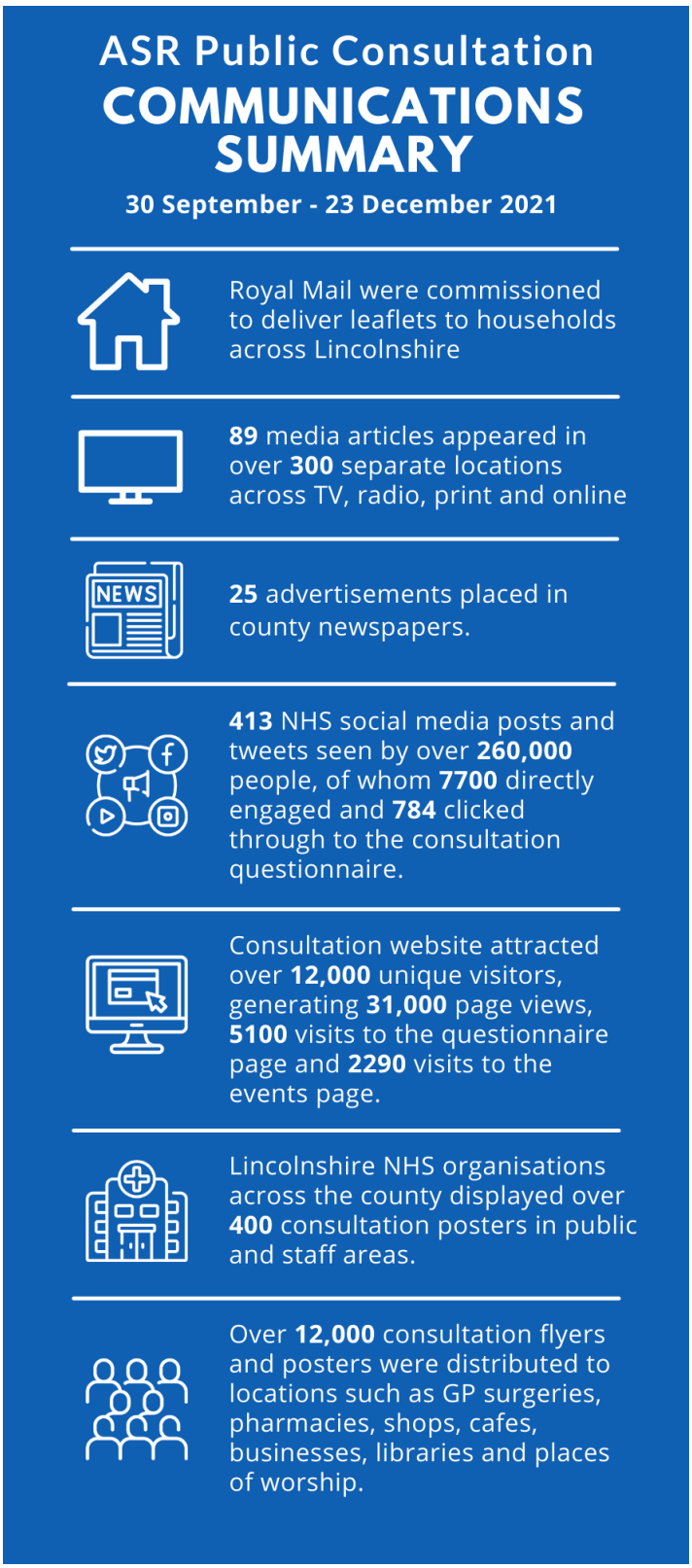
Stakeholders

- Updates and discussions with various stakeholders including District Councils, local MPs, campaign groups, regulators, Stakeholder Board and briefings for lay members
- Attendance at existing stakeholder meetings and events as well as formal attendance at Health Overview and Scrutiny Committee to discuss proposals

2.2 Summary of communications activities

The Public Consultation was supported by a comprehensive communication strategy.

The reach of the consultation was extensive:



It was essential to make the consultation as accessible and visible as possible, using all established methods of communication and engagement such as printed materials in a range of formats, online, email and telephone contact through a dedicated team, as well as embarking on a range of channels of engagement through social media.

Partnerships were also formed with local media organisations to maximise reach and raise awareness about the consultation.

In addition to the communications directly controlled by Lincolnshire's NHS which are summarised here, partners and relevant agencies across the county (such as the local authority) were asked to promote access to the consultation on their channels.

3. Consultation launch and distribution

3.1 Pre-launch materials

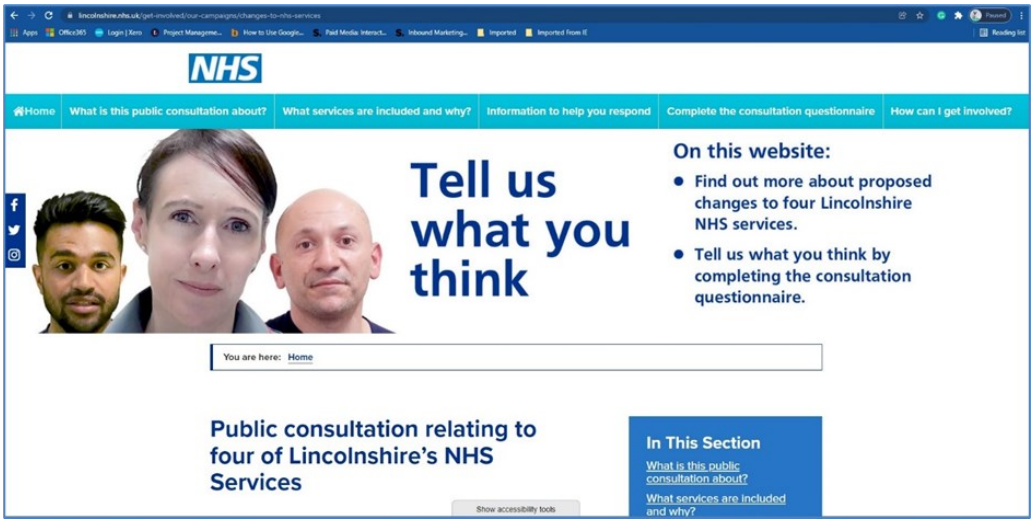
To fulfil the consultation objectives and ensure that people across Lincolnshire were alerted and then motivated to take part in the consultation, a targeted communication programme and supporting materials were developed.

Key consultation products:

1. Consultation website

The public consultation website was created as an easy to navigate gateway for members of the public, staff and stakeholders to access information about the consultation and its proposals, as well as a portal to fill in the consultation questionnaire online and book onto events. This website was produced in accessible formats and was also made fully functional for mobile phone and tablet devices.

Fig.1 Consultation website homepage (desktop/tablet)



The website was divided into the following areas to ensure respondents were provided with full and robust information on which to make an informed decision when responding to the consultation:

What is this public consultation about?

This section of the site covered the following topics:

- Who are we?
- What is public consultation?
- Why are we consulting?
- Who are we consulting?
- Does Lincolnshire NHS have a preferred way of improving?
- What this consultation includes and what it does not

- What will happen with feedback?
- How have we involved the public so far?
- What impact has the public involvement had so far?
- Why we need to change

What services are included and why?

- Focus on four NHS services
- How we developed our change proposals
- Overview of our change proposals
- How these four NHS services are currently organised and how they could look in the future
- Orthopaedic surgery
- Urgent and emergency care at Grantham Hospital
- Acute medical beds at Grantham Hospital
- Stroke services

Information to help you respond

This section included a number of resources that could be viewed online and/or downloaded.

- Pre-Consultation Business Case
- Equality Impact Assessments/Quality Impact Assessments
- East Midlands Clinical Senate Report
- Lincolnshire's Orthopaedic Surgery Pilot report
- Healthy Conversations 2019 Final Report
- People's Partnership HC2019 Final Report
- Glossary
- Frequently Asked Questions

How can I get involved?

This section provided site visitors with clear options and instructions to engage with the consultation and complete the questionnaire. This included the ability to book places at consultation live and virtual events, join the consultation's online 24/7 event, help to spread the word about the consultation by becoming an Involvement Champion or join the Citizen's Panel

- **Attend an event** – this page allowed members of the public to book a place at the scheduled consultation live and virtual events. Telephone and email contact details were provided for those who were unable to book online. Booking on events was essential to ensure management of numbers and social distancing during the Covid pandemic.

- **Online 24/7 event** – this event was created for those unable to attend one of the consultation live or virtual events. It enabled members of the public to watch an online 24/7 event film and then post questions using the Slido app.

- **Become an Involvement Champion** - The Involvement Champion programme strengthens the existing patient and public involvement channels within the NHS, by encouraging and supporting people to become trusted voices in their local area, so that they can help the NHS reach as many people from different communities as possible.
- **Join our Citizen's Panel** – the Citizens' Panel is a sample of residents who have volunteered to take part in regular research and questionnaires.
- **Help and support** – this page provided users with information about how to request the consultation questionnaire in another language or format. It also signposted the consultation helpline (01522 421860) as a means to access support in completing the questionnaire or obtaining additional Information. The information on this page also appeared in nine other languages.
- **Contact us**

2. Public Consultation A5 Flyer

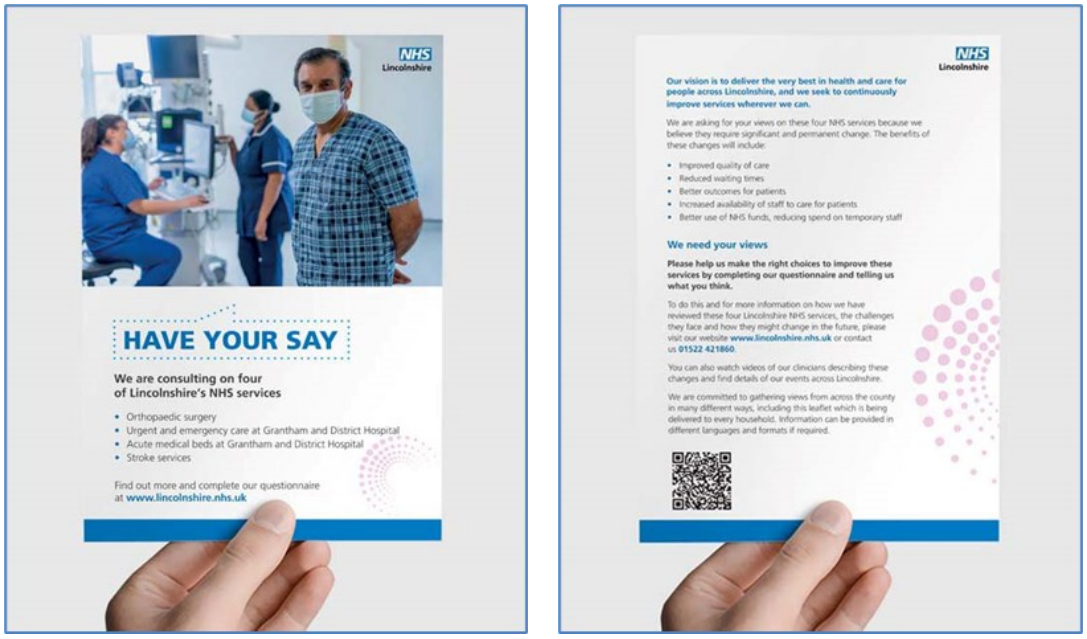


Fig. 2 Public Consultation A5 flyer – front and reverse

The Public Consultation A5 flyer was created to provide a versatile and tangible means to:

- Awake and build awareness of the consultation.
- Increase understanding of the proposed service changes.
- Signpost/link people to the public consultation website and helpline phone and email.
- Provide consultation team members with a means of engaging with and passing information to the public at live events, market days etc.
- Commissioned Royal Mail to deliver leaflets to households across Lincolnshire

The flyer included:

- Calls to action – ‘HAVE YOUR SAY’, ‘We need your views’ and ‘Please help us to make the right choices to improve these services by completing our questionnaire and telling us what you think’.
- An outline of the four service areas under consultation.
- The suggested benefits of the proposed service changes.
- Information on how to find out more and complete the questionnaire.
- Helpline number and email address.
- A QR code providing direct link to Public Consultation website. Information on this page also appeared in nine other languages.

3. Key information document



Fig. 3 Public Consultation Key Information document

Accepting that not all members of the public would be motivated to read the full public consultation document due to the necessary length and detail within it, an 8-page key information document was developed as a quicker reference guide to the consultation in order to increase the number of people who engaged in an informed manner. It provided the narrative for and description of the proposed changes to each of the four service areas. It summarised the details in the full consultation document whilst also signposting to it and the website for those who wanted more detail and was available in a range of formats.

The document included the following sections:

What is this public consultation about?

- What services are included in this consultation?
- Why we need to change

Overview of our change proposals

- Orthopaedic surgery
- Urgent and emergency care at Grantham and District Hospital
- Acute medical beds at Grantham and District Hospital
- Stroke services

Have your say

This section provided information on how to get involved in the consultation and complete the questionnaire.

The Key Information document was awarded the Crystal Mark accreditation by the Plain English Campaign for its clarity and the use of 'plain English'.

4. Full Consultation Document

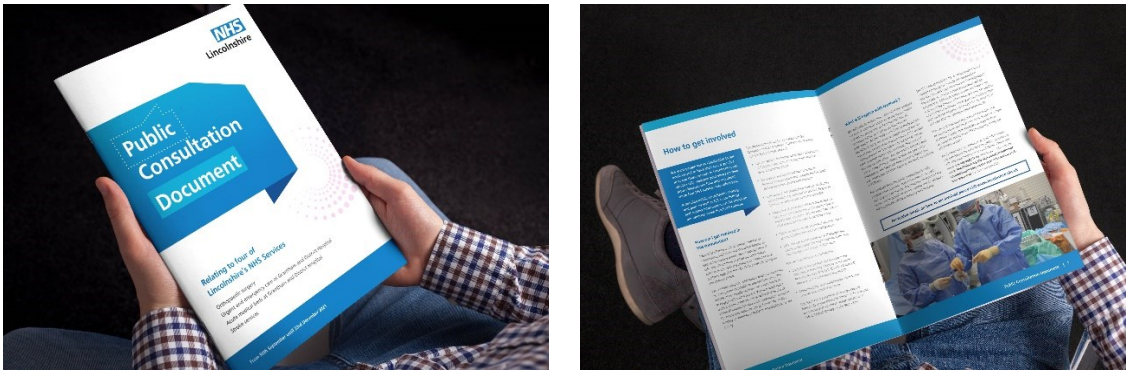


Fig. 4 Public Consultation Document – cover and interior

In recognition that more detailed information would be required by some people, a 44-page **Full Consultation Document** was also produced. This document mirrored the comprehensive information that appeared on the consultation website and included the following sections:

1. What is this public consultation about?

- What is public consultation?
- Why are we consulting?
- Who are we consulting?
- Does Lincolnshire NHS have a preferred way of improving?
- What this consultation includes and what it does not.

2. Why we need to change

3. How to get involved

- How can I get involved in this consultation?
- What will happen with feedback?

4. How have we involved the public so far?

- Acute Service Review timeline summarised
- Focus on four NHS services
- What impact has the public involvement had so far?

5. How we developed our change proposals

- Identifying NHS services for improvement
- How potential solutions for improving NHS services were developed and considered
- Option evaluation criteria
- Progressing the preferred option
- Impact assessments

6. Overview of our change proposals

7. Sections on each of the four service areas for which changes are proposed: Orthopaedic Surgery, Urgent and emergency care at Grantham and District Hospital, Acute medical beds at Grantham and District Hospital and Stroke services.

- What are we asking you to consider?
- What are the services and how are they organised?
- What are the challenges and opportunities?
- The feedback from engagement and how we have used it
- What is our proposal for change?
- Impact analysis

5. Public Consultation Easy Read booklet – 'Changes to some hospital services in Lincolnshire. What do you think?'

The 16-page Public Consultation Easy Read booklet provided information about the consultation in an accessible, easy-to-understand format. This document was created to provide access to consultation information for people with learning difficulties and those with other conditions affecting how they process information.

The information was presented in the following sections:

- Introduction
- Why Change
- Our ideas for change
- Tell us what you think
- Descriptive images

The document was available in a hard copy version (50 produced) and as a digital PDF, downloadable from the consultation website or emailed on request by the consultation helpline team.

6. Translated Consultation documents

Translated versions of the **Public Consultation Questionnaire**, **A5 flyer** and **A4 portrait poster** were produced to provide access to consultation information for those for whom English is not their first language.

These materials were produced in the following languages:

- **Bulgarian**
- **Czech**
- **Italian**
- **Latvian**
- **Lithuanian**
- **Polish**
- **Portuguese**
- **Romanian**
- **Russian**

These materials were produced in the following quantities, with a commitment to printing more as they were required:

- Translated Public Consultation Questionnaire 450 (50 available in each of the 9 languages)
- Translated A5 Flyer 450 (50 available in each of the 9 languages)
- Translated A4 Poster 90 (10 available in each of the 9 languages)

Healthwatch Readers Panel kindly supported us to develop the documentation and reviewed it prior to finalisation and publication.

3.2 Launch

Pre-launch communications management

Media

Local and regional media were sent an invitation to a media briefing session led by expert clinicians and executives, to take place on launch day, Thursday 30 September at 12 noon. This briefing event incorporated presentations about the proposed changes, opportunity for Q&As and then individual opportunities to explore them in further detail. Those who couldn't attend were able to access the event online. The presentations given at the launch event were filmed and made available to those who couldn't attend. Invited media included:

Regional News

BBC News – East Yorkshire & Lincolnshire

BBC News – Look North

ITV News – Calendar

Capital Midlands News

Central News East

County News

Lincolnshire Echo

Lincs FM/Planet Radio

Lincolnshire Live

Lincolnshire Reporter

Lincolnshire World

Lincolnshire County Council News

Lincolnshire UK News

Local authority news

Boston Borough Council

City of Lincoln Council

East Lindsey District Council

Gainsborough Town Council

Lincolnshire County Council

North Kesteven District Council

Sleaford Town Council

South Holland District Council

South Kesteven District Council

West Lindsey District Council

Local News

Boston Standard

Boston Target

Boston VIBE

Boston's 107 Endeavour FM

Bourne Local

East Coast & Wolds Target

Grantham Matters

Grantham Nub News

Gainsborough Standard

Gainsborough Target

Grantham Journal

Grimsby Telegraph

Horncastle News

The Linc

Lincoln City Radio

The Lincolnite

Louth Leader

Market Rasen Mail

Newark Advertiser

North Lincoln Advertiser

Peterborough Today

Siren FM

Skegness Standard

Sleaford Standard

Local News

Sleaford Target

Spalding & South Holland Voice

Spalding Guardian

Spalding Today

Stamford Mercury

Tulip FM

Worksop Guardian

Other

Healthwatch News

Infection Control News

The Lowdown (NHS Support federation)

Mental Health Mail

Press Association

Launch Day Communications

Communications activity on Thursday 30 September included:

- Staff briefing sessions across all Lincolnshire NHS organisations.
- Distribution of a staff briefing newsletter to all NHS Lincolnshire staff by email, closed Facebook groups and internal communications channels.
- Embargoed media briefing session thereafter at 12 noon
- Direct contact and distribution of stakeholder briefing packs to a wide range of stakeholders (see detail below)
- Media embargo lifted at 2pm and a press release was distributed to all media
- Launch of NHS social media messaging via NHS Communications teams

3.3 Initial Distribution and Communication

Coinciding with the stakeholder and media launch, and to make the consultation directly accessible to a range of patients and the public we disseminated a 'consultation launch' email to a range of people outlined in the below table.

The email contained direct links to the consultation website where people could find further detail about the proposals, give feedback via the online questionnaire and see how they can get involved and what events are taking place across Lincolnshire. We also included phone and email details of our dedicated consultation hotline.

To enable us to provide many more opportunities for the public and stakeholders to find out about the consultation and how they can get involved, we also asked partners and community organisations to share the materials and launch email with their members, groups and wider communities.

General Distribution	
Audience	**Consultation Distribution**
Staff and internal	LCHS ULHT LPFT NHS Lincolnshire CCG Governing Bodies inc. NEDs and Lay Members Primary Care Networks and Alliance GPs and Primary Care Staff PPGs Patient Council
Provider memberships	ULHT – 1,200 members, 30 patient panel members LPFT – 9429 members
Unions	Unison GMB Royal College of Nursing

General Distribution	
Audience	**Consultation Distribution**
Health Partners	Health Education England East Midlands Academic Health Science Network – shared via the Public Face Bulletin National Centre for Rural Health and Care STP Stakeholder Board Clinical Learning Network Local Medical Committee Local Pharmaceutical Committee Local Dental Committee Local Optometric Committee POD Committee EMAS Neighbouring CCGs including; • Bassetlaw CCG • Cambridge and Peterborough CCG • Doncaster CCG • East Leicestershire and Rutland CCG • NHS North East Lincolnshire CCG • NHS North Lincolnshire CCG • NHS Nottingham and Nottinghamshire CCG • Norfolk and Waveney CCG Neighbouring Trusts including; • University Hospitals of Leicester NHS Trust • North West Anglia NHS Foundation Trust • Queen Elizabeth Hospital, Kings Lynn NHS Trust. • Doncaster & Bassetlaw NHS Trust • Notts Healthcare NHS Trust • North Lincs & Goole NHS Trust University of Lincoln CQC NHSEI Public Health England Boston Health and Wellbeing Board East Lindsey Quality of Life and Wellbeing Board Lincolnshire Resilience Forum DHU Healthcare
Lincolnshire County Council inc. all staff and councillors	Leaders Health Overview and Scrutiny Committee Health and Wellbeing Board Staff and members
District Councils inc. all council staff and councillors	City of Lincoln Council Boston Borough Council East Lindsey District Council West Lindsey District Council North Kesteven District Council South Kesteven District Council South Holland District Council
Parish Councils	Approx. 370 active parish councils across Lincolnshire sent via LALC

General Distribution	
Audience	**Consultation Distribution**
Voluntary Engagement Teams	Age UK Lincoln and S Lincs Action for Children Active Lincolnshire Age UK Lindsey Lincs and Notts Air Ambulance Alzheimers UK Butterfly Hospice Children's Links Community Lincs Development Plus Every-one Framework Housing Healthwatch LACE Housing Lincolnshire CVS Lincolnshire Home Independence Agency Lincolnshire Rural Stress Network Lincolnshire Voluntary Centre Services Linkage LIVES South Kesteven Blind Society St Barnabas Hospice Walnut Care YMCA Involving Lincs
Local MPs	Matt Warman, Skegness and Boston MP Caroline Johnson, Sleaford and North Hykeham MP Gareth Davies, Grantham and Stamford MP Victoria Atkins, Louth and Horncastle MP John Hayes, South Holland and The Deepings MP Karl McCartney, Lincoln MP Edward Leigh, Gainsborough and Market Rasen MP
Local Employers	GLLEP Visit Lincoln Bishop Grosseteste University Riseholme College Lincoln College University of Lincoln Anglian Water The Environment Agency Large private employers including: • Siemens • Co-Op • RAF • Stagecoach • East Midlands Trains Local Factories via LCHS Patient Experience Officer Published in Business NK's Newsletter – reach 2000 businesses ELDC Economic Development Team – sharing in their business bulletin reach (7000)

General Distribution	
Audience	**Consultation Distribution**
Public sector providers	Lincolnshire Police and Crime Commissioners Lincolnshire Police Lincolnshire Fire and Rescue Housing associations including: • ACIS Housing • Longhurst Housing Group • Platform • Anchor Housing • Stonewater • Lace Housing • Advance Housing and Support • Framework Education – Schools and Colleges via Lincolnshire County Council
Campaign Groups	SOS Pilgrim Fighting 4 Grantham Fighting 4 Louth Fighting 4 Life Lincs
NHS Lincolnshire Peoples Panel	Citizens Panel Viewpoint Panel Readers Panel
Community Stakeholders inc. Volunteer groups, support groups etc.	Community and voluntary groups Support groups LGBT communities BAME communities Disability groups (Physical and Mental) Older people groups Younger people groups Carers groups Supermarkets Eastern European community Traveller groups Faith and religious organisations

3.4 Circulation of consultation materials

The distribution of the Public Consultation materials was both thorough and considered. The distribution plan had three clear aims:

1. To distribute materials widely, ensuring fair and inclusive coverage across the county, in urban, rural and coastal communities.
2. To make considerable effort to reach areas and groups that would not usually take part in formal consultation, e.g., vulnerable and economically disadvantaged groups etc as generally speaking these groups are the heaviest users of healthcare services and 'hardest to reach'.
3. That the distribution of materials should be responsive.

Distribution activity

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). This activity was commissioned to further boost our 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 it's Swindon bundling centre).

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 85 GP surgeries in Lincolnshire. The totalmaterials distributed were: 2550 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.

4. Consultation activities

4.1 Questionnaire

The online questionnaire was signposted as the prime feedback channel to ensure all views were considered within the full analysis of the consultation. It was available in different formats including paper copies as well as an online version on our website, a link to which was shared with all of our stakeholder database.

The online questionnaire was regularly promoted through various channels including:

- Social media (Twitter, Facebook and Instagram) across the CCG and Trust's accounts as well as requests regularly being sent to Lincolnshire partners to share and extend the reach
- NHS Lincolnshire Engagement Bulletin
- At all face to face and online events
- Hospital screens and in staff areas
- Press releases
- Next Door online forum
- LPFT carers WhatsApp
- Provider's member databases

In addition, 4447 friends and family tests (FFT) were sent via text message to patients attending Lincolnshire's hospitals during the consultation. Each of these texts contained a direct link to the public consultation website information and a link to the questionnaire.

The questionnaire and supporting consultation materials were also available in print, easy read, and translated into from English to Bulgarian, Polish, Czech, Portuguese, Italian, Romanian, Latvian, Russian, Lithuanian

A freepost address was also provided to enable completed paper copies of the questionnaire to be returned directly to ORS free of charge.

4.2 Events

Throughout the consultation we incorporated a number of different activities to give as many people as possible the opportunity to get involved and share their views in a way that suits them. Since the consultation launch, we held 11 face to face events and 9 online events, advertised locally, online and across social media at a variety of locations and times as shown in the tables below.

Face to face events

Face to face events were bookable using Eventbrite or by contacting us directly via the dedicated email address and telephone number. This enabled monitoring of numbers attending to enable social distancing and the safe delivery of public events. Where it was Covid safe to do so we admitted those who hadn't pre-booked events, such as we did at the first event held in Grantham. Throughout the consultation we did not turn anyone away from an event.

These were hosted by a range of senior managers and clinicians; the latter always being in attendance in order to answer as many of the clinical enquiries the public had as immediately as possible. During the events, attendees were provided with overviews of each proposal, either presented by a clinician in attendance or via a pre-recorded video of the clinician to ensure consistency if some clinicians could not attend all events, which sometimes occurred due to the simultaneous 'level four' pressures the NHS was experiencing nationally at the time. During the events, attendees were able to ask questions and give feedback on the four service proposals.

To ensure everyone was able to benefit from the sessions and to not exclude anyone, feedback and questions were able to be submitted in various ways including:

- Directly asking questions to the panel
- Paper feedback forms
- Paper Q&A cards
- Paper questionnaires with a freepost return address
- Slido (Interactive Audience Software – submit questions directly to us from a phone or tablet)
- Leaving an email address for us to respond to
- Telephoning the dedicated consultation phone number or emailing the team

Attendees were also advised during the events that any answers to questions not answered on the day would be provided in the FAQs section of the consultation website.

Face to Face Public Events			
Date and time	**Location**	**Venue**	**Number of Attendees (number of people who booked)**
Tuesday 12 October 10-12pm	**Boston**	Boston United Football Club Pilgrim Way Boston PE21 7NE	5 (7)
Thursday 14 October 6.30-8.30pm	**Grantham**	Jubilee Church Life Centre 5 London Road Grantham NG31 6EY	42 (33)
Saturday 16 October 6.30-8.30pm	**Lincoln**	The Showroom Tritton Road Lincoln LN6 7QY	0 (3)
Monday 8 November 6.30-8.30pm	**Gainsbor-ough**	United Services Club 136 Bridge Street Gainsborough DN21 1LP	0 (1)

Face to Face Public Events			
Date and time	**Location**	**Venue**	**Number of Attendees (number of people who booked)**
Thursday 11 November 2-4pm	**Skegness**	The Storehouse North Parade Skegness PE25 1BY	5 (10)
Sunday 14 November 2-4pm	**Sleaford**	The New Life Conference Centre, 25 Mareham Lane, Sleaford, NG34 7JP	2 (4)
Tuesday 16 November 10-12pm	**Spalding**	The Red Lion Conference Quarter Red Lion Street Spalding PE11 1SX	8 (8)
Sunday 12 December 2-4pm	**Grantham**	Grantham West Community Centre Trent Road Grantham NG31 7XW	13 (32)
Tuesday 14 December 10-12pm	**Lincoln**	The Showroom Tritton Road Lincoln LN6 7QY	1 (4)
Tuesday 14 December 6.30-8.30pm	**Louth**	The Mason Arm 13 Corn Market Louth LN11	3 (3)
Saturday 18 December 2-4pm	**Boston**	Len Medlock Centre St Georges Road Boston PE21 8YB	12 (20)



Online events

The online events were bookable via Eventbrite and had no limit on the number of people who could attend. The online events were run in the same format as the face-to-face events to deliver equitable access to information, and this was done via Microsoft Teams. Similarly, to the face-to-face events, these were also held on a variety of days at a number of different times to enable a higher rate of participation from the public.

Any questions received would then be answered via the FAQs section on the website, continuously adding to the growing bank of public information and clarity to all.

Online Events		
Date and Time	**Format**	**Number of attendees (number of people who booked)**
Monday 18 October 2-4pm	**Online**	1 (1)
Wednesday 20 October 6.30-8.30pm	**Online**	2 (2)
Friday 22 October 10-12pm	**Online**	2 (2)
Sunday 24 October 2-4pm	**Online**	0 (2)
Thursday 18 November 6.30-8.30pm	**Online**	2 (4)
Saturday 20 November 2-4pm	**Online**	1 (2)
Thursday 16 December 6.30-8.30pm	**Online**	3 (9)
Monday 20 December 10-12pm	**Online**	1 (2)
Wednesday 22 December 2-4pm	**Online**	0 (2)

24/7 Online Event

As well as the 9 online events, we also had a 24/7 accessible online event on the consultation website. This format presented videos of clinicians explaining the full range of information on the proposals that was available at the face-to-face events as well as the consultation document and questionnaire for completion. Questions or feedback could be submitted during the 24/7 video via Slido.

Any questions received would then be answered via the FAQs section on the website, continuously adding to the growing bank of public information and clarity to all.

4.3 Staff and Stakeholder meetings

In order for the consultation to be successful we recognised the importance of proactively seeking and attending various existing meetings that were happening across Lincolnshire. Where possible we attended these events and promoted opportunities for involvement and discussed the consultation directly with individuals.

Due to the situation with Covid at the time, some groups were not meeting regularly or did not want us to attend their groups. In those instances, we provided them with briefings to enable the stakeholders themselves to support their groups or organisations to understand the proposals in the consultation and get involved by completing the questionnaire or attending an event.

Additional meetings and briefings were undertaken with staff as well as attendance at key stakeholder meetings such as Health Scrutiny Committee, Health and Wellbeing Board and Partner organisations.

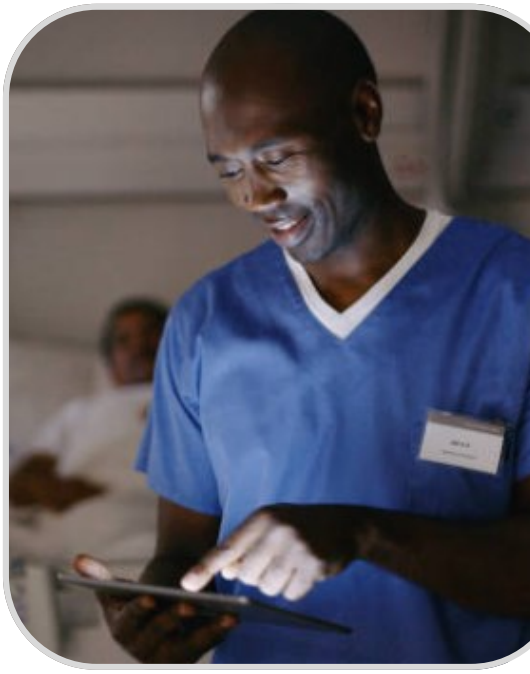
Date	Activity	Location	Number of attendees
30-Sep	ULHT Staff briefing	Virtual	25
30-Sep	ULHT Staff briefing	Virtual	27
4-Oct	Grantham Rotary Club Talk	Virtual	
5-Oct	ULHT Staff Engagement Event ELT Live	Virtual	35
13-Oct	Health Overview and Scrutiny Committee – Consultation Introduction	Face to face	15
27-Oct	NHS Lincolnshire CCG Board meeting	Virtual	18
1-Nov	Countywide PPG meeting	Virtual	26
9-Nov	CCG Involvement Champions meeting	Virtual	16
10-Nov	Health Overview and Scrutiny Committee – Deep dive into Urgent and Emergency Care at Grantham and District Hospital and Stroke Services	Virtual	17
24-Nov	NHS Lincolnshire CCG Board meeting	Virtual	24
1-Dec	Skegness Town Council Meeting	Face to face	19
1-Dec	Voiceability – Voices for All	Virtual	15
6-Dec	ULHT Patient Panel	Virtual	14

Date	Activity	Location	Number of attendees
7-Dec	Lincolnshire Sensory Service – Boston	Face 2 face	19
7-Dec	CCG Involvement Champions Meeting	Virtual	9
9-Dec	Boston PCN Board Meeting	Face 2 Face	12
13-Dec	Grantham Senior Citizens Club 1-1 meeting on behalf of members	Telephone	1
14-Dec	NHS Staff Event - LCHS, LPFT and Primary Care	Virtual	8
15-Dec	Health Overview and Scrutiny Committee – Deep Dive on Acute Medical Beds at Grantham and Hospital and Orthopaedics	Virtual	16
16-Dec	1-1 Meeting with member of Lincolnshire Neurological Alliance	Telephone	1
16-Dec	1-1 Meeting with member of Polio Survivors Network	Telephone	1
21- Dec	1-1 Meeting Grantham Councillor	Virtual	1
21- Dec	1-1 Meeting Grantham Campaigner	Virtual	1
21- Dec	1-1 Meeting Chief Executive Officer ULHT and Grantham A&E Sister	Virtual	1

ULHT Clinical Support Services division staff engagement events

A number of virtual engagement events were held by the ULHT Clinical Support Services Division on the following dates:

- 07 October 2021
- 12 October 2021
- 25 October 2021
- 05 November 2021
- 10 November 2021
- 15 November 2021
- 23 November 2021
- 13 December 2021
- 20 December 2021



4.4 Out and about

During the consultation we visited 19 locations across Lincolnshire where we spent time at local markets and speaking to members of the public. Leaflets were handed out to 976 people and printed questionnaires and key information documents were handed to 65 people who did not have access to the internet.

Market Days		
Date and time	**Location**	**Documentation distributed**
Monday 25 October 7.30am onwards	**Sleaford Market**	• 5 leaflets • 7 key information documents and questionnaire
Tuesday 26 October 7.30am onwards	**Gainsborough Market**	• 37 leaflets • 4 key information documents and questionnaire
Wednesday 27 October 7.30am onwards	**Boston Market**	• 49 leaflets • key information documents and questionnaire
Thursday 28 October 7.30am onwards	**Mablethorpe Market**	• 45 leaflets • 7 key information documents and questionnaire
Friday 29 October 7.30am onwards	**Long Sutton Market**	• 25 leaflets • 5 key information documents and questionnaire
Saturday 30th October 7.30am onwards	**Grantham Market**	• Postponed to 27th November
Tuesday 2 November 7.30am onwards	**Market Rasen Market**	• 25 leaflets
Wednesday 3 November 9.00am onwards	**Lincoln Waterside Centre**	• 74 leaflets
Saturday 6 November	**Louth Market**	• 120 leaflets • 20 key information documents and questionnaire • 2 Full consultation documents
Friday 19 November 7.30am onwards	**Wainfleet All Saints Market**	• 30 leaflets • 7 Key information documents and questionnaires
Monday 22 November 7.30am onwards	**Spilsby Market**	• 21 leaflets • 2 Key information documents

Market Days		
Date and time	**Location**	**Documentation distributed**
Thursday 25 November 7.30am onwards	**Horncastle Market**	• 34 leaflets
Friday 26 November 7.30am onwards	**Crowland Market**	• 45 leaflets • 1 key information document and questionnaire
Saturday 27 November 7.30am onwards	**Caistor Market**	• Cancelled due to adverse weather
Saturday 27 November 7.30am onwards	**Grantham Market**	• 219 leaflets
Tuesday 30 November 7.30am onwards	**Spalding Market**	• 55 leaflets • 5 key information documents and questionnaire
Thursday 2 December	**Lincoln Christmas Market**	• 12 leaflets
Thursday 2 December 7.30am onwards	**Holbeach Market**	• 40 Leaflets, • 1 key information and questionnaire
Tuesday 7 December 7.30am onwards	**Alford Market**	• 10 Leaflets • 3 key Information documents
Wednesday 8 December	**Stamford**	• 25 Leaflets
Thursday 9 December 7.30am onwards	**Bourne Market**	• 5 leaflets

4.5 Support from our Involvement Champions

Involvement Champions are volunteers who, with training and support, help to champion the involvement needs of communities; to ensure their collective voices are heard by the CCG, including voices from seldom heard and marginalised groups. The Involvement Champions empower and motivate people to get involved in health promoting activities, signpost people to relevant services and create groups to meet local needs.

Individuals act as a point of contact between NHS Lincolnshire CCG and the group or community that they are a part of and represent. They will present the viewpoints and feedback about health services from their communities and groups to the CCG so that we can hear and act on the patient voice from the community we serve.

As part of the consultation process, the Involvement Champions were asked to promote the online leaflets and posters to friends, families, and their communities. Paper copies (15 posters and 30 leaflets) were also sent to 14 of the champions for dissemination in their communities.

The Involvement champions confirmed that they had shared the consultation information in the following ways:

1. **Electronically, via the Lincolnshire Veterans and Families' Wellbeing Network Update on 10 November 2021**

Those who receive this update are as follow:

Ministry of Defence	Project Nova
Department of Work and Pensions	Every-One
Lincolnshire Police and Crime Commission-er	Carers First
Lincolnshire County Council	Age UK
City of Lincoln Council	South Kesteven District Council
Lincolnshire YMCA	West Lindsey District Council
Lincolnshire United Hospitals NHS Trust	South Holland District Council
NHS Lincolnshire CCG	East Lindsey District Council
Lincolnshire Community Hospitals Service NHS Trust	Mindspace (Stamford)
Lincolnshire Partnership NHS Foundation Trust	We Are With You
OP COURAGE	Only a Pavement Away
Lincolnshire Community and Voluntary Services	Blind Society
The Well Head Centre	Macmillan
Lincolnshire Fire and Rescue	Shine Network
Royal Air Forces Association	Lincolnshire Sensory Services
Forces Online	Healthwatch Lincolnshire
Royal British Legion	Harborough District Council
Citizens Advice	Rutland County Council
Ever Green Care	Royal National Institute for Deaf People
Veterans Support Service	Headway Lincolnshire

(There are approximately 140 addressees in the network that further cascade the distributed information)

2. Stamford Area

Information was distributed to all local parishes, displayed at Morrisons supermarket, posted on local village notice boards (Uffington) and at Lakeside GP surgery. Better Healthcare 4 Stamford have also published the information.

3. Alford Area

Leaflets and posters were displayed at the Alford Community Hub by Community Information Point Coordinator and the Alford Hub Co-Ordinator.

4. Boston High School

The consultation promotion was distributed electronically to the school by the Involvement Champion

5. East Lindsey Area

Promoted locally on village noticeboards in South Willingham and Benniworth

6. Sleaford

Promoted to Sleaford Medical Group PPG via Facebook

7. East Lindsey District

Promoted at 5 parish council meetings (Saltfleetby, Kettlethorpe, Maltby, Witham & associated villages, Carlton). Also requested repeat promotion via their (Councillor for Withern & Theddlethorpe Ward) weekly members information and staff communications. Verbal communication of the consultation people within the community)

8. South Lincolnshire

Distributed to other governors in South Lincolnshire. Distributed to Care Home owners and County Court care homes. Printed copies were circulated to Grand lodge, Blue Bird and Radcliffe Care homes. Information was sent electronically to Citizens Advice Bureaus in Spalding. Printed leaflets distributed to St Georges Advice Centre, Stamford.

9. Grantham

The consultation was promoted via 'Fighting for Grantham Hospital' and the Nextdoor online forum, with friends and family, and Ancaster GP Surgery.

10. Disability groups

The consultation was also shared with specific people who are on personal health budgets & with the user led organisation for people with disabilities. It was promoted via the Involvement Champions' Facebook, Twitter and Instagram accounts (500 following).

4.6 Seldom Heard and Protected Characteristic Groups

Our consultation activities were informed by demographics of Lincolnshire and the Equality Impact Assessments undertaken. The activities helped to ensure that all voices in our community were given an opportunity to be heard.

Many engagements and consultations only reach a small segment of a community, due to this we recognised the importance of proactive and targeted engagement with seldom heard groups such as younger people, travellers, economically disadvantaged, disabled people, people with mental health issues and minority ethnic groups.

Whilst we already have an established database of local and community groups based on all protected characteristics, where possible we tried to attend existing group meetings and events to further promote opportunities for involvement and discuss these options directly with individuals and protected characteristic groups.

Further to this, we also used our existing links on social media with protected characteristic groups to reach out and share widely across communities as well as attending local outlets such as Eastern European Cafés, supermarkets in economically deprived areas in additional to reaching out to local authority contacts with access to Homeless and Traveller groups.

Throughout the consultation we also worked closely with charity and voluntary organisations who have links into seldom heard groups and particularly those potentially affected by the proposed changes (elderly, disability, and economically disadvantaged groups).

Protected Characteristics and Seldom Heard		
Audience	**Consultation Distribution**	**Consultation Activities**
Age – Older	Document, questionnaire, leaflet, poster and link to website directly email to 172 contacts: • Vitality (exercise groups for over 60s) • Senior Citizens club • Age UK • PPGs	• Age UK Lincoln and South Lincolnshire – Easy read document and questionnaire posted. Documents being distributed to any new clients they receive • Information and advice officers are informing clients of the consultation, also discussing on phone appointment. • Posters displayed in restaurants and receptions. • Community connectors, patient support service and volunteers sharing information on our behalf • Contacted LinCa to distribute across care homes in Lincolnshire • Attended the Age UK Lindsey bus tour in Louth • 300 leaflets sent to Age UK Lindsey for distributing • 1-1 meeting with Grantham Senior Citizens member who gave feedback on behalf of its 50 members • Magna Vitae (Trust for Leisure and Culture in East Lindsey) circulated information to colleagues and elderly groups in East Lindsey as we were unable to attend their meeting December due to the group having prior commitments • TED circulated information to all YMCA contacts on our behalf • 400 leaflets sent to Walnut Care to distribute to every resident • Recruitment campaign – email and social media posts inviting those aged 70+ to have an informal chat about the consultation proposals and how they may impact them specifically

Protected Characteristics and Seldom Heard		
Audience	**Consultation Distribution**	**Consultation Activities**
Age - Young	39 young groups such as: • Children's Centres • Grantham Youth Centre • Homestart Lincolnshire • Action for Children • Schools and sixth forms	• Information sent to NKDC Youth Forum • Lincolnshire County Council to distribute to Young Carers • Shared with Lincolnshire Youth Council and V4C (Children in Care Council) • Skegness TEC College – sent to 54 learners via teams, 27 staff via email, 53 local employer contacts and shared on social media • University of Lincoln circulated on social media • Sent to Lincolnshire County Council for distribution to all primary and secondary schools across Lincolnshire • Leafleting event at Lincoln College • Direct email to University of Lincoln Wellbeing requesting support of distribution to networks, volunteers etc. • KIDS Lincolnshire sharing information via social media to their members on our behalf • NKDC circulated information to all schools within North Kesteven • Information shared with North Kesteven Student Council
Disability - Physical	58 Groups including: • Grantham and District talking newspaper for the blind • MS Society • Deaf Society • Lincolnshire Sensory Services • Sickle Cell Society	• Meeting with people with sensory impairment through Lincolnshire Sensory Services in Boston. BSL interpreter at the meetings. Created a video from the easy read document with a BSL interpreter which was made available on their website. Distribution to their membership • Grantham Hard of Hearing to distribute to 8 members • Meetings were also scheduled for the Mablethorpe and Grantham Sensory service but were stood down due to increasing Covid infection rates and risk to staff and public • Telephone interview with member of Grantham Hard of Hearing • Telephone interview with Polio Survivors Network member • Connected with Lincs Disabled Activities, Event and Facilities on social media who have been sharing information on our behalf

Protected Characteristics and Seldom Heard		
Audience	**Consultation Distribution**	**Consultation Activities**
Disability Mental Impair-ment	37 groups including: • Lincoln Dementia Café • Lincolnshire Autism Society • Lincolnshire Neurological Alliance	**SEND** • Designated Clinical officer for Children and Young People with Special Education Needs and Disability – sent information to Lincolnshire Young Voices, promotion via social media **Learning disabilities** • Presented at Voiceability event (County board for people with learning disabilities) • Request to present at Mental Health Programme Board, information shared with board members • Request to present at the Transforming Care Board • County Council to share with Learning Disabilities Partnership, efforts were also made to connect via social media **Autism** • County Council to share with Autism Board network board members and working groups with a request to share within their networks • Requested details to be promoted via the Connect to Support website and via Lincolnshire County Council media channels **Neurological** • 1-1 meeting with founder member and trustee of Lincolnshire Neurological Alliance • LPFT circulated documents to 320 contacts
Gender reassign-ment	8 Groups including: • University of Lincoln LGBT+ Society • Just Lincolnshire • Lincolnshire parents of LGBT children • Transhaven Boston	• Contacted LincsTransnb and Think2Speak via direct message on social media asking to share with their community • Direct email sent to LGBT Lincoln Student Union • Direct email sent to LGBTLincs and also tagged in consultation posts on social media • Direct contact made with LGBT Business Directory and Forever with Pride E-Magazine requesting for support with distribution to their networks • Direct email to Transhaven Boston
Sexual Orienta-tion	15 groups including: • Gay Outdoor Club • LGBT+ Sleaford • University of Lincoln LGBT+ Society	• Direct social media message to The Scene and Lincoln Pride UK requesting support to gather feedback • Recruitment campaign – email and social media posts inviting those from LGBT+ backgrounds to have an informal chat about the consultation proposals on how they may impact them specifically

Protected Characteristics and Seldom Heard		
Audience	**Consultation Distribution**	**Consultation Activities**
Race/ ethnicity	30 groups including: • Lincolnshire Traveller Initiative • Just Lincolnshire • BME Inclusion Services • Factories with Eastern European workforce	Translated poster and leaflets in Polish/migrant cafes, restaurants and supermarkets and Delis: • European Cuisine Family Restaurant • Grill Janosik • Swojskie Jadlo • Syrenka • Julia Polish Shop • Polish Dinner • Sweet Bakery • Pollea • Paradise • Bistro Polonia • Polish Bar and Restaurant • Polka Polish Cuisine • U Ani Polish Restaurant • Korzinka Taste of Europe • Korzinka Taste of Europe • Super Lincs • Polish-Deli • Poziomka • Pewex - Food Plus • Malinka • Delicja • Baltic Food and Grocery Ltd • Pasikonik • Frucktolinka • Lajkonik • Boston Supermarket • World Star OF License • Spalding Market • European Market • Leaflet and poster drop in Boston to 15 Eastern European cafés/ shops • Translated posters and leaflets circulated to local factories with migrant workforces via LCHS patient experience officer **Lincolnshire Traveller Initiative** • Well Woman group in Gainsborough (8-10 Traveller women) – talking to them on our behalf and collating feedback • Grantham Traveller rep speaking to Grantham area on our behalf • Direct message sent to Black Lives Matter Lincoln requesting support/distribution of information • Recruitment campaign – email and social media posts inviting those from BAME backgrounds to have an informal chat about the consultation proposals on how they may impact them specifically

Protected Characteristics and Seldom Heard		
Audience	**Consultation Distribution**	**Consultation Activities**
Religion/ belief	30 groups including: • Salvation Army • Churches Together in Grantham and District • Samaritans • Lincoln Mosque • Sleaford Islamic Centre	• Direct social media message sent to Lincolnshire Faith Council who are sharing consultation information on social media on our behalf • Direct message sent to Lincolnshire Jewish Community asking for support to connect/share
Gender	30 Groups including: • The Women's Institute • Dad's Saturday Club in Grantham • Active Lincolnshire	• Active Lincolnshire shared with local sports groups across the county – Groups include rugby, football, cricket, and golf. • Andrew Morgan held a meeting with Grantham Rotary Club • Information distributed to Boston's Men Shed • Information distributed to Men's Shed in Louth • Contact made via social media with WI Lincolnshire South and Lincolnshire North Federations for feedback and support to promote information
Carers	• Carers First • EveryOne • Lincolnshire Parent Carer Forum	• Meeting with Carers First, who will promote via social media, dedicated focus groups with carers in December • Meeting confirmed with Carers First, unfortunately due to no carers booking on the meeting had to be stood down last minute • Met with EveryOne – who have over 400 organisation that are accredited with the carers award and will distribution information to all • 42 carers champions helped promote the consultation • Dedicated carer mailout list • Contacted LPCF who will share on their website • Lincolnshire County Council to distribute to Young Carers • Information distributed to carers Whatsapp group with 50+ carers • Consultation information sent out in Adult Care Bulletin and asked Adult Care staff to share • LSAB sent out to all partners and social media • V4C promoted to young people in care

Seldom Heard Groups		
Economi-cally deprived	• Towns identified from community profiling • Foodbanks • Job Centres • Citizens Advice • Homeless	• Leafleting and where possible, market days in areas highlighted from Mosaic profiling • Leaflets and posters handed to the Church Family worker at Louth Methodist Church during the Lighthouse Outreach Project • Posters and leaflets posted to Job Centres, foodbanks, Citizens Advice Centre
Rurality	• Farming community • Parish Councils	• Midpoint contact – secondary offer was made to visit or present at council meetings - Approx. 370 active parish councils across Lincolnshire sent via LALC • NFU Mutual - distribution of information and support • Consultation information and links published in the Business NK Newsletter • Contacted East Lindsey District Council to distribute to Caravan Parks
Veterans	• Via CCG Involvement Champions	• Posted in the Veterans health and Wellbeing Newsletter via CCG Involvement Champions

Transport and Voluntary Car Schemes

Recognising that travel and transport was identified as a concern during pre-consultation engagement and via the Equality Impact Assessments, we also circulated posters and leaflets to the following volunteer transport services. This was done either via social media, emailing or printed copies sent out in the post with the ask to support the CCG in distribution.

Transport and Voluntary Car Schemes	
Audience	**Consultation Distribution**
Community and patient transport groups	**East Lindsey** • Sutton on Sea Community Voluntary Car Service • Louth and District Voluntary Car scheme • Lincolnshire Royal Voluntary Services • CallConnect • Age UK Lindsey **West Lindsey** • Lincolnshire Royal Voluntary Services • CallConnect • Gainsborough Community Wheels • Age UK Lindsey **North Kesteven** • Sleaford and District Voluntary Car Scheme • Lincolnshire Royal Voluntary Services • Heckington area Voluntary Car Services • Collingham and District village care **South Kesteven** • Grantham area community Transport • Christchurch Community Transport Scheme • Age UK Lincoln & South Lincolnshire **South Holland** • South Holland Parish Voluntary Car Service • Age UK Lincoln & South Lincolnshire • Crowland Cares **Boston** • Lincolnshire Royal Voluntary Services • CallConnect • Age UK Lincoln & South Lincolnshire **City of Lincoln** • Lincolnshire Royal Voluntary Services • CallConnect • Dialaride • Age UK Lincoln & South Lincolnshire

Economically deprived, Age and Disability

The Equality Impact Assessments identified that the groups potentially impacted by these proposals were economically deprived, age and disability. To ensure these groups were provided with direct promotion of the consultation to encourage involvement we also undertook a number of days distributing leaflets directly to various localities and venues across Lincolnshire.

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
East Lindsey					
Wainfleet	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • Post Office • Wainfleet Pets Petshop • Bits and Bobs Gift Shop • All Saints Church Tea Room • Filling Station Sandwich Shop • Antiques and Vintage Shop • From Alsage Tea Room and Gift Shop • Beau Chic Gift Shop • Suttons Fish and Chips Shop • Hair FX Hair Dresser	X		X	X
Spilsby	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • Post Office • Dentist • Cornhill Café • Vets • Age UK Shop • Greyhound Sanctuary Shop • Four Seasons Fruit and Veg shop • Centre piece tearoom • Poundaholic shop • Bijoux Deli • It Only gift shop • Sentiments floral designs • G.Barber Wool Shop • AE Wildman & Son Bike Shop • Lanegs Discount Store • All Wrapped Up • Don Noble • Dexter and Sharpe Accountants • Just Cuts Barbers • Archways (Lincs) Ltd	X	X		

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
East Lindsey					
Mablethorpe	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • Ocean Fish and Chips • Mobile Phone Accessories • PG's Accessories • The Ark Charity Shop • Pet Shop • Café Lounge • Poyntons Shoes • American Nails • Shoezone • Envy Hair and Beauty • Busy Bee Café • Factory Direct Clothes Shop • Vape Shop • All Sorts Gift Shop • Erics Charity Shop • Ians @ 46A Shop • Premier Express • William Hill • Betting Agent • Bladez & Fadez Hair Dresser • St Barnabas Charity Shop • Woodcocks Butchers • The Coastal Centre Community Hub • The Louth Pub • Gerardos Café • Mablethorpe Wildlife Rescue • Charity Shop • Revolutions Hair • Dressers and Nail salon • Mablethorpe Community Hall • Marisco Medical Practice • Dentists • Library • Childrens Centre • Pharmacy	X		X	X
Horncastle	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • Newsagents • local café • Barbers shop • Costa Coffee • Co-op • Opticians • Charity Shops x 2 • Post Office • Pharmacy			X	

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
East Lindsey					
Skegness	**1. Public Event**	X	X		X
Woodhall Spa	**1. Leafleting** Posters and leaflets left in the following locations: • Optiks Opticians • Neat and Pressed Dry Cleaners • Walters Estate Agents • Woodhall Spa Library • Stations Butchers • RSPCA Shop • Lincolnshire Coop • Premier Pet Care Shop • Pinch Cushion Interiors • Woodlands Café • McColls • Newsagent • Hair and Beauty by Jade • Molly and Me Shop • Bar Eleven • Lilys Shop • Jeffersons Vegan Shop • The Book Fayre book shop • Golf Hotel • Robert Bell Estate agent • Janets Tea Room • Archies Coffee House • Little Dorrits Tea Room • Age UK Lindsey • Harrys Home • Hardware Shop • Martins Newsagents			X	
Sutton on Sea	**1. Leafleting** Posters and leaflets left in the following locations: • Bennetts Butchers • Boots • Gregorys Mobility • Dolphin Fish and Chips • Ice Rock Café • Home Hardware Shop • Shes Hair and Beauty • The Mill Book Shop • Sutton Pet Supplies • Waldos Fish and Chips • Julie Anns Boutique • UPVC Windows • Lloyds Pharmacy • Spar • The Bacchus Hotel			X	

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
East Lindsey					
Alford	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • Snips Barber • ATP - Charity Shop • Town Council • Opticians • Alford Deli • Alford Community Hub • Dentist • Angelenes Patisserie • Handyman Shop • Glamourpuss Cosmetics • Fen Bank Greyhound Rescue Shop • Grays of Alford • Alzeimers Research Shop • The Doghouse Pet Shop • Foot Clinic • Windmill Pet and • Tackle Shop • Willow Restaurant and Tea Room • Wilsons Property Professionals • Alford Craft Market Centre • Manor House Tea Room • Bargain Guys Shop • Hardware Shop			X	X
Coningsby	**1. Leafleting** Posters and leaflets left in the follow locations: • Chalet • Lincolnshire Coop • Age UK • Ford Service and Parts • Vape Shop • Sivill Gallery • Fish an Chip shop • Sivill Service Shop • Tattershall Lakes - Shop, • Bar and Main Entrance		X	X	

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
East Lindsey					
Louth	**1. Market** **2. Public Event** **3. Leafleting** Posters and leaflets left in the following locations: • Masons Arms • Interskill • Gaff Barbers • Little Owl Fabrics • MSR Newsagents • Boots • Boyes • Butterfly Hospice Charity Shop • Millie Maes Tea Room • Louth Learning Centre • Oxfam • Cancer Research • Age UK • Sue Ryder • Faulkners Electrical Shop • Methodist Church		X		
Louth North Holme	**1. Leafleting** Posters and leaflets left in the following locations: • Darkes Petrol Station • Darkes Car Showroom • KFC • Starbucks • Louth Tennis Centre • Louth Business Centre • NFU Mutual • Bush Tyres • Halfords • Mr Tyre • NT Shaws of Louth • R&Y Autos • Buckets Pt Food Shop				X
West Lindsey					
Gainsborough	**1. Market** **2. Leafleting**	X	X	X	X
Market Rasen	**1. Market**	X			X

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
Boston					
Skirbeck	**1. Leafleting** Posters and leaflets left in the following locations: • Boston Men's Shed • Skirbeck Community Centre	X	X	X	X
Fenside	**1. Leafleting** Posters and leaflets left in the following locations: • Fenside Community Centre	X	X	X	X
Fishtoft	**1. Leafleting** Posters and leaflets left in the following locations: • Boston Renal Services	X		X	
Old Leake and Wrangle	**1. Leafleting** Posters and leaflets left in the following locations: • Wrangle Community Centre • Old Leake Community Centre				X
North Kesteven					
Sleaford	**1. Market**	X			
North Hykeham	**1. Leafleting** Posters and leaflets left in the following locations: • Mind charity shop • Forum Quality Meats • St Barnabas charity shop • Coffee Culture • Paper Kisses • Tanning Shop • Curtis's • BetFred • Sue Ryder charity shop • McColls • Co-op Pharmacy • Fone Doctor		X		

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
South Kesteven					
Grantham Earlesfield, Harrowby and Springfield	**1. Leafleting** **2. Grantham public event** **3. Market** Posters and leaflets left in the following locations: • Earlesfield Community Centre • Meres Leisure Centre • Vaccination Centre	X		X	
Stamford	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • Charity Shops • Stamford Arts Centre			X	
Bourne	**1. Market**		X	X	X
South Holland					
Sutton Bridge, Long Sutton, Moulton	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • Long Sutton Pharmacy Long Sutton local shop • Long Sutton charity shop • Moulton Village Hall Moulton Sports Centre Moulton Post Office • Sutton Bridge Curlew Community Centre	X	X	X	X
Holbeach	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • Holbeach Tesco • Holbeach Charity Shop • Holbeach Parish notice • Holbeach Community Centre	X	X		
Crowland	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: Pharmacy • Estate agents • Library • Parish Council notice board • Crowland Cares			X	

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
Spalding, Cowbit and Pinchbeck	**1. Market** **2. Leafleting** Posters and leaflets left in the following locations: • South Holland Centre • British Red Cross • Lidl (Spalding) • Post office/local shop • Cowbit Village Hall • Cowbit Parish Council notice board • Cecil Francis Business Park (5 busi-nesses) • Pinchbeck Pharmacy • Pinchbeck Post Office • Pinchbeck Village Hall	X	X	X	
City of Lincoln					
Sincil Bank	**1. Leafleting as part of the covid vaccination event** Posters and leaflets left in the following locations • Lincoln Football Stadium	X	X		X
Birchwood, Hartsholme, Moorland, Boultham and Lower Brace-bridge	**1. Leafleting** Posters and leaflets left in the following locations: • Birchwood Neighbourhood Centre • Epoch Chiropractors • Café Latte • Linc Vet • BetFred • Occasions Cards • Curtis's • Co-op Florists • Police Station • Dylan's Barbers • St Barnabas charity shop • Linkage Trust charity shop • Seacroft Mobility • Diva Hairdressers • Sage Care	X	X	X	X

Location	Activities carried out	Economi-cally deprived	Age - Younger	Age - Older	Disability
Minster and Castle	**1. Christmas Market** **2. Leafleting** Posters and leaflets left in the following locations: • Kranz Kitchen • The Lion and Snake • Prince of Wales • Duke of William • Greggs • Curtis • Card shop • Jewellery shops • Stalls selling food outside of Greggs • Multiple outlets along the Bailgate			X	

Direct messaging to reach seldom heard groups

Throughout the consultation we constantly reviewed the amount and type of feedback received to enable us to amend our activities accordingly to enable as many people as possible to get involved. During the consultation it was evident we had received less feedback from certain groups of people than we had hoped and proactive distribution of consultation materials to these groups hadn't been as successful as anticipated to encourage their involvement.

The groups we had received less feedback from were:

- BAME
- LGBTQ+

To further promote the consultation to these groups we put out a 'Call for Action' asking anyone who identified as BAME or LGBTQ+ to get involved and share their views with us in their preferred way. We requested support from numerous channels to support this and spread the message widely: we emailed our stakeholders, community and voluntary groups, Citizen Panel members, PPGs, Viewpoint Panel and Readers Panel as well as regular posts across social media sites such as Facebook, Twitter, and Instagram and the Nextdoor online forum.

In addition, to ensure we continued to receive feedback from those groups identified in the Equality Impact Assessment we included older people (Aged 70+) and those with disabilities in this promotion.

4.7 Other promotional activities

Delivery of poster and leaflets

Posters, packs of leaflets and on request key information documents and questionnaires were also posted out across Lincolnshire:

Number	Location
85	GP practices
31	Eastern European cafes / delis / restaurants
20	Housing Association organisations
21	Libraries
150	Supermarkets in economically deprived areas
114	Pharmacies
51	Gyms
29	Foodbanks
10	Job centres
8	All hospitals in Lincolnshire (waiting areas, staff areas)
5	Local colleges/Learning centres
100	Active Lincolnshire award Ceremony
400	Walnut Care
Approx. 20	North Thoresby Listening Clinic
7	Swineshead Listening Clinic
20	Age UK
400	Age UK Lindsey
100	South Holland Centre

NHS Lincolnshire Engagement Bulletin

The NHS Lincolnshire CCG Engagement Team produces a regular bulletin which is distributed to a variety of community and voluntary groups, PPGs, Citizen Panel members, Viewpoint Panel, Readers Panel and to people who sit on the different Trusts' stakeholder lists.

Information in relation to the consultation such as how to book onto upcoming events, links to the questionnaire and further information were included in five editions of the engagement bulletin.

Next Door Online Forum

During the consultation we also established an account with Next Door online forum to help encourage participation at events and increase completion of the questionnaire. The total reach of the NHS Lincolnshire CCG Next Door account is 88,372 people, and this reaches a variety of communities, villages and towns across Lincolnshire.

The table below demonstrates the number of impressions (people that saw each particular post on the Next Door app) throughout the consultation.

Next Door Promotions	Impressions as of 21st December
18th November	6602
23rd November	5472
30th November	3457
30th November	4002
2nd December	3754
3rd December	1153
6th December	4554
9th December	4876
13th December	3433
14th December	4289

5. Communications and promotion

5.1 Press and Media

Media Articles

NHS Communications and Press and Media activity generated or contributed to **89 media articles** across the period of the consultation period. These media articles appeared in over **300 separate locations** across TV, print, radio and online.

Of these articles/broadcasts:

- **50** directly promoted the consultation and were the direct result of NHS Communications press releases and liaison.
- **23** related to campaign group activity and included interviews and content provided by NHS Communications press team.
- **16** related to other healthcare news, but included information about the consultation, including interviews and content provided by NHS Communications press team.

Media and news organisations that ran articles on the consultation included:

Regional News

BBC News – East Yorkshire & Lincolnshire

BBC News – Look North

ITV News – Calendar

Capital Midlands News

County News

Lincolnshire Echo

Lincs FM/Planet Radio

Lincolnshire Live

Lincolnshire World

Lincolnshire County Council News

Lincolnshire UK News

Other

Healthwatch News

The Lowdown (NHS Support Federation)

Mental Health Mail

Local News

Boston Standard

Boston Target

East Coast & Wolds Target

Grantham Matters

Grantham Nub News

Gainsborough Target

Grantham Journal

The Lincolnite

Louth Leader

North Lincoln Advertiser

Skegness Standard

Sleaford Standard

Sleaford Target

Spalding & South Holland Voice

Spalding Guardian

Spalding Today

Stamford Mercury

Consultation press releases

Date	Press release
29/09/21	**General Public Consultation release (embargoed until 30/09/21)**
14/10/21	**Lincs FM Statement in response to proposed demonstration**
13/10/21	**Look North Statement** These proposals have been developed by our senior clinicians here in Lincolnshire over a number of years and are based on their professional medical and clinical advice and national clinical evidence focused on how the best care possible is provided for patients we serve.
13/10/21	**ITV Calendar Press Statement** The proposals set out in this consultation have been developed by our senior clinicians here in Lincolnshire over a number of years and are based on their professional medical and clinical advice and national clinical evidence, focused on how the best care possible is provided for the patients we serve.

Date	Press release
15/10/21	**General press release relating to consultation live events: 'Lincolnshire's residents encouraged to get involved in NHS public consultation events'**
15/10/21	**Lincolnshire Live Statement** Our proposal for urgent and emergency care services in Grantham has been developed by Lincolnshire NHS' senior clinicians and is based on their professional medical and clinical experience and national clinical evidence regarding the how to deliver the best care possible for the patients we serve
27/10/21	**ITV Calendar Press Statement in response to £36m funding investment in A&E services at Pilgrim Hospital, Boston**
01/11/21	**General release announcing Lincolnshire NHS Stroke Service Crowned National Award Winners**
05/11/21	**General press release relating to consultation live events: 'Lincolnshire's residents encouraged to get involved in NHS public consultation events'**
11/11/21	**General press release relating to consultation live events: 'Lincolnshire's residents encouraged to get involved in NHS public consultation events'**
22/11/21	**General press release relating to consultation live events** NHS Lincolnshire Clinical Commissioning Group (CCG) is inviting the people of Lincolnshire to take part in our biggest public consultation to date.
09/12/21	**General press release relating to consultation live events: 'Lincolnshire's residents invited to have their say in NHS public consultation events'**
11/12/21	**Village Link – Response to inaccuracies in statements about Grantham Hospital proposals made by campaign groups**
17/12/21	**General press release: '**Don't miss your chance to have your say on the future of four Lincolnshire NHS services'

Media articles written in response to consultation press releases

30/09/2021	Grantham: Further details emerge concerning hospital plans	Grantham Nub News
30/09/2021	Grantham Hospital A&E changes part of consultation plans	BBC News - East Yorkshire and Lincolnshire
30/09/2021	Grantham to get 24/7 Urgent Treatment Centre in latest Lincolnshire healthcare shake-up	The Lincolnite
30/09/2021	Plans revealed to permanently close A&E department at Grantham and District Hospital	Lincolnshire Live
30/09/2021	Grantham Hospital A&E changes part of consultation plans	LincolnshireUK News - Twitter
01/10/2021	12-week public consultation starts on new plans to close Grantham A&E department	ITV News online
01/10/2021	Lincolnshire Health Bosses push ahead with consultation on the possibility of replacing Grantham hospital's A and E	Lincs FM/Planet Radio
01/10/2021	Grantham: SOS Grantham Hospital responds to review of hospital services	Grantham Nub News
01/10/2021	Grantham Hospital A&E changes part of consultation plans	North Lincoln Advertiser
01/10/2021	A&E shake up plans could see Grantham Urgent Treatment Centre return and stroke services shift from Boston to Lincoln	Lincolnshire World
01/10/2021	A&E shake up plans could see Grantham Urgent Treatment Centre return and stroke services shift from Boston to Lincoln	Sleaford Standard
01/10/2021	A public consultation has started on new plans to permanently downgrade Grantham's A&E unit to an urgent treatment centre.	ITV News online
01/10/2021	Launch of public consultation on the future of four Lincolnshire NHS services	Healthwatch Lincolnshire
02/10/2021	Plans are being considered to have a 24/7 Urgent Treatment Centre at Grantham Hospital in Lincolnshire.	Capital Midlands News - Twitter
05/10/2021	How you can have your say on NHS services in Lincolnshire	Lincolnshire Echo/ Lincolnshire Live
07/10/2021	It is vital we have our say on Grantham Hospital services as consultation starts - updated article	Grantham Journal online
13/10/2021	Health Scrutiny urges strong response to consultation on Lincolnshire NHS services	Lincolnshire County Council news www. lincoln-shire.gov.uk/news
13/10/2021	Health committee urges people to take part in consultation on health services including Grantham A&E	Grantham Journal
13/10/2021	County councillors urge strong response to consultation on Lincolnshire NHS services	Lincolnshire World
18/10/2021	A series of virtual, online public consultation events are taking place this week	Grantham Journal online
18/10/2021	Online events all this week for the public to have their say on hospital plans	BBC Look North
22/10/2021	South Holland stroke patients could be treated in Lincoln in NHS shakeup	Spalding Today

Media articles written in response to consultation press releases

02/11/2021	Lincolnshire NHS Stroke Service crowned national award winners article includes: Have your say on the future of four NHS services in Lincolnshire	Lincolnshire Live website
04/11/2021	Residents urged to join in online consultations over changes to Lincolnshire hospitals	Boston Standard
04/11/2021	Residents urged to join in online consultations over changes to Lincolnshire hospitals	Lincolnshire World
06/11/2021	How to get involved in NHS Lincolnshire Clinical Commissioning Group's consultation on services at Grantham Hospital	Grantham Journal
09/11/2021	A series of online public consultation events start on 8 November	Mental Health Mail
15/11/2021	Consultation events over healthcare changes in Spalding tomorrow	Spalding and South Holland Voice
22/11/2021	I have respect for the workers but not for the planners after NHS Spalding consultation meeting'	Spalding Today
29/11/2021	South Kesteven District Council puts support behind 24/7 accident and emergency unit in Grantham Hospital	Grantham Journal online
29/11/2021	South Kesteven District Council supports 24/7 emergency healthcare in Grantham	Grantham Journal online
09/12/2021	Lincolnshire residents invited to have their say in latest round of NHS public consultation events	Lincolnshire World
10/12/2021	NHS reassurance over proposals for patients to travel longer distances for specialist orthopedic and stroke care	Lincolnshire World
15/12/2021	Patients on the East Coast could have to travel to Grantham for operations	Lincolnshire Live website
15/12/2021	“Apathy” concerns over lack of attendance at health review events	The Lincolnite
16/12/2021	Grantham councillor raises concerns that people are now showing “apathy” to the latest health reviews	Grantham Journal
16/12/2021	Don’t miss your chance to have your say on the future of four Lincolnshire NHS services	Lincolnshire Live website
17/12/2021	Have your say on the future of NHS services in Lincolnshire at consultation events	Lincolnshire World
17/12/2021	Have your say on the future of NHS services in Lincolnshire at a consultation event in Boston tomorrow (Saturday).	Boston Standard
18/12/2021	Last chance for you to have your say on future of four Lincolnshire NHS services	Grantham Matters
20/12/2021	Consultation on Grantham hospital services closes this week	Grantham Journal
20/12/2021	Countywide NHS consultation ends this week - but it’s not too late to have your say	Lincolnshire Live website
20/12/2021	Get your response in on Lincolnshire NHS services consultation	Lincolnshire County Council news www. lincoln-shire.gov.uk/news
23/12/2021	Consultation on Grantham hospital A&E and county services ends today	Grantham Journal

Media articles written in response to campaign group or other activity relating to the consultation

30/09/2021	More than five years ago, a campaign was started to keep Grantham Hospital's A&E open 24 hours a day started.	ITV News Calendar online
04/10/2021	Reader says online hospital consultation is concerning as there is no reference to keeping Grantham A&E	Grantham Journal
04/10/2021	"People will die" if plans to close Grantham's A and E go ahead	Lincolnshire Echo/ Lincolnshire Live
05/10/2021	Hospital campaigners will hold protest near consultation meeting in Grantham	Grantham Journal
05/10/2021	Grantham Hospital campaigners plan protest ahead of consultation on loss of A&E	Lincolnshire World
05/10/2021	Grantham: Campaigners plan protest outside hospital consultation	Grantham Nub News
06/10/2021	Grantham man stung by wasp 'saved' by town's A and E despite it being closed	Lincolnshire Live website
09/10/2021	Grantham Against Local Healthcare Cuts stage protest this week. Why not join them?	Grantham Matters
13/10/2021	Protest against Grantham health cuts to be held in town tomorrow - add your voice!	Grantham Matters
13/10/2021	Hospital campaigners will hold protest near consultation meeting in Grantham	Grantham Journal
14/10/2021	Protests taking place against plans to turn Grantham A&E into Urgent Treatment Centre	Lincs FM/Planet Radio
14/10/2021	Desperate protesters fight against plans to axe Lincolnshire town's A&E department.	Lincolnshire Live website
14/10/2021	Campaigners gather to voice opposition to A&E cuts at Grantham Hospital	Lincolnshire World
14/10/2021	We're at a protest against plans to close Grantham's A&E	BBC News - East Yorkshire and Lincolnshire
14/10/2021	Another protest over proposals to downgrade Grantham A&E	BBC Radio Lincolnshire
14/10/2021	Campaigners to protest over plans to close Grantham Hospital's A&E department	ITV News Calendar online
15/10/2021	Health consultation meeting in Grantham turns 'chaotic' after protesters gather in town centre	Grantham Journal
15/10/2021	"No ifs, no buts, no A&E cuts": Protests against Grantham Hospital plans	The Lincolnite
15/10/2021	Campaigners say an urgent treatment centre in Grantham would be a glorified GP surgery	The Lincolnite
15/10/2021	Protesters fight against plans to axe Grantham's A&E department	Grantham Matters
16/10/2021	Councillor launches petition to 'stop cuts to Grantham hospital	Grantham Journal
16/10/2021	Campaigner calls A & E consultation a 'shambles'	Lincolnshire Live website

Media articles written in response to campaign group or other activity relating to the consultation

26/10/2021	£30m investment is hospital's A&E (er, not yours, Grantham)	Grantham Matters
26/10/2021	Download SOS Grantham Hospital Petition - Vital	Grantham Matters
27/10/2021	Dismay at £30M investment in Boston Pilgrim Hospital but nothing for Grantham	Grantham Matters
28/10/2021	Councillor says upgrade plans for A&E at Pilgrim Hospital, Boston, are 'a slap in the face' to Grantham residents	Grantham Journal
01/11/2021	Campaigners fight Grantham downgrade	The Lowdown/NHS Support Federation
04/11/2021	ULHT Staff Awards 2021 - meet your winners!	Grantham Matters
10/11/2021	Stroke services "unattractive" to Lincolnshire staff as locums walk away from Boston	The Lincolnite
11/11/2021	Hospitals at breaking point as handover delays leave patients on trolleys for 12 hours	The Lincolnite
11/11/2021	Lincoln actor calls for people to help city's hospital after 14 hour wait for bed	The Lincolnite
11/11/2021	Lincolnshire A&E departments at breaking point with ambulance handover delays and overcrowding	Grantham Journal
11/11/2021	Ambulance handover delays at Lincolnshire hospitals	Lincolnshire World
11/11/2021	Ambulance handover delays at Lincolnshire hospitals	Louth Leader
11/11/2021	Lincolnshire A&E departments at breaking point with ambulance handover delays and overcrowding	Spalding Today
11/11/2021	Struggling to attract stroke staff to Boston Pilgrim Hospital to treat south Lincolnshire patients	Spalding Today
11/11/2021	Patients turned away from Skegness Urgent Treatment Centre due to being short-staffed	Lincolnshire Live website
11/11/2021	Patients turned away from Lincolnshire Urgent Treatment Centre due to 'high demand'	The Lincolnite
20/11/2021	I am still pressing to guarantee everyone's experience of driving on the A1 is a safe one, says Grantham MP	Grantham Journal
23/12/2021	Decision on closing Grantham's A and E expected in March	Lincolnshire Live website
23/12/2021	Consultation into Grantham Hospital and county health services leaves me with a number of concerns	Grantham Journal

5.2 Digital Activity

The public consultation digital strategy included the following elements:

- NHS Communication team's social media activity (Twitter, Facebook) to push traffic towards the Public Consultation website and planned events.
- Video marketing via YouTube and the Public Consultation website.
- Online advertising via media partners and other local news sources and platforms.

NHS Communications teams – social media activity

Across the period of the Consultation, significant activity was undertaken by the Communications Teams at Lincolnshire NHS CCG, Lincolnshire NHS, ULHT and LCHS to build awareness and drive engagement through a schedule of activity on their social media platforms, most significantly Facebook and Twitter.

Combined, the four NHS communications teams posted **199 Facebook posts**, **reaching 172, 827** people and generating **5889 post engagements**, **481 click throughs** to the Consultation website and **202 comments**.

Combined, the four NHS communications teams issued **214 tweets and 18 retweets**, with these tweets being seen **87,367 times**, generating **1834 tweet engagements** and **303 click throughs** to the Consultation website.

Social sharing

NHS Communications team Facebook posts were actively shared with the following organisations:

Local authorities

- Boston Borough Council
- City of Lincoln Council
- East Lindsey District Council
- Gainsborough Town Council
- Lincolnshire County Council
- North Kesteven District Council
- Sleaford Town Council
- South Holland District Council
- South Kesteven District Council
- West Lindsey District Council

Media

- BBC East Yorkshire & Lincolnshire
- BBC Radio Lincolnshire
- Boston Standard
- Boston VIBE
- Boston's 107 Endeavour FM
- Gainsborough Standard
- Grantham Journal
- Grantham Matters
- Lincoln Free Press and Spalding Guardian
- Lincolnite
- Lincolnite Breaking News
- Lincolnshire Live
- Lincs FM
- Louth Leader
- Skegness Standard
- Sleaford Standard
- Spalding and South Holland Voice

Non-NHS Social Listening

The Consultation Communications team engaged in an active programme of social listening throughout the period of the consultation.

The benefits of social listening to the consultation communications efforts were:

- It enabled the team to monitor and assess the reach and penetration of the consultation
- It enabled to team to identify both where public awareness and understanding of the proposed changes were strong and where there was potential to improve communications.
- It enabled the team to identify misinformation and misconceptions relating to the proposed services changes and the consultation programme and to address these, redressing the balance of misinformation.
- It helped the team to be more responsive to public needs as the consultation progressed.
- It helped the team to identify formal participation opportunities.
- It enabled to team to assess public sentiment towards the proposed changes to services and the consultation process.

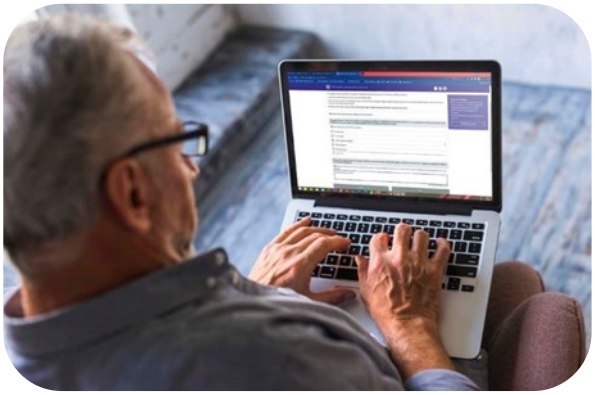
Non-NHS social media activity (news articles, comment pieces, campaign activity) generated over **1600 comments and conversations** during the consultation.

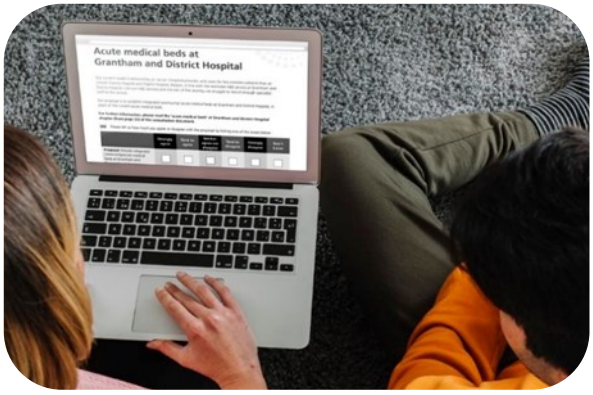
5.3 Consultation website engagement

Over the period of the consultation, **12,294 unique visitors** accessed the dedicated consultation microsite, generating **30,967 page views** (an average of 2.51 page views per visitor). **5101 visits were made to the online Questionnaire** embedded in the site, with **2290 people visiting the consultation events page**.

Of those visiting, 49% accessed the site via mobile phone, 35% accessed via desktop device and 8% via tablet.

Almost half of those visiting found the site through organic search, 19% came to the site directly, 13% via referral and 11% via social media.





5.4 Paid print and online advertising

Media partnerships were created with Reach Solutions and Iliffe Media to increase awareness of the consultation beyond the other channels and methods employed.

Print advertisements

Throughout the consultation **25 adverts** were placed in local and county newspapers, providing general information about the consultation proposals and promoting participation in the consultation and related events. There were over **454,000 opportunities** to see these newspaper advertisements (based on newspaper readership figures) across seven county newspapers. This approach enabled the programme to target audiences that might not have access to online engagement channels.













Online advertisements

Online advertising was used to raise further awareness of the consultation, increasing online exposure both on social media and across other online platforms. A wide range of digital ad formats were employed, from display ads through to FB articles and 'advertorial' content. Several of these online ad campaigns were targeted at specific audiences in terms of demographics or geographic location.

Those engaging with the advertisements were encouraged to click through to the consultation website and complete the consultation questionnaire. This approach enabled the programme to target audiences that might not have been exposed to some of the other more traditional forms of advertising.

Through the consultation, paid online activity included:

- **3 x editorial articles**
- **16 x display advertisements**
- **15 x InYourArea advertisements**
- **4 x Facebook advertisements**

Combined, these advertisements were seen by **1,365,000 people,** with **9502 people directly engaging** with the advertisements and **2865 clicking through** to the consultation website.







Fig.10 Example Public Consultation display advertising artwork



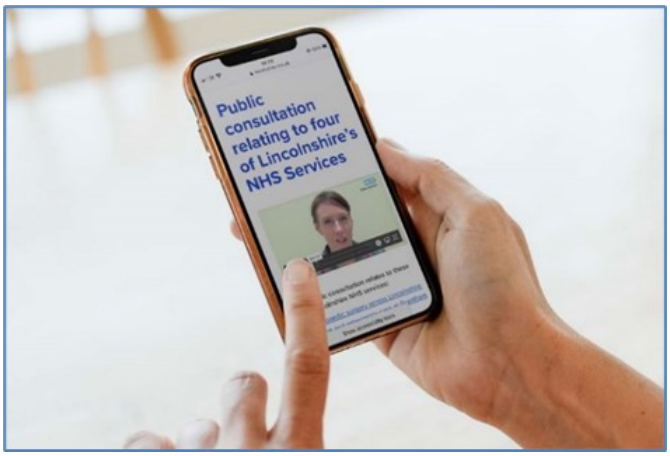


Fig.11 Example Public Consultation Facebook Advertising artwork

6. Mid consultation and final stakeholder updates

On **2 December**, a 'consultation mid-point update' email was sent to the full list of stakeholders who had received the consultation launch email. This list included:

Staff and internal stakeholders	Voluntary engagement teams
Provider memberships	Local MPs
Unions	Local employers
Health partners	Public sector providers
Lincolnshire County Council including all staff and councillors	Campaign groups
District Councils including all staff and councillors	NHS Lincolnshire Peoples Panel
Parish Councils	Community Stakeholders, including volunteer groups, support groups etc

This update email contained:

- Direct links to the consultation website where people could find further detail about the proposals, give feedback via the online questionnaire and see how they can get involved and what events are taking place across Lincolnshire. We also included phone and email details of our dedicated consultation hotline.
- A brief update on consultation engagement to date.
- A schedule of remaining consultation Face to Face events.
- A call to action to stakeholders to ask partners and community organisations to share the materials and mid-point update email with their members, groups and wider communities.

On **21 December**, a 'consultation final update' email was sent to the full list of stakeholders who had received the consultation launch and mid-point update email.

This final update email contained:

- Direct links to the consultation website where people could find further detail about the proposals, give feedback via the online questionnaire and see how they can get involved and what events are taking place across Lincolnshire. We also included phone and email details of our dedicated consultation hotline.
- A brief update on consultation engagement to date.
- A brief update on media coverage to date.
- A thank you to stakeholders for their continued support in helping to extend the reach of the consultation.
- A request for any feedback stakeholders may have received that directly related to the proposals and a call to action to submit feedback to the dedicated consultation email address at lccg.asr-enquiries@nhs.net

7. Ongoing adjustments

Responding to confusion and misinformation around proposals for Grantham and District Hospital

As the consultation entered its third month, public feedback and social listening undertaken by the consultation team highlighted a range of misconceptions and concerns relating to the proposals for Grantham and District Hospital. These included:

- Concerns that acute medical beds would be reduced or closed at the hospital.
- Concerns that the proposals suggested cuts to acute and emergency services in Grantham.
- Uncertainty around what the proposals for stroke services would mean for the people of Grantham.
- Uncertainty around the conditions that would be treated at the proposed UTC at Grantham & District Hospital.

To respond to these questions and concerns, it was decided to publish a full-page advertisement in The Grantham Journal on Friday 10 December. This advertisement also sought to counter a highlighted spread of misinformation by local campaign groups ahead of the second Grantham Face to Face event, which was due to take place on Sunday 12 December.

The Grantham Journal, both in print and online, had been extremely active in reporting on the consultation and service proposals, largely as they related to Grantham and District Hospital. The publication's website and social media had also become key arenas for comment and debate about the consultation, particularly from local campaign groups.

The full-page advertisement included:

- A brief summary of the consultation and the proposed changes to four NHS services.
- A larger section devoted to responding to 'common requests for clarity the consultation team had received from the people of Grantham' – these being the concerns listed above.
- Information about the forthcoming Grantham Face to Face event taking place on Sunday 12 December, and a call to action to register to attend.
- A call to action to complete the consultation questionnaire.

Don't miss your chance to have your say on the future of four Lincolnshire NHS services



A 12-week public consultation on the future of four Lincolnshire NHS services ends on **Thursday 23 December**. The consultation, which launched on 30 September, is giving people from across the county the chance to share their views on the future delivery of the following services:

- **Urgent and emergency care at Grantham & District Hospital**
- **Acute medical beds at Grantham & District Hospital**
- **Orthopaedic surgery across Lincolnshire**
- **Stroke services across Lincolnshire**

We are aware that the level of detail included in the review work to date can be complicated to understand for anyone unfamiliar with the services. Some of the common requests for clarity we have received from the people of Grantham include:

Do your proposals mean that acute medical beds will be reduced or closed in Grantham & District Hospital?
No. The acute medical beds change proposal focuses on retaining this service, retaining acute specialists and strengthening it through greater integration with community and primary care providers. There is no planned reduction to the number of acute medicine beds under the proposal.
There is some confusion with this proposal and the SDEC (same day emergency care) and the ACU (acute care unit) services, which are different, but have also not closed. During the COVID pandemic the 6 bedded ACU was temporarily closed to ensure the separation of medical and surgical patients for safety reasons. These beds were immediately re-provided on the surgical and medical wards, where they remain. Since this time the overall number of beds has increased to 8.

Do the proposals suggest cuts to acute and emergency services in Grantham?
No. We believe the proposals provide much needed stability to the acute and urgent & emergency care services in Grantham. We are committed to securing services in Grantham for the future and the proposals, which include a centre of excellence for planned orthopaedic care, are part of our dedicated drive towards towards sustainability and ensuring Grantham & District Hospital as an employer of choice for health professionals wishing to build their career.

What do the proposals for stroke services mean for the people of Grantham?
Grantham has not provided acute or hyper-acute stroke services at the hospital since 2008 and this would not change under the proposal. In the event that a patient presented at Grantham having experienced an emergency such as a stroke, the team would have the clinical expertise and equipment to resuscitate, intubate and stabilise a patient until transfer, if required, to an alternative site where the correct, specialist care can be provided to best support the patient. This happens now and would continue to do so under the proposals.

Can I go to Grantham with a fracture?
Yes. Simple fractures would be treated at the proposed UTC at Grantham & District Hospital. Any patient who was found to need specialist treatment for a more complicated fracture would be transferred to ensure they had access to the care that they need. This happens now and would continue to do so under the proposals.

Join us at the Grantham event this Sunday

We are holding another event in Grantham on **Sunday 12 December**. At this event, clinicians will explain the service proposals in more detail, and those attending will have the opportunity to ask questions and share their views. Attendees must register before the event.

For more information about this event and to register please visit **www.lincolnshire.nhs.uk**, call **01522 421860** or email **lccg.asr-enquiries@nhs.net**

This is our largest public consultation to date, and we are encouraging as many people as possible to get involved. Don't miss your chance to have your say and help us shape the future of these four services.

To **complete the questionnaire**, and for more information on how we have reviewed these four services, the challenges they face and how they might change in the future, visit our website at **www.lincolnshire.nhs.uk** or contact us on **01522 421860**.

www.lincolnshire.nhs.uk

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Louth event

In response to feedback we received regarding the locations of the consultation events, we subsequently added an event in Louth and provided further information to respondents as and when requested to ensure they were informed and could get involved in the consultation.

Weekly team meetings

Throughout the public consultation, routine weekly meetings were held with the core consultation team to review the ORS consultation dashboard, providing 'live' monitoring of the questionnaires completed alongside main respondent characteristics to inform further specific targeting of consultation activities if required to increase representation of response.

Routine weekly meetings and briefings were also undertaken with the wider team, system leaders and clinicians to review feedback from consultation events and communications, and give team members who had attended recent events an opportunity to share feedback regarding the queries and concerns they heard. This allowed shared understanding of any key themes as they emerged, improving the ability of the team to ensure they discussed such issues raised in future events, press interviews and via direct contact with individuals.

8. Consultation Support

The consultation team provided a dedicated phoneline **(01522 421860)** and email address **(lccg.asr-enquiries@nhs.net).**

These provided channels for members of the public who:

- Required hard copy version of consultation materials, including the Public Consultation Document, Key Information Document and Consultation questionnaire.
- Wished to comment or had questions relating to the Consultation proposals or to the consultation process itself.
- Required further information about the live and virtual consultation events. Participation at these events could also be booked via email or over the phone.
- Wished to speak about their general experience of using NHS services.

Over the period of the consultation members of the public submitted **110 emails** and made **56 telephone calls** to the consultation communications team. These contacts included:

- **63** requests for a hard copy of the questionnaire
- **62** requests for information about consultation live and virtual events – these included **49** event booking requests.
- **17** questions relating to the consultation service proposals or the consultation process
- **27** comments about the consultation service proposals or the consultation process

Respondents were also signposted to the Patient Advice and Liaison Service (PALS) and Healthwatch if they required further, independent support to get involved in the consultation.

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Contact us

Email: lccg.involveus@nhs.net

To request this document in an alternative format please contact us using the details above

Appendix B

Equality Review of consultation process

Maktub Consulting Ltd

Equality Review of the Public Consultation Relating to four of Lincolnshire's NHS Services

30th September 2021 – 23rd December 2021

Version	3.0
Status	Final
Author	Maktub Consulting Ltd
Owner	Lincolnshire CCG
Origination Date	14 November 2021
Next review date	May 2022: COMPLETE
Target audience	NHS Lincolnshire CCG Board Decision Making Business Case. 25th May 2022

Overview

NHS Lincolnshire CCG aimed to fulfill its statutory duty to involve patients and the public in service change proposals relating to four NHS services provided by United Lincolnshire Hospitals NHS Trust which were:-

- Orthopaedic surgery across Lincolnshire
- Urgent and emergency care at Grantham and District Hospital
- Acute medical beds at Grantham and District Hospital
- Stroke services across Lincolnshire

The consultation was focused on these four NHS services as described in the pre-consultation business case because significant and permanent improvement is required to them. Such change would ensure that the highest possible standards of patient care are provided in line with clinical evidence and best practice, giving the best possible outcomes for patients.

The consultation was undertaken to understand the potential impact of the proposed changes on key stakeholders including staff, patients, carers, potential service users and people with protected characteristics as defined in the Equality Act 2010.

The perceived benefits of the proposed changes are:-

- Improved quality of care
- Reduced waiting times

- Better outcomes for patients
- Increased availability of staff to care for patients
- Better use of NHS funds, reducing spend on temporary staff.

Improvement to these services is required to avoid a continued risk that the quality of care of the services provide to patients would deteriorate. In addition, there is a risk that the staffing levels and expertise needed to provide the service would not be sufficient to provide high standards of care. If these issues are not addressed, these services will remain unsustainable

Purpose of the Report

This report provides an independent analysis of the consultation methodology 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.

It seeks to provide assurance that every reasonable attempt has been made to make reasonable adjustments in order that consultees with protected characteristics have had an opportunity to participate in the way that they choose.

This document presents a summary of the considerations taken in the design and development of the patient and public consultation process; it should be noted that this document is an equality review of the consultation methodology undertaken. Individual EIAs have been undertaken for each of the four services.

Legislation

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs have duties to involve the public in commissioning, (sections 242, 14Z2 and 13Q respectively). This report specifically considers the arrangements being made to involve people from groups protected by the Equality Act 2010 and by the Health and Social Care Act 2012 as described below.

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it is unlawful to treat someone.

The Public Sector Equality Duty came into force across Great Britain on 5 April 2011. It means that public bodies must consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

It also requires that public bodies have due regard to the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations between different people when carrying out their activities.

For more information visit https://www.gov.uk/guidance/equality-act-2010-guidance

Consideration of the Equality Act in public consultation processes have been challenged via judicial review many times. The most significant case was tested in the Court of Appeal between R (ex parte Bracking & others) v Secretary of State for Work and Pensions [2013] EWCA Civ 1345 which resulted in the 'Bracking Principles'.

The principles are laid down by the court of appeal to define 'due regard' as it appears in the legislation.

In summary, the Bracking principles recognise:

- Equality duties are integral and important
- The need to record the steps taken in seeking to meet the statutory requirements
- The personal duty of the decision maker
- A decision maker must assess the risk and extent of any adverse impact and the ways the risks may be eliminated before the adoption of proposals
- Due regard must be exercised in substance, with rigour and with an open mind
- It is not for the court to determine whether appropriate weight has been given to the public sector equality duty
- A proper and conscientious focus on the statutory criteria
- Decision makers must be properly informed before taking a decision. Organisations have a duty to acquire information.

The NHS Accessible Information Standard

The NHS England Accessible Information Standard (AIS) aims to ensure that people with a visual, hearing or learning disability have access to information they can understand, and any reasonable communication support they may need. All organisations that provide NHS care and / or publicly funded adult social care are legally required to follow the Accessible Information Standard.

The NHS England (AIS) principles are re-enforced under the duty within the Equality Act 2010 to make reasonable adjustments for people with disabilities.

Under this duty, consultors should provide easy access to information and make reasonable adjustments.

Documents should be written in plain Language and provided in alternative formats.

Support for those who want to participate in non-English or sign language for example, should be offered.

This should be communicated in all key documents and it often helps to work with local voluntary organisations to raise awareness that this is available.

Community Cohesion

The consultation process sought to promote community cohesion in the following ways:-

- By meeting individual and community needs to be heard and to influence how services are developed within their area
- By identifying and addressing any potential barriers to fair access and inclusion and report these to decision makers to inform their decision making.

Scope of the Consultation

Lincolnshire CCG sought the views of the people of Lincolnshire. This includes patients who have used, are currently using or could use in the future, services in Lincoln, Boston and Grantham hospitals. It also includes their families and carers; NHS staff; people who live or work in Lincolnshire; people in neighbouring areas; partner organisations; the community and voluntary sector and elected representatives.

The CCG also worked closely with the Lincolnshire County Council Health Scrutiny Committee with regard to their oversight responsibilities in relation to public consultation

As well as consulting widely across the county, targeted activity was undertaken to seek the views of groups of people, defined by their protected characteristics, who might be most affected by the proposals.

This element of the consultation was informed by the Equality Impact Assessments undertaken which at a high level, across the four services, revealed the groups most likely to be affected by the proposals were:-

- People who are economically disadvantaged
- People with a disability
- People who may be affected due to their age (i.e. they are in the older or younger age brackets)
- Carers (specifically of those in the above groups)

Independent Review and Assurance

In order to ensure that all reasonable attempts have been considered in the consultation, Maktub Consulting Ltd were commissioned to undertake an independent assessment of the consultation methodology as they are specialists in this field. An overview is provided as Annex B.

A midpoint review was undertaken to identify and close any gaps in responses. More targeted communication activities were undertaken to reach all groups. For example, additional recruitment with LGB&T and BAME communities was implemented. The CCG also responded to requests for involvement from different community groups by making adjustments throughout the process. Additional events were added in certain geographies.

In addition, an independent Quality Assurance process by the Consultation Institute has

been commissioned to advise on whether the consultation process meets best practice standards.

Definitions of Seldom heard groups

In accordance with NHS England Statutory Guidance*, the CCG recognised that the following protected groups and health inclusion groups may experience barriers to being involved in public sector consultation and therefore were considered 'seldom heard':

Statutory protected groups

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex or gender
- Sexual orientation

Other seldom heard groups

- People misusing alcohol and/or drugs
- Asylum seekers and/or refugees
- Carers (including young carers)
- Veterans and armed forces families
- Women experiencing or at risk of female genital mutilation (FGM)
- Gypsies, Roma and travelling communities
- Homeless people and rough sleepers
- People who have experienced human trafficking or modern slavery
- People living with mental health issues
- Sex workers
- Trans people and members of non-binary community
- People in the criminal justice system
- People with low levels of health literacy
- People with low levels of IT literacy
- People whose first language is not English/do not speak English.
- Working well/unwell – people who work 9-5 or are on long shift patterns
- People in health and care poverty

The CCG undertook an EIA and health inequality assessment of each of the four service change proposals and found there could be a potential impact on the following groups.

IMPACT ASSESSMENT The services will impact upon the following:-			
	Yes	**No**	**Indirectly**
Patients, service users	✓		
Carers or family	✓		
General public	✓		
Staff	✓		
Partner organisations	✓		

Findings

The CCG sought to ensure that the consultation plan identified any barriers to involvement and used a blend of consultation methods and channels to ensure people within protected groups were effectively involved in the consultation.

There is evidence in the Consultation Plan that the CCG used the Equality Impact Assessments to:

- Inform the planning of consultation activity with protected and seldom heard groups
- Reduce as many barriers to participation as possible

Patient involvement has been woven throughout each stage of the options appraisal and development of the pre-consultation business case and throughout the consultation there were opportunities to seek and listen to the feedback from protected groups.

Stakeholder mapping was undertaken to target groups who were most likely to be impacted by the proposals and identify the right channels and tools to reach them.

This was a challenge for the CCG as the population profile reveals many rural areas where the population is dispersed and there is not a great deal of infrastructure in terms of support networks/groups to work with. The CCG used Mosaic profiling to understand the demography and geography of the population. The most isolated communities were actively targeted with face to face and outreach activity.

Demographic and equality monitoring information was requested from all respondents making it clear that it is a personal choice whether to provide this information.

Patients / service users and staff were involved in the options appraisal process as evidenced in the Pre-Consultation Business Case.

Alongside the Full Consultation Document and Key Information Document, the CCG proactively reached out to the more seldom heard groups seeking their feedback on the options and how future healthcare services could be delivered.

It was refreshing to read that the CCG stated that their perceived benefits of involvement were:

- “Services will improve because they will benefit from learning from ‘lived experience’ rather than just data
- We are likely to see new perspectives that we may not have expected
- It’s a productive way of working and the outcomes are meaningful It has the potential to improve our relationship with patients and communities. This will be centred around empowering people to participate in the health and care system
- It builds on the NHS Constitution pledge to work in partnership and involve people in discussions about care.”

This translated across to the Equality Impact Assessments which were used to inform the Decision Making Business Case and mitigations to any barriers to accessing services highlighted by protected groups.

The outcomes of the consultation have been scrutinised in a number of ways, including:

- Quality Assurance by the Consultation Institute
- Communications and Engagement experts involved in the consultation
- Health Overview and Scrutiny Committees
- Public accountability through interested community groups, digital, print and social media and by local elected politicians working on behalf of their constituents.

Conclusion

The design of the consultation process aimed to remove common barriers to participation, such as lack of information, difficulties in the use of English and lack of time. It also aimed to simplify the route to making a contribution by offering multiple opportunities and different methods of providing views and preferences. These are provided in Annex A.

For transparency, all formal consultation patient and public participation documents were available on the consultation hub website Changes to NHS services :: Lincolnshire STP

The CCG worked in partnership with the voluntary sector and directly engaged with representatives of seldom heard groups. By doing this, they sought to provide opportunities for local people to raise any issues of negative impacts and any barriers to access to services, information, and premises.

The analysis of responses to the consultation by ORS was disaggregated by protected groups, such as it was collected, to help decision makers to identify any significant trends and to consider all feedback received in advance of any decision being made.

This can be found in the Communications & Consultation activity report.

Overall, in a large rural county with relatively small numbers of diverse race and ethnic communities, the CCG has made reasonable attempts to reach the protected groups identified in the area, particularly those who would be affected by the options proposed and decisions taken. Communities such as Travellers, Eastern Europeans and people in economically deprived areas were targeted and supported to participate in a way that they chose.

Risk Matrix

Following the completion of the consultation, the risk assessment is scored as 9. There is still the possible risk of a legal challenge from a campaign group or interested party. However, the aim is to be able to sufficiently defend any such legal challenge should a Judge be willing to hear it.

RISK MATRIX					
	Risk level				
Consequence level	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**VERY LIKELY 5**
1. Negligible	**1**	**2**	**3**	**4**	**5**
2. Minor	**2**	**4**	**6**	**8**	**10**
3. Moderate	**3**	**6**	**9**	**12**	**15**
4. Major	**4**	**8**	**12**	**16**	**20**
5. Catastrophic	**5**	**10**	**15**	**20**	**25**
Consequence Score: Likelihood Score: **Risk score = consequence x likelihood**					**Risk Score**
Risk *of not being considered to have made reasonable attempts to involve patients/service users from protected / seldom heard groups leading to legal challenge: Consequence score of 3 and Likelihood score of 3*					*9*
Any comments / records of different risk scores over time (e.g. reason for any change in scores over time): There is a possible risk of legal challenge which can be defended through the actions taken during the consultation and the independent assessment and Quality Assurance by the Consultation Institute.					

Annex A Consultation Plan: Reaching the 'seldom heard'

To encourage participation by the seldom heard groups identified, the information below describes the potential barriers and the mitigating actions that were taken during the consultation.

The barriers identified are adopted and adapted from the NHS England Statutory Guidance: Patient and Public Participation, Equality, and health inequalities – full analysis and associated resources, NHS England, April 2016 https://www.england.nhs.uk/publication/patient-and-public-participation-equality-and-health-inequalities/

Overarching accessibility of the consultation

Potential barrier	Mitigating actions

Lack of awareness of the consultation taking place	• Consultation launch email with link to hub website
	  • Accessibility tools available including language translation and alternative formats
	• House to house mailshot
	• Dedicated consultation hotline
	• Online questionnaire regularly promoted
	  • Social media (Twitter, Facebook and Instagram) across the CCG and Trust's accounts
	  • NHS Lincolnshire Engagement Bulletin
	  • At all face to face and online events
	  • Press releases
	  • Nextdoor online forum
	  • LPFT carers Whatsapp
	• Posters in multiple languages
	• A5 leaflets in multiple languages
	• Circulated posters and leaflets to volunteer & transport services via social media, email or printed copies sent out in the post
	• Partners shared comms messages
	• Newsletters
	• Consultation & Delivery Plan EIA
	• Leafleting, posters and survey placed in socially deprived communities and across main localities and public places

	• Involvement champions recruited
Potential barrier	**Mitigating actions**
Participants unable to provide feedback	• Directly asking questions to the panel at events • Paper feedback forms • Paper Q&A cards • Paper questionnaires with a freepost return address • Easy Read documents made available • Slido (Interactive Audience Software – submit questions directly to us from a phone or tablet) • Leaving an email address for us to respond to • Telephoning the dedicated consultation phone number • FAQs • Market day events for the digitally excluded • Stakeholder and staff events
Potential barrier	**Mitigating actions**
The working well and those disengaged in public life. Lack of time to participate (people who work 9-5 and people who work long shift patterns)	• Events in a variety of means including face-to-face (different times and days of the week) and online events • Videos of clinicians talking through each option and any consultation questions or feedback could be submitted via Slido • Community events.
Potential barrier	**Mitigating actions**
People not aware of the CCG or its role but do participate in public life through established groups	• Database of local and community groups based on all protected characteristics • Attend existing group meetings and events to further promote opportunities for involvement and discuss these options directly with individuals and protected characteristic groups. • Use of existing links on social media with protected characteristic groups • attending local outlets such as Eastern European Cafés, supermarkets in economically deprived areas in addition to reaching out to local authority contacts with access to Homeless and Traveller groups. • Worked closely with charity and voluntary organisations who have links into seldom heard groups and particularly those potentially affected by the proposed changes (elderly, disability, and economically disadvantaged groups).

Protected Characteristic Groups

Examples of activities to reach Protected Characteristics Groups and actions to support their involvement in the consultation. Full details are provided in the Communications & Consultation activity report.		
Audience	**Consultation Distribution**	**Consultation Activities**
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 UK Lincoln and South Lincolnshire** – Easy read document and questionnaire posted. Documents being distributed to any new clients they receive • Information and advice officers are informing clients of the consultation, also discussing on phone appointment. • Posters displayed in restaurants and receptions. • Community connectors, patient support service and volunteers sharing information on our behalf • Contacted LinCa to distribute across care homes in Lincolnshire • Attended the **Age UK Lindsey** bus tour in Louth • 300 leaflets sent to **Age UK Lindsey** for distributing • 1-1 meeting with Grantham Senior Citizens member who gave feedback on behalf of its 50 members • Magna Vitae (Trust for Leisure and Culture in East Lindsey) circulated information to colleagues and elderly groups in East Lindsey as we were unable to attend their meeting December due to the group having prior commitments • TED circulated information to all YMCA contacts • 400 leaflets sent to Walnut Care to distribute to every resident • Recruitment campaign – email and social media posts inviting those aged 70+ to have an informal chat about the consultation proposals and how they may impact them specifically
Age - Young	39 young groups such as: • Children's Centres • Grantham Youth Centre • Homestart Lincolnshire	• Information sent to NKDC Youth Forum • Lincolnshire County Council to distribute to Young Carers • Shared with Lincolnshire Youth Council and V4C (Children in Care Council)

	• Action for Children • Schools and sixth forms	• Skegness TEC College – sent to 54 learners via teams, 27 staff via email, 53 local employer contact and shared on social media • University of Lincoln circulated on social media • Lincolnshire County Council distributed to all primary and secondary schools across Lincolnshire • Leafleting event at Lincoln College • Direct email to University of Lincoln Wellbeing requesting support of distribution to networks, volunteers etc. • KIDS Lincolnshire sharing information via social media to their members on our behalf • NKDC circulated information to all schools within North Kesteven • Information shared with North Kesteven Student Council
Disability - Physical	58 Groups including: • Grantham and District talking newspaper for the blind • MS Society • Deaf Society • Lincolnshire Sensory Services • Sickle Cell Society	• Meeting with people with sensory impairment through Lincolnshire Sensory Services in Boston. BSL interpreter at the meetings. • Easy read document translated into sign language and made available on their website • Distribution to their membership • Grantham Hard of Hearing to distribute to 8 groups • Meetings were also scheduled for the Mablethorpe and Grantham Sensory service but were stood down due to increasing Covid infection rates and risk to staff and public • 1-1 meeting with member of Grantham Hard of Hearing • 1-1 meeting with Polio Survivors Network member • Connected with Lincs Disabled Activities, Event and Facilities on social media who have been sharing information on our behalf
Disability – Mental Impairment	37 groups including: • Lincoln Dementia Café • Lincolnshire Autism Society • Lincolnshire Neurological Alliance	**SEND** • Designated Clinical officer for Children and Young People with Special Education Needs and Disability – sent information to Lincolnshire Young Voices, promotion via social media **Learning disabilities** • Presented at Voiceability event (County board for people with learning disabilities) • Request to present at Mental Health Programme Board, information shared with board members • Request to present at the Transforming Care Board

		• County Council to share with Learning Disabilities Partnership, efforts were also made to connect via social media **Autism** • County Council to share with Autism Board network board members and working groups with a request to share within their networks • Requested details to be promoted via the Connect to Support website and via Lincolnshire County Council media channels **Neurological** • 1-1 meeting with founder member and trustee of Lincolnshire Neurological Alliance LPFT circulated documents to 320 contacts
Gender reassignment	8 Groups including: • University of Lincoln LGBT+ Society • Just Lincolnshire • Lincolnshire parents of LGBT children • Transhaven Boston	• Contacted LincsTransnb and Think2Speak via direct message on social media asking to share with their community • Direct email sent to LGBT Lincoln Student Union • Direct email sent to LGBTLincs and also tagged in consultation posts on social media • Direct contact made with LGBT Business Directory and Forever with Pride E-Magazine requesting for support with distribution to their networks • Direct email to Transhaven Boston
Pregnancy and Maternity	108 groups including: • Little SNapps (Boston premature baby group • Better births • Sleaford breastfeeding group • Parent and toddler groups • Lincolnshire Maternity Voices	• Booking confirmed to present at the Lincolnshire Maternity voices board meeting, unfortunately due to significant covid pressure and staff redeployment this was stood down by the Lincolnshire Maternity Partnership Board • Sharing on their social media account and distributed across their networks
Race/ethnicity	30 groups including: • Lincolnshire Traveller Initiative	Translated poster and leaflets in Polish/migrant cafes, restaurants and supermarkets and Delis: • European Cuisine Family Restaurant • Grill Janosik

	• Just Lincolnshire • BME Inclusion Services • Factories with Eastern European workforce	• Swojskie Jadlo • Syrenka • Julia Polish Shop • Polish Dinner • Sweet Bakery • Pollea • Paradise • Bistro Polonia • Polish Bar and Restaurant Graffiti • Polka Polish Cuisine • U Ani Polish Restaurant • Korzinka Taste of Europe • Boston Supermarket • Korzinka Taste of Europe • Super Lincs • Polish-Deli • Poziomka • Pewex - Food Plus • Malinka • Delicja • Baltic Food and Grocery Ltd • Pasikonik • Frucktolinka • Lajkonik • Spalding Market • Lajkonik • European Market • World Star OF License • Leaflet and poster drop in Boston to 15 Eastern European cafés/shops • Translated posters and leaflets circulated to local factories with migrant workforces via LCHS patient experience officer **Lincolnshire Traveller Initiative** • Well Woman group in Gainsborough (8-10 Traveller women) – talking to them on our behalf and collating feedback

		• Grantham Traveller rep speaking to Grantham area on our behalf • Direct messages sent to Black Lives Matter Lincoln requesting support/distribution of information Recruitment campaign – email and social media posts inviting those from BAME backgrounds to have an informal chat about the consultation proposals on how they may impact them specifically
Religion/belief	30 groups including: • Salvation Army • Churches Together in Grantham and District • Samaritans • Lincoln Mosque • Sleaford Islamic Centre	• Direct social media message sent to Lincolnshire Faith Council who are sharing consultation information on social media on our behalf • Direct message sent to Lincolnshire Jewish Community asking for support to connect/share
Gender	30 Groups including: • The Women's Institute • Dad's Saturday Club in Grantham • Active Lincolnshire	• Active Lincolnshire shared with local sports groups across the county – Groups include rugby, football, cricket, and golf. • Andrew Morgan held a meeting with Grantham Rotary Club • Information distributed to Boston's Men Shed • Information distributed to Men's Shed in Louth • Contact made via social media with WI Lincolnshire South and Lincolnshire North Federations for feedback and support to promote information
Sexual Orientation	15 groups including: • Gay Outdoor Club • LGBT+ Sleaford • University of Lincoln LGBT+ Society	• Direct social media message to The Scene and Lincoln Pride UK requesting support to gather feedback • Recruitment campaign – email and social media posts inviting those from LGBT+ backgrounds to have an informal chat about the consultation proposals on how they may impact them specifically
Carers	• Carers First • EveryOne • Lincolnshire Parent Carer Forum	• Meeting with Carers First, who will promote via social media, dedicated focus groups with carers in December • Meeting confirmed with Carers First, unfortunately due to no carers booking on the meeting had to be stood down last minute • Met with EveryOne – who have over 400 organisation that are accredited with the carers award and will distribution information to all • 42 carers champions who are going to help promote the consultation

		• Dedicated carer mailout list • Contacted LPCF who will share on their website • Lincolnshire County Council to distribute to Young Carers • Information distributed to carers Whatsapp group with 50+ carers on • Consultation information sent out in Adult Care Bulletin and asked Adult Care staff to share • LSAB sent out to all partners and social media • V4C promoted to young people in care

Annex B Maktub Consulting Ltd

Anna Collins FCIM, Director of Maktub Consulting Ltd: Director of Maktub Consulting Ltd has over 20 years' experience in the public sector working in senior leadership roles in communication, engagement and corporate services. She is experienced in creating accessible narrative and dialogue to help clients to find their corporate voice, tackle tricky reputational issues and involve stakeholders in their decision making.

Underpinning the advice and hands-on delivery is an approach to good governance with the aim of minimising the risk of legal challenge and making sure that decision makers are empowered to adopt good practice methodology to inform their thinking.
Anna is a Fellow of the Chartered Institute of Marketing and an Associate of The Consultation Institute with 20 years' experience in the public sector and was Marketing Manager for Europe for ICL computers for 11 years prior to that.

Anna has operated at executive level as Director of Communication & Corporate Affairs in the NHS at a Foundation Trust where her portfolio included communication, governance, legal services, information governance and the hospital charity.

She has also worked as Associate Director of Communication & Engagement for the six Staffordshire Clinical Commissioning Groups and the Sustainability & Transformation Partnership. Whilst there, she delivered several contentious transformational change consultation programmes including the prescribing of gluten free foods, proposals to merge the six CCGs and the reconfiguration of community hospitals and community hub services without legal challenge.

She led on communication and involvement on behalf of the CCGs for the system wide change programme 'Together We're Better' managing several supplier relationships to deliver against both statutory duties and best practice. She has successfully delivered to regulatory assurance frameworks and has a proven track record in building positive relationships with campaigners, scrutineers and elected members at local and national level.

Anna's passion lies in giving service users, particularly the seldom heard, and stakeholders a voice to inform decision making using innovative and best practice methodology and has experience of managing the tactical delivery of a citizen's jury, large and focussed deliberative events and digital engagement. She has a personal interest in health literacy and the 'It's OK to Ask' campaign was shortlisted for an HSJ award.

Anna also has 14 years public sector communication and engagement leadership experience with two Cheshire Police & Crime Commissioners and Cheshire Police Authority where she managed public consultation about the police budget, priorities and the recommissioning of victim support services as well as proposals for police station closures and police force mergers.

Anna was the Equality & Diversity lead under Sir Peter Fahy when the ‘Secret Policeman’ documentary highlighted the need for better awareness of culture and racial issues and led on the development of the Equality Strategy and Equality and Community Impact Assessments. She was the lead for Hate Crime and undertook some intense engagement activity with ethnic communities, LGBT victims of hate crime, young people’s experiences of Stop & Search as well as working with survivors of sexual assault and domestic abuse. She supported the National ACPO lead for Disability. She led on equality and diversity and managed the Constabulary’s Independent Advisory Group.

Appendix C

NHS Lincolnshire Public Consultation 2021 Feedback Report

Lincolnshire NHS public consultation on proposed changes to four services

Public consultation feedback report

Opinion Research Services
May 2022

Lincolnshire NHS public consultation on proposed changes to four services

Public consultation feedback report

Opinion Research Services

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As with all our studies, findings from this report are subject to Opinion Research Services' Standard Terms and Conditions of Contract.

Any press release or publication of the findings of this report requires the advance approval of ORS. Such approval will only be refused on the grounds of inaccuracy or misrepresentation

This study was conducted in accordance with ISO 20252:2019 and ISO 9001:2015.

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Key Findings

Summary of main findings

The key findings below are expanded upon in the executive summary and covered in comprehensive detail in the main body of the report.

» 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; and
- 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, however, 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.

1. Executive summary

Introduction

1.1 United Lincolnshire Hospitals NHS Trust (ULHT) provides acute hospital services to the population of Lincolnshire. Beginning in 2013, NHS Commissioners in Lincolnshire have been undertaking engagement with members of the public and other stakeholders as part of a major review of acute hospital services.

1.2 In 2017, the present phase of planning and engagement began, culminating most recently in 'Healthy Conversation 2019', a six-month exercise during which NHS Lincolnshire CCGs and other partners sought feedback from the public and other stakeholders on a range of health and care services to understand their views. The range of NHS services in Lincolnshire involved in this conversation included four acute services.

The proposals

1.3 Following a period of options development and appraisal that involved senior clinicians, key stakeholders and members of the public, proposals for changes to the following four NHS services were put forward for public consultation over a 12-week period from 30th September 2021 until 23rd December 2021:

Proposals for orthopaedic surgery

- Consolidate planned orthopaedic surgery in a 'centre for excellence' at Grantham and District Hospital; and
- Create a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery.

Proposals for urgent and emergency care at Grantham and District Hospital

- Grantham and District Hospital A&E department to become an 24/7 Urgent Treatment Centre.

Proposals for acute medical beds at Grantham and District Hospital

- Integrated community/acute medical beds at Grantham and District Hospital.

Proposals for stroke services

- Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.

The nature of public consultation

1.4 Public consultation promotes accountability and assists decision making; public bodies give an account of their plans or proposals and listen to feedback. Consultation has therefore been described as a dialogue, based on a genuine and purposeful exchange of views.

1.5 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 take into account the issues raised.

1.6 Opinion Research Services (ORS), a company that grew out of Swansea University, now with a UK-wide reputation for social research and major statutory consultations, was appointed by NHS Lincolnshire CCG to support engagement, and to analyse and report the outcomes of this public consultation programme of engagement with members of the public, clinicians and other NHS staff, and other stakeholders.

1.7 All types of consultation responses are important, and this report presents an independent analysis so that all of them may be taken into account. Some contributions have been highlighted based on at least one of the following aspects:

- Relevant to and/or having implications for one or more of the proposals under consideration;
- Evidenced – for example, submissions from professional bodies, staff and concerned people or local groups that point to additional information or evidence to support their perspective;
- Deliberative – based on thoughtful discussion in public meetings and other group settings;
- Representative of the general population and/or particular localities, groups or points of view;
- Focused on the views from under-represented people or equality groups; or
- 'Novel' – in the sense of raising 'different' issues from those being repeated by a number of respondents or arising from a different perspective.

1.8 The report also identifies where strength of feeling may be particularly intense, either in relation to specific themes or possible outcomes, or coming from specific groups of respondents. It is not ORS' role, however, to 'make a case' for the proposals, or to make any recommendations as to how decision makers should use the reported results. It is for the appropriate bodies to take decisions based on all of the evidence available, of which consultation feedback is one part.

The consultation process

1.9 The 12-week consultation began on 30 September 2021 and ended on 23 December 2021. It was widely promoted via stakeholder organisations, leaflets commissioned to be delivered to 370,000 households across Lincolnshire, posters and leaflets in GP practices and public locations, online and traditional media coverage and advertisement, and to ULHT, Lincolnshire Community Health Services NHS Trust (LCHS) and Lincolnshire Partnership Foundation NHS Trust (LPFT) service users, among others.

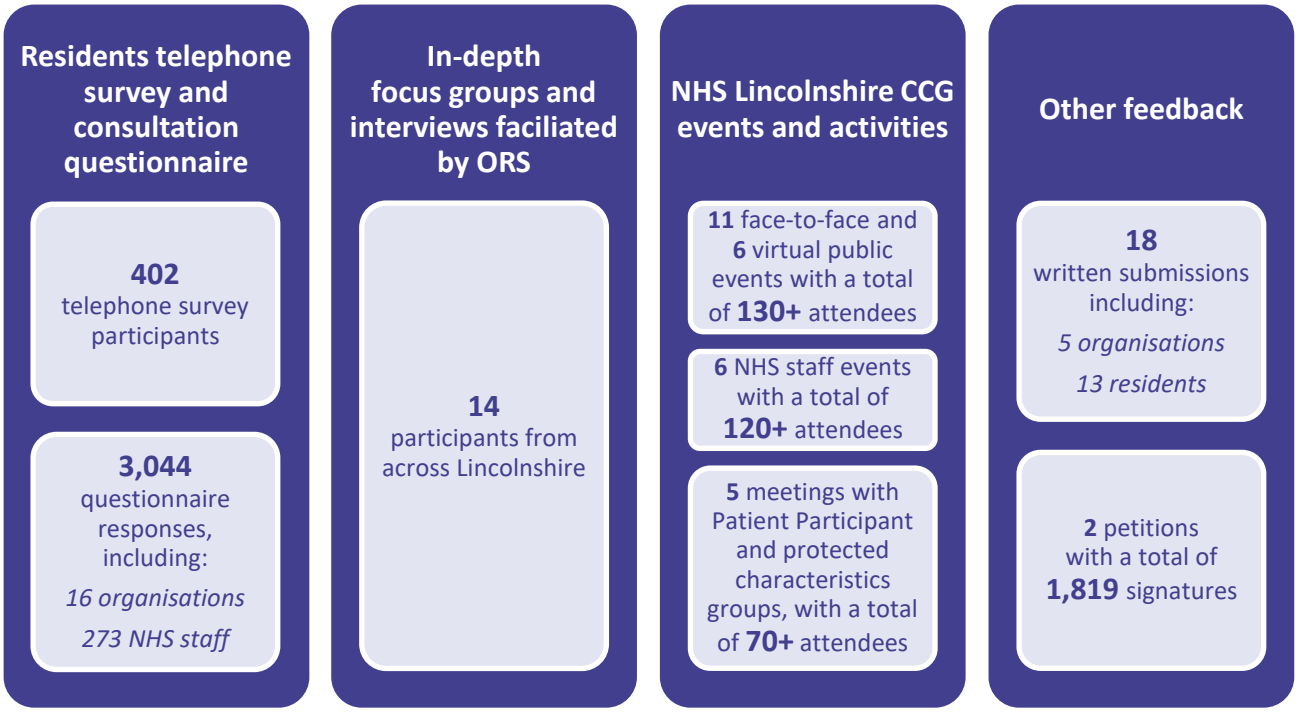
1.10 During the consultation period, stakeholders were invited to provide feedback through:

- A consultation questionnaire for all residents, 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 residents survey administered by telephone, and representative of Lincolnshire's population; 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 NHS staff members, stakeholders and services users; and
  - 'Pop-up' engagement activities at market days across Lincolnshire;

» Written or email submissions from residents, stakeholders and organisations; and

» Petitions (organised by two local campaign groups and submitted to ORS).

1.11 The consultation response is summarised below:



Executive summary and consultation feedback report

1.12 This full consultation feedback report brings together the feedback received through each of these different elements and provides a comprehensive evidence base to help inform the decision-making process for the NHS Lincolnshire CCG. This executive summary concisely reviews the full range of feedback received and brings together those common themes that have emerged.

1.13 Verbatim quotations are used in the full report not because ORS agrees or disagrees with them, but for their vividness in capturing recurrent points of view. ORS does not endorse the statements made but seeks only to portray them accurately and clearly.

1.14 Whereas this executive summary brings together the overall perspectives fairly quickly, the full report covers public, professional and stakeholder opinions and feelings in considerable detail to achieve a more comprehensive understanding – and it is the journey, as well as the destination, that will matter to those wishing to understand the assumptions, arguments, conclusions and feelings about current and future healthcare services in the area.

1.15 By contrast, the full report considers the feedback from each element of the consultation in turn, which can at times be repetitive given that similar issues emerged across the different strands – but it is important that the full report provides an accurate reflection of all of the feedback received. We trust that both the executive summary and full report will be helpful to all concerned.

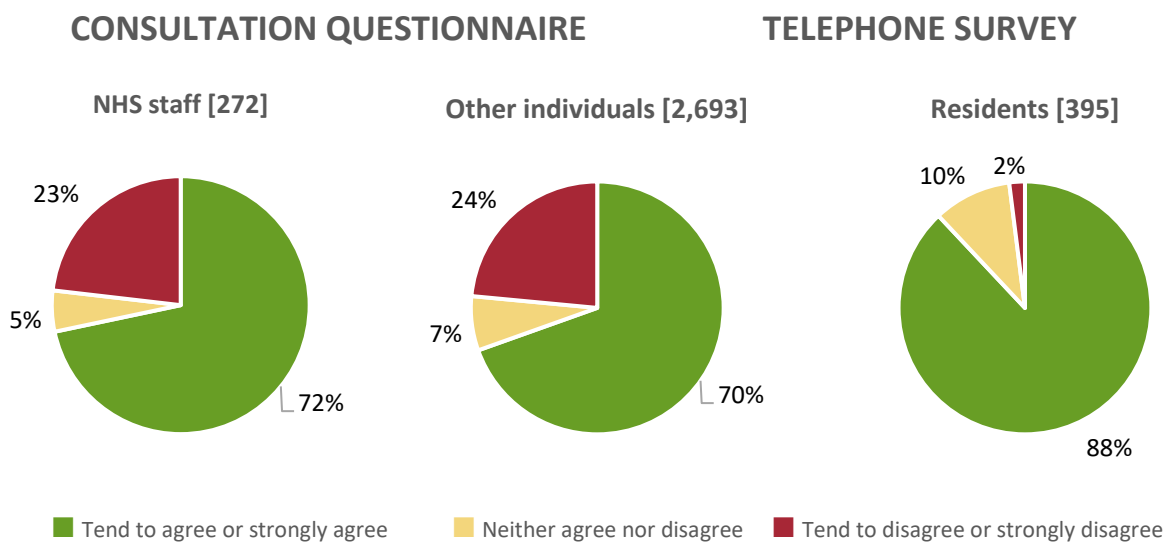
Summary of feedback: the need for change

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

1.16 In the consultation questionnaire over two thirds of the individuals (72% of NHS staff and 70% of other individuals) who responded 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 (Figure 1).

1.17 Based on the residents survey that was representative of the overall Lincolnshire population, support was overwhelming, with 88% of residents (+/- 6%) agreeing that changes should be made in principle, while just 2% disagreed.

Figure 1 - 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)

1.18 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.

1.19 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.

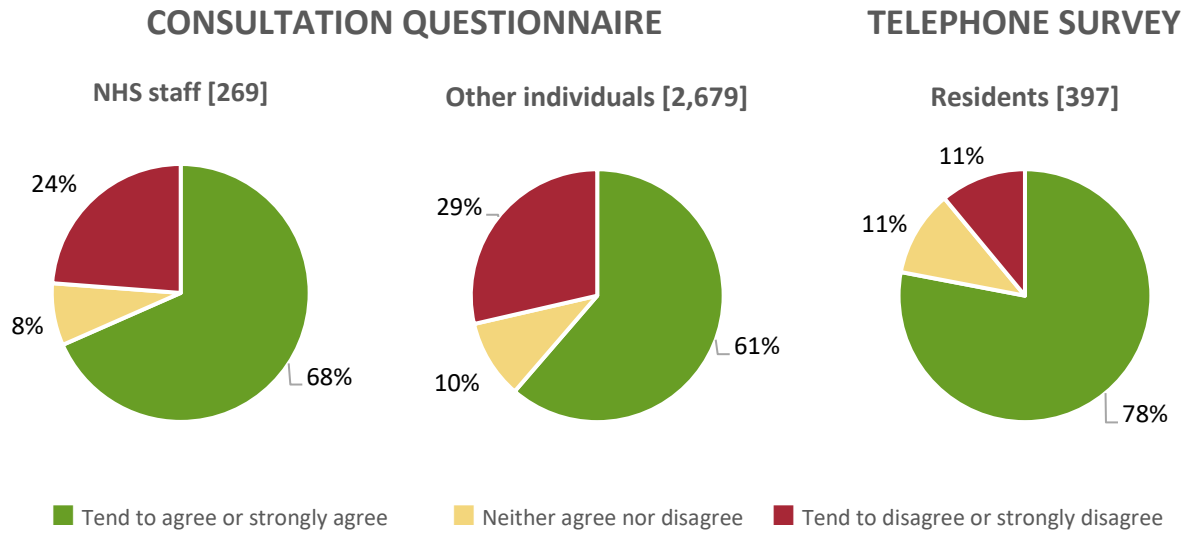
Summary of feedback: orthopaedic surgery services in Lincolnshire

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

1.20 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 (Figure 2).

1.21 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 2 - Views on 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 (from the consultation questionnaire and residents telephone survey, BY STAKEHOLDER TYPE)



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

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

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

1.23 Feedback about the high quality of current orthopaedic services at Grantham and District Hospital was forthcoming across several consultation strands; the potential to see further improvements in staff recruitment and retention, as well as quality of care, were therefore viewed positively.

1.24 The provision of a dedicated day case centre at County Hospital in Louth was widely supported, although there were some misgivings about travel and transport to that location from other parts of Lincolnshire.

1.25 Similarly, access to Grantham and District Hospital, particularly from the east coast of Lincolnshire, was also raised as a concern both by those who supported the proposal and those who disagreed.

1.26 While there were concerns about the possibility that some residents might have to travel further to reach the orthopaedic services that they require, there was a view that the benefits of access to specialist Centre of Excellence would outweigh the increased time.

1.27 Furthermore, there was also feedback indicating that, given Lincolnshire's rural geography, many people were used to travelling to access hospital services already and might therefore be less concerned or impacted as a result.

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

1.28 Central to much of the disagreement with the proposals for orthopaedic surgery services in Lincoln is the view that all acute hospital services should be delivered locally, and that orthopaedic surgery should be performed at hospitals close to patients' homes. In this vein, there were some suggestions that all hospitals should become Centres of Excellence, or that specialist orthopaedic services should be rotated between sites.

1.29 Some respondents to the consultation, particularly those submitting standardised responses in the petition organised by local campaign groups, saw the proposed removal of *emergency* orthopaedic services from Grantham and District Hospital as linked to proposed changes to urgent and emergency care in Grantham.

1.30 Concern was also expressed by opponents to the proposals that there would be negative impacts on the quality and timeliness of emergency orthopaedic care, with increased pressure on those services at Lincoln County Hospital, as well as on the ambulance service if more or longer transfers were needed.

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

1.31 Travel and transport implications for service users who might need to visit different hospital sites across Lincolnshire were raised as cause for concern, with reassurances being sought about whether pre-operative assessments and post-operative care, as well as related services such as fracture clinics, would be available at local hospitals or in the community. There were also some comments around whether staffing two separate centres for orthopaedic services might present challenges for recruitment, with calls to ensure that NHS staff are consulted.

Equalities and health inequalities impacts of proposals for orthopaedic surgery

1.32 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.

1.33 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.

1.34 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.

Mitigations, alternative suggestions and additional considerations around orthopaedic surgery in Lincolnshire

1.35 The Chartered Society of Physiotherapy (CSP), in their response to the consultation, raised concerns that lack of funding for weekend rehabilitation services is resulting in increasing patient length of stay, and sought confirmation that high quality care and best practice rehabilitation for orthopaedic discharged patients would be put in place under the proposed changes.

1.36 Measures which might mitigate against challenges that some service users might face around travelling to more distant or unfamiliar hospitals sites were suggested, such as increased provision of patient transport services, working with local authorities to explore improvements to public transport links and more follow-up appointments being provided in the community.

1.37 Beyond the view from some respondents that emergency orthopaedic surgery should be retained at Grantham and District Hospital, alongside a new Centre of Excellence, few suggestions of alternative approaches to delivery of planned orthopaedic services were forthcoming.

1.38 There were, however, a few additional points for consideration raised in feedback around the proposals:

- Communication between care facilities, including hospital departments and GPs, needs to be addressed urgently to ensure the timely flow of information on patient care and treatment;
- The NHS Lincolnshire should work with and learn from private hospitals to improve patient care and assist with the crisis; and
- That Grantham and District Hospital is in a poor state of maintenance, and that it would be more cost effective in the long run to build a brand new centre for orthopaedic services.

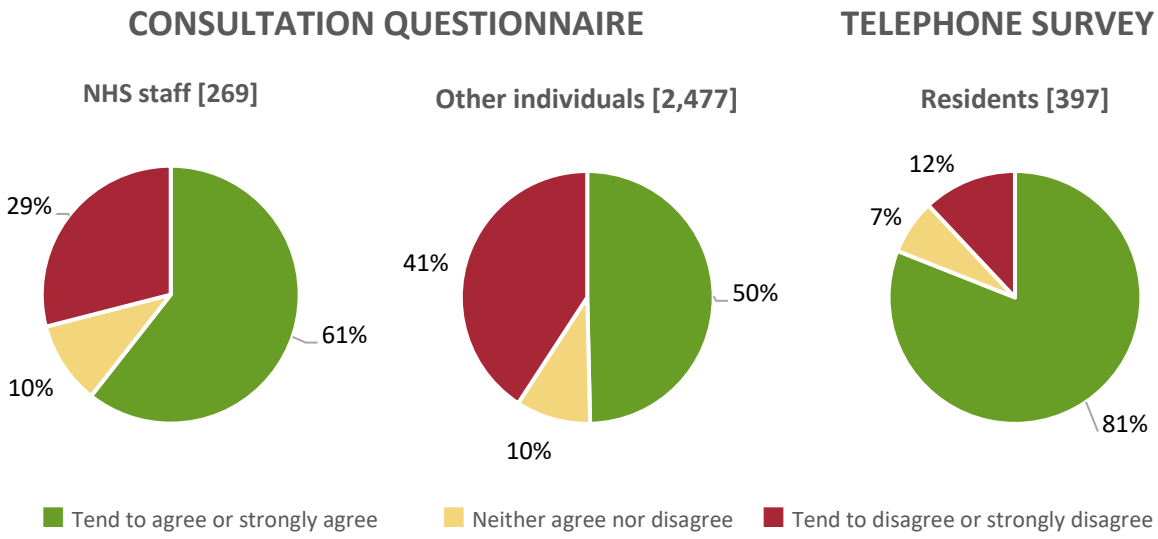
Summary of feedback: urgent and emergency care at Grantham and District Hospital

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

1.39 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%) NHS staff members and two fifths (41%) of other individual respondents either tended to disagree or strongly disagreed (Figure 3).

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

Figure 3 - 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)

1.41 Among the 14 organisations that responded to this question, 8 agreed with the proposals for urgent and emergency care in Grantham, 2 neither agreed nor disagreed, and 4 disagreed.

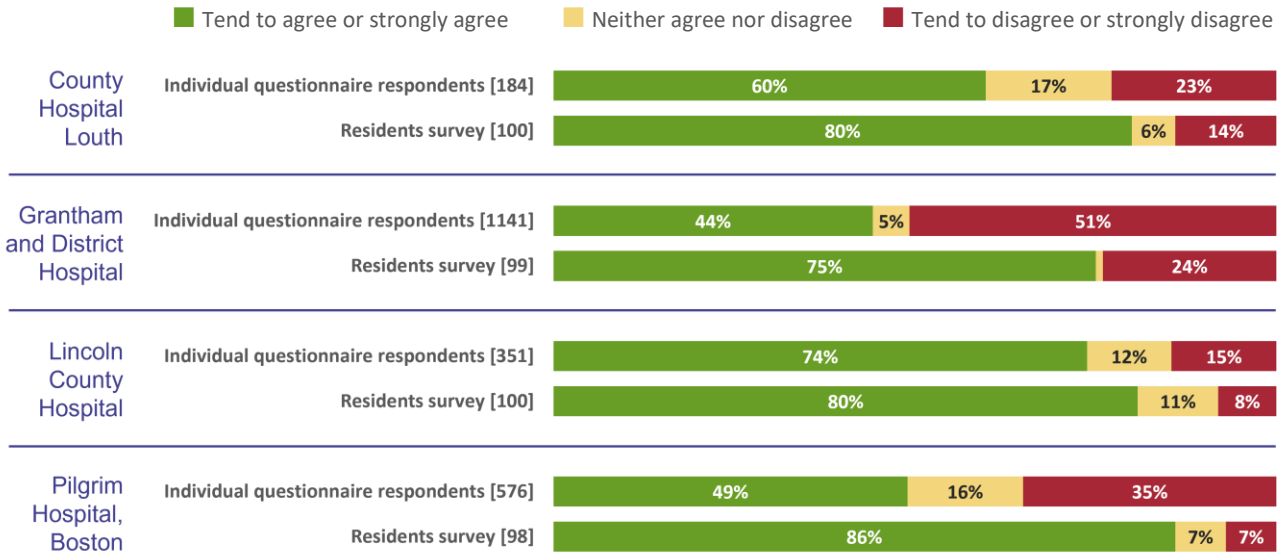
There was, however, evidence of differing views on the proposal for a 24-hour UTC at Grantham and District Hospital between those living in different areas of Lincolnshire

1.42 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 (Figure 4). 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.

1.43 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 living closest to Grantham and District Hospital disagreeing with the proposals (Figure 4).

1.44 Just over a third of questionnaire respondents (35%) living closest to Pilgrim Hospital, 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 4 - 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)

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

1.45 Across all consultation strands, there was support for 24-hour access to urgent care services in Grantham. It is important to note, however, that there was a marked divide between those who agreed with the proposal for a 24/7 Urgent Treatment Centre, and those who felt that the proposals were insufficient and therefore advocated for increased provision and a fully equipped and staffed 24-hour A&E at the site.

1.46 For many respondents, a 24-hour UTC was viewed as preferable to the current limited services A&E department operating from 8:00am - 6:30pm. While they might have preferred full accident and emergency services to be available locally, there was acknowledgement that a high percentage of evening and overnight visitors to the A&E departments at Lincoln County Hospital or Peterborough City Hospital could actually be treated at a more local UTC.

1.47 There was recognition from those who agreed with the proposal, including those who participated in in-depth discussions at the focus groups and through interviews, that 24-hour access to a walk-in UTC might relieve pressure on Lincoln County Hospital's A&E, as well as benefiting those living in and near to Grantham if the majority of them would not need to travel to Lincoln to receive out of hours urgent care.

1.48 It is important to note that those who accepted the proposal around urgent and emergency care in Grantham tended to express similar concerns to those who disagreed, particularly on issues such as Grantham's growing and aging population, and travel to Lincoln County Hospital. For these respondents and residents, however, the proposals represented a reasonable 'real world' compromise, and that these were issues that could be mitigated against - not least by ensuring that local residents are made fully aware of what services a UTC would be able to provide overnight.

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

1.49 The vast majority of those who rejected the proposals for a 24-hour UTC at Grantham and District Hospital did so, not on the basis that they favour the status quo of current service provision, but rather because they want a full, 24/7 A&E department in place of the current 8:00am to 6:30pm service.

1.50 The strongest disagreement with the proposals was seen among those living closest to Grantham and District Hospital, the same area from which the largest volume of responses to the consultation was received. There was a strong narrative in the negative feedback about protecting, and even expanding the services delivered at the hospital.

1.51 For many who opposed the proposals, any changes to acute services at the hospital in Grantham were viewed as unacceptable and, in many cases, seen as a continuation of under-investment and a process of service reduction at Grantham and District Hospital over a period of a number of years. There was a very strong view among those that disagreed outright with the proposals that *more* services should be delivered from the hospital, with reference made to emergency orthopaedic surgery and stroke services in particular.

1.52 Foremost among the reasons given for requiring 24/7 A&E services in Grantham, were concerns related to risk to life as a result of increased travel times in life-threatening emergencies. Respondents who disagreed with the proposal cited concerns about ambulance conveyance times to more distant Accident and Emergency Departments at Lincoln County Hospital and other locations, as well as the view that the proximity of the A1, major railway links and airports increases the risk of a major incident that might overwhelm remaining A&E services without Grantham and District Hospital being able to provide support.

1.53 The strength of feeling from some members of the public was further evidenced by the submission of two petitions with a combined total of 1,818 signatures or online indications of support calling for a 24-hour A&E department at Grantham and District Hospitals. The most robust disagreement across the consultation was often characterised by a lack of trust in the case for change put forward by NHS Lincolnshire CCG and strong concern that the proposal is another step in a deliberate 'downgrading' of Grantham and District Hospital.

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

1.54 Travel and access to A&E services was a concern for many respondents; if the proposal was to go ahead it was felt that there would be an impact on members of the public who might find it difficult to travel to and from Lincoln County Hospital and other locations. Issues raised included poor transport links to Lincoln County Hospital and increased costs and journey times, particularly for those who might rely on public transport or be discharged late at night.

1.55 Reassurances that a 24-hour Urgent Treatment Centre would be appropriate for the vast majority of patients requiring out-of-hours assessment and treatment and might therefore lead to shorter waiting times and less pressure on A&E services in other locations in Lincolnshire, were accepted by many of those who agreed with the proposals. There was also recognition that most people who would require full A&E services, such as trauma patients, would in any case be transported by ambulance to the nearest appropriate site.

1.56 Despite this, however, concerns remained about ambulance conveyance times and the potential for increased pressure on East Midlands Ambulance Services; the rural geography of much of Lincolnshire led to concerns about acute and emergency health service provision becoming more 'spread out' at a time when the population is growing, particularly around Grantham. As well as impacting patients, there was concern expressed around access by visitors if patients were to be admitted, both in terms of their own journeys, and the potential impacts on patient wellbeing and recovery if they were to be isolated from family and carers.

1.57 Finally, there were some concerns expressed about the quality of care provided at A&E departments at Lincoln County Hospital and Pilgrim Hospital, Boston, as well as the long waiting times that some respondents had experienced. Without any A&E services at Grantham and District Hospital, it was felt that these issues might become worse.

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

1.58 As outlined above, the majority of feedback around the potential impacts of the proposed changes related to travel and access. Some was positive, with recognition that a 24-hour UTC in Grantham and District Hospital would mean that many local service users would not have to travel to Lincoln or Boston to access urgent care between 6:30pm and 8:00am.

1.59 Concerns about negative impacts also focused on travel and access, with many of those who disagreed with the proposal expressing the view that large numbers of patients would have to travel further to access the services they need, increasing the risk of serious harm or loss of life as a result.

Equalities and health inequalities impacts of proposals for urgent and emergency care in Grantham

1.60 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.

1.61 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.

1.62 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.

1.63 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 was again focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.

Mitigations, alternative suggestions and additional considerations around urgent and emergency care

1.64 In light of the concerns about travel and access, the main mitigation measure suggested was that more patient transport options be offered between hospital sites, and to help patients to return home following discharge if they were transferred from the UTC to an A&E at a different hospital.

1.65 In feedback, it was also seen as vital that a UTC at Grantham and District Hospital should always operate as a walk-in service, rather than requiring people to contact NHS 111 first, to ensure that people make use of the service and do not travel elsewhere unnecessarily.

1.66 As discussed above, by far the most common alternative that was proposed was for the current part-time, limited A&E department at Grantham and District Hospital to be replaced by (or 'restored to') a full Type 1 Accident and Emergency Department.

1.67 There were several other alternative suggestions forthcoming, including:

- If the proposals for a 24/7 UTC goes ahead, ULHT should provide their own emergency and non-emergency transfer service to local A&E departments, so that East Midlands Ambulance Services are not affected;
- A&E services should continue to be offered at Grantham and District Hospital during the day, with a UTC in operation only overnight;
- That additional Nurse ACPs[1] be trained to compensate for the shortage of consultants; and
- A similar urgent treatment service be provided at Stamford to cover areas south of Grantham.

1.68 Finally, there was also a suggestion for a more radical approach - that a new specialist hospital be built near Sleaford to deal with all emergency care, leaving other hospitals in Lincolnshire to deal with routine and planned care.

[1] Advanced Clinical Practitioners

Summary of feedback: community/acute medical beds at Grantham and District Hospital

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 benefit of patients

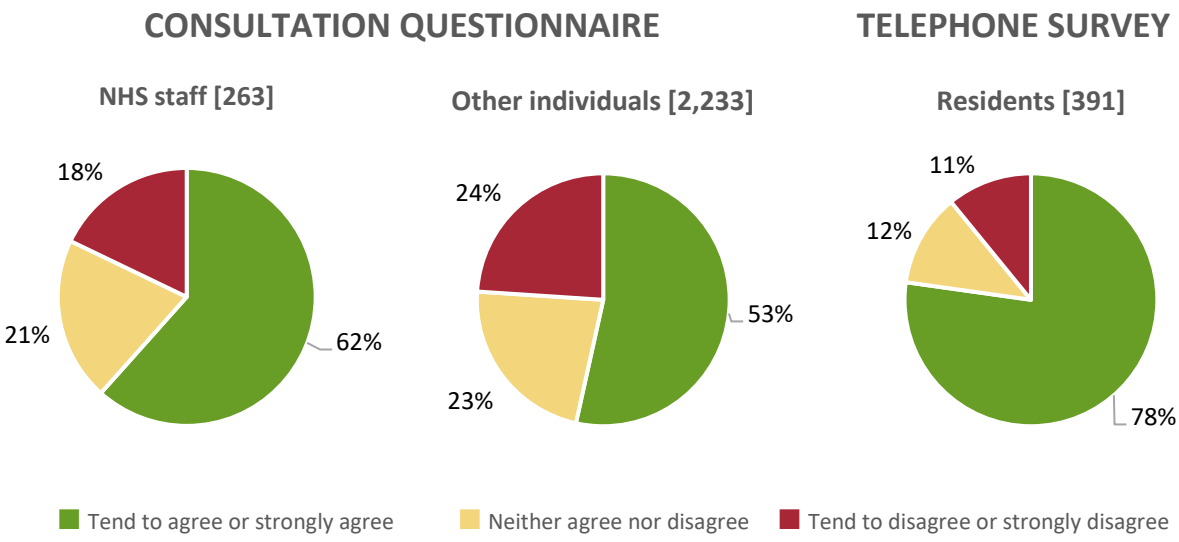
1.69 There was majority support for the proposals to provide integrated community/acute medical beds across all stakeholder and consultation strands. Of note, however, is evidence of a level of uncertainty about the proposal, with many consultation respondents indicating that they neither agreed nor 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.

1.70 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, with fewer than one in five (18%) expressing disagreement (Figure 5).

1.71 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.

1.72 Over three quarters (78%, +/- 6%) of Lincolnshire residents expressed support for the proposals (Figure 5), with around one in ten (11%) disagreeing and a similar proportion (12%) neither agreeing nor disagreeing.

Figure 5 - 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)

1.73 Of the 12 organisations that submitted valid responses to this question, 7 agreed with the proposals, 2 neither agreed nor disagreed, and 3 disagreed.

1.74 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.

1.75 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.

1.76 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.

1.77 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.

Equalities and health inequalities impacts of the proposal for community/acute medical beds at Grantham and District Hospital

1.78 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.

1.79 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.

1.80 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.

Mitigations, alternative suggestions and additional considerations around community/acute medical beds

1.81 In terms of mitigating against potential challenges, difficulty accessing primary care was said to result in minor illnesses not being treated, leading in some cases to increased severity and hospitalisation. As such, it was suggested that the NHS could reduce demand for hospital beds by ensuring that residents can more easily organise appointments with their GP.

1.82 A significant recruitment drive was also thought to be needed to achieve the requisite numbers of clinicians, care-workers and therapists – and related to this, research and development linked to universities was suggested, as was attracting graduates by asking them what they want and need.

1.83 Some alternative suggestions or enhancements to the proposal were suggested as follows:

- » If acute and community beds are available at Grantham, blood tests should be too;
- » Establish acute and rehabilitation pathways:
    - An acute pathway (for acutely/medically unstable patients) consisting of an Emergency Assessment Unit (EAU) and one more medical ward to allow patient flow with multi-disciplinary team (MDT) discharge facilitation; and

- A rehabilitation pathway including step down from acute beds and step up from community beds, to incorporate a rehabilitation ward with stroke and general rehabilitation beds for patients with any other conditions, including frail elderly and post-Covid patients. Establishing this at Grantham and District Hospital would allow service provision for patients closer to their home and access for visitors;

» Provide 'halfway house' care wards for those who are medically well but unable to cope with going home, offering convalescence and low dependency beds, and the potential for occupational therapy;

» Acute medical beds should not be provided at Grantham, given the limited support and other services there. Grantham should be an elective surgery and community hospital, providing high quality care outside an acute setting; and

» Hospital and ongoing social care should be staffed by fully integrated MDTs to facilitate seamless transfer of patients from hospital into the community. This would involve integrated social services and hospital financial structures to end delayed discharge.

1.84 One NHS staff member raised specific concerns about lack of provision of Level 2 Respiratory beds at Grantham and District Hospital and suggested that respiratory ACPs could manage respiratory beds with support from anaesthetists and additional funding for recruitment and training.

1.85 It was also suggested that: mental health beds should be treated as a priority in future planning; and that patients with chronic health conditions and co-morbidities like obesity should be centralised in one location in the county to allow staff to develop specialisms.

1.86 Finally in relation to proposal around acute medical beds at Grantham and District Hospital, there some was criticism based on the view that there was a lack of detailed information on the integrated model in the consultation document.

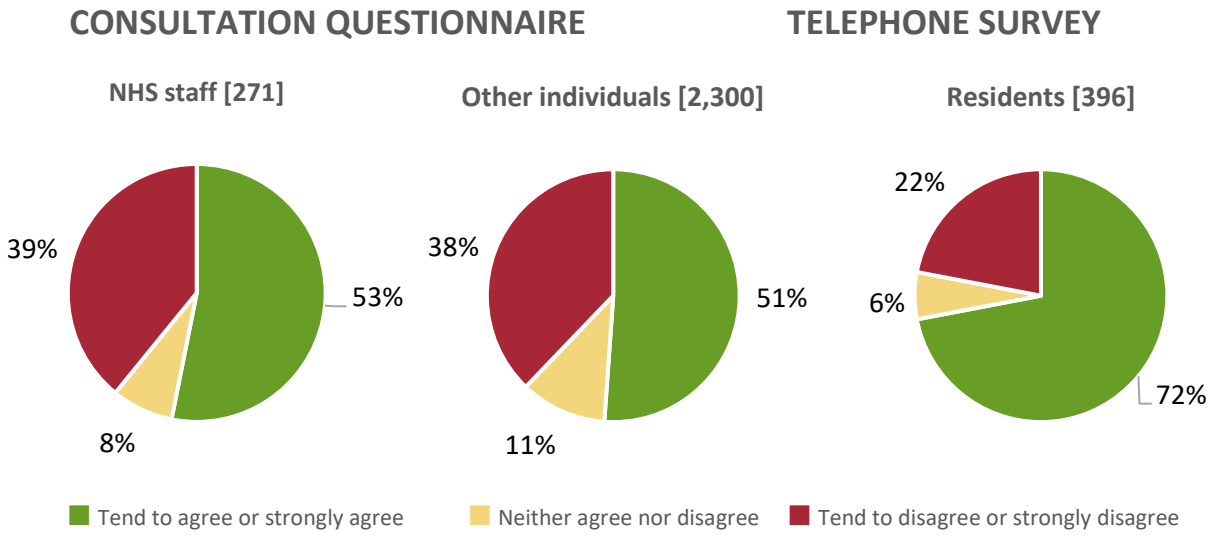
Summary of feedback: stroke services in Lincolnshire

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

1.87 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, just over half of whom expressed agreement (51%) and just under two fifths (38%) disagreed.

1.88 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 6 - Views on the proposal to provide a Centre of Excellence at Lincoln County Hospital offering both a hyperacute 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)

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

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

1.90 There is evidence that concerns about the proposals for stroke services are strongest among those living nearest to Pilgrim Hospital, Boston (Figure 7). 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.

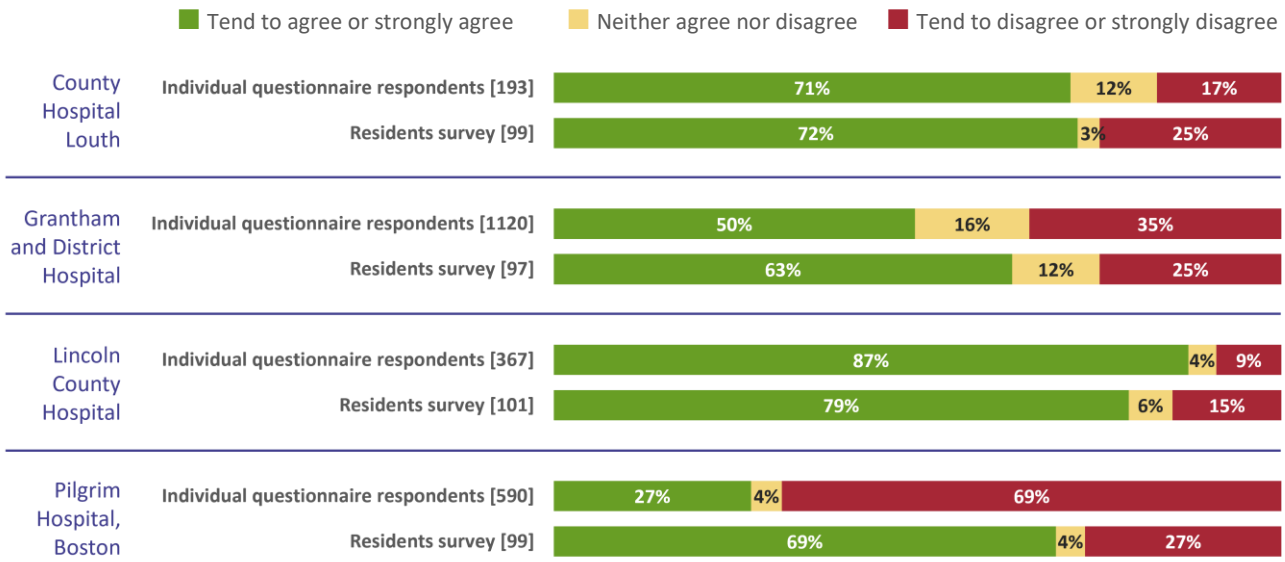
1.91 The residents telephone survey, by contrast, indicates that there is majority support from the overall resident population, including among living closest to Pilgrim Hospital, Boston, where more than two thirds (69%) agree with the proposals (Figure 7).

1.92 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.

1.93 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.

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

Figure 7 - Views on the proposal to provide a Centre of Excellence at Lincoln County Hospital offering both a hyperacute 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)

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

1.95 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.

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

1.96 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.

1.97 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.

1.98 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 provides 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.

1.99 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.

1.100 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.

Other concerns were around ambulance availability, capacity and infrastructure at Lincoln County Hospital, and the impact of the proposed changes on staff

1.101 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.

Equality and health inequalities impacts of the proposal for stroke services

1.102 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.

1.103 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.

1.104 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.

1.105 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.

1.106 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.

1.107 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).

Mitigations, alternative suggestions and additional considerations for stroke services

1.108 The following mitigations were mentioned in relation to the proposal for stroke services:

- Social care provision should be strengthened to reduce the length of hospital stays;
- An air ambulance to cover the East of the county;
- Improved recruitment with higher wages and better benefits so staff feel valued;
- More beds, staff (including staff with thrombolysis training) and other resources;
- A telemedicine system that matches some models used in Europe or other remote areas, whereby more junior staff members could be upskilled to initiate investigations and treatment plans with the help of consultants, to keep patient care local; and
- Additional therapy staffing in the stroke unit and community stroke team to support more timely assessment and discharge planning – as well as discharges themselves.

1.109 Two more general alternative suggestions were made; firstly, that both Lincoln County Hospital and Pilgrim Hospital, Boston should be centres of excellence for stroke; and secondly, that specialist stroke services should be located in Boston to better suit the overall needs of the population.

1.110 More specifically, the following suggestions were made in relation to the hyper-acute and acute wards:

- Train teams stepping into hyper acute care in a timely way; for example, specialist strokes and registrants stepping onto Advanced Clinical Practitioner (ACP) university courses using 'learning beyond registration' (LBR) funds or apprenticeship levies;
- If there is to be a second ward at Lincoln, this should be a small hyper-acute ward (close to the stroke unit), and the current stroke unit should be used for acute care and rehabilitation as it already has several therapy rooms. Therapy teams should work across the two wards to provide consistency of care and help maintain cover during annual leave/staff absence etc.;
- It would be beneficial to have a dedicated MDT/discharge co-ordinator(s);
- Keep the hyper-acute at site; make consultants and ACPs work pan-trust and put money into ACP training for experienced stroke nurses; and
- A standard operating procedure should be in place that allows thrombolysis to be given in the emergency department if the time to transfer to a hyper-acute stroke unit (HASU) is greater than 45 minutes. Patients should then be transferred to HASU post-thrombolysis. This, it was said, is supported by NICE and there are examples of it working in practice elsewhere in the country.

1.111 And the following suggestions were made in relation to rehabilitation:

- Grantham and District Hospital should have a rehabilitation service, but not an acute service if there is no A&E unit there;

- Ringfence specialist beds at Boston to create a hub and spoke stroke rehabilitation service across Lincolnshire. This would provide highly specialised stroke service provision in a centre with ongoing rehabilitation and preparation for discharge to the community. High quality service provision should link the pathway for rehabilitation across acute and community sectors;
- An appropriate stroke rehabilitation ward would ensure throughput is sufficient to allow new patients to be admitted and longer-term patients to receive the rehabilitation they require;
- Community rehabilitation services must be in place for stroke and other neurological conditions, especially brain injury – as well as a step up and down inpatient/outpatient unit where all patients can go to regain lost skills; and
- Provide step down beds in Pilgrim and Grantham and District Hospitals to allow a manageable caseload for Lincoln County Hospital, and so that patients can receive specialist stroke rehabilitation closer to home.

Summary of feedback: equalities and health inequalities impacts

1.112 Analysis of questionnaire and survey responses did not indicate that there were strong differences in views on the proposals, or specific additional concerns being expressed by respondents from groups with protected characteristics under the Equalities Act 2010 (e.g., age, ethnicity, gender) or other demographic groups. 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.

1.113 As mentioned above, the one exception to this was that there was some evidence that residents with the most life-limiting disabilities and long term conditions were more negative than other residents about the proposals around acute medical beds and urgent and emergency care at Grantham and District Hospital, and to a lesser extent the proposal for stroke services, (although on all proposals there was still majority agreement from this group). The feedback suggested, however, that it was again concerns about travel and transport and local provision of services that were behind these more negative views.

1.114 Where concerns were raised in feedback about particular groups, the focus was predominantly on travel and transport, particularly for those with limited access to private transport. Specific groups and communities were mentioned in this regard, including:

- People with physical disabilities, and long-term conditions and co-morbidities;
- People with learning disabilities, and neurodiverse people such as those ASD;
- Older people;
- People living in areas of deprivation or with low incomes;
- Residents in rural and isolated communities; and
- Those without access to private vehicles or who routinely rely on public transport.

1.115 Where concerns were raised that did not relate directly to travel, they tended to focus on issues around lack of familiarity with ‘new’ or different locations. For example, there were concerns that older people from Grantham might be taken by ambulance to Lincoln, Boston or Peterborough to be treated in an emergency. The unfamiliar setting, it was felt, could cause additional distress. Furthermore, there was a concern that increased travel times for care would have a negative impact on the mental health of the older population in particular.

1.116 Similarly, the needs of people with sensory disabilities who might be used to accessing certain hospitals and were therefore confident that they would receive any additional support they might require at those locations, were also raised as an issue for consideration.

1.117 Finally, Healthwatch Lincolnshire strongly urged the CCG to fully consider all potential impacts on people and communities when reviewing the public consultation feedback and Equality Impact Assessments.

The consultation process

1.118 On a final note, there was some criticism of the consultation process in relation to a perceived lack of clarity about the proposals in the documentation, and the process being about saving money, not improving service provision. There was also some feeling that the views expressed by members of the public earlier in the engagement process have been ignored, that ‘minds have already been made up’, and that implementing the proposed changes would provide further evidence that people’s concerns are not being heard.

2. Consultation overview

Commission and methodology

Introduction

2.1 United Lincolnshire Hospitals NHS Trust (ULHT) provides acute hospital services to the population of Lincolnshire, commissioned by NHS Lincolnshire Clinical Commissioning Group (NHS Lincolnshire CCG). Their vision is to deliver high-quality health care services for all residents of Lincolnshire.

2.2 Beginning in 2013, NHS Commissioners in Lincolnshire have been undertaking engagement with members of the public and other stakeholders as part of a major review of these acute hospital services, undertaken in partnership with senior clinicians from the NHS in Lincolnshire.

2.3 In 2017, the present phase of planning and engagement began, culminating most recently in 'Healthy Conversation 2019', a six-month exercise during which NHS Lincolnshire CCGs and other partners sought feedback from the public and other stakeholders on a range of health and care services to understand their views. The range of NHS services in Lincolnshire involved in this conversation included four acute services.

2.4 These acute services, identified as requiring significant and permanent improvement to ensure the highest possible care in line with clinical evidence and standards for best practice, are orthopaedic surgery and stroke services across Lincolnshire, and urgent and emergency care and acute medical beds at Grantham and District Hospital.

The current challenges: need for change

2.5 There are well-known, key challenges facing hospital nationally: increased demand due to a growing population that is living longer with more complex conditions; and recruiting and retaining staff. In order to ensure the quality and sustainability of acute services in the face of these challenges, NHS Lincolnshire CCG are proposing changes to the way that four of these services are delivered.

2.6 NHS Lincolnshire CCG believes that the proposals will address these national challenges and improve the quality of care by:

- Reducing waiting times and cancellations for planned orthopaedic procedures in Lincolnshire;
- Improving urgent and emergency care for patients across Lincolnshire;
- Leading to clinically optimum hospital stays and better hospital care for recovering stroke patients;
- Integrating community and hospital medical services;
- Providing quicker access to specialist staff across these four NHS services;
- Reduced risk that Lincolnshire would lose these services if they became unsustainable;
- Increasing the ability of the NHS in Lincolnshire to attract new staff to work in the county and to better retain staff already in the county, as they would be working for more sustainable and progressive services; and
- Reducing spend on temporary and locum staff to fill gaps in rotas, caused by too few permanent staff to fill them.

The proposals

2.7 Following a period of options development and appraisal that involved senior clinicians, key stakeholders and members of the public, proposals were developed for changes to these four acute services. In summary, these proposals are:

- To consolidate planned orthopaedic surgery in a 'centre for excellence' at Grantham and District Hospital and create a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery;
- For Grantham and District Hospital A&E department to become an 24/7 Urgent Treatment Centre;
- To provide integrated community/acute medical beds at Grantham and District Hospital; and
- To consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.

The commission

2.8 Opinion Research Services (ORS), a company that grew out of Swansea University, now with a UK-wide reputation for social research and major statutory consultations, was appointed by NHS Lincolnshire to support engagement activities, and to analyse and report the outcomes of this public consultation programme of engagement with members of the public, clinicians and other NHS staff, and other stakeholders.

The consultation programme

2.9 The 12-week public consultation began on 30 September 2021 and ended on 23 December 2021. While social distancing guidelines due to COVID-19 were still in place during the consultation period, NHS Lincolnshire CCG were able to undertake a mixture of face-to-face and online engagement activities, in line with UK Government guidance at the time.

2.10 During the consultation period, residents and other stakeholders were invited to provide feedback through a wide range of methods, including all of the following:

- A consultation questionnaire for all residents, 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 residents survey administered by telephone, and representative of Lincolnshire's population; and
  - Online focus groups and 1:1 in-depth interviews with members of the public.
- Engagement activities undertaken by NHS Lincolnshire CCG, including face-to-face and online public events, a 'virtual' 24/7 event, meetings with NHS staff members, stakeholders and services users, and engagement activities at market days across Lincolnshire;
- Written or email submissions from residents, stakeholders and organisations; and
- Petitions (organised by two local campaign groups and submitted to ORS).

2.11 NHS Lincolnshire CCG planned and delivered a comprehensive communications programme to raise awareness of the consultation and to tell residents and other stakeholders how to take part.

2.12 Information and resources were available on the NHS Lincolnshire website, www.lincolnshire.nhs.uk, along with a link to the online questionnaire which was setup and hosted by ORS. During the consultation period, the consultation website attracted over 12,000 unique visitors, generating 31,000 page views, 5,100 visits to the questionnaire page and 2290 visits to the consultation events page.

2.13 Paper copies of documentation and the consultation questionnaire were also available, including accessible and other languages versions, and were distributed at face-to-face meetings and other engagement events, as well as being available on request via telephone or email.

2.14 The consultation was supported by a comprehensive communications programme undertaken by NHS Lincolnshire which included:

- Press and publicity activity, including 25 advertisements in county newspapers, generating 93 media articles appearing in over 300 separate locations across TV, print, radio and online, as well as on these media outlets' social media and digital pages;
- Delivery of a consultation leaflet was commissioned targeting 374,193 households across Lincolnshire;
- Posters and leaflets in physical locations such as GP practices, libraries, pharmacies, gyms, etc. and attendance at market days in 19 areas across Lincolnshire, handing out leaflets to 970+ people;
- Through an extensive list of partner and stakeholder organisations and databases;
- Via NHS Lincolnshire CCG's Nextdoor online forum and by sending the consultation website link to over 4,400 ULHT and Lincolnshire Community Healthcare Services NHS Trust (LCHS) patients; and
- 431 social media posts and tweets seen by over 260,000 people, of whom over 7,700 directly engaged and 784 clicked through to the consultation website.

2.15 Protected characteristics and seldom heard groups were also consulted via social media, direct email, distribution of posters and leaflets and meetings, as well as by NHS Lincolnshire CCG working with community groups such as food banks and job centres to promote the consultation. Full details of the communications programme can be found in NHS Lincolnshire CCG's Public Consultation Communications Activity and Engagement Report; feedback from and about protected characteristics groups are included in this report.

The nature of public consultation

2.16 Public consultation promotes accountability and assists decision making; public bodies give an account of their plans or proposals and listen to feedback. Consultation has therefore been described as a dialogue, based on a genuine and purposeful exchange of views.

2.17 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 take into account the issues raised.

The consultation report

2.18 In contrast to the more thematic approach in the executive summary, the full report considers the feedback from each element of the consultation in turn (which can at times be repetitive given that similar issues emerged across the different strands) because it is important that the overall report provides a full evidence-base for those considering the consultation and its findings.

2.19 All types of consultation responses are important, and this report presents an independent analysis so that all of them may be taken into account. Some contributions have been highlighted based on at least one of the following aspects:

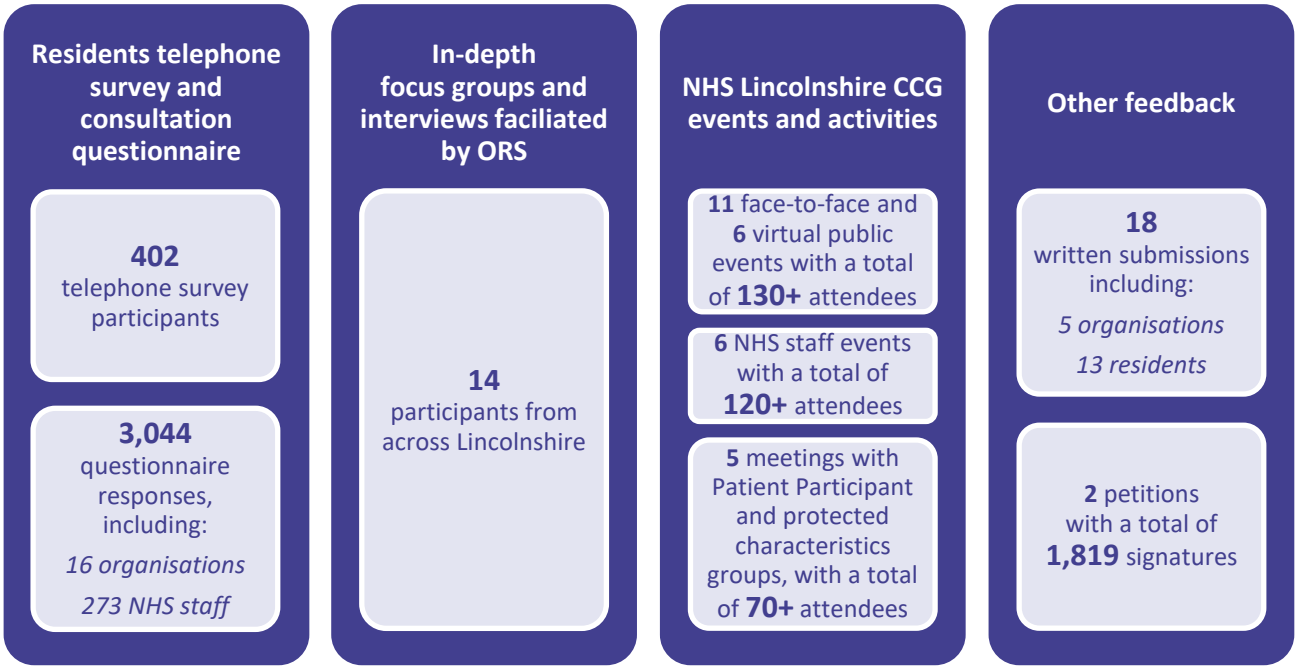
- Relevant to and/or having implications for one or more of the proposals under consideration;
- Well-evidenced – for example, submissions from professional bodies, staff and concerned people or local groups that point to evidence to support their perspective;
- Deliberative – based on thoughtful discussion in public meetings and other group settings;
- Representative of the general population and/or particular localities, groups or points of view;
- Focused on the views from under-represented people or equality groups; or
- 'Novel' – in the sense of raising 'different' issues from those being repeated by a number of respondents or arising from a different perspective.

2.20 The report also identifies where strength of feeling may be particularly intense, either in relation to specific themes or possible outcomes, or coming from specific groups of respondents. Those with strong concerns or objections are more likely to provide these views robustly and in detail; furthermore, ORS has an obligation to comprehensively report these concerns and contrary views, in order for decision-makers to be able to conscientiously consider the issues raised (Gunning Principle 4). It should be noted, however, that this can mean that the feedback can appear more 'negative' than was actually the case.

2.21 Finally, it is not ORS' role to 'make a case' for or against the proposals, nor to make any recommendations as to how decision makers should use the reported results. It is for the appropriate bodies to take decisions based on all of the evidence available, of which consultation feedback is one part. To this end, ORS trusts that both the executive summary and full report will be helpful to all concerned.

Consultation response

2.22 The consultation response from the different research strands is summarised below:



Quantitative consultation activities

Open consultation questionnaire

2.23 An open consultation questionnaire was available for anyone to complete - either via the dedicated consultation website or by completing a paper version. The questionnaire was designed to be completed on the basis of the issues presented in the consultation document, with questions about the need for change, the individual proposals, and potential equalities and health inequalities issues. Respondents were given the opportunity to raise concerns, as well as to suggest alternative solutions to the current challenges.

2.24 Open questionnaires are important, being inclusive and giving opportunity to express and explain views, including disagreement with proposals; they are not random sample surveys of a given population, however, and cannot necessarily be expected to be representative of the general balance of opinion.

2.25 For example, the young are usually under-represented while the elderly and residents living in more affluent areas tend to be over-represented. Respondents from groups or areas who feel disproportionately affected by the proposals are also typically over-represented compared with others; for example, the number of respondents living near to Grantham and Boston were proportionally greater than those from other areas.

2.26 The total number of questionnaire responses received was 3,044 (2,998 online and 46 paper questionnaires).

Residents survey

2.27 A residents telephone survey was undertaken by ORS in order to ensure that a representative profile of opinions was gained across the area from residents aged 18 and over, using similar questions to the consultation questionnaire. 402 telephone interviews were completed with Lincolnshire residents.

2.28 The residents telephone survey was primarily designed to be reflective of views across the whole of Lincolnshire, and it was conducted using a quota based sampling approach, ensuring that residents who were less likely to engage with the wider consultation were included and encouraged to give their views.

2.29 The extent to which results can be generalised from a sample depends on how well the sample represents the population from which it is drawn, and different types of people in different places may have been more or less likely to take part. This is known as response bias and can be corrected through statistical weighting.

2.30 To understand how views differ according to residents' proximity to different hospitals, the sample was designed so that equal numbers of interviews (i.e., 100 each) were targeted with residents living within the catchment area for each of the four main hospitals (County Hospital Louth, Grantham and District Hospital, Lincoln County Hospital and Pilgrim Hospital, Boston). This was taken into account in the weighting process, to give each group a proportional influence on the overall result relative to the size of its population. The remaining quotas (i.e., those for age and gender) were designed to be representative of the overall population of Lincolnshire, based on the most recent available secondary data.

2.31 The achieved sample was compared against secondary data for district, age, gender, working status, ethnicity, housing tenure, disability, and IMD (Index of Multiple Deprivation) and subsequently weighted by IMD decile, tenure, working status, and interlocked age and gender, and finally by nearest hospital. As a result of this process, the survey results are broadly representative of the overall population of Lincolnshire, to within around +/- 6 percentage points at a 95% confidence level. Therefore, if the survey estimated that 50% of respondents agreed with a proposal, 19 times out of 20 the actual result for the entire population would be between 44% and 56%. Results for smaller subgroups of the sample will have a greater confidence interval.

Qualitative consultation activities

Focus groups and interviews with members of the public

2.32 To hear some more detailed feedback from local residents on NHS Lincolnshire's proposals, ORS was commissioned to organise and facilitate a number of online focus groups and in-depth interviews. To ensure that a mixture of views were heard, participants were recruited by ORS' social research call centre using a mix of purchased and randomly generated telephone numbers for Lincolnshire residents.

2.33 The focus groups and interviews took place in early December 2021 with 14 participants: five from the Grantham and District Hospital catchment area; four from the Lincoln County Hospital catchment area; three from the Pilgrim Hospital, Boston catchment area; and two from the County Hospital Louth catchment area. Participants were selected for the focus groups based on residency; that is, each discussion group or interviews was specific to residents from the affected hospital catchment areas.

2.34 The events/interviews lasted for between one and two hours and were successful in exploring and encouraging wide-ranging debate and discussion related to the proposals. In all discussions, consultation information was covered one stage at a time – looking first at the case for change, followed by the proposed model of care, and finally the three site options. This was to ensure that participants had opportunity to ask questions and clarify information, before discussing their immediate and more considered reactions.

Meetings, events and activities organised and hosted by NHS Lincolnshire CCG and ULHT

2.35 Over 320 members of the public, NHS staff, service users and carers, and representatives of organisations and groups participated in 28 meetings and events organised and hosted by NHS Lincolnshire CCG or ULHT. More details and a full list of these events can be found in the relevant chapter of this report and in NHS Lincolnshire CCG's Public Consultation Communications Activity and Engagement Report

2.36 The public events were promoted widely as part of the communications programme described above. For example, posters, flyers and consultation documents contained links and QR codes to guide readers to the consultation website where they could find out about the upcoming events. During the consultation there were 2,290 visits to the consultation events page, and by email and telephone there were 62 requests for information about consultation live and virtual events – these included 49 event booking requests.

2.37 Events and meetings were hosted by senior NHS managers and clinicians, with clinicians describing the proposals either in person or via video presentations; depending on the format of the event, attendees could ask questions and give feedback in several ways: verbally; using paper feedback forms, 'Q&A cards' or paper consultation questionnaires; via text chat functions (e.g., SLIDO); by email; or via the online questionnaire.

2.38 ORS provided a structured template for staff at each event to use to capture and record the feedback raised. At the close of consultation, completed forms from 28 meetings and engagement activities were returned to ORS for analysis and reporting.

Written submissions and petitions

2.39 During the formal consultation process, 18 written submissions were received, all of which have been read and summarised by ORS. These included five submissions from organisations and 13 from residents.

2.40 ORS received two petitions in response to the consultation; the first, with a total of 1,302 signatures, was submitted by United GDH Campaigners while the second, with 517 signatures, was submitted anonymously.

3. Residents telephone survey

Introduction

3.1 The purpose of the telephone survey was to achieve a broadly representative set of views on the proposals from residents of Lincolnshire aged 18 and over. The survey was conducted using a quota sampling approach with targets set on the numbers of interviews required by age, gender and area.

3.2 ORS targeted 400 interviews between 28th November and 19th December 2021, using a Computer Assisted Telephone Interviewing (CATI) methodology, with interviews undertaken by ORS's social research call centre (with interviewers working from home as per the government guidelines). The survey used primarily random-digit dialling, supplemented by purchased mobile sample.

3.3 A short summary of background information was included to be 'read out' for each question within the survey, for the benefit of allowing respondents to answer them from an informed perspective.

Respondent profile

3.4 The extent to which results can be generalised from a sample depends on how well the sample represents the population from which it is drawn, as different types of people may be more or less likely to take part. Such 'response bias' is corrected by statistical weighting based on a comparison of the demographic characteristics of the respondents with data for the whole population.

3.5 In order to better understand how views differ according to residents' proximity to different hospitals, the sample was designed so that equal numbers of interviews (i.e., 100 each) were targeted with residents living within the catchment area[2] for each of the four main hospitals (County Hospital Louth, Grantham and District Hospital, Lincoln County Hospital and Pilgrim Hospital, Boston). This was taken into account in the weighting process, to give each group a proportional influence on the overall result relative to the size of its population. The remaining quotas (i.e., those for age and gender) were designed to be representative of the overall population of Lincolnshire, based on the most recent available secondary data.

3.6 The achieved sample was compared against secondary data for district, age, gender, working status, ethnicity, housing tenure, disability, and IMD (Index of Multiple Deprivation) and subsequently weighted by IMD decile, tenure, working status, and interlocked age and gender, and finally by nearest hospital. As a result of this process, the survey results should be broadly representative of the overall population of Lincolnshire to within around +/- 6 percentage points at a 95% confidence level. This means that if the survey estimated that 50% of respondents agreed with a proposal, 19 times out of 20 the actual result for the entire population would be between 44% and 56%. Results based on smaller subgroups of the achieved sample will have a greater confidence interval.

[2] Please note that a very small minority of respondents (particularly in the south-west or north-east of the county) are likely to travel outside of Lincolnshire to access some or all NHS hospital services; for the purposes of reporting this survey, respondents have been categorised according to which is their nearest main hospital *within* Lincolnshire. It is also important to note that if proposals were taken forward, some of these residents who currently travel to other hospitals for services, *could* in future potentially use some services at hospitals within Lincolnshire instead.

3.7 The table below shows both the unweighted and weighted demographic profile of respondents to the survey, compared with the population aged 18+ (based on Mid-Year Population Estimates 2020 and Census 2011 - with the exception of working status where the Annual Population Survey has been used).

Table 1: Demographic response profile to the residents survey, compared with the Lincolnshire population aged 18+

Characteristic	Unweighted Count	Unweighted Valid %	Weighted Valid %	Resident Population 18+ %
BY AGE				
18 to 34	74	18%	25%	23%
35 to 44	84	21%	14%	13%
45 to 64	84	21%	33%	34%
65 to 74	71	18%	15%	16%
75 or over	89	22%	13%	14%
Total valid responses	**402**	**100%**	**100%**	**100%**
BY GENDER				
Male	134	33%	50%	49%
Female	267	67%	50%	51%
Other	1	*	*	-[3]
Total valid responses	**402**	**100%**	**100%**	**100%**
BY WORKING STATUS				
Working	198	49%	55%	52%
Retired	162	40%	29%	33%
Otherwise not working	42	10%	16%	15%
Total valid responses	**402**	**100%**	**100%**	**100%**
BY TENURE				
Owned (including shared ownership)	295	77%	76%	72%
Social rent	42	11%	10%	12%
Private rent	46	12%	14%	16%
Total valid responses	**383**	**100%**	**100%**	**100%**
Not known	*19*	-	-	-
BY DISABILITY / LIMITING ILLNESS				
Activities limited a lot	50	13%	12%	11%
Activities limited a little	63	16%	14%	13%
No limiting illness/disability	277	71%	74%	77%
Total valid responses	**390**	**100%**	**100%**	**100%**
Not known	*12*	-	-	-
BY ETHNIC GROUP				
White British	372	96%	94%	93%
Other ethnic groups	16	4%	6%	7%
Total valid responses	**388**	**100%**	**100%**	**100%**
Not known	*14*	-	-	-

3.8 The table overleaf shows both the area profile of responses to the survey (based on nearest hospital and IMD), again presented as both unweighted and weighted.

[3] No suitable secondary data currently exists for 'other'; therefore Resident Population aged 18+ is based on male/female only.

Table 2: Response profile to the residents survey by area compared with the Lincolnshire population aged 18+

Characteristic	Unweighted Count	Unweighted Valid %	Weighted Valid %	Resident Population 18+ %
BY NEAREST HOSPITAL				
County Hospital Louth	101	25%	12%	12%
Grantham and District Hospital	100	25%	23%	23%
Lincoln County Hospital	101	25%	34%	34%
Pilgrim Hospital, Boston	100	25%	30%	30%
Total valid responses	**402**	**100%**	**100%**	**100%**
BY DEPRIVATION LEVEL (IMD QUINTILE)				
1 – most deprived	77	19%	16%	19%
2	102	25%	20%	20%
3	85	21%	24%	22%
4	72	18%	21%	19%
5 – least deprived	66	16%	19%	20%
Total valid responses	**402**	**100%**	**100%**	**100%**

Interpretation of the Data

3.9 The results of the residents survey are presented in a largely graphical format. The pie and bar charts (and other graphics) show the proportions (percentages) of residents making responses. Where possible, the colours of the charts have been standardised with a 'traffic light' system in which:

- Green shades represent positive responses;
- Beige and purple/blue shades represent neither positive nor negative responses;
- Red shades represent negative responses;
- Bolder shades highlight responses at the 'extremes', for example, strongly agree or strongly disagree.

3.10 Where percentages do not sum to 100, this may be due to computer rounding, the exclusion of 'don't know' categories, or multiple answers. Throughout the chapter an asterisk (*) denotes any value less than half of one per cent. The number of valid responses recorded for each question (base size), are reported throughout. As not all respondents answered every question, these base sizes vary between questions.

3.11 It should be remembered that a sample, and not the entire population of Lincolnshire, has been interviewed. In consequence, all results are subject to sampling tolerances, which means that not all differences are statistically significant. Differences between results that are not said to be statistically significant are indicative only. Statistical significance has been calculated at a 95% level of confidence.

Differences in views by demographic sub-groups

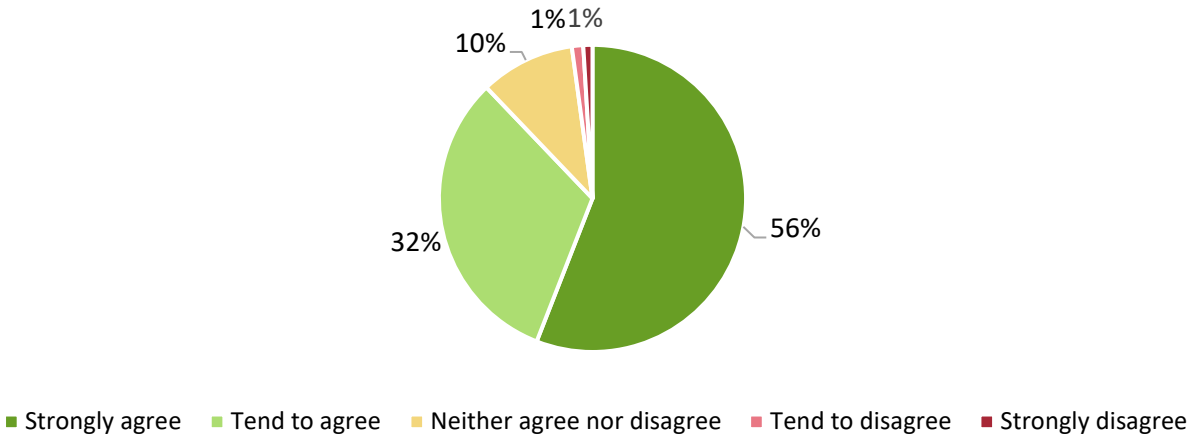
3.12 Charts in each section below provide a summary of the weighted results by demographic sub-groups and by level of deprivation (based on IMD quintiles).

3.13 Each bar represents the proportion agreeing with the proposal; results showing levels of agreement that are significantly higher than the overall result are highlighted in green and significantly lower levels of agreement are highlighted in red. Statistical significance is calculated at a 95% level of confidence. Occasionally results may need to be interpreted with caution due to lower base sizes.

Residents' views on the need for change

3.14 Overall, the vast majority of residents (88%) agreed with making changes to respond to the challenges, and only 2% disagreed.

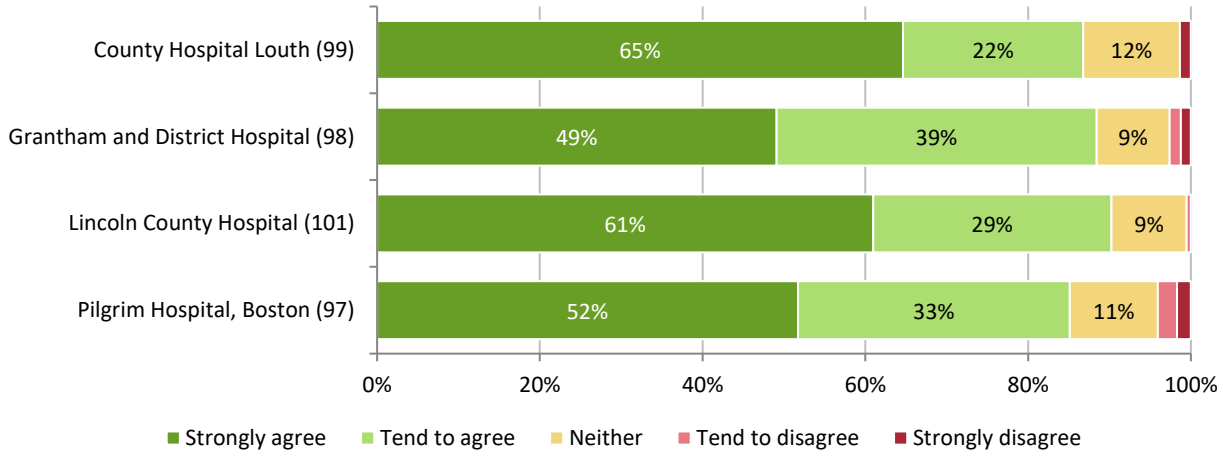
Figure 8: To what extent do you agree or disagree that Lincolnshire's NHS needs to make changes to respond to the challenges? OVERALL



Base: All residents (395)

3.15 Figure 9 below presents results to the question about the case for change broken down by residents' closest hospital and shows that there was, in general, a high level of agreement across the areas with only limited differences in views: 87% agreement for those living nearest to County Hospital Louth, 88% for those nearest to Grantham and District Hospital, 90% for those nearest to Lincoln County Hospital, and 85% for those nearest to Pilgrim hospital.

Figure 9: To what extent do you agree or disagree that Lincolnshire's NHS needs to make changes to respond to the challenges? BY NEAREST HOSPITAL

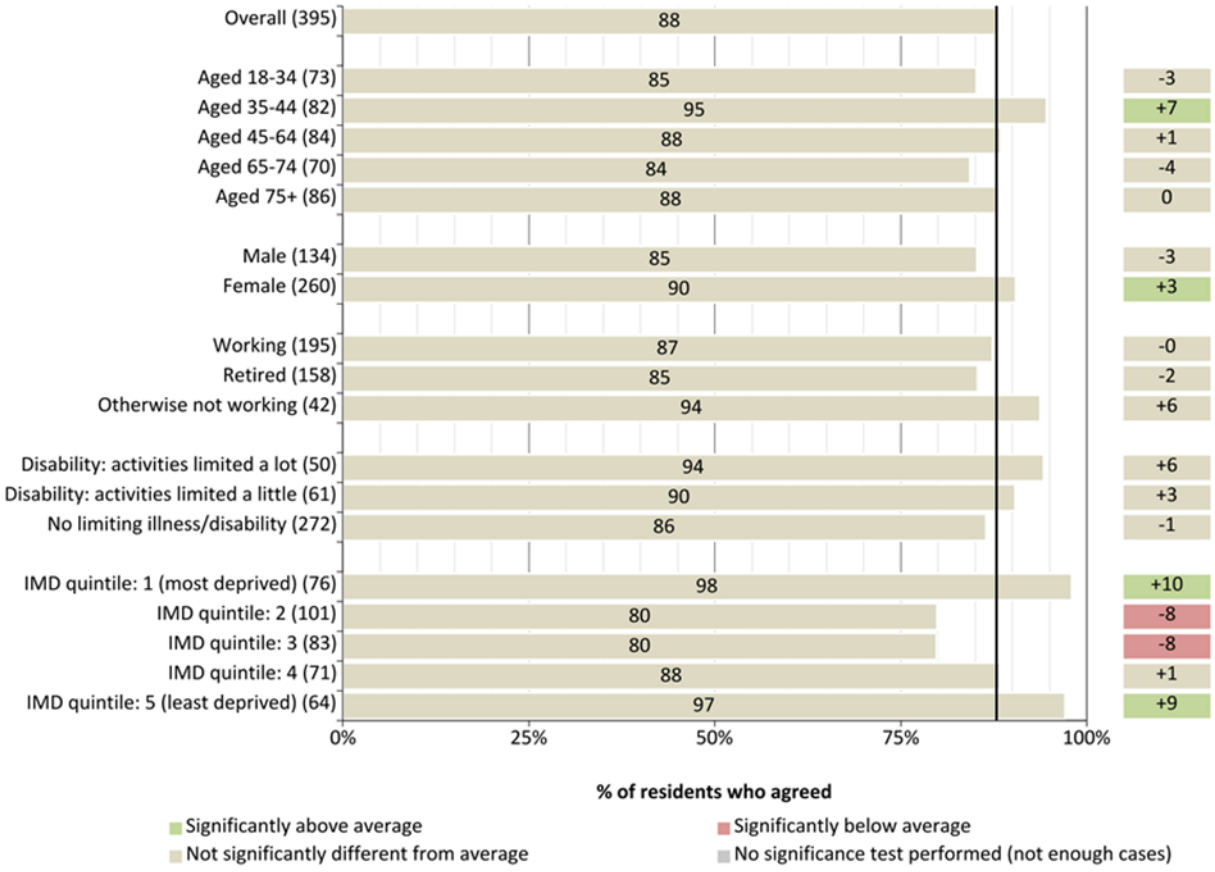


Base: All residents (numbers shown in brackets)

Residents' views on the need for change by demographic sub-groups

3.16 In relation to the question about whether there is a need to make changes, female residents, residents aged 35-44, and residents in the highest and lowest IMD quintiles, were all significantly more likely to agree compared with the overall result (Figure 10).

Figure 10: Level of agreement that Lincolnshire's NHS needs to make changes to respond to the challenges, BY POPULATION CHARACTERISTICS

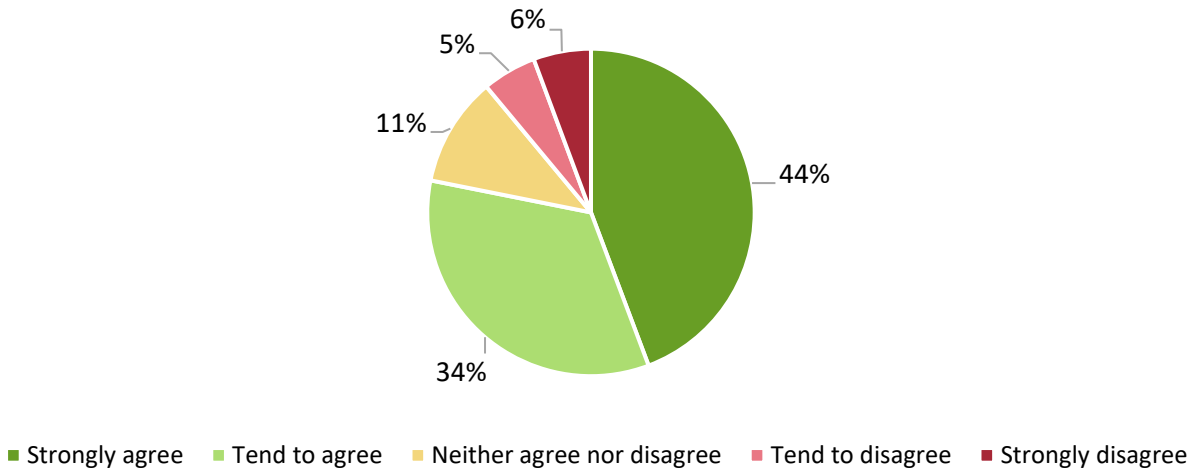


Base: All Respondents (number of respondents shown in brackets)

Residents' views on the proposal for orthopaedic surgery in Lincolnshire

3.17 More than three quarters of residents (78%) agreed with the proposal for orthopaedic surgery. However, around a tenth (11%) disagreed.

Figure 11: To what extent do you agree or disagree with this proposal for orthopaedic surgery? OVERALL

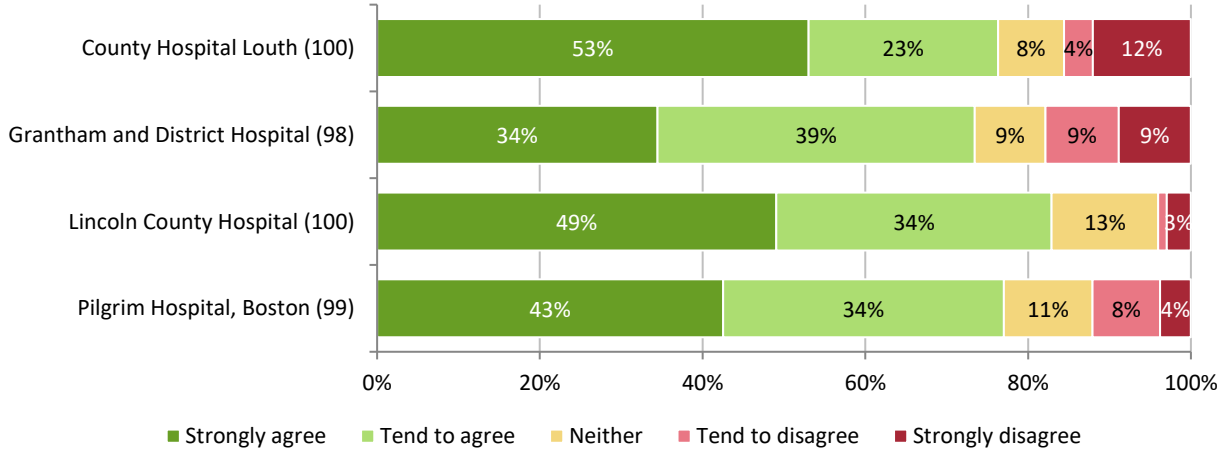


Base: All residents (397)

3.18 A majority of residents in each area agreed with the proposal for orthopaedic surgery. Specifically, 76% of those who lived closest to County Hospital Louth agreed, as did: 73% of those living closest to Grantham and District Hospital, 83% of those living closest to Lincoln County Hospital, and 77% of those living closest to Pilgrim Hospital, Boston.

3.19 It is worth noting that nearly a fifth (18%) of residents whose closest hospital is Grantham and District Hospital *disagreed* with the proposal for orthopaedic surgery, which is significantly higher than the proportion that disagreed at the overall level (11%).

Figure 12: To what extent do you agree or disagree with this proposal for orthopaedic surgery? BY CLOSEST HOSPITAL

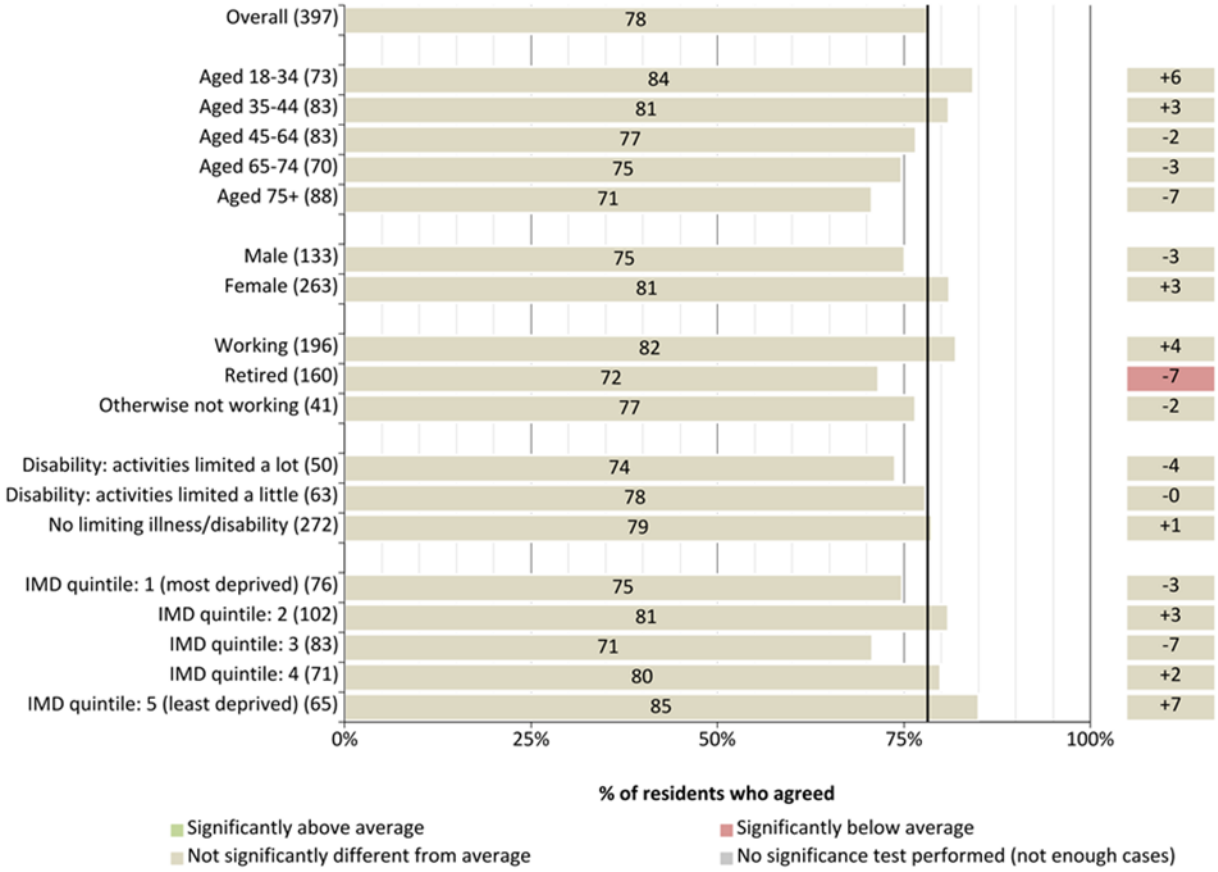


Base: All residents (numbers shown in brackets)

Residents' views on the proposal for orthopaedic surgery in Lincolnshire by demographic sub-groups

3.20 Against a background of strong support, retired residents were statistically significantly less likely (than the overall result) to agree with the proposal for orthopaedic services (Figure 13), although more than seven in ten (72%) agreed with the proposal.

Figure 13: Level of agreement with the proposal for orthopaedic surgery, BY POPULATION CHARACTERISTICS

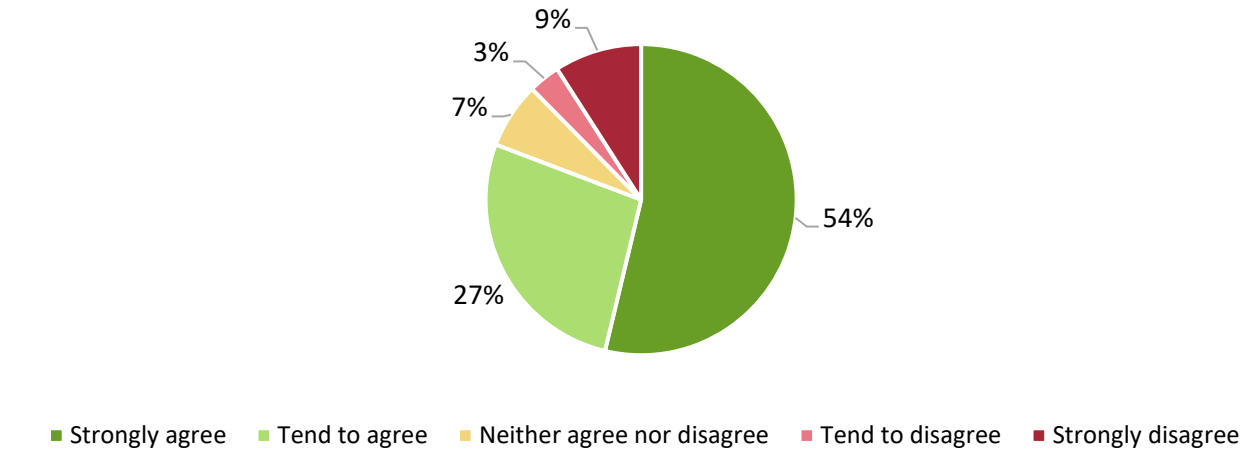


Base: All Respondents (number of respondents shown in brackets)

Residents' views on the proposal for urgent and emergency care at Grantham and District Hospital

3.21 When asked to provide a view on the proposal for urgent and emergency care at Grantham and District Hospital, around four-fifths of residents agreed (81%) – moreover, over half (54%) agreed *strongly*. However, around one in eight residents disagreed (12%).

Figure 14: To what extent do you agree or disagree with this proposal for urgent and emergency care at Grantham Hospital? OVERALL

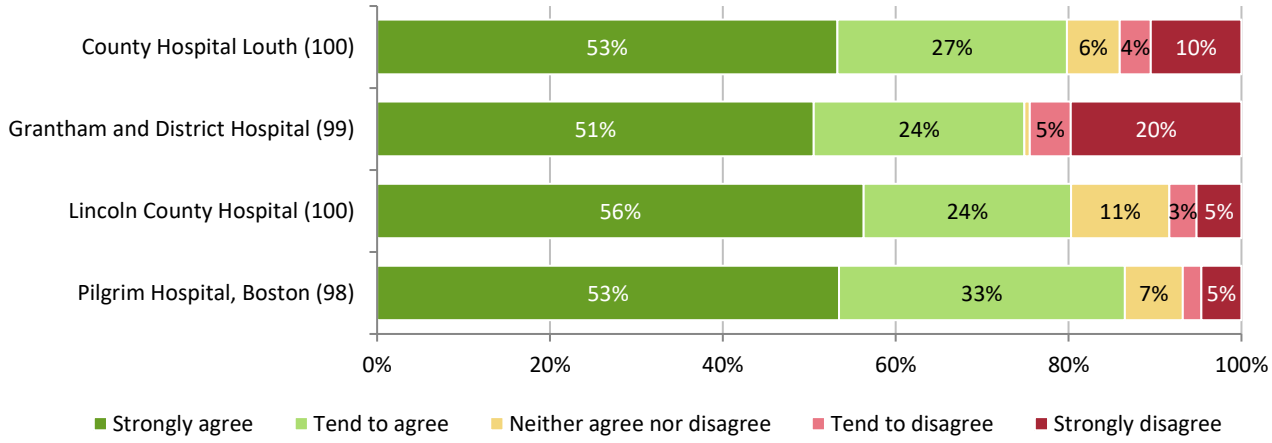


Base: All residents (397)

3.22 As with the previous proposal, most residents in the vicinity of each hospital agreed: 80% for those living closest to County Hospital Louth, 75% for those living closest to Grantham and District Hospital, 80% for those living closest to Lincoln County Hospital, and 86% for those living closest to Pilgrim Hospital, Boston.

3.23 Around a quarter (24%) of residents whose closest hospital is Grantham and District Hospital disagreed with the proposal – and it is again worth noting that this is statistically higher than the overall result (of 12% disagreeing).

Figure 15: To what extent do you agree or disagree with this proposal for urgent and emergency care at Grantham Hospital? BY CLOSEST HOSPITAL



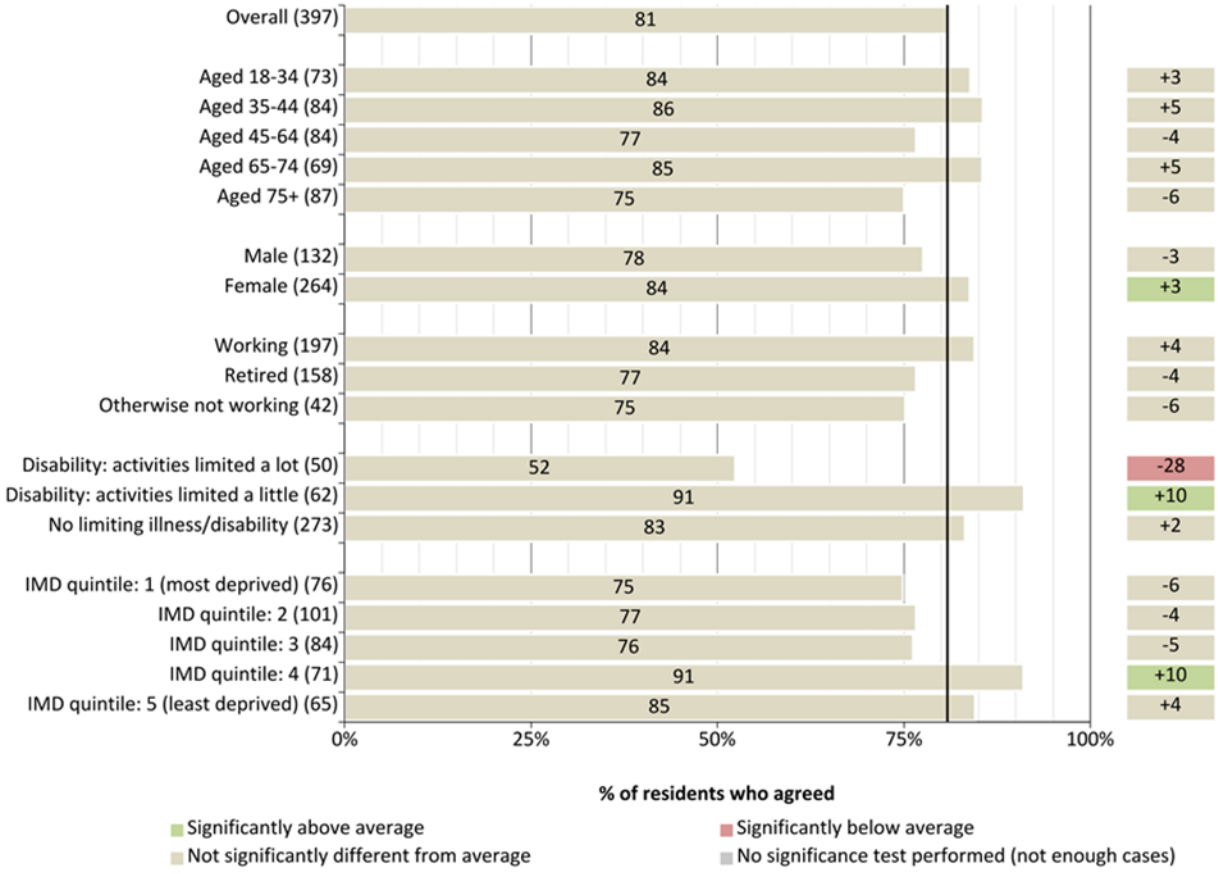
Base: All residents (numbers shown in brackets)

Residents' views on the proposal for urgent and emergency care at Grantham and District Hospital by demographic sub-groups

3.24 In relation to the proposal for urgent and emergency care (Figure 16), residents with a substantially limiting disability or illness were significantly less likely than other residents to agree (52% compared to 81% overall) and were also more likely to disagree (34% compared to 12% overall).

3.25 There were also some statistically significant differences in terms of gender and deprivation. Feedback comments indicated that concern about the proposal was focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.

Figure 16: Level of agreement with the proposal for urgent and emergency care at Grantham Hospital, BY POPULATION CHARACTERISTICS

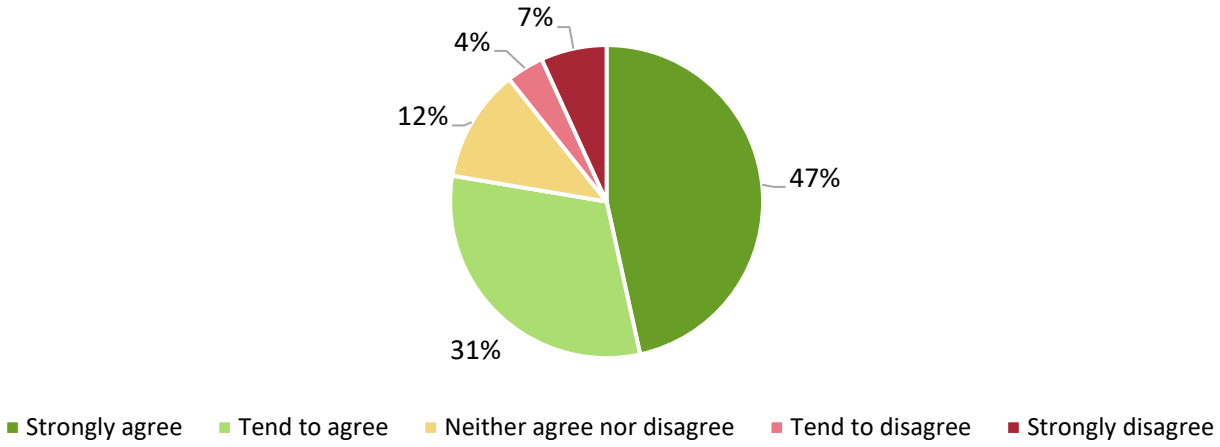


Base: All Respondents (number of respondents shown in brackets)

Residents' views on the proposal concerning acute medical beds at Grantham and District Hospital

3.26 Close to four fifths of residents (78%) agreed with the proposal for acute medical beds at Grantham and District Hospital. Around a tenth disagreed (11%).

Figure 17: To what extent do you agree or disagree with this proposal for acute medical beds at Grantham and District Hospital? OVERALL

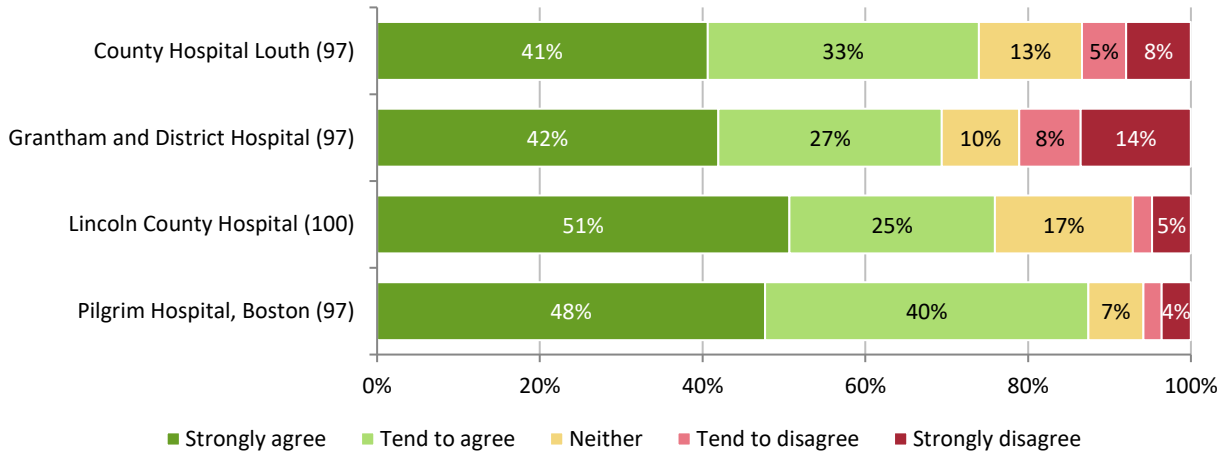


Base: All residents (391)

3.27 While majorities of residents agreed irrespective of which was their closest hospital, there was some variation in views around this proposal. Residents living closest to Grantham and District Hospital were significantly *less likely* than other residents to agree (69%, 9 percentage points lower than overall levels of agreement) and *more likely* to disagree (21%, 10 percentage points higher than overall levels of disagreement). On the other hand, those living closest to Pilgrim Hospital, Boston were significantly *more likely* to agree (87%) with the proposal.

3.28 Levels of agreement for residents living closest to County Hospital Louth (74%) and Lincoln County Hospital (76%) were somewhat more in line with the overall result.

Figure 18: To what extent do you agree or disagree with this proposal for acute medical beds at Grantham and District Hospital? BY CLOSEST HOSPITAL



Base: All residents (numbers shown in brackets)

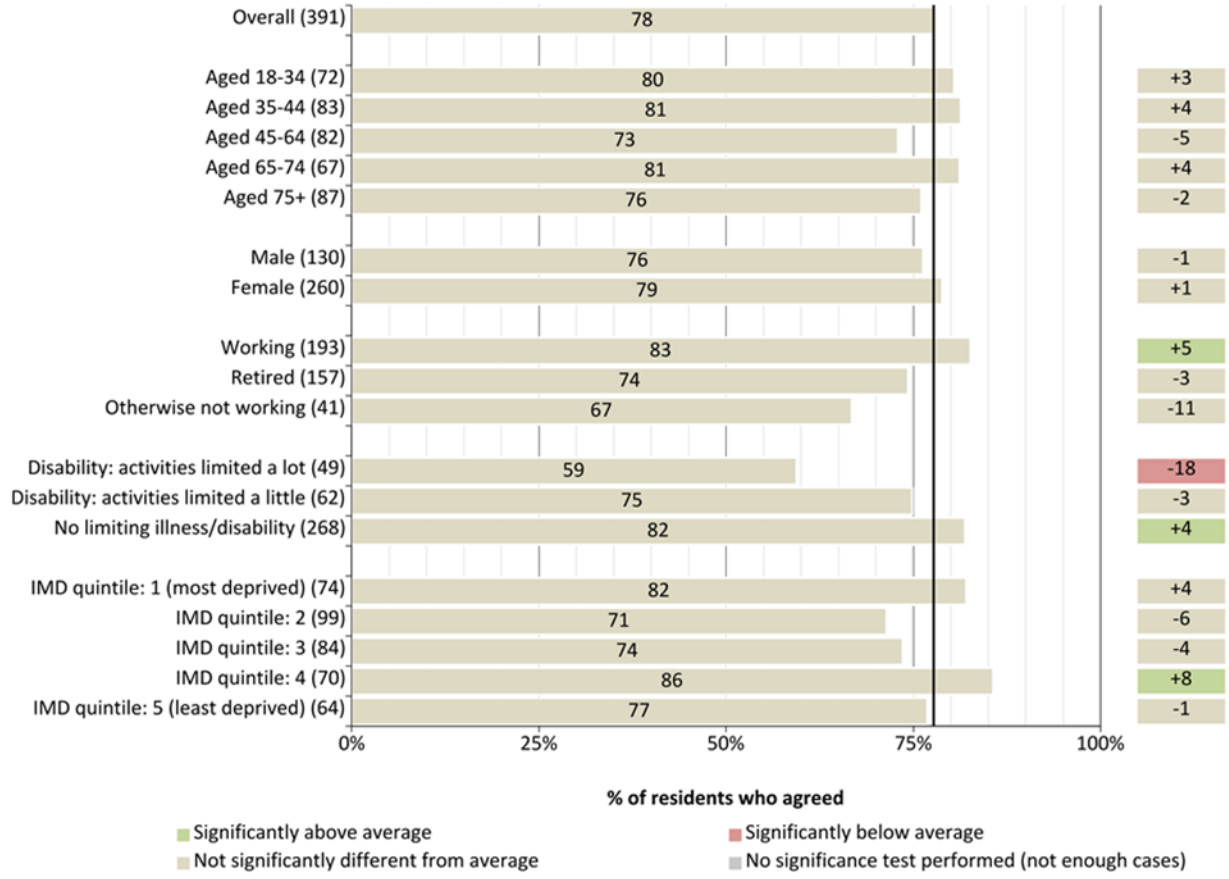
Residents' views on the proposal for acute medical beds at Grantham and District Hospital by demographic sub-groups

3.29 In relation to the proposal for integrated community/acute medical beds (Figure 16), residents with a substantially limiting disability or illness were significantly less likely than other residents to agree (59% compared to 78% overall) and were also more likely to disagree (33% compared to 11% overall), whereas those who do not have any limiting disability or illness were significantly more likely to agree.

3.30 Where disagreement was expressed, feedback indicated that it was based on concerns about loss of acute services and travel and access to alternative sites.

3.31 There were also differences in terms of working status and IMD (with residents who are working, and residents from the 4th IMD quintile, being more likely to agree).

Figure 19: Level of agreement with the proposal for acute medical beds at Grantham Hospital, BY POPULATION CHARACTERISTICS

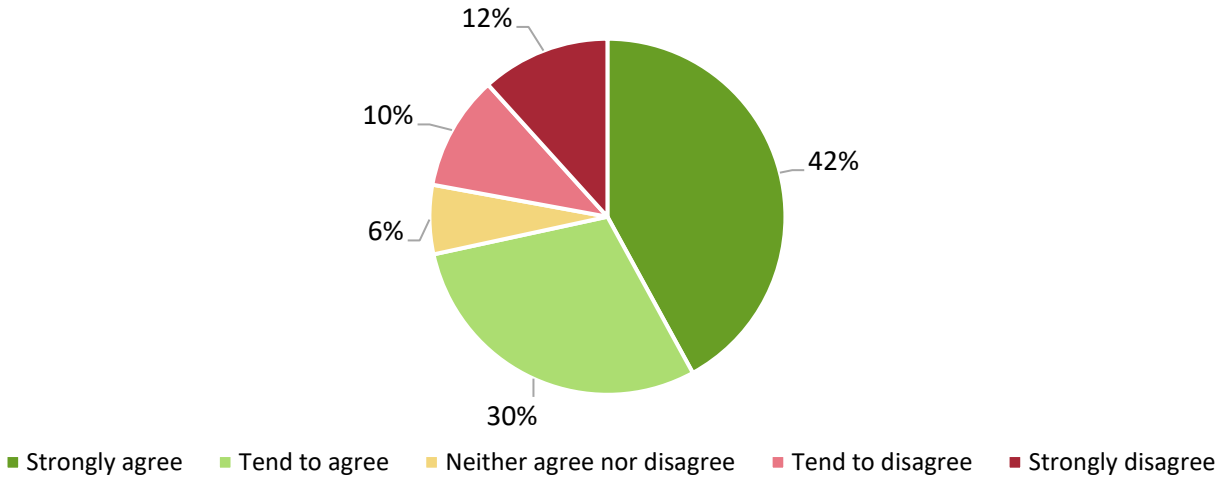


Base: All Respondents (number of respondents shown in brackets)

Residents' views on the proposal for stroke services

3.32 Overall, around seven-in-ten residents (72%) agreed with the proposal for stroke services. However, just over a fifth of residents (22%) disagreed.

Figure 20: To what extent do you agree or disagree with the proposal for stroke services? OVERALL



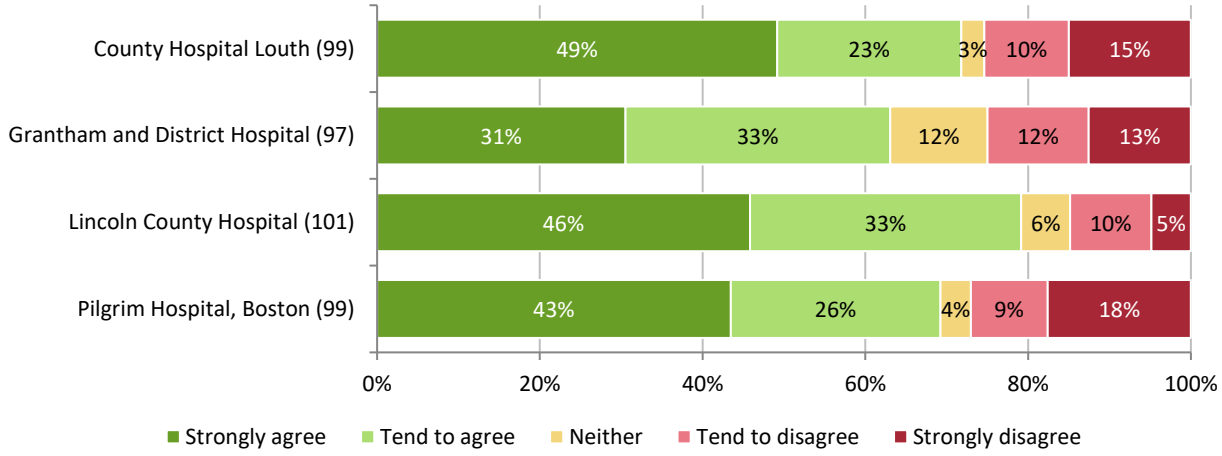
Base: All residents (396)

3.33 Compared with the overall result, residents whose closest hospital is Lincoln County Hospital were significantly more likely to agree with the proposal for stroke services (79%).

3.34 Residents living closest to Grantham and District Hospital were significantly less likely than other residents to agree (63%, 9 percentage points lower than overall levels of agreement), while agreement levels among those living closest to County Hospital Louth (72%) and Pilgrim Hospital, Boston (69%) were more closely in line with the overall result.

3.35 Around a quarter of residents living closest to County Hospital Louth (25%), Grantham and District Hospital (25%), or Pilgrim Hospital, Boston (27%) disagreed with the proposal for stroke services. Those living closest to Lincoln County Hospital were significantly less likely to disagree (15%), however, compared with the overall result.

Figure 21: To what extent do you agree or disagree with the proposal for stroke services? BY CLOSEST HOSPITAL

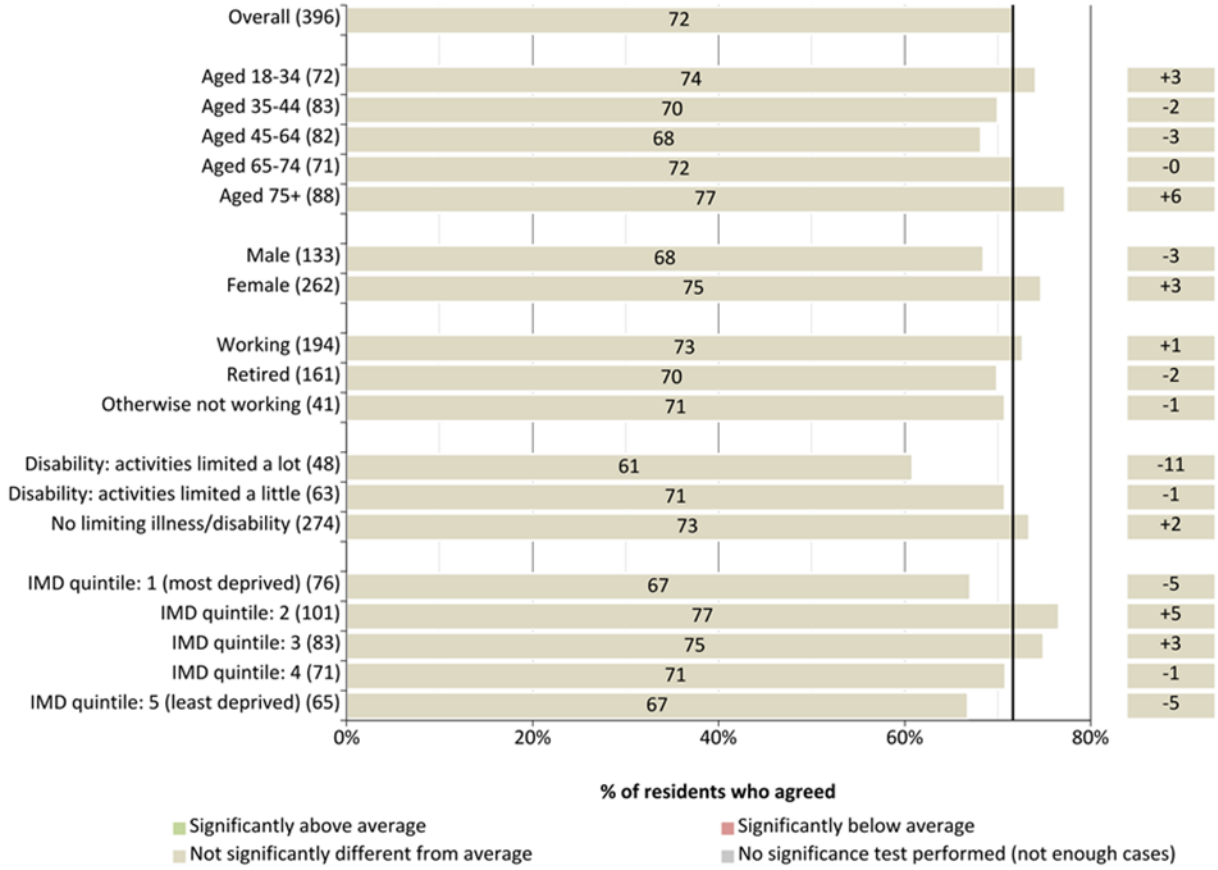


Base: All residents (numbers shown in brackets)

Residents' views on the proposal for stroke services in Lincolnshire by demographic sub-groups

3.36 Figure 22 provides an overview of the views of the various sub-groups in relation to the proposal for stroke services. Although not statistically significant at the 95% confidence level, there was some indication (at a 90% confidence level) that residents with disabilities that limit their activities a lot, were less likely to agree, and in fact more likely to disagree with this proposal, compared to other residents.

Figure 22: Level of agreement with the proposal for stroke services, BY POPULATION CHARACTERISTICS



Base: All Respondents (number of respondents shown in brackets)

Feedback comments in the residents survey

3.37 In addition to being asked to indicate whether they agreed or disagreed with each proposal, respondents were given an opportunity to share any final views by making additional comments.

3.38 Less than half of participants chose to make further comments. Of those who did, most made general comments rather than focusing on a particular proposal or service.

3.39 The most prevalent themes were:

- Comments expressing general agreement with the proposals put forward;
- Comments expressing concerns about travel and access issues in general;
- Comments expressing concerns about being able to access services at Lincoln County Hospital;
- Comments expressing a view that improvements and/or investment is needed across the hospitals generally;
- Comments expressing a view that improvements and/or investment is needed at Grantham and District Hospital specifically;
- Comments suggesting ways to improve the recruitment and retention of staff, e.g., through wages and benefits, housing provision etc;
- Comments reflecting on staffing issues and quality of care issues in general; and
- Comments urging that a full 24/7 A&E service at Grantham and District Hospital be restored.

4. Consultation questionnaire

Introduction

4.1 Throughout the 12-week public consultation (which began on 30 September 2021 and ended on 23 December 2021), stakeholders were signposted to NHS Lincolnshire website, www.lincolnshire.nhs.uk, or provided with paper documentation. A range of information and resources were available, including the CCG's full consultation document and separate summary versions.

4.2 A structured consultation questionnaire was designed to allow stakeholders to provide feedback in a consistent format. Appropriate summary information was included for each question, with additional signposting to more detailed information; feedback was invited around any concerns or alternative solutions, and potential equalities impacts. Finally, a profiling section gathered stakeholder type and demographics.

Summary of main findings

4.3 There was broad support for **the overall need for change** from all stakeholder groups responding to the consultation questionnaire. 72% of NHS staff and 70% of other individuals agreed with the need for changes to be made in response to challenges facing NHS hospital services in Lincolnshire.

4.4 There was also broad support for **the orthopaedic surgery proposal**. Two thirds of NHS staff who responded (68%) and three fifths (61%) of other individual respondents agreed with the proposed changes.

4.5 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, but views were more varied:

- Overall, around three fifths of NHS staff who responded (61%) agreed with the proposal, and half (50%) of other individual respondents agreed with the proposal to create a UTC at Grantham and District Hospital, while two-fifths (41%) of other individuals disagreed;
- There were differing views, however, between those living in different areas of Lincolnshire: a slight majority of questionnaire respondents living nearest to Grantham Hospital (51%) disagreed with the proposal, while elsewhere views were somewhat more supportive; and
- Many of those who disagreed with the proposal called for a 24/7 A&E instead.

4.6 There was broad agreement with the **proposal for community/acute medical beds at Grantham and District Hospital**; just over three fifths (62%) of NHS employees and more than half of other individuals (53%), agreed.

4.7 There was also majority support from stakeholders for **the proposal to create a Centre of Excellence for acute and hyper-acute stroke at Lincoln County Hospital**; as with proposals for urgent and emergency care at Grantham Hospital, however, views did vary across different areas within Lincolnshire:

- Overall, more than half (53%) of NHS staff and other individual respondents (51%) expressed agreement; however
- Concern about the proposals for stroke services is strongest among those respondents living closest to Pilgrim Hospital, Boston, more than two thirds (66%) of whom expressed disagreement.

Methodology

4.8 The questionnaire was available online (hosted by ORS), and paper questionnaires were also widely circulated and available on request. An easy read version and translated documents were also available.

4.9 All questionnaire responses submitted by the closing date, and subsequently received by ORS or Lincolnshire CCG, in which at least one of the consultation questions was answered, were included in the analysis, regardless of whether or not any profile questions were answered.

4.10 A total of 3,044 questionnaires were completed, which included 2,998 online responses and 46 paper copies.

4.11 It is important that consultation questionnaires are open and accessible to all, while being alert to the possibility of multiple completions (by the same people) distorting the analysis. Therefore, while making it easy to complete the questionnaire online, ORS monitors the IP addresses through which questionnaires are completed. A similar analysis of "cookies" was also undertaken – where responses originated from users on the same computer using the same browser and the same credentials (e.g., user account).

4.12 After careful analysis of the raw dataset, ORS did not find any responses that appeared to be attempting to systematically skew results and no records were excluded from the final dataset on this basis.

4.13 It is important to reiterate that while open questionnaires are inclusive and give people an opportunity to express and explain any views, the results are not generally expected to be representative of the general balance of opinion in the wider population. The results in this chapter should be interpreted in this context.

Questionnaire responses: respondent types and demographics

4.14 The 3,044 responses were comprised of the following:

- 16 responses submitted on behalf of an organisation;
- 273 responses from individuals identifying themselves as employees of the NHS;
- 2,755 responses from other individual respondents, mainly local residents.

4.15 Eleven responses from 12 named organisations or departments were submitted (Table 3). A further five organisational responses were completed, although the organisation name or other details were not included. Nonetheless, these responses are included in the organisation responses section of this chapter.

Table 3: Named organisations responding via the consultation questionnaire

Boston Borough Council, East Lindsey District Council and South Holland District Council (joint response)
Grantham Senior Citizens Club Ltd.
Homecare
Lincolnshire Local Medical Committee (LMC)
Lincolnshire Neurological Alliance
Lincolnshire Traveller Initiative Health champion (Grantham)
Lincolnshire Traveller Initiative, Well-Woman group.
Older people's Forum
Skegness Town Council (covers the parish of Skegness and Winthorpe with 21 elected members)
Chartered Society of Physiotherapy (professional, educational and trade union body for the 60,000 chartered physiotherapists, physiotherapy students and support workers across the UK)
United Lincolnshire Hospitals NHS Trust Orthoptic Service at Pilgrim Hospital, Boston

4.16 Data from the consultation questionnaire has not been combined to produce "overall" findings across the different stakeholder groups, because the size of the stakeholder groups, and the numbers of their respective responses, are very different; moreover, they have distinctive views and feedback cannot simply be merged.

4.17 With this in mind, the views of NHS employees have in some key places been reported separately to those of other individual respondents, as their perspective may be informed by their experience of working within the NHS. In these cases, for convenience of reporting and to provide clarity, the views of staff are generally reported first. This is for reasons of reporting convenience, but in no way is intended to suggest that views from staff are considered as any more or less important than those from residents and other individuals.

4.18 Table 4 below summarises the demographic information of those who responded to the consultation questionnaire. Lincolnshire CCG population data is used as a comparator, to give some general indication of how well the response profile of the questionnaire matches the wider population. An asterisk has been used to denote percentages greater than zero, but less than half of one per cent.

4.19 There are some small parts of the county (in the north east and south west) where some residents currently use certain services outside of Lincolnshire, and some questionnaire responses were received from people living outside Lincolnshire; however, all questionnaire responses have been included irrespective of location (i.e., even if a respondent is understood to live outside of the Lincolnshire CCG catchment).

Table 4: Demographic response profile to the consultation questionnaire: age, gender, disability, ethnic group – compared with the Lincolnshire population aged 16+

Characteristic		Questionnaire Responses		Population aged 16+
		Number of Respondents	%	
BY AGE	Under 25	18	1%	12%
	25 to 34	134	5%	13%
	35 to 44	247	10%	13%
	45 to 54	423	17%	16%
	55 to 64	580	24%	17%
	65 to 74	762	31%	16%
	75 or over	280	11%	13%
	Total valid responses	**2,444**	**100%**	**100%**
	Not known	*584*	-	-
BY GENDER	Male	774	33%	49%
	Female	1,560	67%	51%
	Other[4]	11	*	-
	Total valid responses	**2,345**	**100%**	**100%**
	Not known	*683*	-	-
BY DISABILITY	Has a disability	569	24%	23%
	No disability	1,821	76%	77%
	Total valid responses	**2,390**	**100%**	**100%**
	Not known	*638*	-	-

[4] No suitable comparative data is available for 'other'; population figures are therefore based on male/female only.

BY ETHNIC GROUP	White	2,264	97%	98%
	Mixed/multiple ethnic groups	16	1%	1%
	Asian/Asian British	25	1%	1%
	Black/Black British	8	*	*
	Other	10	*	*
	Total valid responses	**2,323**	**100%**	**100%**
	Not known	*705*	-	-

4.20 Table 5 summarises other consultation response demographic information, with an asterisk again used to denote a percentage greater than zero, but less than half of one per cent.

Table 5: Demographic response profile to the consultation questionnaire: other characteristics

Characteristic		Questionnaire Responses	
		Number of Responses	%
BY RELIGION	Buddhist	10	*
	Christian	1,449	63%
	Hindu	8	*
	Jewish	9	*
	Muslim	5	*
	Sikh	1	*
	Other religion	35	2%
	No religion	771	34%
	Total valid responses	**2,288**	**100%**
	Not known	*740*	
BY PREGNANCY/ HAVING GIVEN BIRTH IN THE LAST 12 MONTHS	Yes	26	1%
	No	2,422	99%
	Total valid responses	**2,448**	**100%**
	Not known	*580*	-
BY WHETHER RESPONDENT HAS ANY DEPENDENT CHILDREN	Yes	481	20%
	No	1,971	80%
	Total valid responses	**2,452**	**100%**
	Not known	*576*	-
BY WHETHER RESPONDENT PROVIDES HELP / SUPPORT TO OTHERS[5]	Yes	920	38%
	No	1,488	62%
	Total valid responses	**2,408**	**100%**
	Not known	*620*	-
BY WHETHER GENDER IS THE SAME AS ASSIGNED AT BIRTH	Yes	2,345	99%
	No	16	1%
	Total valid responses	**2,361**	**100%**
	Not known	*667*	-

[5] Defined as being any help or support provided to family members, friends, neighbours or others because of long-term physical or mental ill-health/disability or problems relating to old age

BY SEXUAL ORIENTATION	Bisexual	17	1%
	Gay or lesbian	34	2%
	Heterosexual or straight	2,194	97%
	Other	14	1%
	Total valid responses	**2,259**	**100%**
	Not known	*769*	-

Questionnaire responses: by area and deprivation

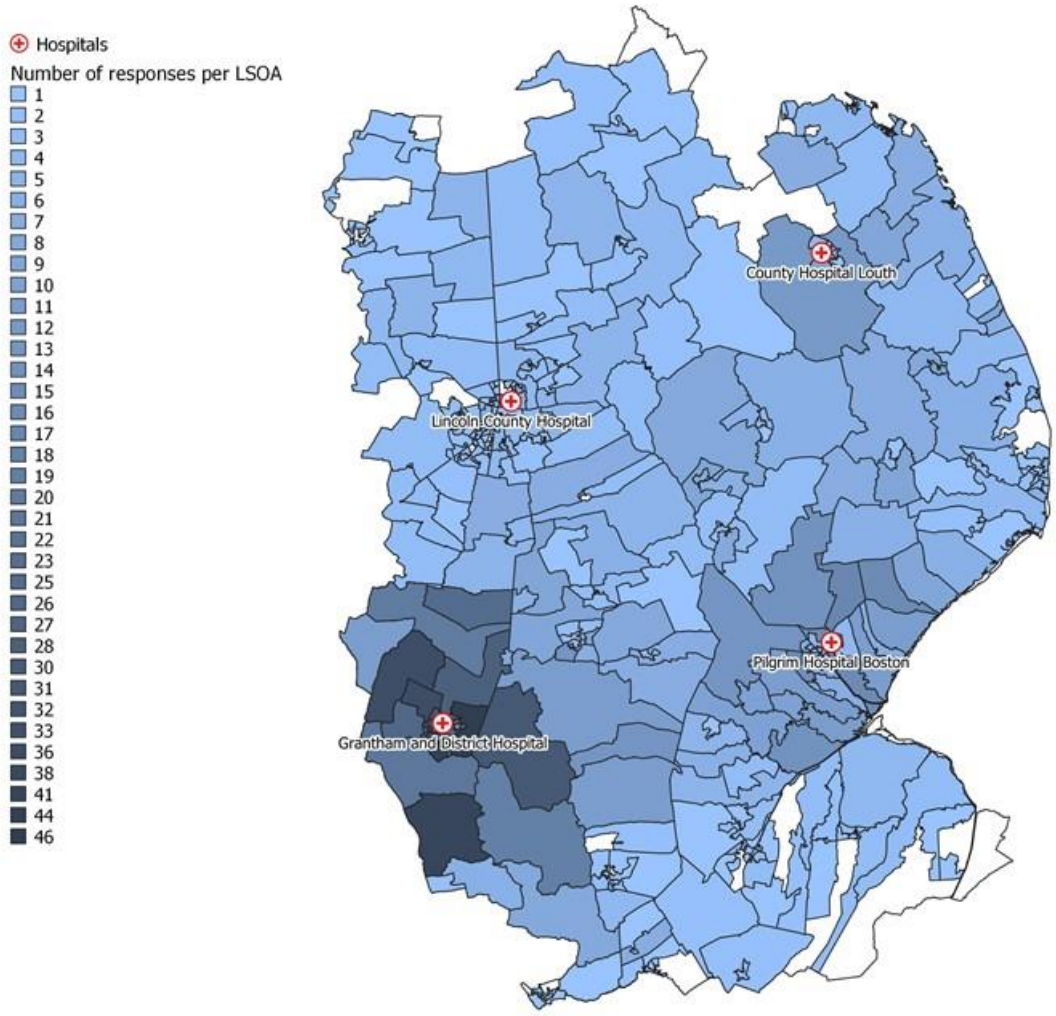
4.21 Table 6 summarises the number of responses received in each district of Lincolnshire, by nearest Lincolnshire hospital and by relative levels of deprivation (based on postcodes, where this information was provided as part of the questionnaire response). The locations of roughly a quarter of respondents (701) are unknown, but it is likely that the distribution of those responses is consistent and similar to the distribution of responses where postcodes are provided.

Table 6: Distribution of questionnaire responses received, by district, nearest Lincolnshire hospital and by deprivation

Characteristic		Questionnaire Responses		Population aged 16+
		Number of Responses	%	
BY DISTRICT	Boston	339	15%	9%
	East Lindsey	348	15%	19%
	Lincoln	126	6%	13%
	North Kesteven	255	11%	15%
	South Holland	87	4%	12%
	South Kesteven	1,001	44%	18%
	West Lindsey	109	5%	13%
	Total responses in Lincolnshire	**2,265**	**100%**	**100%**
	Outside Lincolnshire	*62*	-	-
	Not known	*701*	-	-
BY NEAREST HOSPITAL	County Hospital Louth	199	9%	12%
	Grantham and District Hospital	1,155	50%	23%
	Lincoln County Hospital	375	16%	34%
	Pilgrim Hospital, Boston	598	26%	30%
	Total valid responses	**2,327**	**100%**	**100%**
	Not known	*701*	-	-
BY DEPRIVATION LEVEL (IMD QUINTILE)	1 – most deprived	281	12%	19%
	2	495	22%	20%
	3	526	23%	22%
	4	455	20%	19%
	5 – least deprived	508	22%	20%
	Total valid responses	**2,265**	**100%**	**100%**
	Not known	*763*	-	-

4.22 From the table above and Figure 23 below, it is clear that a far larger proportion of responses are from respondents in areas closest to Grantham District Hospital (50%), and to a lesser extent Pilgrim Hospital, Boston (26%), compared to responses from areas closer to County Hospital Louth and Lincoln County Hospital. It is also of note that fewer responses have been received from the most deprived quintile of Lincolnshire (12%), relative to other quintiles (which each received 20%-22% of all responses).

Figure 23: Map showing number of responses per LSOA (for questionnaires where a postcode was provided)



Interpretation of the data

4.23 For simplicity and ease of access, the results of the consultation questionnaire are presented in a largely graphical format. Where possible, the colours used on the charts have been standardised with a 'traffic light' system in which:

- Green shades represent positive responses
- Beige shades represent neutral responses
- Red shades represent negative responses.

4.24 The numbers on pie charts are percentages indicating the proportions of respondents giving a particular view. It should be noted that, when reporting combined percentages of poor and very poor, or good and very good, responses in the text commentary, the figure may sum differently (+/- 1%) to the figures shown on stacked bar charts due to rounding of decimal places.

4.25 The number of valid responses recorded for each question (base size) are reported throughout. As not all respondents answered every question, the valid responses vary between questions. Every response to every question has been taken into consideration.

4.26 As noted above, the views of NHS employees have in some key places been reported separately to those of other individual respondents. In these cases, for convenience of reporting and to provide clarity, the views of NHS staff are generally reported first. This is for terminology reasons: as many staff also responded in some other capacity e.g., as individual residents, it therefore it makes sense in the commentary to able to refer firstly to staff, and then secondly to '*other* [non-NHS] *individuals*'.

4.27 Where percentages do not sum to 100, this may be due to computer rounding, the exclusion of "don't know" categories, or multiple answers. Throughout the report an asterisk (*) denotes any value greater than zero, but less than half of one per cent. In some cases, figures of 2% or below have been excluded from graphs for presentational reasons.

4.28 Finally, several organisations provided detailed responses around one or several of the proposals; views and feedback from organisations are reported separately under each proposal in turn, with more general comments related to equalities and health inequalities impacts reported at the end of the chapter.

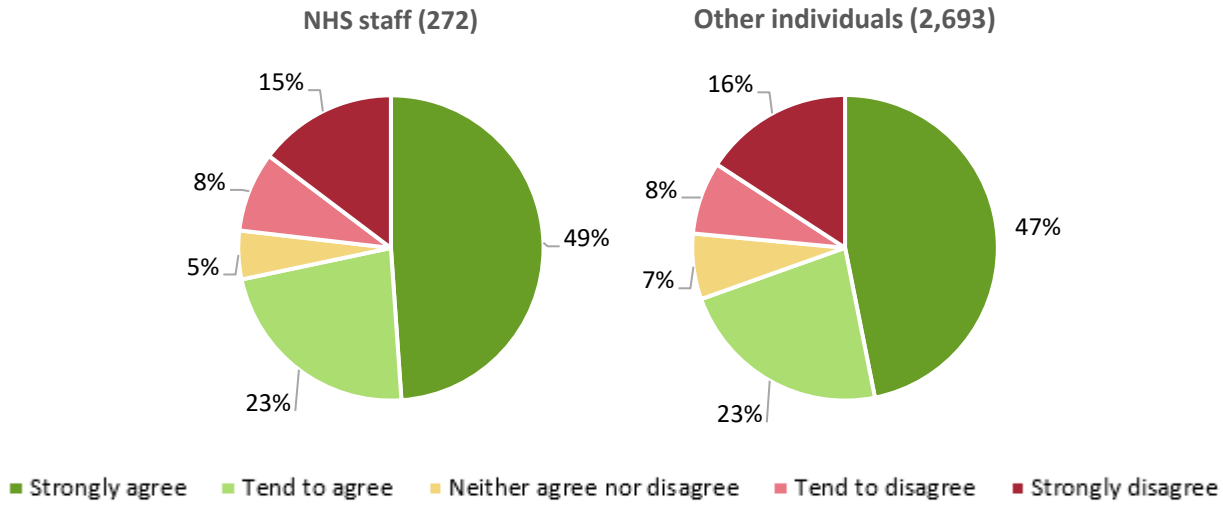
Questionnaire feedback

Respondents' views on the need for change

4.29 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.

4.30 Nearly a quarter (23% of staff and 24% of other individuals) disagreed (i.e., either tended to disagree or strongly disagreed) (Figure 24).

Figure 24: Views on the need for change, BY STAKEHOLDER TYPE (individual questionnaire respondents only)

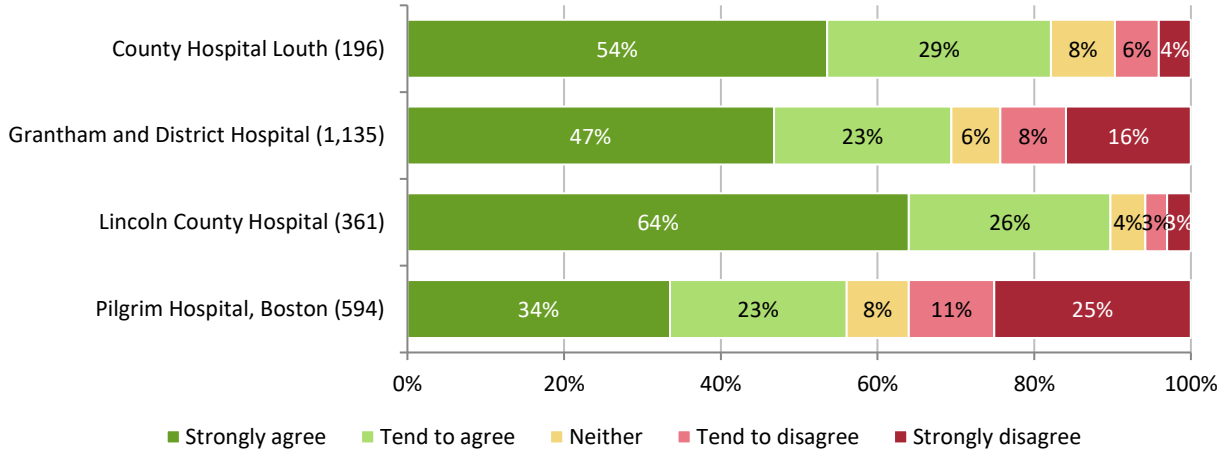


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.31 Figure 25 overleaf indicates that, while there was majority agreement with the need for changes to be made among respondents, views were most mixed among those living closest to Pilgrim hospital, of whom nearly three fifths (56%) agreed that changes are needed, compared to more than one third (36%) who disagreed.

4.32 To a somewhat lesser extent, views on the need for change were also more varied among those living closest to Grantham and District Hospital, of whom nearly a quarter (24%) disagreed with the need for change.

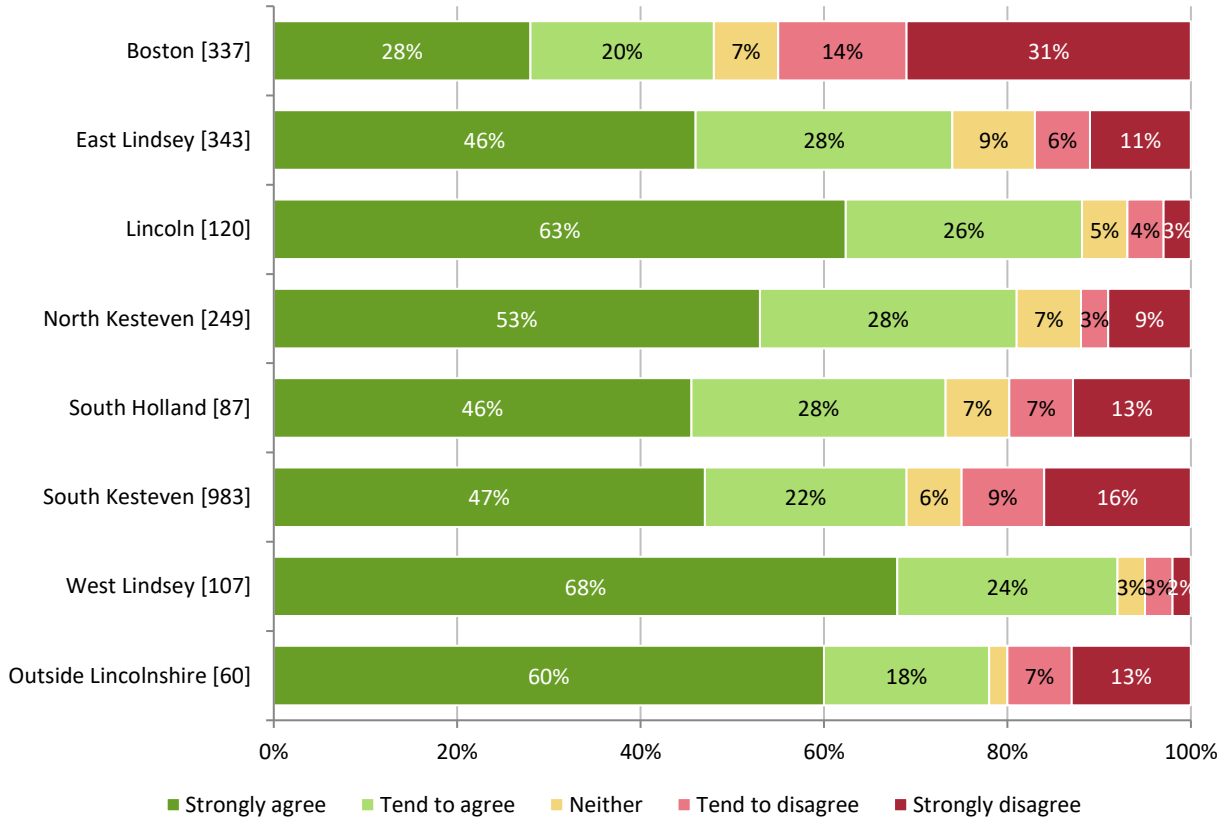
Figure 25: Views on the need for change BY CLOSEST HOSPITAL (all individual respondents, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.33 Similarly, Figure 26 demonstrates that views among questionnaire respondents living in Boston District are fairly evenly balanced, with 47% agreeing with the need for change compared to 45% who disagreed.

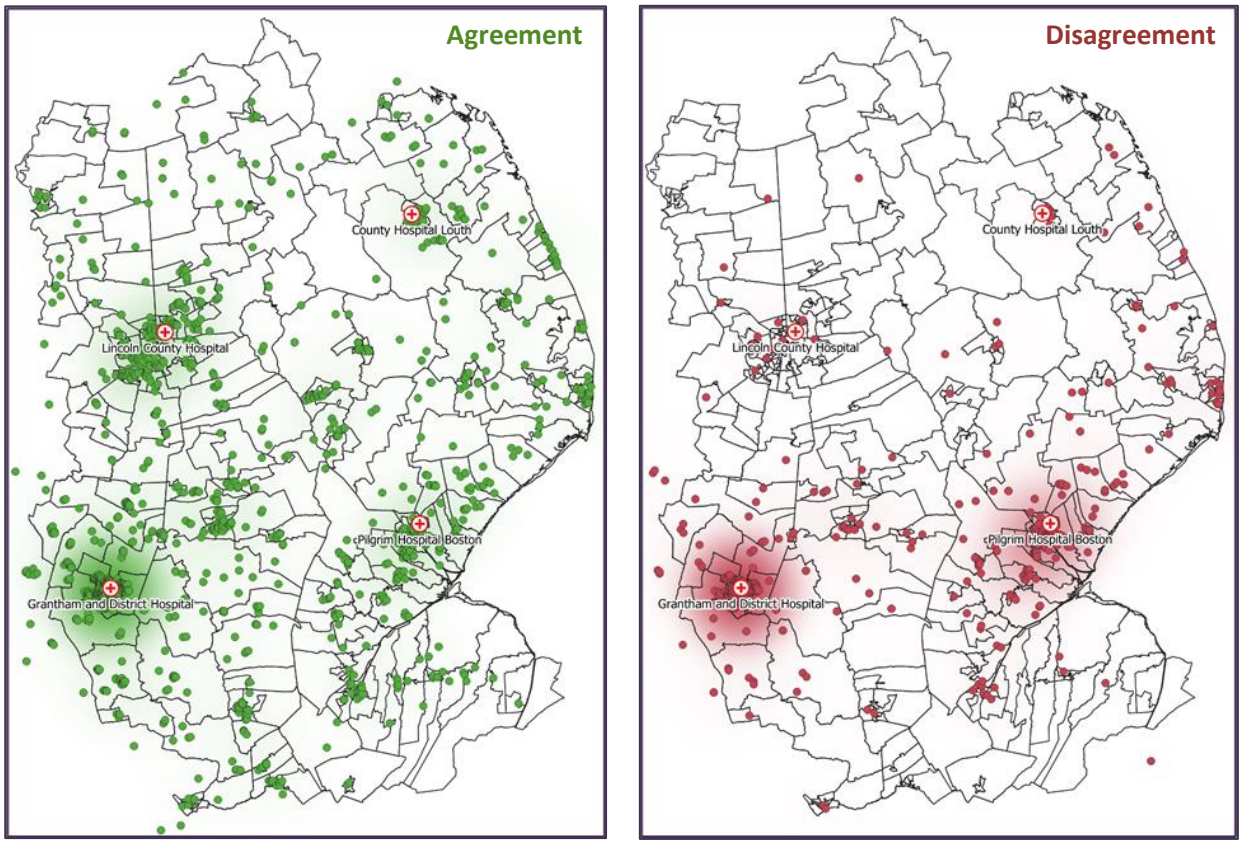
Figure 26: Views on the need for change BY DISTRICT (individuals respondents only, where postcodes are provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

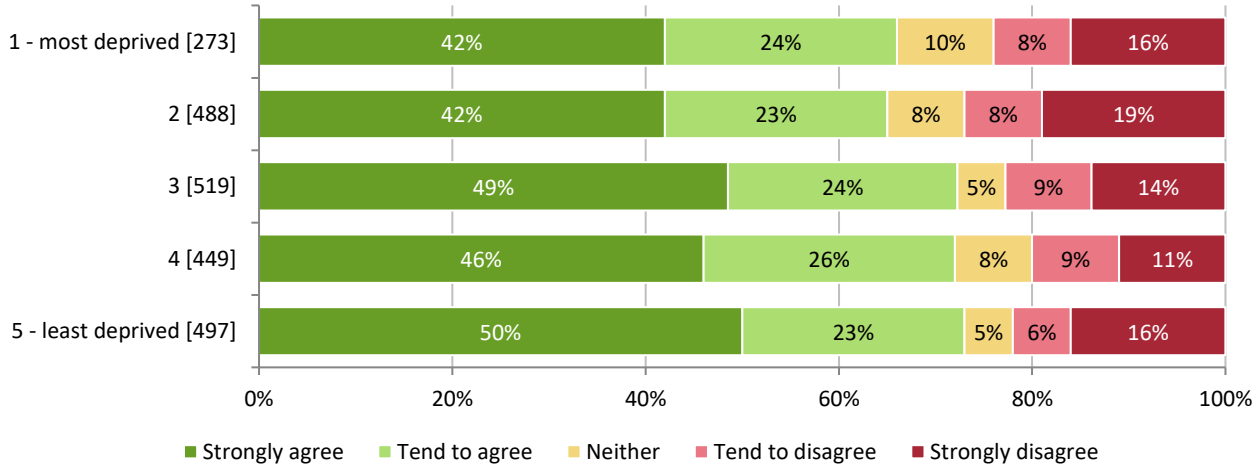
4.34 The maps in Figure 27 below illustrate that the most concentrated disagreement from questionnaire respondents is from those living in the south of the county, and particularly those living close to the towns of Grantham and Boston. Agreement, by contrast, is more geographically widespread, including support among many of those questionnaire respondents living closest to Grantham and Boston.

Figure 27: Maps illustrating agreement (green) and disagreement (red) of questionnaire respondents with the need for change, with their location (based on individual respondents who provided their postcode); darker shading indicates the most concentrated areas of agreement or disagreement



4.35 Figure 28 presents all individual questionnaire respondents views on the need for change, broken down by IMD quintiles (1 being the most deprived areas within Lincolnshire, 5 being the least deprived). It indicates that, while there are some small variations in views, the trend is similar across the results.

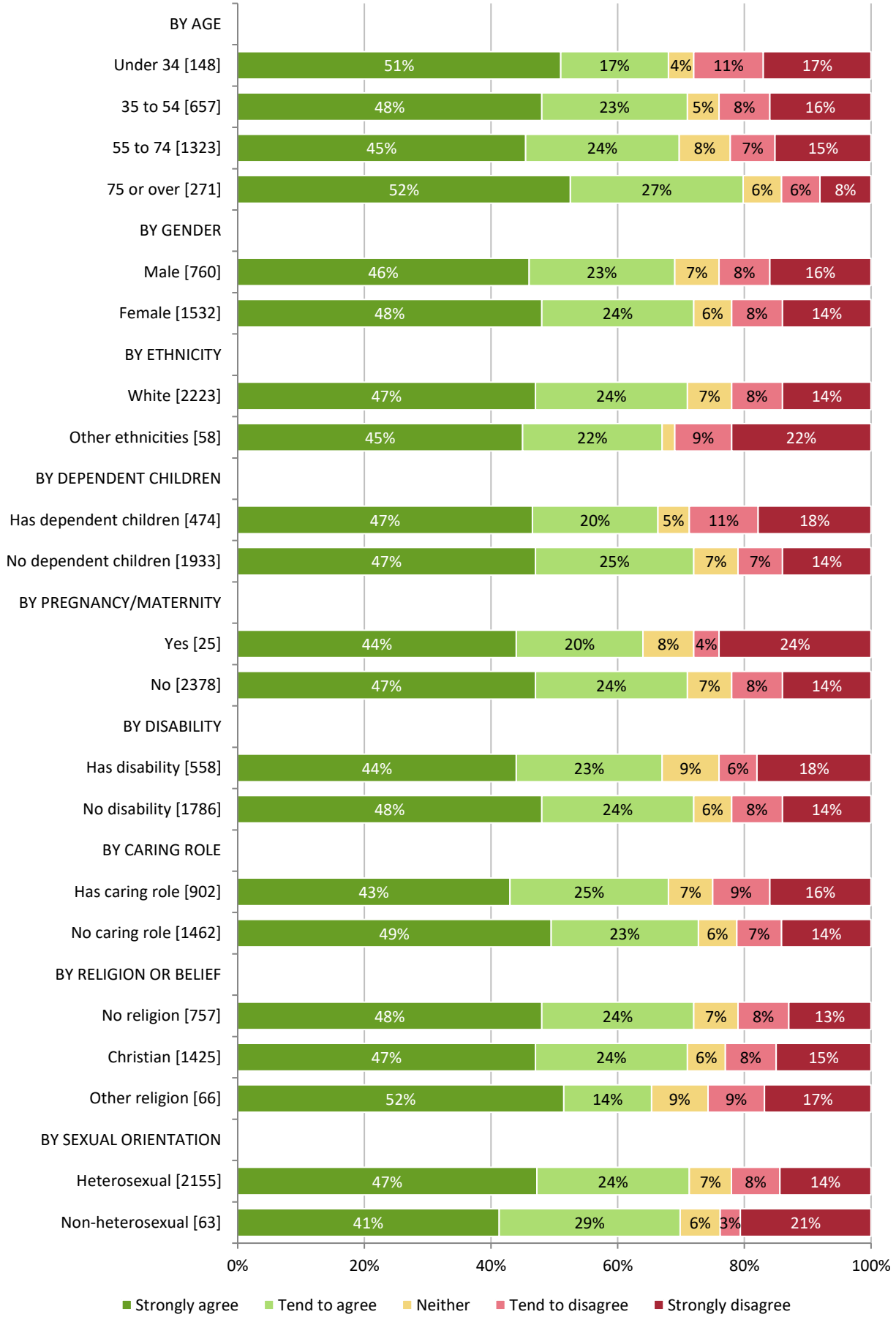
Figure 28: Views on the need for change BY INDICES OF MULTIPLE DEPRIVATION (IMD) (all individual respondents living in Lincolnshire only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.36 Similarly, Figure 29 overleaf presents questionnaire respondents' views on the need for change, broken down by key demographics, including protected characteristics such as age, gender, ethnicity etc.); as with deprivation, there are some slight variations but there is majority agreement across all groups.

Figure 29: Views on the need for change BY KEY DEMOGRAPHICS (individuals only)

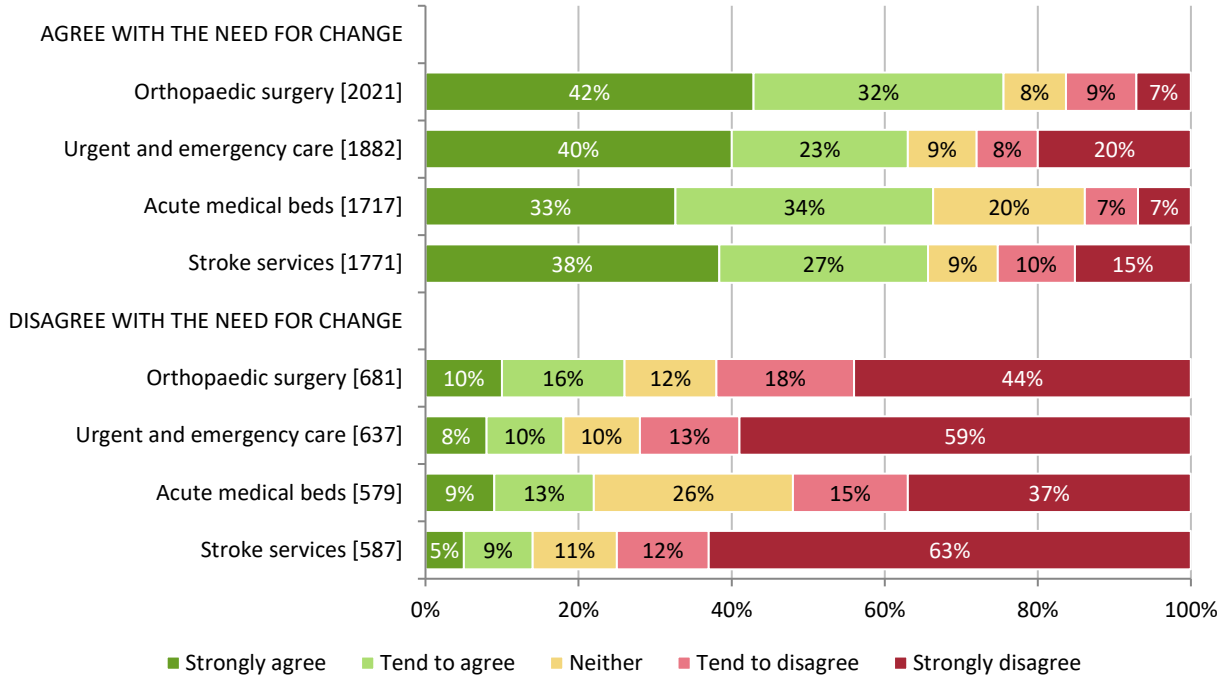


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Understanding views on the need for change

4.37 It should be noted that there was evidence among consultation questionnaire responses that, for many people, their views on the individual proposals were linked to their views on the need for change. Across all four acute services, those respondents who agreed with the need for change more commonly agreed with the proposed changes (Figure 30). By contrast, those respondents who disagree with the need for change most often disagreed with the proposals as well.

Figure 30: Views on the proposals for acute services BY AGREEMENT OR DISAGREEMENT WITH THE NEED FOR CHANGE (individuals only)



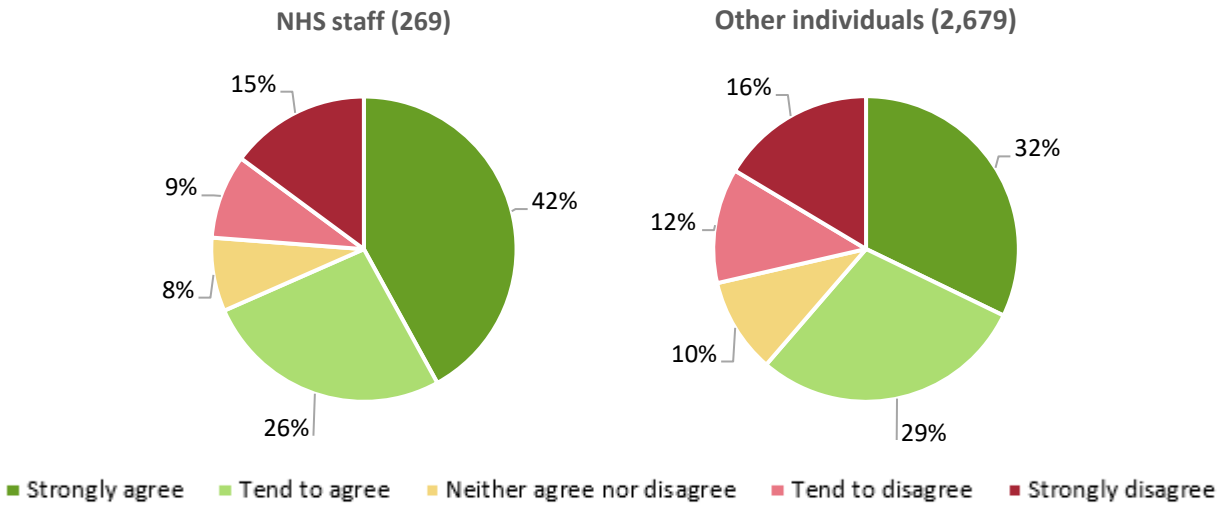
Base: Number of respondents shown in brackets (excludes 'don't know' responses and those who neither agreed nor disagreed with the need for change)

4.38 It is also important to note that the feedback received in text responses from those questionnaire respondents who disagreed with the need for change, indicated that they did not simply believe that the status quo should be maintained, but rather that *more* services need to be available at *more* hospitals in Lincolnshire. This was most markedly the case with the proposals around the delivery of urgent and emergency care at Grantham and District Hospital and is explored in more detail in this chapter.

Respondents' views on the proposal for orthopaedic surgery

4.39 Around two thirds of NHS staff (68%), and nearly as many of the other individuals who responded to the questionnaire (61%), agreed with the proposal for orthopaedic surgery. Almost a quarter of NHS staff disagreed with the proposal (24%), as did roughly three tenths of the other individuals who responded (29%).

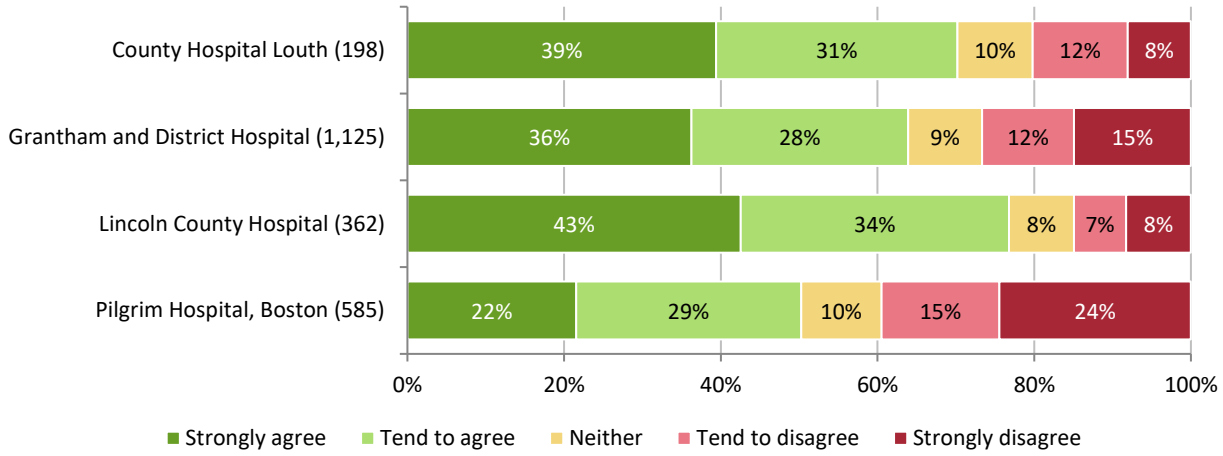
Figure 31: Views on the proposal for orthopaedic surgery, by stakeholder type



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.40 Figure 32 below indicates that, while there was majority agreement with the orthopaedics proposal among questionnaire respondents, views were more mixed among those living closest to Pilgrim Hospital, Boston, of whom half (50%) agreed that changes are needed, compared to around two fifths (39%) who disagreed.

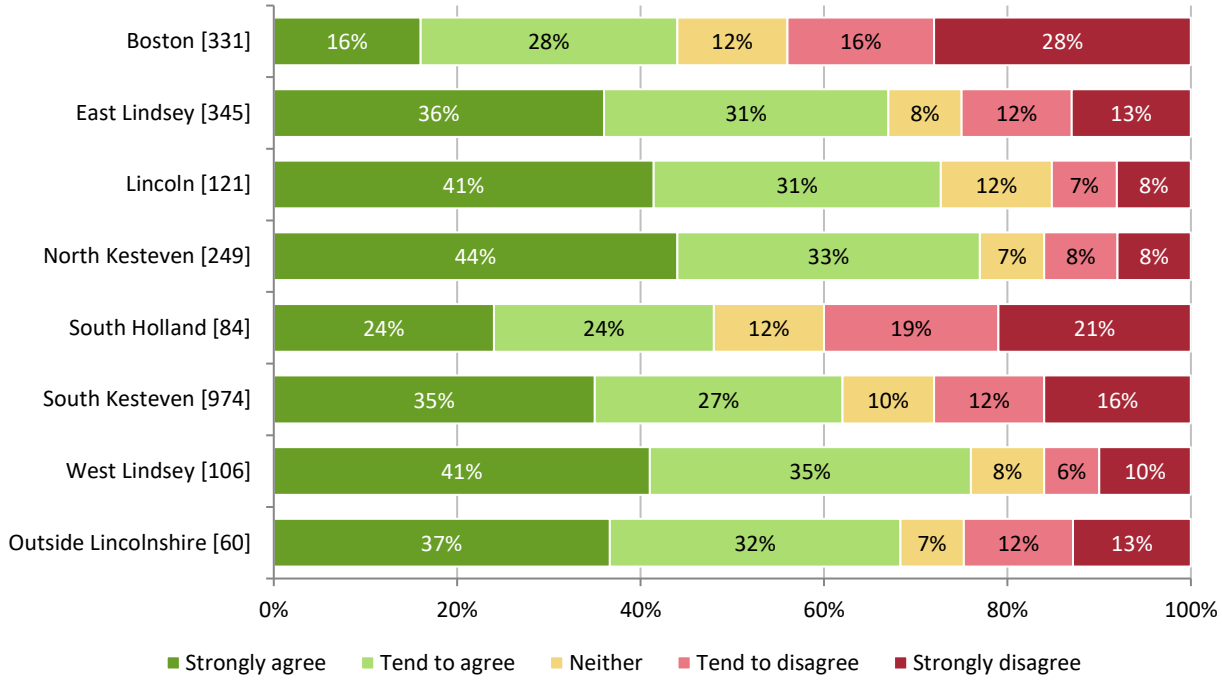
Figure 32: Views on the proposal for orthopaedic surgery BY CLOSEST HOSPITAL (individuals only)



4.41 Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.42 Figure 33 indicates that views among respondents in Boston District were evenly split, with 44% of respondents agreeing with the proposals and the same proportion disagreeing with the suggested changes. Similarly, just under a half of respondents living in South Holland (for whom Pilgrim hospital would be their closest acute hospital in Lincolnshire) agreed with the proposals (48%). A sizeable minority of two fifths (40%) of respondents from South Holland, however, disagreed with the proposals.

Figure 33: Views on the proposal for orthopaedic surgery BY DISTRICT (all individual respondents only)

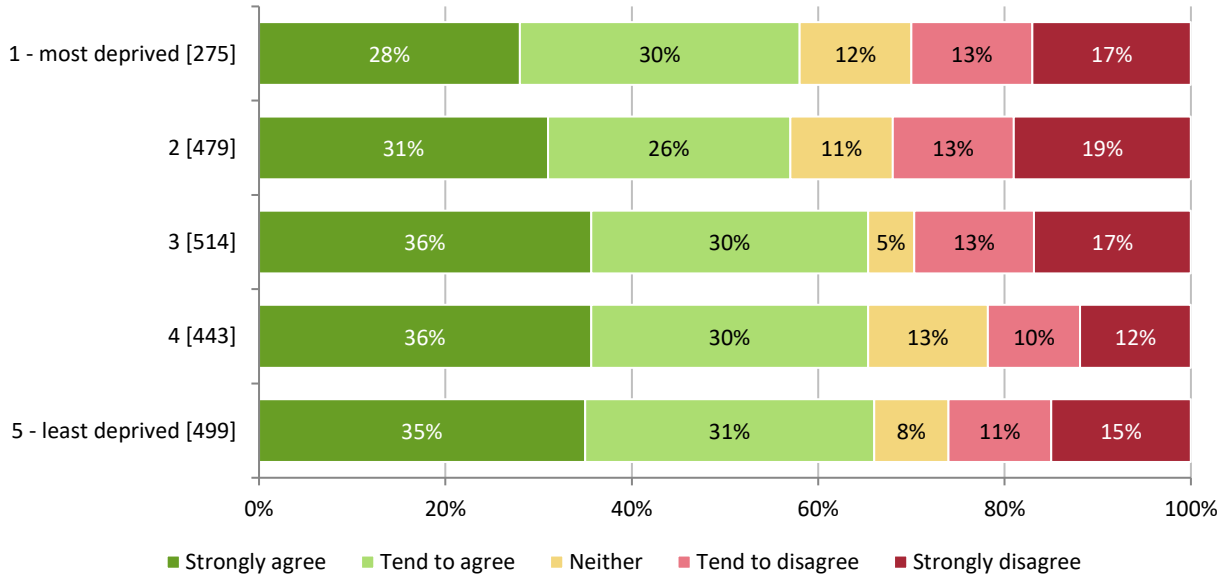


4.43

Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.44 Figure 34 presents all individual questionnaire respondents views on the proposals for orthopaedic surgery in Lincolnshire, broken down by IMD quintiles. It indicates that, while there are some small variations in views, the trend is similar across the results.

Figure 34: Views on the proposal for orthopaedic surgery BY INDICES OF MULTIPLE DEPRIVATION (IMD) (individuals only)

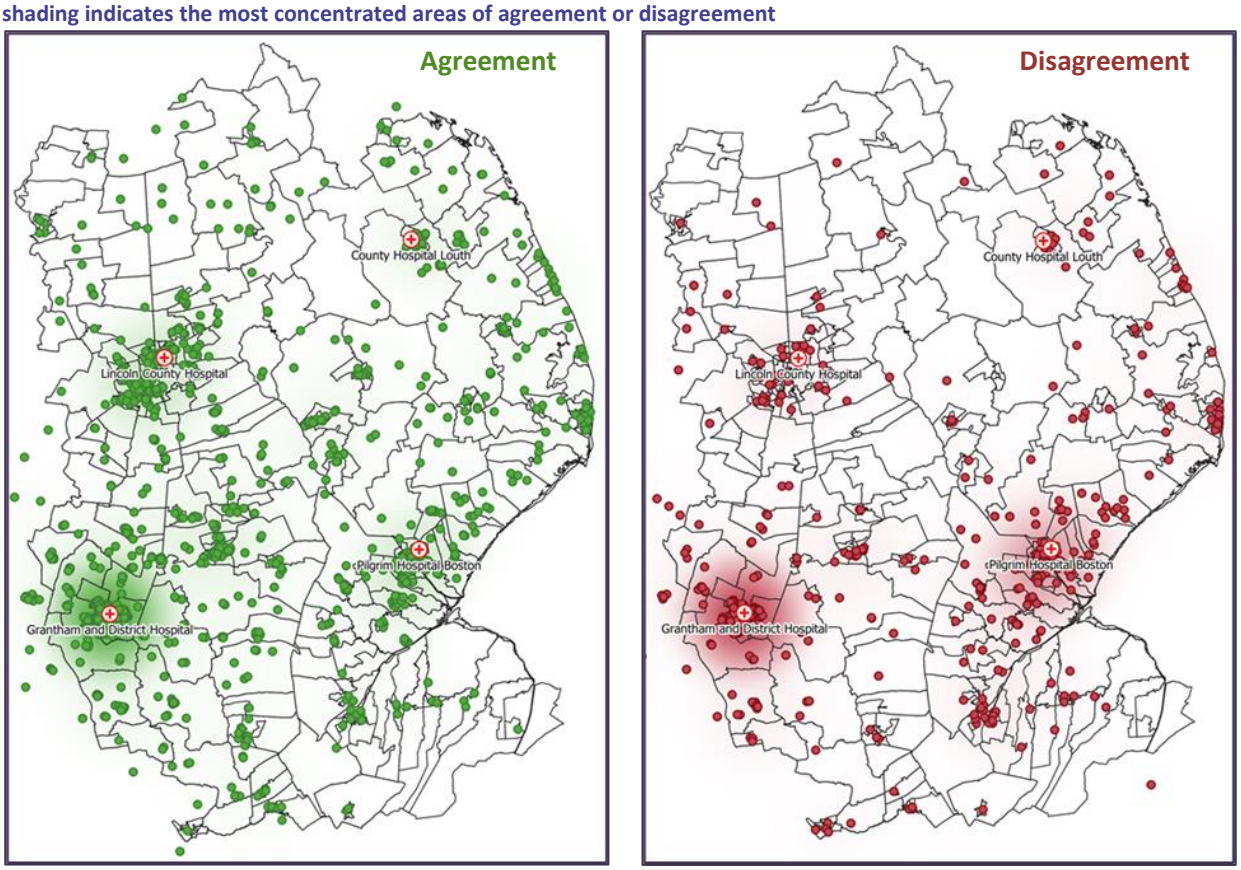


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.45 The maps in Figure 35 below illustrate that the most concentrated disagreement from questionnaire respondents around proposals for orthopaedic surgery is among those living in the south of the county, and particularly those living close to Grantham and Boston. Agreement, by contrast, is more geographically

widespread, while still retaining support among many of those questionnaire respondents living closest to Grantham and Boston.

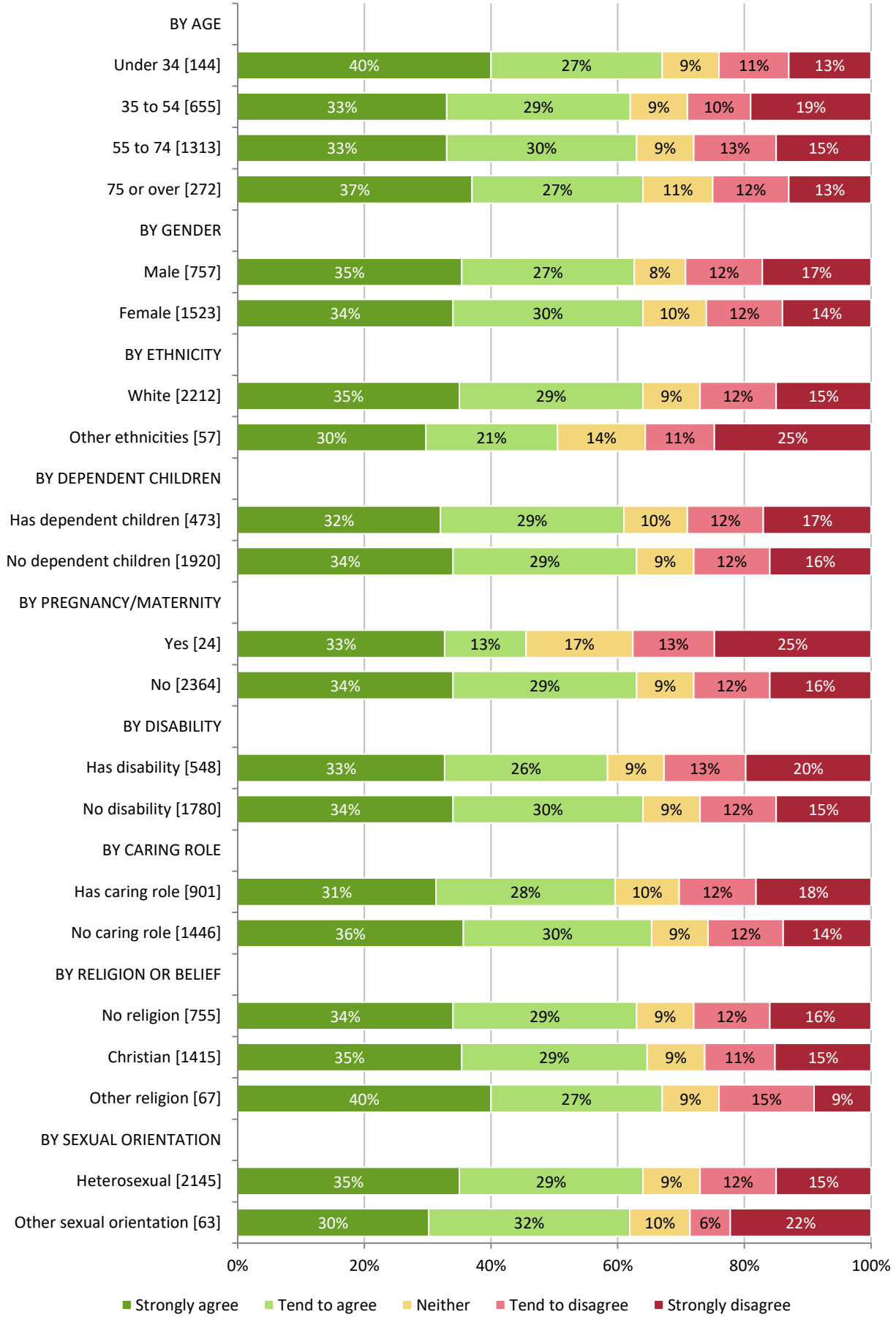
Figure 35: Maps illustrating agreement (green) and disagreement (red) of questionnaire respondents with proposals for orthopaedic surgery in Lincolnshire, with their location (based on individual respondents who provided their postcode); darker shading indicates the most concentrated areas of agreement or disagreement



4.46 Similarly, Figure 36 overleaf presents questionnaire respondents' views on the orthopaedics proposal, broken down by key demographics. The results indicate that fewer respondents who are pregnant or providing maternity care, or are from ethnically diverse communities, agreed with the proposals than was the case for other respondents.

4.47 It should be noted, however, that more than four fifths (83% and 89% respectively) of respondents in both demographic groups lived closest to Pilgrim hospital or Grantham and District Hospital. Agreement with the proposals was somewhat lower among *all* individual questionnaire respondents from both of those areas, indicating that this is likely to be reflective of broader geographic differences in views.

Figure 36: Views on the proposal for orthopaedic surgery BY KEY DEMOGRAPHICS (individuals only)

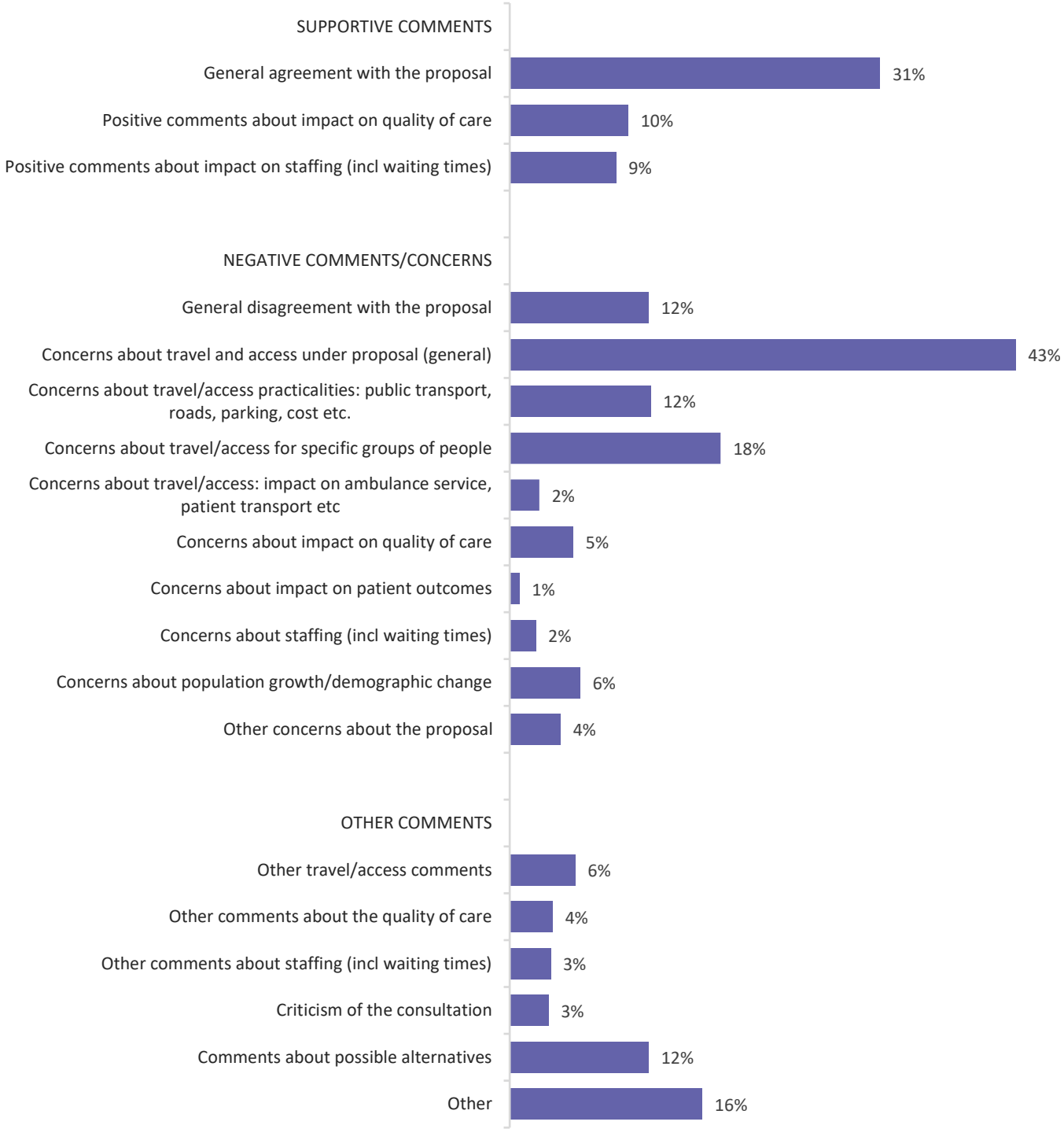


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Comments about the proposal for orthopaedic services

4.48 A high-level summary of the comments provided in relation to the text question about the proposal for orthopaedic surgery is shown in the figure below.

Figure 37: High-level summary of the further comments made in response to the text question about the proposal for orthopaedic services.



Base: All individual respondents who provided comments (1,684)

4.49 Close to a third of individuals who commented on the proposal for orthopaedic services stated that they generally agreed, agreed with the location of the centre of orthopaedic excellence in Grantham, or agreed with the principle of a centre of excellence (without referencing a location).

4.50 Around a tenth mentioned the prospect of the proposal improving the quality of care provided: either in general or with specific reference to fewer cancellations due to, for example, emergency admissions at acute sites. A similar proportion suggested there would be a positive impact on staff recruitment/retention and on service efficiencies/waiting times.

4.51 However, there was some disagreement with the proposal: either on the basis that the centre of excellence should be located somewhere other than in Grantham, and/or that Lincoln and Boston should continue to offer planned orthopaedics, and/or that Grantham should continue to offer unplanned and emergency care.

4.52 The biggest area of concern was in relation to travel and access; over two-fifths of those who commented had concerns in general, felt that services needed to remain local to reduce travel, and/or had concerns about the accessibility of different sites.

4.53 Around a tenth raised various concerns around travel and access practicalities including costs, public transport (in the sense of lacking coverage, being too infrequent etc), issues with road infrastructure and congestion, and parking.

4.54 Some respondents had concerns about quality of care, primarily in the sense that sites are already under pressure and the proposal will either fail to alleviate this, or may in fact have a negative impact by increasing the current pressures. A few also doubted that the proposal would address waiting times and staffing issues.

4.55 A few doubted whether the proposals took sufficient account of a growing and aging local population. Other concerns raised by small proportions related to possible environmental impacts (i.e., if people have to travel further) and a perception that the proposal has been motivated by a desire to achieve financial savings rather than to improve care, and/or that it is part of an ongoing trend towards downgrading of services at Grantham.

Individuals' comments on equalities impacts of the orthopaedics proposal

4.56 Nearly a fifth of respondents foresaw access issues for particular groups of people, specifically: the elderly, people with disabilities, people from low income or deprived backgrounds, children, and other vulnerable groups (e.g., refugees or those experiencing homelessness).

4.57 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.

4.58 A small proportion were concerned about impacts on the ambulance service and on patient transport. In regard to potential impacts on vulnerable groups, one respondent requested assurance that there will be a review of the eligibility criteria for patient transport services to address any potential barriers to access, particularly for the most deprived communities in rural and inner city areas, and that additional support and transport will be provided to address need.

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

Alternative suggestions and other comments from individual respondents around orthopaedic surgery in Lincolnshire

4.60 The most common suggested alternatives concerned investment and/or restoring services, particularly at Grantham and District Hospital. A very small number were in favour of having teams of staff rotate between the different sites, and a few suggested that all hospital sites in Lincolnshire should be equipped to handle planned and unplanned orthopaedic surgery.

4.61 Small numbers of respondents suggested that having free transport between sites, e.g., a shuttle bus might help mitigate some travel impacts; this same suggestion was also made by smaller numbers in relation to the other proposals.

4.62 There were a few critical comments about the consultation process (which were also expressed in relation to the other proposals), with small numbers of individuals feeling that more information was needed or that the proposals were not clearly explained.

4.63 Several NHS staff members, while often positive about the prospect of separating planned and unplanned orthopaedic surgery, commented on the need to ensure that appropriate plans are in place to deal with high-risk elective cases and incidences of unexpected complications during operations.

4.64 Other comments from a small number of individual respondents included:

- Requests for reassurance that fracture clinics would continue to take place locally;
- That NHS Lincolnshire should ensure that policies and pathways are robust and clear for continuous improvements to be made and filtered throughout the organisation;
- That procurement work with private hospitals should be implemented to improve patient care and assist with the crisis; and
- A view that the proposal represents a short term contingency plan to cope with deep rooted problems not being addressed by NHS and governments; namely, beds, staff recruitment and retention and quality of care.

Views from organisations on proposals for orthopaedic surgery in Lincolnshire

4.65 Nine of the sixteen organisations agreed with the proposals for orthopaedic surgery, six strongly. Four disagreed, and two neither agreed nor disagreed (the remaining organisation answered ‘don’t know’). The comments made by organisations about the proposals are below.

Benefits of the proposals

4.66 Lincolnshire Local Medical Committee, Homecare and three of the area’s borough/district councils (Boston, East Lindsey and South Holland) agreed with the proposed separation of emergency and planned surgery as a means of ‘insulating’ the latter from the impacts of the former and developing centres of excellence.

> *Dedicated planned care centre and day case centre will insulate it from acute activity and thus provide cleaner facilities and less risk of cancellation.*
>
> ***Lincolnshire Local Medical Committee***
>
> *It makes sense to concentrate on excellence.*
>
> ***Homecare***

Positive to note that there will be a centre of excellence in Lincolnshire and that there will be a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery. Good that both planned surgery for high risk patients will remain at Pilgrim hospital as well as continued provision for unplanned surgery at this site.

Boston Borough Council, East Lindsey District Council and South Holland District Council

4.67 Grantham Senior Citizens Club also supported the better utilisation of facilities at Grantham and District Hospital.

It makes sense to utilize Grantham hospital more, rather than the facilities in large part standing empty.

Grantham Senior Citizens Club

Issues of concern: travel and access

4.68 Travel and access were noted as issues by five of the sixteen organisations. Public transport infrastructure was a particular concern, with Boston Borough Council, East Lindsey District Council, South Holland District Council, and Skegness Town Council all raising it as a potential issue in need of mitigation. Moreover, the three borough/district councils questioned whether patients would still be able to choose treatment at hospitals out-of-county if they are geographically closer.

In the document, planned surgery seems to be day case or inpatient overnight. If there are occasions where a patient may need to stay in hospital for longer, consideration to travel for relatives and support network needs to be given … Would echo the feedback from previous engagement regarding concerns about distances travelled and transport infrastructure – particularly in East Lindsey and South Holland. This is both for patients accessing the service and visits from their support networks … For those no longer able to access unplanned orthopaedic surgery at GDH, what mitigations are in place for travelling to a site further away and will there be transport support available if needed? Outside of county, at which other facilities are these services available and will there still be an option for patient choice at facilities out of county if these are more accessible for them? This is particularly relevant for South Holland residents living closer to Peterborough or King's Lynn.

Boston Borough Council, East Lindsey District Council and South Holland District Council

Discontinuing planned orthopaedic surgery at both Pilgrim and Lincoln hospitals will mean patients will have longer to travel in an area where a significant proportion of the population does not have access to a car and where public transport links are limited. These changes will put a significant pressure on non-urgent hospital transport and may mean family or friends are unable to visit loved ones. Skegness Town Council would like orthopaedic surgery to remain available at both Pilgrim and Lincoln hospital.

Skegness Town Council

4.69 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.

> *As a non-driver I need to be at Spalding or Pilgrim Hospital Lincolnshire.*
>
> ***Older People's Forum***
>
> *Good idea in theory however, I think the cost to the NHS in transport for patient without could outweigh the good.*
>
> ***Lincolnshire Traveller Initiative Health Champion***

Issues of concern: patient rehabilitation

4.70 The Chartered Society of Physiotherapy neither agreed nor disagreed with the proposals for orthopaedic surgery. However, they raised concerns around weekend rehabilitation provision in its response and sought reassurance that patient rehabilitation will remain of high quality, conforming to best practice and enabling patient choice.

> *The CSP does note and would flag a clear concern regarding funding for weekend cover. It would appear that there is only a half day of rehabilitation service provision from physiotherapy services. This level of funding would clearly undermine the timely rehabilitation of patients over the weekend and be detrimental to patient flow through the service which could, and is likely to, increase patient length of stay. We would also require confirmation that the rehabilitation of orthopaedic patients throughout the patient pathway will provide high quality care through best practice, with availability of rehabilitation as an in-patient, which crosses the service boundary into community with either a pull or push system in place to support appropriate early discharge. Care must also be taken to ensure that patients are provided with their choice of provider at the start of the pathway (point of referral), which is laid out through the NHS choice framework and remains in line with the NHS constitution.*
>
> ***The Chartered Society of Physiotherapy (CSP)***

Issues of concern: recruitment and retention

4.71 Staff recruitment and retention was a concern for Skegness Town Council.

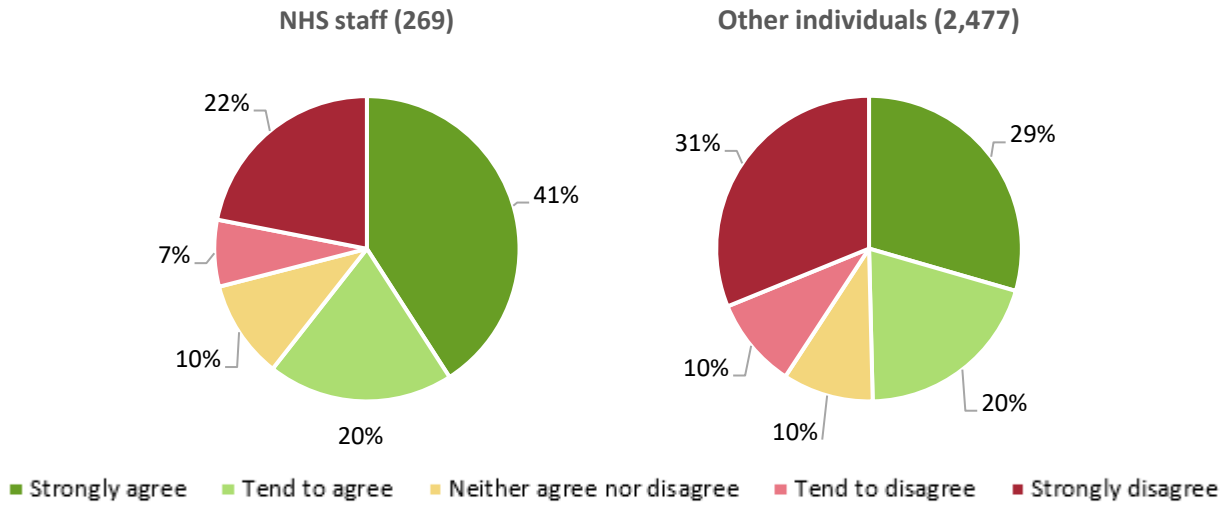
> *Issue of recruitment and retention needs to be addressed rather than cutting local services… Services should be kept at Pilgrim and Lincoln.*
>
> ***Skegness Town Council***

Respondents' views on the proposal for urgent and emergency care at Grantham and District Hospital

4.72 Around three fifths of NHS staff (61%) and half of the other individuals who responded (50%) agreed with the proposal to provide 24/7 urgent care services in Grantham via an Urgent Treatment Centre.

4.73 However, 29% of staff and 41% of other individuals disagreed with this proposal for urgent and emergency care.

Figure 38: Views on the proposal for urgent and emergency care, by stakeholder type

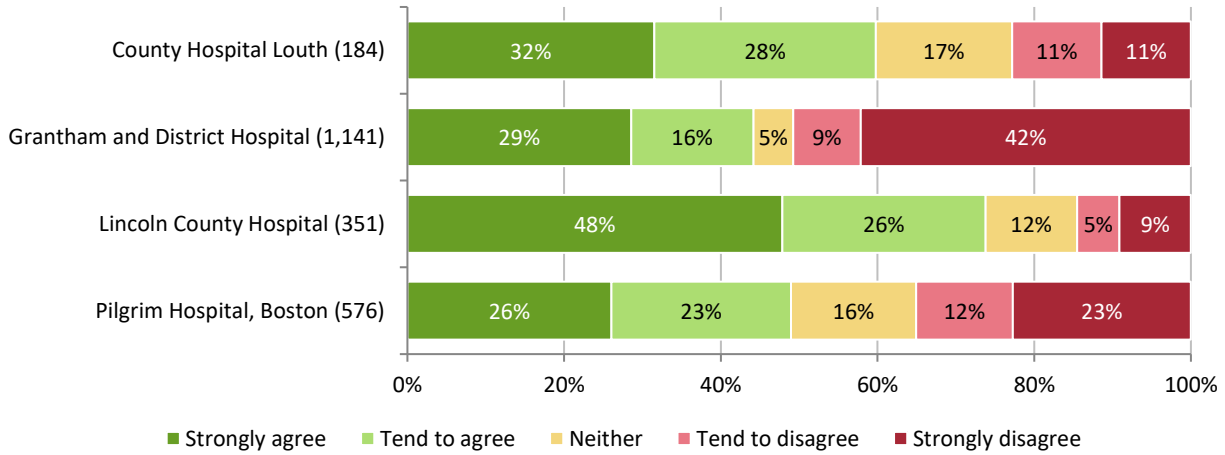


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.74 The lowest levels of agreement were seen among respondents whose nearest hospital is Grantham (Figure 39); just over two fifths agreed with the proposal for urgent and emergency care at this hospital (44%) whereas around half disagreed (51%).

4.75 Around half of respondents living closest to Pilgrim Hospital, Boston agreed (49%) while around a third disagreed. Elsewhere, most respondents agreed, specifically: 60% of those living closest to County Hospital Louth and 74% of those living closest to Lincoln County Hospital.

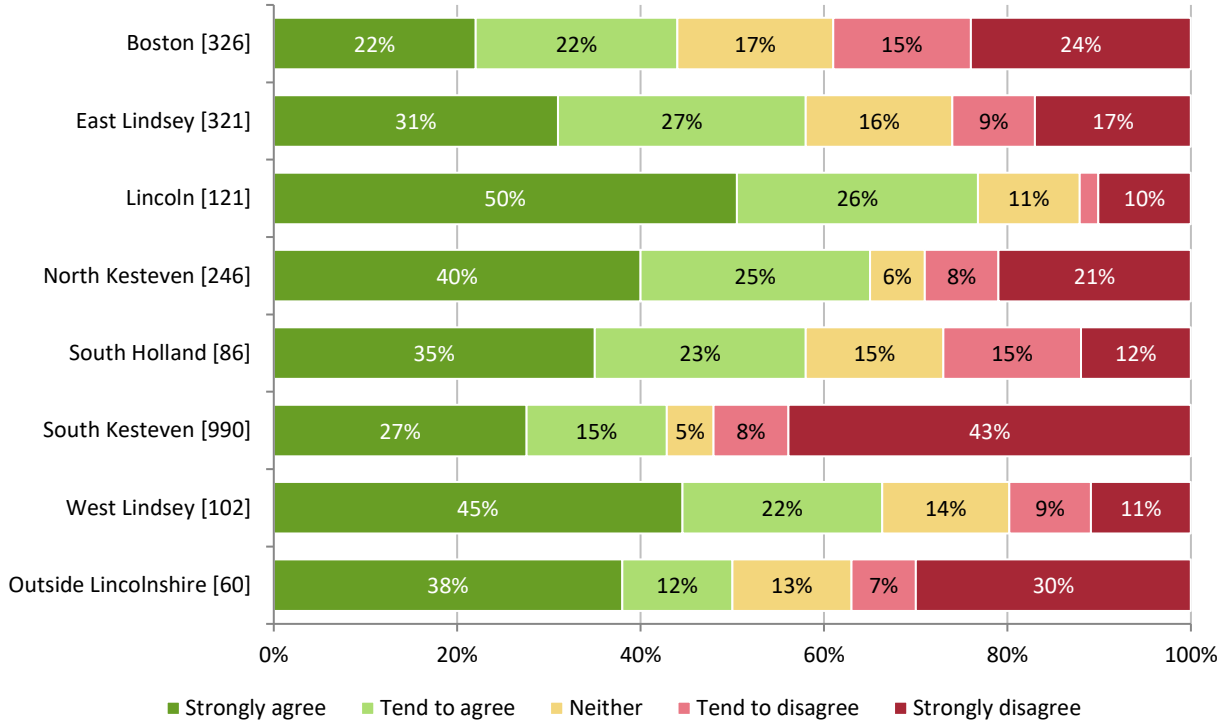
Figure 39: Views on the proposal for urgent and emergency care BY CLOSEST HOSPITAL (individuals only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.76 Similarly, Figure 40 indicates that support for proposals for a 24/7 UTC at Grantham and District Hospital was lower among questionnaire respondents living in South Kesteven and Boston. More than half (52%) of respondents from South Kesteven disagreed with the proposal, compared to just over two fifths (43%) who agreed. Respondents from Boston District were fairly evenly split, with 44% of respondents agreeing with the proposal and 39% disagreeing.

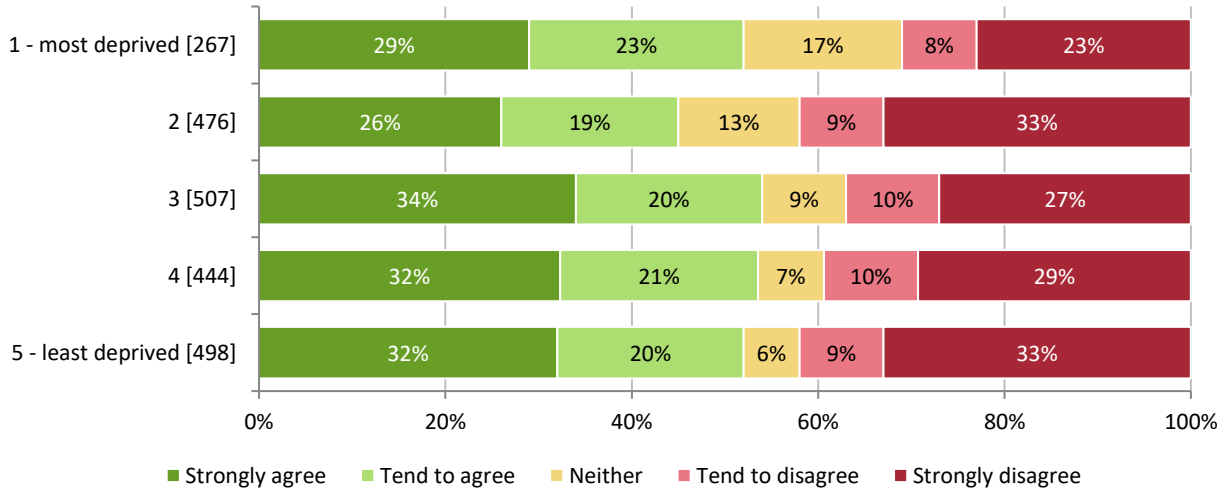
Figure 40: Views on the proposal for urgent and emergency care BY DISTRICT (individuals only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.77 Figure 41 presents all individual questionnaire respondents views on the proposals around urgent and emergency care in Lincolnshire, broken down by IMD quintiles. It indicates that, while there are some small variations in views, the trend is similar across the results. The lower level of support from respondents in the 2nd IMD quintile should be viewed in the context that more than three fifths of these respondents live in South Kesteven and Boston District, the areas where support among respondents is lower across all quintiles.

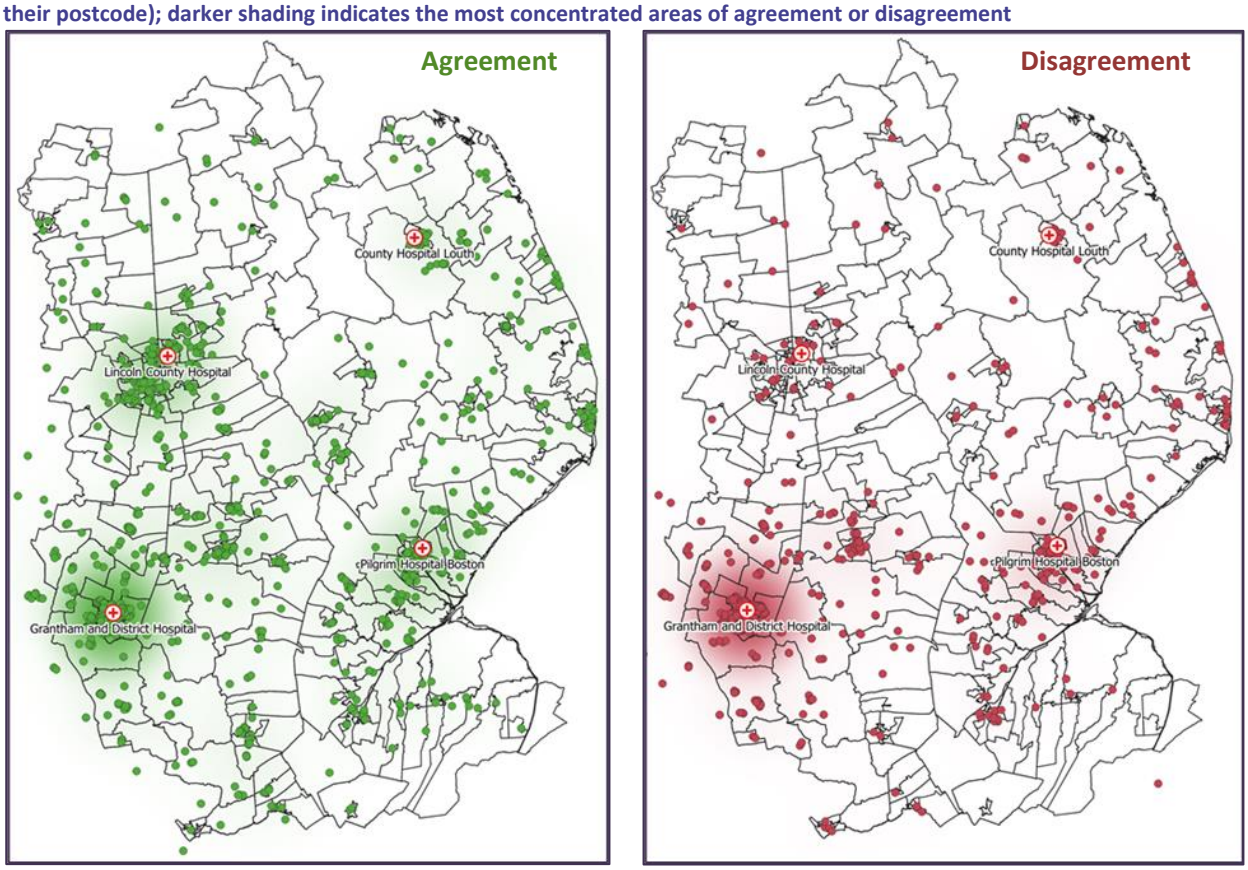
Figure 41: Views on the proposal for urgent and emergency care BY INDICES OF MULTIPLE DEPRIVATION (IMD) (individuals only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.78 The maps in Figure 42 illustrate that the most concentrated disagreement from questionnaire respondents around proposals for urgent and emergency care at Grantham and District Hospital is among those living close to Grantham and, to a lesser extent, close to Boston. Agreement, by contrast, is more geographically widespread, including across South Kesteven more widely, and the proposals are also supported by many of those questionnaire respondents living near to Grantham and District Hospital.

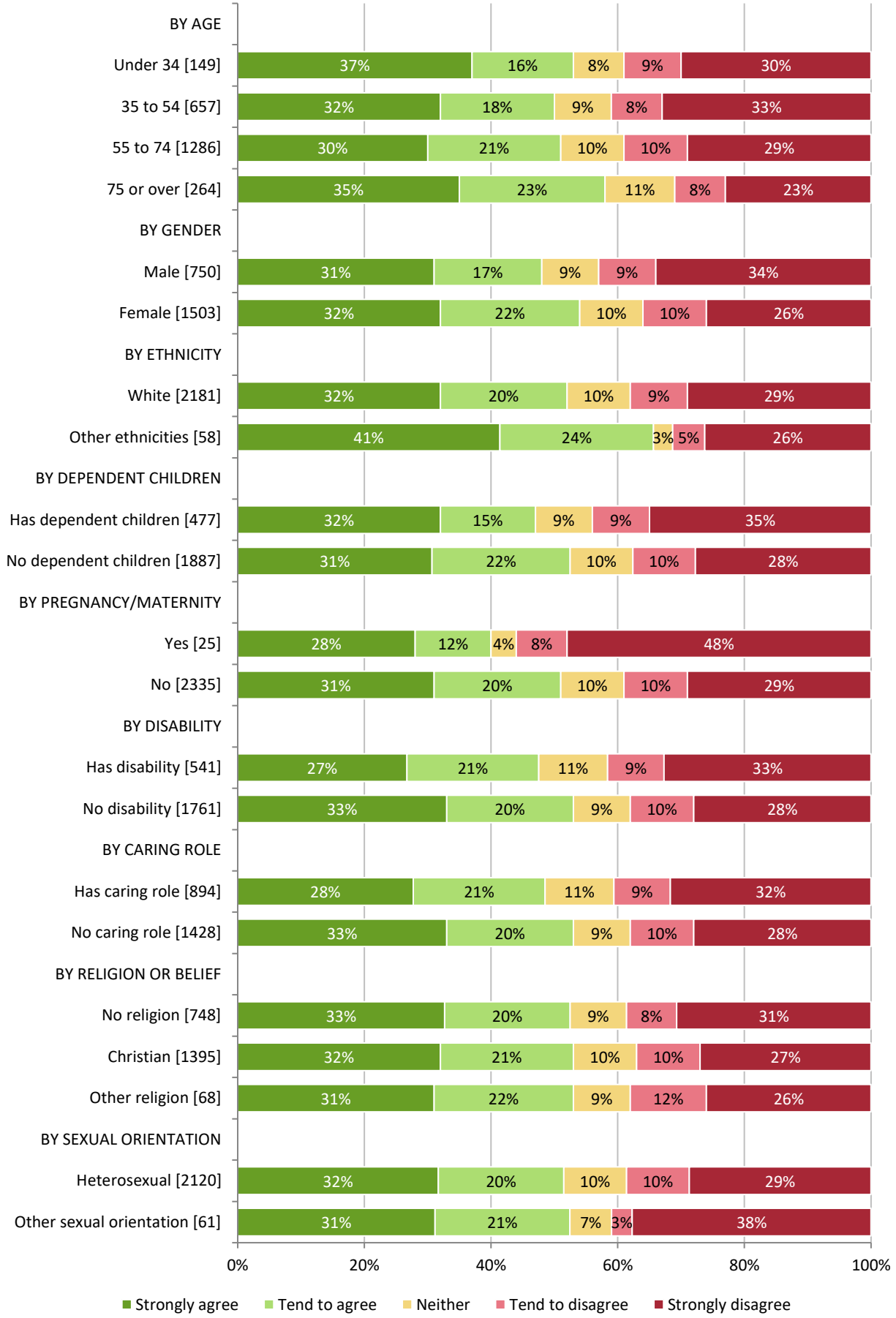
Figure 42: Maps illustrating agreement (green) and disagreement (red) of questionnaire respondents with proposals for a 24/7 Urgent Treatment Centre at Grantham and District Hospital, with their location (based on individual respondents who provided their postcode); darker shading indicates the most concentrated areas of agreement or disagreement



4.79 Figure 43 overleaf presents questionnaire respondents' views on the proposal for a 24/7 UTC at Grantham and District Hospital, broken down by key demographics.

4.80 The results indicate that fewer respondents who are pregnant or providing maternity care agreed with the proposals than disagreed which, as with the proposals for orthopaedic surgery, is likely to be linked to broader concerns about local services. Analysis of open text responses showed that only two respondents expressed particular concern about young children being particularly impacted by the changes.

Figure 43: Views on the proposal for urgent and emergency care BY KEY DEMOGRAPHICS (individuals only)

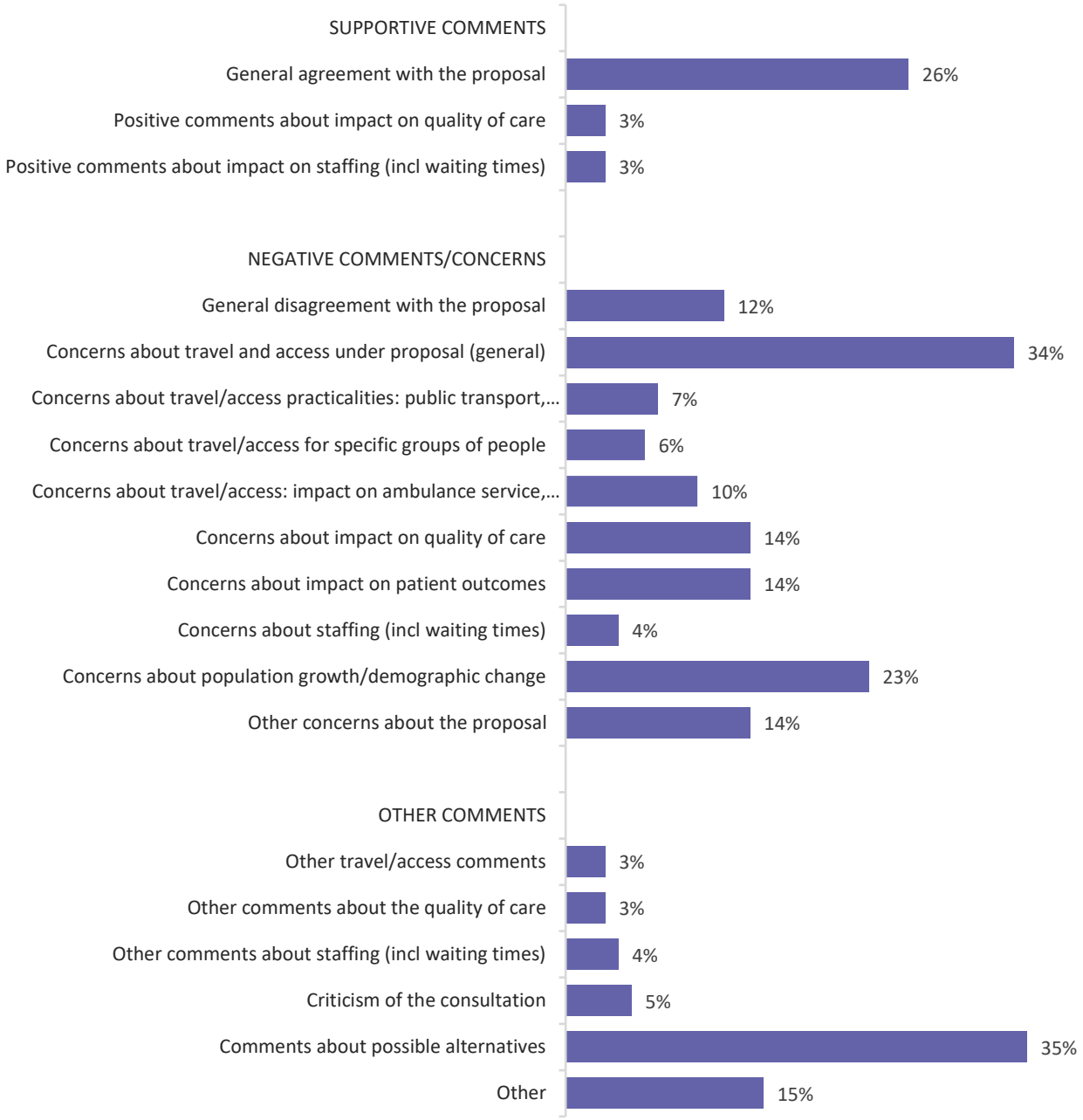


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Comments about the proposal for urgent and emergency care

4.81 A high-level summary of the comments provided in relation to the text question about the proposal for urgent and emergency care is shown in the figure below.

Figure 44: High-level summary of the further comments made in response to the text question about the proposal for urgent and emergency care.



Base: All individual respondents who provided comments (1,829)

4.82 It can be seen that around a quarter of individuals who commented expressed broad agreement with the proposal for a 24/7 Urgent Treatment Centre at Grantham and District Hospital, with small proportions identifying benefits in terms of quality and care and staffing.

4.83 However more than a tenth generally disagreed – with many of these respondents suggesting that emergency care should continue to be provided at Grantham and/or at services should remain the same.

4.84 A third had general concerns relating to travel and access themes: the accessibility of emergency services at the remaining sites, the need for some local emergency provision in Grantham, and so on. There were also a number of more specific concerns relating to issues such as roads, parking and public transport. A tenth commented about a potential negative impact on the ambulance service and on patient transport (e.g., in terms of greater response times and an inability to cope with demand).

4.85 There were numerous concerns expressed in terms of a potential negative impact on the quality of care and on outcomes for patients, primarily:

- Concerns that existing emergency services are already under pressure and/or unable to cope, and therefore removing services from one location will only exacerbate these pressures;
- Concerns that more patients will die as a result of travelling further for emergency care, particularly for time-critical illnesses such as strokes and heart attacks;
- Concerns around the potential for patients to present at a hospital where there are no staff with the expertise to required treat them; and
- Concerns around the ability to transfer patients to a different site safely in an emergency.

4.86 There was also some scepticism that the proposal will really do anything to improve the recruitment and retention of staff, as well as some concern that the proposals may actually have a negative impact on staffing.

4.87 There were also concerns that the proposal does not take sufficient account of demographic changes, specifically a growth in the overall population (particularly in Grantham, but also more generally), and also an increasingly older age profile across the area, both of which (it was suggested) are likely to result in an increased demand for emergency services.

4.88 Small numbers expressed additional concerns, for example:

- Concerns about Grantham being at greater risk of seeing a major incident, due to its proximity to the A1, rail services, flight paths etc.;
- A perception that Grantham and District Hospital has been downgraded over time, and this latest proposal is likely to be a precursor to further service reductions and/or closure;
- Perceptions that the proposals are short-sighted, motivated by a desire to save money rather than to improve services, and not likely to provide good value; and
- The environmental impacts of longer journeys, particularly by car (as well as risks of traffic accidents).

Individuals' comments on equalities impacts of urgent and emergency care proposals

4.89 As with the orthopaedics question, 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.

Individuals' suggestions and other comments around urgent and emergency care

4.90 The most commonly suggested alternatives included restoration of the A&E service at Grantham, and further investment in services (either in Grantham specifically, but occasionally across the hospitals more generally). Others suggested alternative ways to address staffing issues (e.g., wages, housing provision and other benefits). A very small number of individuals advocated having teams of staff to move between sites.

4.91 The summary below provides some detailed and/or more specific points that were made in support of the suggestion that A&E services should be maintained at Grantham:

- It was suggested that the Lincoln and Pilgrim A&E departments are often stretched with prolonged ambulance handover delays; therefore, ULHT should build the A&E capabilities at Grantham to cut transfer times, reduce risk for patients, make it attractive for staff: *'The challenge for ULHT is to see Grantham as an asset not a liability'*;
- The variety of patient ailments, growth of Grantham and large rural catchment area of patients deserve (it was suggested) a better quality of service than the UTC offers. The issue of staff recruitment is not just specific to A&E doctors; UTCs also experience staff shortages meaning there are barely enough to safely staff the existing UTCs. There is concern over where the experienced ACPs will be found to fill these vacancies;
- A&E services at Grantham should be maintained, with separate walk-in services, run by nurse specialists, in addition to A&E services for emergency/ambulance admissions in Lincoln and Boston;
- The quality of care at the other hospitals (i.e., Lincoln and Pilgrim) is questionable: 'I have received A&E care at Grantham, Lincoln and Pilgrim and the best has been at Grantham'; and
- An alternative might be to provide A&E during the current times in the day at Grantham and a UTC in the evening (thereby providing 24 hour access to urgent/emergency care).

4.92 Other suggestions made were as follows:

- If the 24/7 UTC goes ahead, ULHT should provide their own non-blue light and blue light interfacility transfer service, so they do not affect the running of EMAS's services;
- That the 24/7 UTC would still need x-ray and phlebotomy services to be available;
- A new, easily accessible hospital should be built on the outskirts of Sleaford, to deal with all emergency care through creation of a modern full trauma facility (other existing estates could house low dependency convalescence facilities and thus aid patient throughput);
- ULHT should increase the number of nurse ACPs (Advanced Clinical Practitioners) through training, to compensate for the shortage of consultants; and
- Grantham is a better location for services for those residents living south of Grantham. There should be a similar facility for Stamford to cover the Deepings and Bourne areas.

Views from organisations on proposals for urgent and emergency care at Grantham and District Hospital

4.93 Eight of the sixteen organisations agreed with the proposals for urgent and emergency care (five strongly), while four disagreed (three strongly). Two organisations neither agreed nor disagreed, one did not know, and one did not answer the question at all. The comments organisations made about the proposals are below.

Issues of concern: travel and access

4.94 Travel and accessibility were concerns for multiple organisations, even some who agreed with the proposals. For example, the Older People's Forum acknowledged the benefits of the proposed changes, while noting potential difficulties for those without their own transport. Moreover, access to public transport was again a concern for local councils.

Very good for Grantham people but not people who cannot reach Grantham - non-drivers.

The Older People's Forum

The document also recognises that friends and family of patients receiving treatment at an alternative hospital further away will have to travel further to visit and provide support... There would be implications for those reliant on public transport. Public transport infrastructure can be challenging across the county.

Boston Borough Council, East Lindsey District Council, and South Holland District Council

4.95 The potential for extended travel times to place lives at risk was a worry, particularly for the senior citizens of Grantham.

Removing A & E services will cost lives by adding 28 miles travel over difficult roads in winter and busy roads all year round.

Grantham Senior Citizens Club Ltd.

4.96 Distance and travel time was also concerning from a council perspective, particularly in terms of impacting visitor support and impacting patient recovery. Digital communication options were suggested as solutions to this issue.

Residents will also face additional travel time and cost to get to the nearest A&E or to visit loved ones.

Skegness Town Council

Patient recovery can be impacted by lack of support and visitors. Digital options for communication generally have increased over the last 2 years. There could be opportunities to look at digital options with borrowed mobile tablet devices so that patients can connect with friends and family remotely whilst in hospital.

Boston Borough Council, East Lindsey District Council, and South Holland District Council

Issues of concern: Grantham's population and the demand for A&E services

4.97 There was some difference of opinion over the need for a full A&E in the Grantham area. Those who disagreed with the proposal for an UTC referred to the area's growing population and the consequent demand for services.

Grantham is a growth area with thousands of new houses planned for the immediate future. 1) Removing A&E services will cost lives by adding 28 miles travel over difficult roads in winter and busy roads all year round. 2) bed waiting times at both Boston & Lincoln are currently unacceptable and increasing use will only make this worse.

Grantham Senior Citizen's Club Ltd.

I think a town as big as Grantham and with the proposal of it getting a lot bigger what with two outlet shopping villages at either end of town, and plans of the Spittlegate level industrial park, plus Grantham barracks housing plans, how can a town of that size have NO A&E?

Lincolnshire Traveller Initiative Health Champion

4.98 Lincolnshire Local Medical Committee, though, stated that Grantham's size does not warrant a full A&E department, and supported the development of a 24/7 UTC as 'proportionate'.

> *Grantham does not have the population to justify a full ED and associated required services, thus a 24/7 UTC is proportionate.*
>
> ***Lincolnshire Local Medical Committee***

Issues of concern: pressure on emergency services

4.99 Another concern among local councils was around the risk of placing additional pressure on the East Midlands Ambulance Service (EMAS).

> *The document highlights potential adverse impacts, and that a small percentage of patients may need to attend required specialist services at A&E further afield. These would most likely need to travel by ambulance – is there a risk of additional pressure on EMAS taking patients to Lincoln City Hospital or Peterborough City Hospital?*
>
> ***Boston Borough Council, East Lindsey District Council, and South Holland District Council***
>
> *Don't want to see any reductions of NHS services in Lincolnshire area. Additional pressures would be put on East Midlands Ambulance Service.*
>
> ***Skegness Town Council***

Other issues: need for further consultation

4.100 The Chartered Society of Physiotherapy advocated further consultation with affected staff on the proposal for an UTC at Grantham in order to fully understand the impacts of, for example: social deprivation factors and access issues; increased demand for EMAS; potential risks to patients and outcomes; and staff shortages.

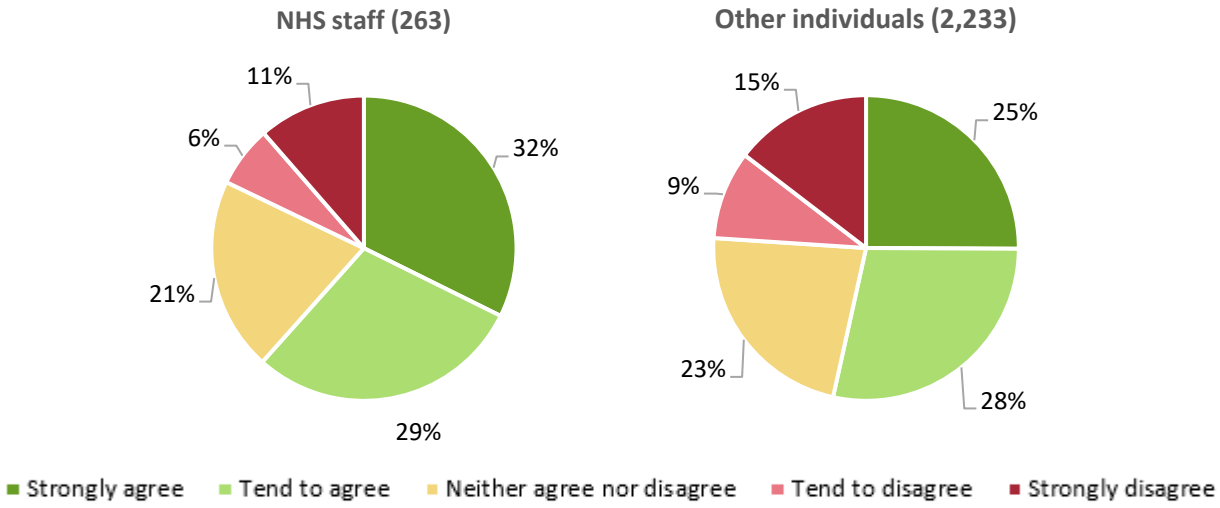
> *The CSP believe that changing the Accident and Emergency department into provision of a twenty-four seven urgent care centre at Grantham and District Hospital must be carefully considered. We would expect to see a wide and meaningful consultation to occur with all affected staff, which would include areas including, but not limited to how proposals would impact: Social deprivation factors and access to services for patients and their family; Ambulance arrivals, including the golden hour and patient handovers; Risks of patient deterioration and escalation processes; Local increases in service demand; Use of inappropriate space for patients; Staff shortages, long term and temporary; Patient outcomes; Early clinical assessment; Impact on terms and conditions of those that staff the current service configuration. We would take this opportunity to highlight the lack physiotherapy staffing in the current service provision, and seek to review the positive impact that having access to rehabilitation assessment and outreach services would have on the falls pathway within the urgent care and emergency departments of Lincolnshire.*
>
> ***The Chartered Society of Physiotherapy (CSP)***

Respondents' views on the proposal concerning acute medical beds at Grantham and District Hospital

4.101 Just over three fifths (62%) of NHS staff agreed with the proposal for integrated community/acute medical beds, as did just over half (53%) of other individuals who responded to the questionnaire (with 18% and 24% disagreeing, respectively).

4.102 Between a fifth and a quarter of individual respondents neither agreed nor disagreed with the proposals for integrated community/acute medical beds; comments indicated that many of these felt unconfident or unqualified to voice an opinion, while a few criticised the explanation of the proposals for a lack of clarity.

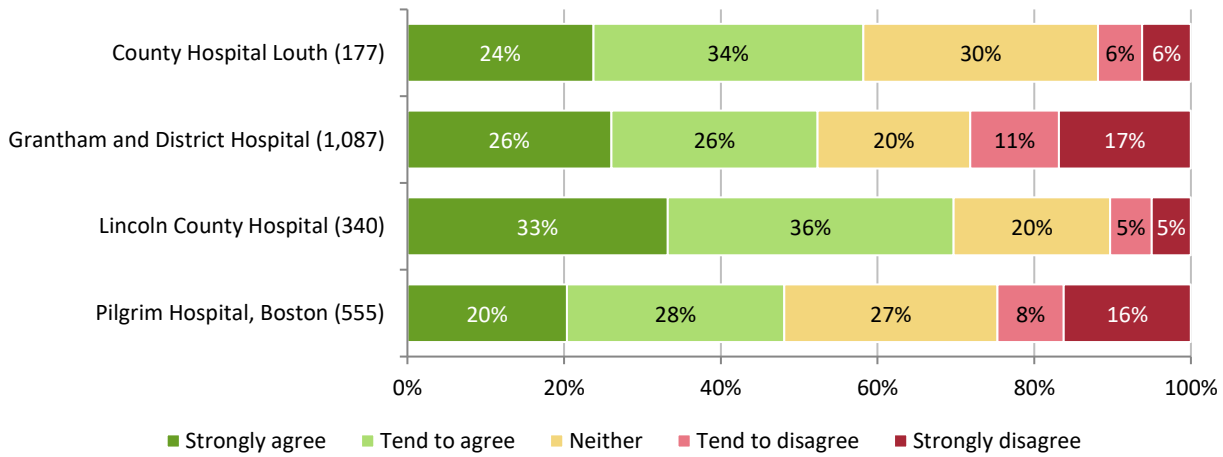
Figure 45: Views on the proposal concerning acute medical beds, by stakeholder type



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.103 Around half of respondents whose nearest hospital is Grantham and District Hospital (Figure 46) agreed with the proposal (52%), although more than a quarter disagreed (28%). The views of respondents living closest to Pilgrim Hospital, Boston were broadly similar: just under half (48%) agreed and a quarter (25%) disagreed. Levels of agreement among respondents living closest to County Hospital Louth or Lincoln County Hospital were somewhat higher (58% and 70% respectively).

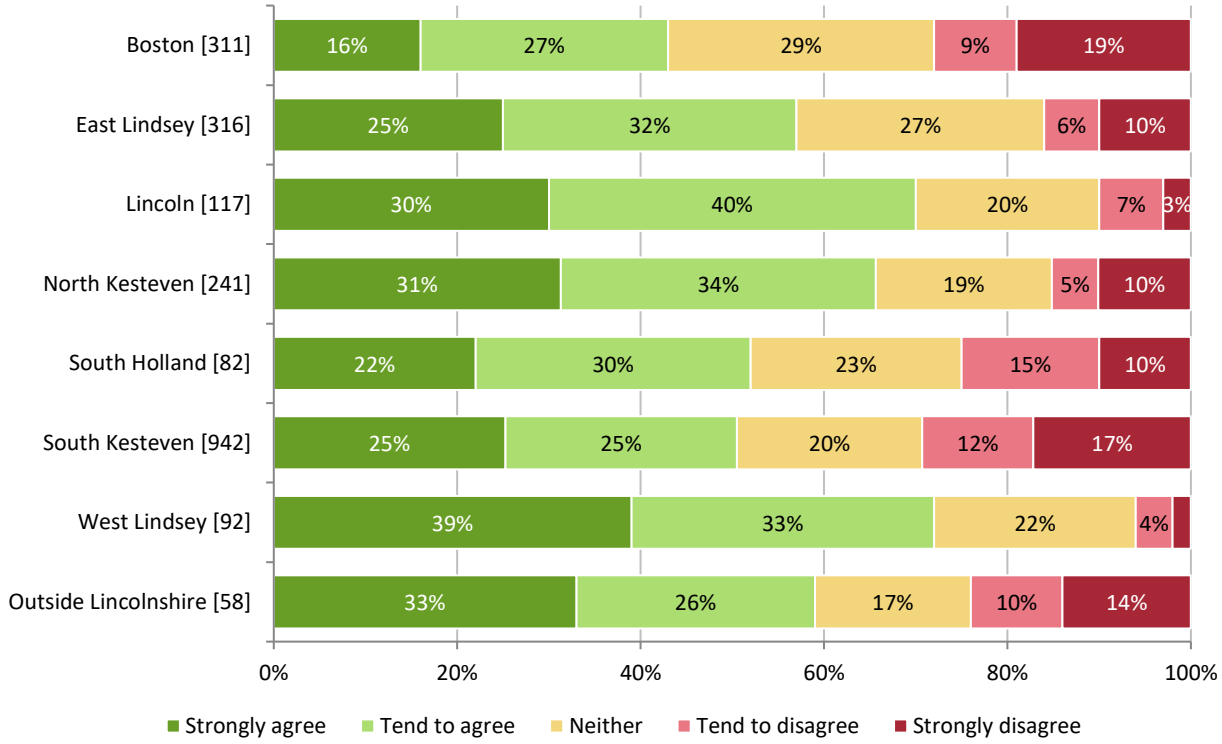
Figure 46: Views on the proposal concerning acute medical beds BY CLOSEST HOSPITAL (individuals only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

A similar pattern was evident when viewing the results by district of residence (Figure 47), with less than half (43%) of respondents living in Boston agreeing with the proposal. It should be noted, however, that very nearly three in ten (29%) respondents from the same area neither agreed nor disagreed, with a smaller proportion (27%) actively disagreeing with the proposed changes to the way that acute medical beds are managed.

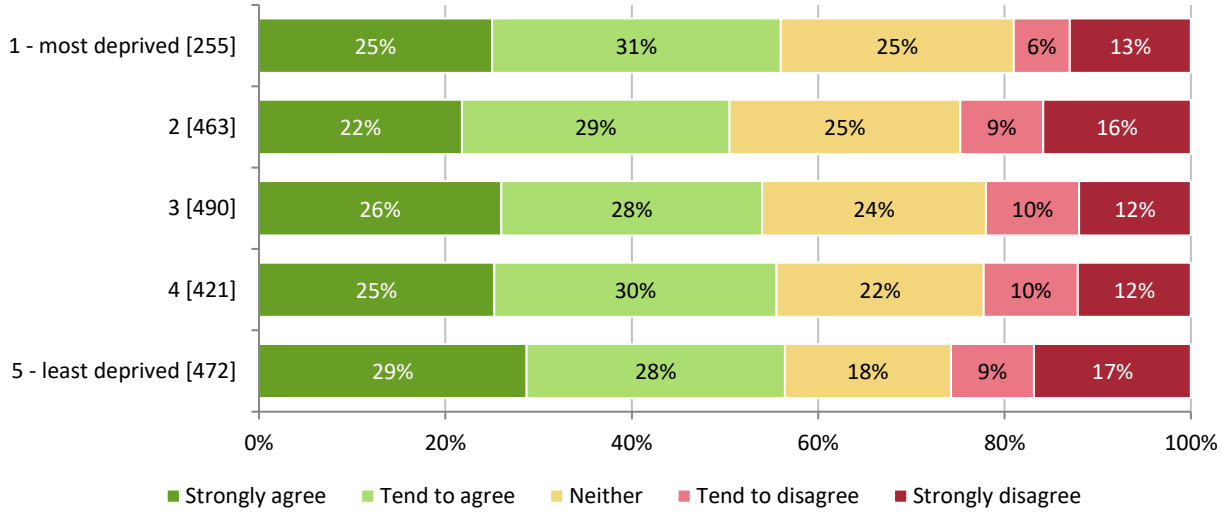
Figure 47: Views on the proposal concerning acute medical beds BY DISTRICT (individuals only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.104 Figure 48 presents all individual questionnaire respondents' views on the proposals for integrated community/acute medical beds at Grantham and District Hospital, broken down by IMD quintiles. It indicates that, while there are some small variations in views, the trends in terms of agreement and disagreement are similar across the results.

Figure 48: Views on the proposal concerning acute medical beds BY INDICES OF MULTIPLE DEPRIVATION (IMD) (individuals only)

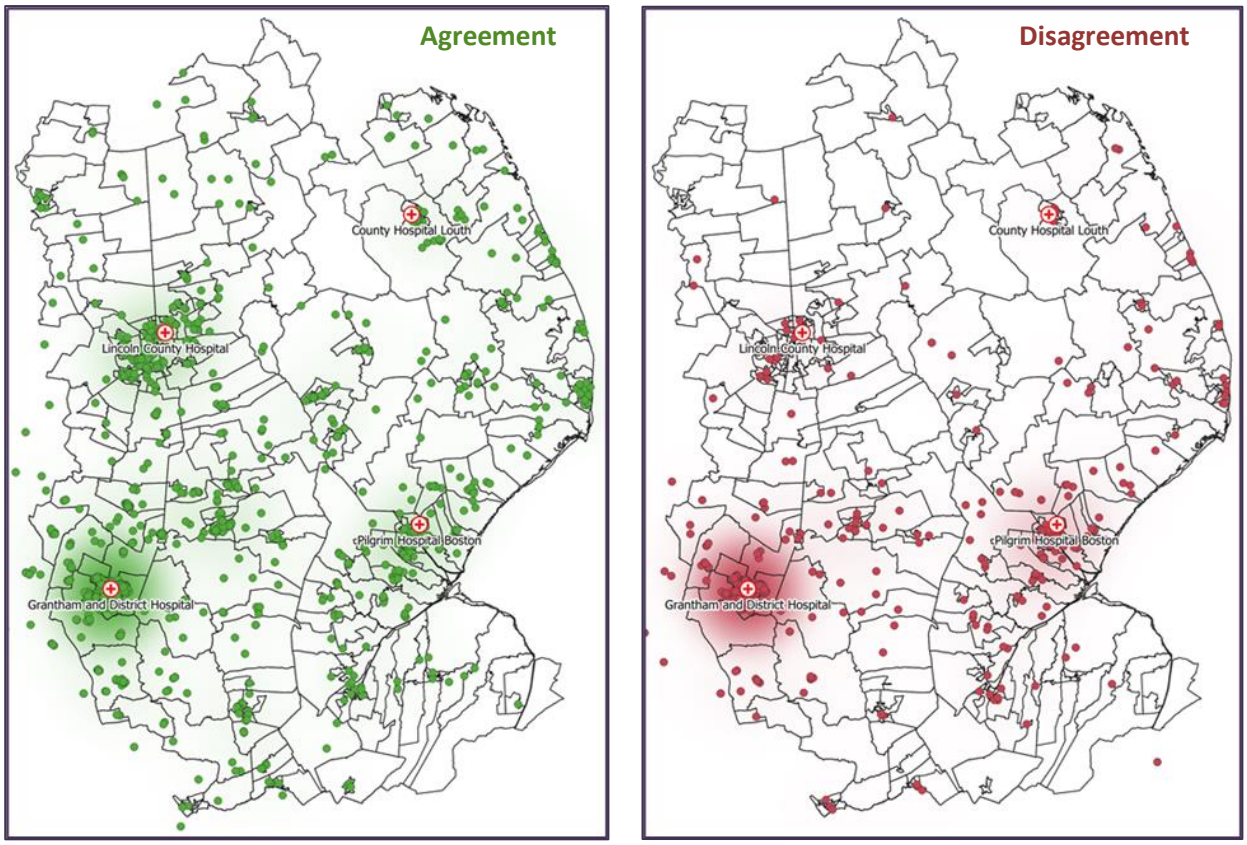


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.105 The maps in Figure 49 below illustrate that the most concentrated disagreement from questionnaire respondents around proposals to introduce community/acute medical beds at Grantham and District Hospital is among those living close to Grantham.

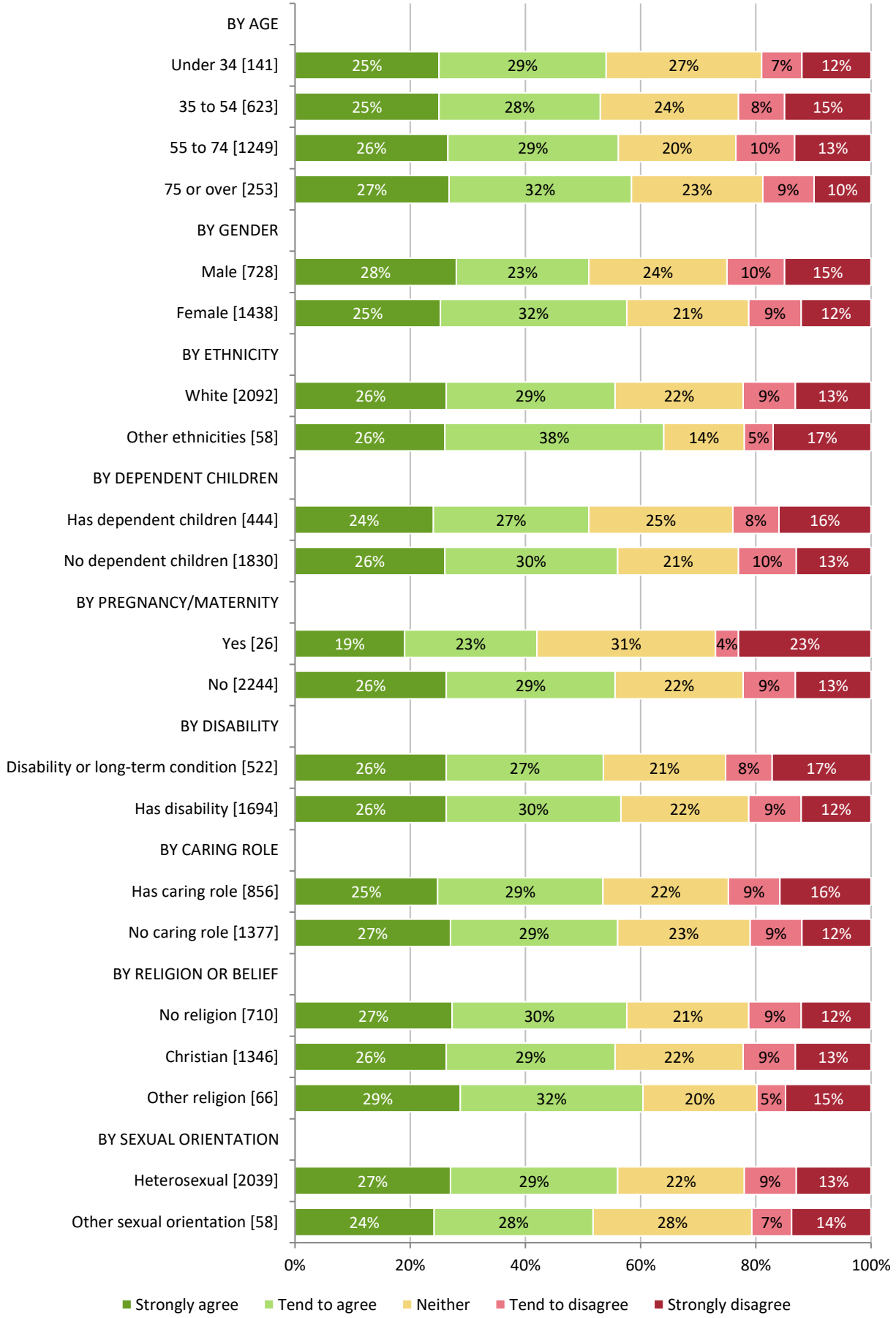
4.106 Agreement, by contrast, is more geographically widespread, including across South Kesteven more widely, and the proposals are also supported by many of those questionnaire respondents living near to Grantham and District Hospital.

Figure 49: Maps illustrating agreement (green) and disagreement (red) of questionnaire respondents with proposals for integrated community/acute medical beds at Grantham and District Hospital, with their location (based on individual respondents who provided their postcode); darker shading indicates the most concentrated areas of agreement or disagreement



4.107 Figure 50 overleaf breaks down questionnaire responses by key demographics and protected characteristics, with no indication of key differences in views on the proposal between different groups.

Figure 50: Views on the proposal concerning acute medical beds BY KEY DEMOGRAPHICS (individuals only)

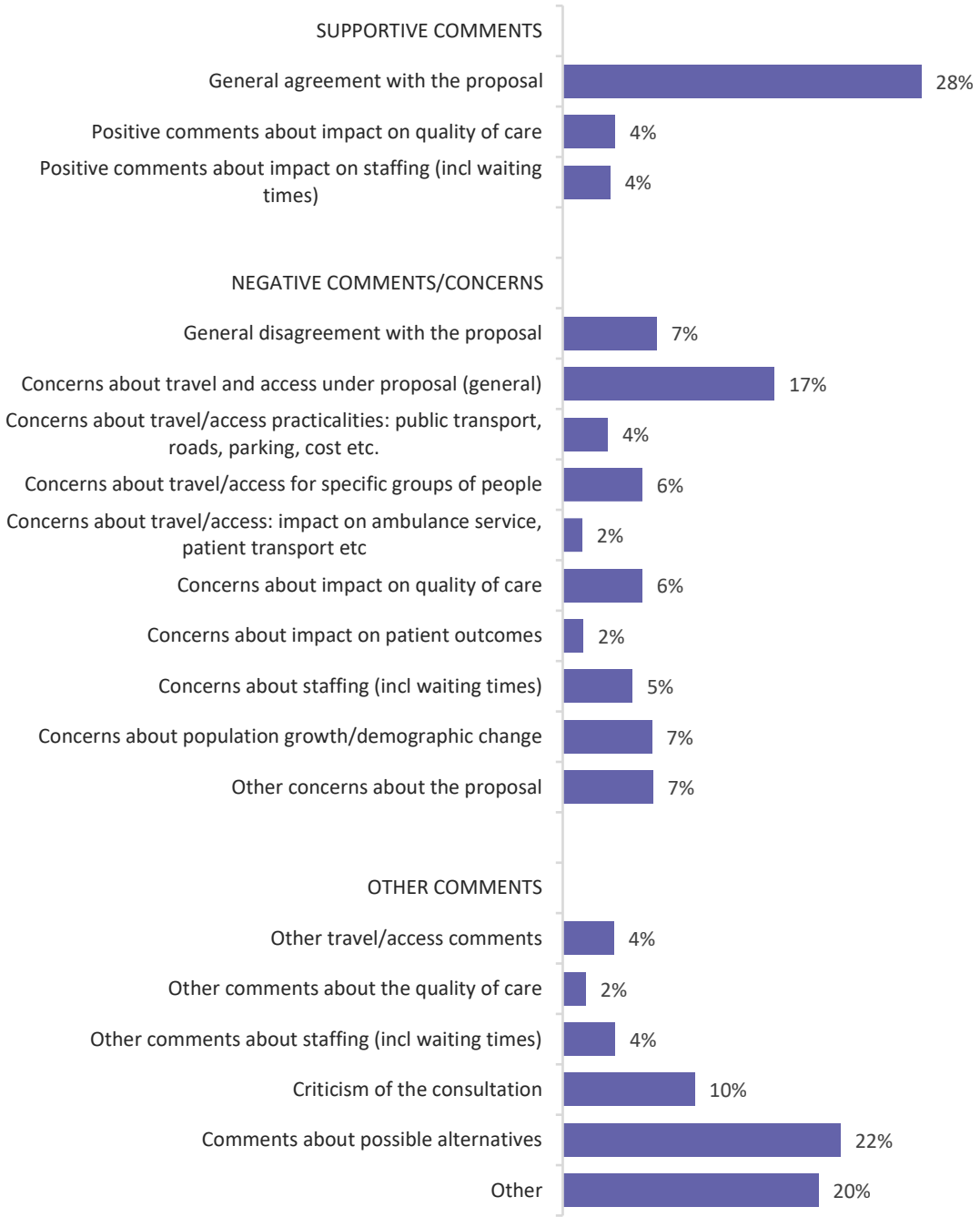


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Comments about the proposal concerning acute medical beds

4.108 A high-level summary of the comments provided in relation to the text question concerning proposals for community/acute medical beds is shown in the figure below.

Figure 51: High-level summary of the further comments made in response to the text question about the proposal for community/acute medical beds at Grantham and District Hospital.



Base: All individual respondents who provided comments (1,045)

4.109 Of those respondents who commented on the proposal concerning integrated community/ acute medical beds at Grantham, over a quarter made generally supportive comments, e.g., either explicitly supporting the proposal or agreeing generally with the principle of better integration between services in the community and in hospital. Small proportions commented about potentially positive impacts on the quality of care and on staffing and the efficiency of services.

4.110 There was nonetheless some disagreement with the proposal, e.g., some respondents thought that acute medical beds should remain available in all hospitals, and some had doubts that the proposal would improve quality of care, patient outcomes and staffing issues.

4.111 As with the questions about the previous proposals, there were various concerns expressed in terms of travel and access issues: either around the general principle of travelling further for care, various practicalities concerning travel/transport, and/or the impact on particular groups (in terms of this latter point, the ability for family and friends to visit patients was felt to be particularly important).

4.112 As with the previous proposal, some concerns were expressed about population growth and demographic change, and some respondents perceived that the proposal was part of a wider pattern of downgrading services at Grantham. As such, among the suggested alternatives were calls to restore services at Grantham (including emergency services) and to improve and invest in its facilities and services. Respondents also felt that consideration should be given to alternative ways to address staffing shortages.

Individual respondents' views on potential equalities impacts of proposals for integrated acute/community medical beds at Grantham and District Hospital

4.113 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.

4.114 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.

Alternative suggestions and other comments from individual respondents around acute medical beds

4.115 Several alternative suggestions or enhancements to the proposal were suggested as follows:

- If acute and community beds are available at Grantham, blood tests should be too;
- That acute and rehabilitation pathways should be established:
  - An acute pathway (for acutely/medically unstable patients) consisting of an Emergency Assessment Unit (EAU) and one more medical ward to allow patient flow with multi-disciplinary team (MDT) discharge facilitation; and
  - A rehabilitation pathway including step down from acute beds and step up from community beds, to incorporate a rehabilitation ward with stroke and general rehabilitation beds for patients with any other conditions, including frail elderly and post-Covid patients. Establishing this at Grantham and District Hospital would allow service provision for patients closer to their home and access for visitors;
- That 'halfway house' care wards should be provided for those who are medically well but unable to cope with going home, offering convalescence and low dependency beds, and the potential for occupational therapy; and
- Hospital and ongoing social care should be staffed by fully integrated MDTs to facilitate seamless transfer of patients from hospital into the community. This would involve integrated social services and hospital financial structures to end delayed discharge.

4.116 One NHS staff respondent suggested that acute medical beds should be removed from Grantham and District Hospital completely, given the limited support and other services there, and that Grantham should be an elective surgery and community hospital, providing high quality care outside an acute setting.

4.117 It was also suggested that: mental health beds should be treated as a priority in future planning; and that patients with chronic health conditions and co-morbidities (e.g., obesity) should be centralised in one location in the county to allow staff to develop specialisms.

4.118 One NHS staff member raised specific concerns about lack of provision of Level 2 Respiratory beds at Grantham and District Hospital and suggested that respiratory ACPs could manage respiratory beds with support from anaesthetists and additional funding for recruitment and training.

4.119 Finally, there was some criticism of the consultation documents and the level of detail provided about the way that a community/acute medical beds model would work in practice.

Views from organisations on proposals for integrated acute/community medical beds at Grantham and District Hospital

4.120 Seven of the sixteen organisations agreed with the proposals for integrated acute/community medical beds in Grantham, five strongly. Three organisations disagreed with the proposal, two neither agreed nor disagreed, and the remaining four either did not know or did not answer the question. The comments made by organisations about the proposals are below.

Benefits of the proposals

4.121 Some general positive comments were made about the proposals, as well as more specific ones around the benefits of providing care closer to home, offering multi-disciplinary care to frail patients, and relieving pressure on acute medical beds for more complex patients at Lincoln County Hospital and Pilgrim Hospital, Boston.

Should be good for people in that area.

Older People's Forum

The potential positive impacts of the proposals are clear in the document and the impact of integrated community and acute beds at Grantham hospital has been supported through stakeholder and public workshops.

Boston Borough Council, East Lindsey District Council, and South Holland District Council

Having community hospital beds for step-up and step down will provide care close to home for these patients, whilst also providing a pressure valve for the acute beds at Lincoln.

Lincolnshire Local Medical Committee

Reducing pressure on acute hospital sites at Lincoln and Boston – specifically in relation to 'frail' population is sensible and the integrated multi-disciplinary care team for frail patients is positive.

Boston Borough Council, East Lindsey District Council, and South Holland District Council

It makes sense to keep the acute medical beds local freeing up beds at larger hospitals for more complex patients.

Homecare

4.122 Indeed, as suggested in the quotations above, Boston, East Lindsey, and South Holland Councils were particularly supportive of the prospect of multi-disciplinary care for frail patients and suggested widening this provision to other areas across Lincolnshire. They also advocated further discussions on preventative measures to avoid hospital admissions for such patients.

> *Where else in the County will this specialism for frailty be available – particularly in rural ageing communities such as East Lindsey and South Holland? Although this consultation is specifically on the treatment services available, further discussion on interventions across the system to prevent frail patients needing hospital services in the first place would be beneficial.*
>
> ***Boston Borough Council, East Lindsey District Council, and South Holland District Council***

Issues of concern: pressure on local acute medical beds

4.123 Skegness Town Council took a different view to that expressed above; they 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.

> *Loss of acute medical beds at Grantham Hospital will put additional pressure on Pilgrim, Lincoln, Louth and any other hospital with acute beds in the area. There will also be an additional impact put onto East Midlands Ambulance Service to transfer people to the nearest hospital with an acute bed. Non urgent hospital transfer may also be affected, as people live further away from the hospital they are admitted to. Family and friends may not be able to visit, the positive impact on a patient's health and wellbeing from a visit from a loved one should not be underestimated.*
>
> ***Skegness Town Council***

4.124 The Council was also of the view that removing local services would most impact vulnerable residents.

> *The most vulnerable people in Lincolnshire (elderly, disabled or anyone with additional needs) are likely to be negatively impacted by services being further away from their home.*
>
> ***Skegness Town Council***

Issues of concern: staffing and other resources

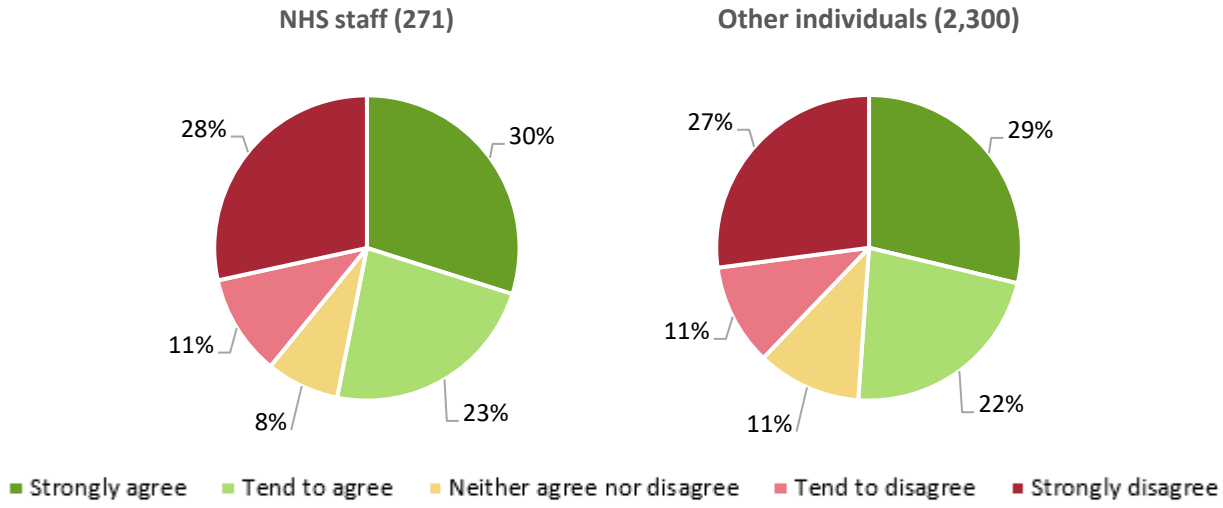
4.125 The Chartered Society of Physiotherapy, while agreeing with the proposal, caveated its support with a request for adequate staffing and resource across the whole pathway to provide a 'comprehensive' service.

> *The CSP would support the integration of acute/community medical beds at Grantham and District Hospital. This is with the proviso that the required workforce across the whole pathway can be attained, with any required training needs met prior to the service being provided. We would expect a meaningful consultation with all potential service users and staff. Adequate staffing and resources must be provided for a comprehensive seven-day service with all professions having the full resources they require to enable a high level of quality of care that facilitates better outcomes for the population of Lincolnshire.*
>
> ***The Chartered Society of Physiotherapy***

Respondents' views on the proposal for stroke services in Lincolnshire

4.126 Just over half of NHS staff (53%) and other individuals (51%) agreed with the proposal for stroke services, while around two fifths (39% and 38% respectively) disagreed.

Figure 52: Views on the proposal for stroke services, by stakeholder type

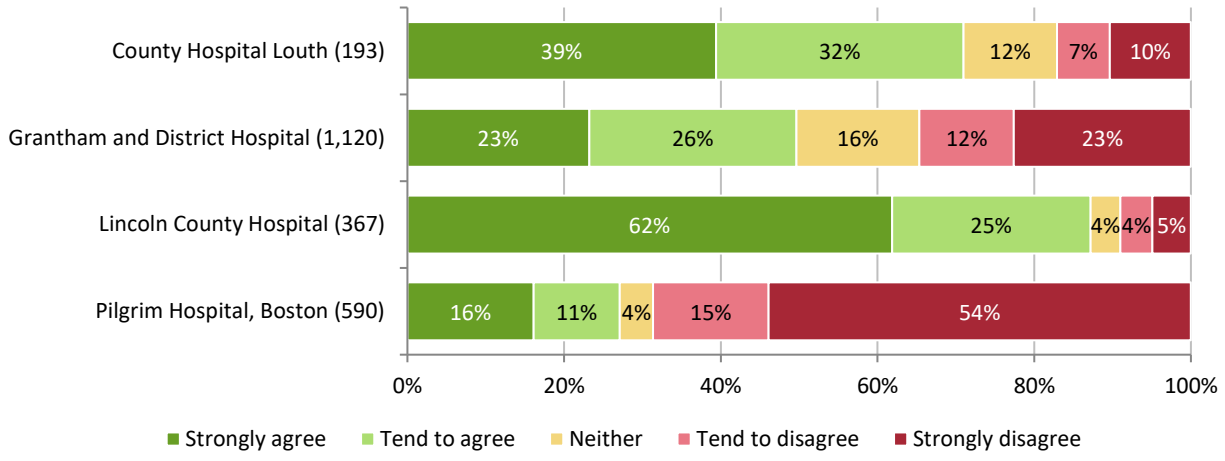


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.127 An analysis of results by individual respondents' closest hospital reveals clear geographical differences in views; only around a quarter (27%) of respondents whose nearest hospital is Pilgrim Hospital, Boston agreed with the proposal for stroke services, whereas over two thirds of these respondents (69%) disagreed (Figure 53).

4.128 On the other hand, the vast majority of respondents living closest to Lincoln County Hospital agreed with the proposal (87%), as did around seven in ten of those living closest to County Hospital Louth (71%). Views were more mixed among respondents living closest to Grantham and District Hospital, half of whom agreed with the proposals for stroke services (50%), whereas over a third disagreed (35%).

Figure 53: Views on the proposal for stroke services BY CLOSEST HOSPITAL (individuals only)

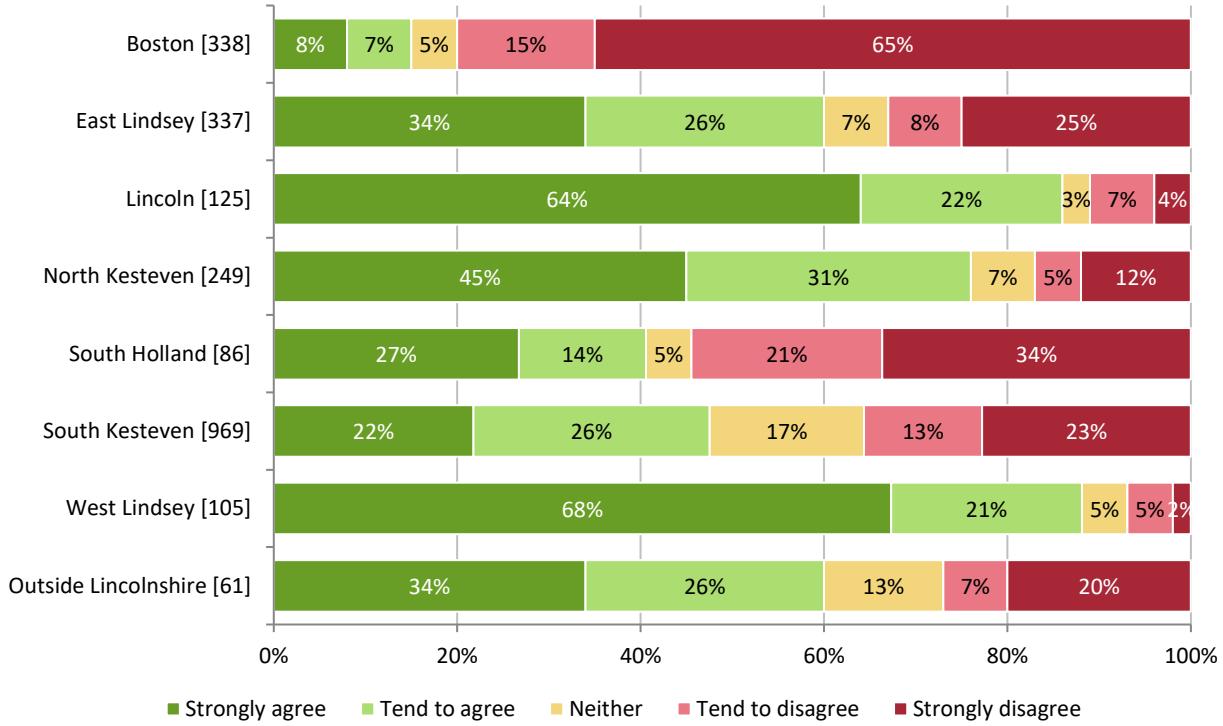


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.129

4.130 Figure 54 highlights these differences in views further, with eight in ten (80%) of respondents living in Boston and over half of respondents from South Holland (55%) disagreeing with the proposals. Views from respondents in South Kesteven were also mixed, with just under half (47%) agreeing with the proposals.

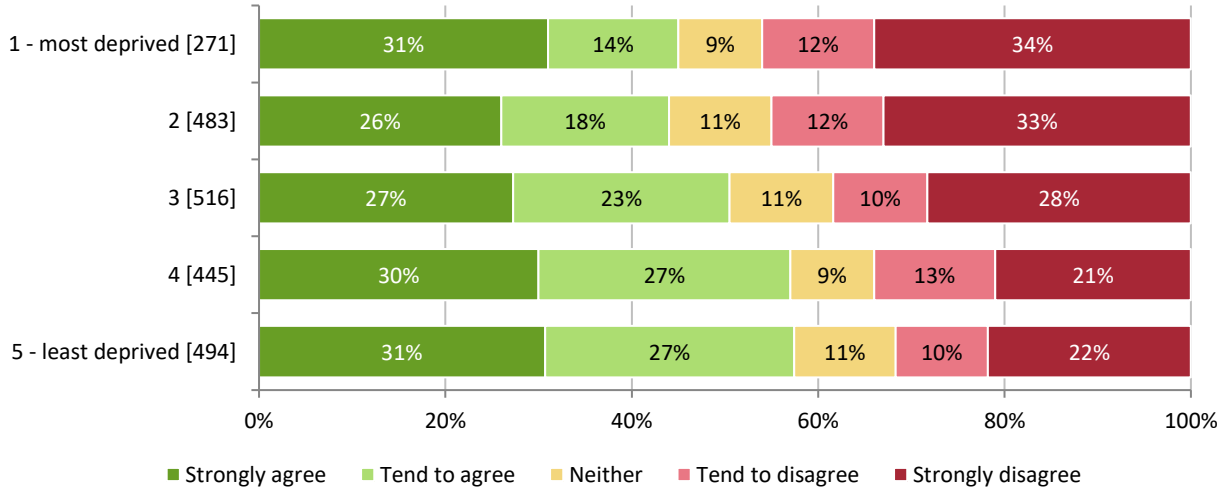
Figure 54: Views on the proposal for stroke services BY DISTRICT (individuals only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.131 A slightly greater proportion of respondents from deprived communities disagreed with proposals for stroke services than agreed (Figure 55). It is important to note, 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. These 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.

Figure 55: Views on the proposal for stroke services beds BY INDICES OF MULTIPLE DEPRIVATION (IMD) (individuals only)

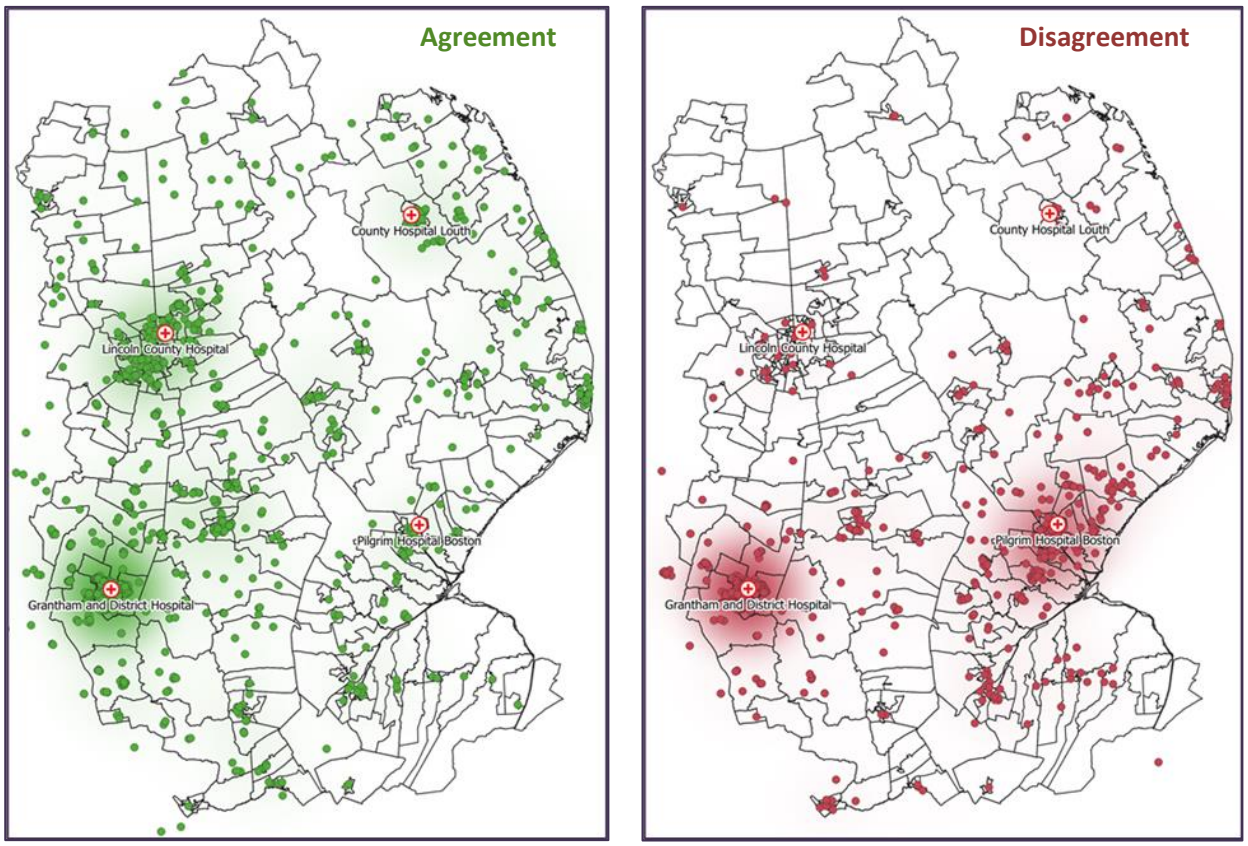


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.132 The maps in Figure 55 below illustrate that the most concentrated disagreement from questionnaire respondents around proposals for stroke services in Lincolnshire is among those in Boston and South Holland districts and, to a lesser extent, those living close to the town of Grantham.

4.133 Agreement, by contrast, is more prevalent across the west and north of Lincolnshire, including across South Kesteven more widely.

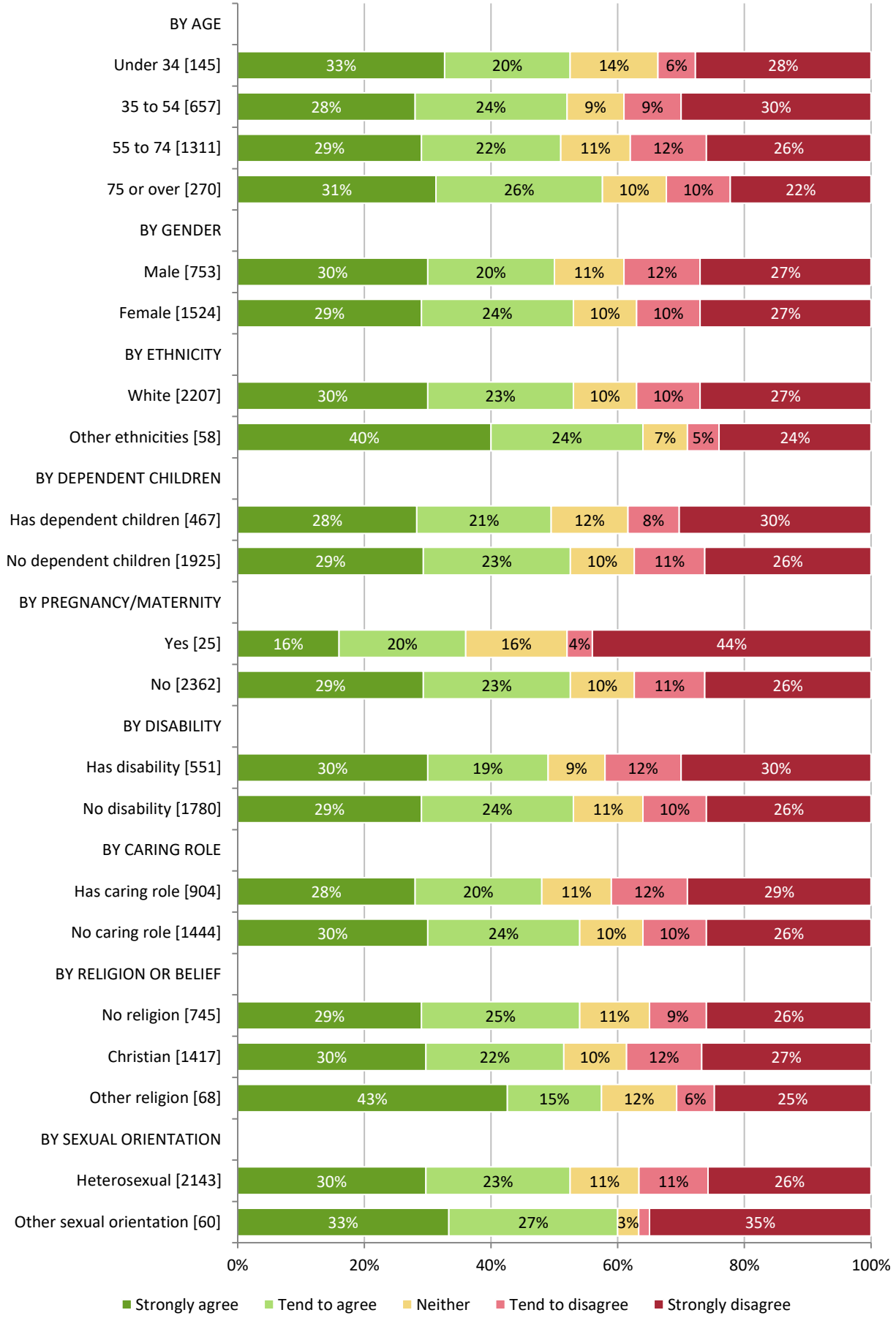
Figure 56: Maps illustrating agreement (green) and disagreement (red) of questionnaire respondents with proposals for stroke services in Lincolnshire, with their location (based on individual respondents who provided their postcode); darker shading indicates the most concentrated areas of agreement or disagreement



4.134 The results broken down by key demographics and protected characteristics (Figure 57, overleaf) indicate that fewer respondents who are pregnant or providing maternity care agreed with the proposals than disagreed.

4.135 As previously, however, further analysis indicated that this is because of the highest proportion of expectant or nursing mothers who responded to the questionnaire living closest in geographic areas where the proposals were viewed more negatively across all respondents.

Figure 57: Views on the proposal for stroke services BY KEY DEMOGRAPHICS (individuals only)

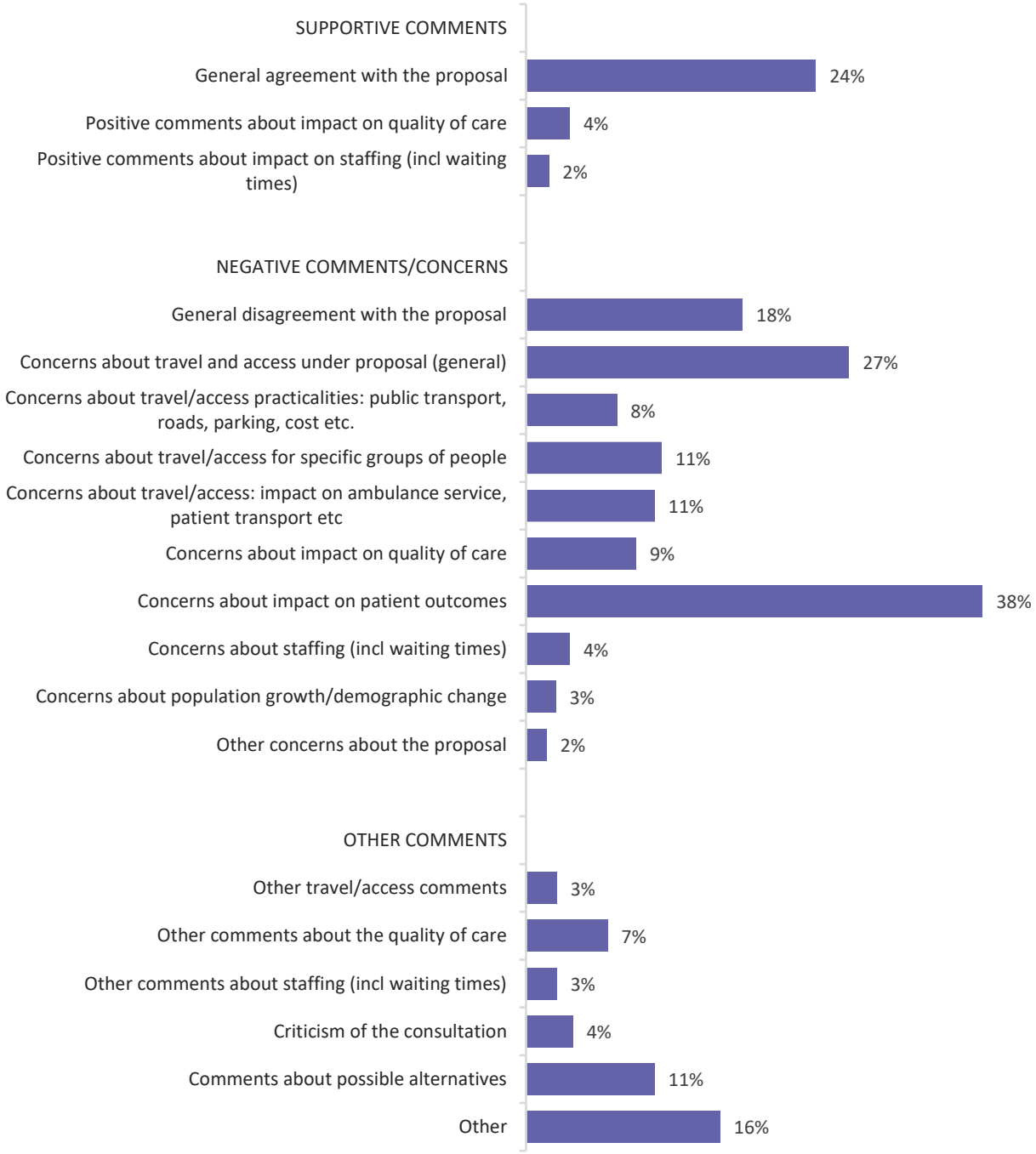


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Comments about the proposal for stroke services

4.136 A high-level summary of the comments provided in relation to the text question concerning stroke services is shown in the figure below.

Figure 58: High-level summary of the further comments made in response to the text question about the proposal for stroke services.



Base: All individual respondents who provided comments (1,540)

4.137 Around a quarter of individuals who commented were broadly supportive of the proposal in general and/or of the proposal for a dedicated centre for stroke/heart problems at Lincoln County Hospital. Smaller proportions foresaw specific potential benefits in terms of quality of care and staffing.

4.138 However, around a fifth expressed some sort of broad disagreement, for example, on the basis that stroke services should be available at all hospitals, or that they should also be available at Grantham and/or Boston specifically.

4.139 Several staff members were concerned that Pilgrim Hospital, Boston had previously been running a safe and high quality stroke service which outperformed Lincoln County Hospital; moving the service, they felt, could lead to experienced staff leaving and thereby put patients at risk.

4.140 Some doubted that the proposal would improve the quality of care provided, and there were significant concerns (expressed by nearly two fifths of all individual respondents who commented) about potential negative impacts on patient outcomes. Many feared travel times would lead to an increased number of patients failing to receive treatments such as thrombolysis or 'clot-busting' medication within the 'golden hour', and therefore to more deaths. Smaller proportions were concerned about the provision of follow-up care after a stroke.

4.141 As with the previous proposals, there were concerns about travel and access issues, with many of these focusing on the perceived inaccessibility of services at Lincoln specifically. Some felt there would be particular issues for service users (i.e., stroke patients), the elderly, people without access to vehicles, and patients' families and friends. Others were concerned about the impacts on ambulance response times and the ambulance service as a whole, as a result of high demand and longer journeys to hospital.

4.142 A number of respondents suggested that looking at other means to address staffing shortages (e.g., through increasing wages and other incentives, and by undertaking more training) and increasing investment in the current facilities might be alternative ways to address the issues.

4.143 Finally, there were a small number of comments expressing concern about the lack of information in the proposals around community rehabilitation beds within care homes or community hospitals. Additionally, a few respondents asked whether there might be a risk of patients with conditions such as dysphagia as a result of a stroke becoming 'stuck' in Lincoln County Hospital acute stroke beds?

Individual respondents' views on equalities impacts of the proposal for stroke services in Lincolnshire

4.144 There were concerns expressed that the proposal could widen health inequalities and negatively impact patient access due to acute stroke services being moved from Pilgrim hospital, with some calls for a Centre of Excellence to be established in Boston as well as, or instead of, the proposed centre at Lincoln County Hospital.

4.145 As with the other proposals, feedback from and about protected characteristics groups and other key demographics tended to express some concerns about travel and transport. The potential impacts on patients' loved ones was also noted, particularly older family members and carers 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.

4.146 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.

4.147 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.

Alternative suggestions and other comments from individual respondents around stroke services

4.148 Many of the detailed alternative or additional suggestions for improvements to stroke services, as well as possible mitigation for the potential impacts of changes, were raised by organisations in the more detailed questionnaire responses reported in the following section.

4.149 There were, however, some alternatives mentioned by individual respondents:

- Social care provision should be strengthened to reduce the length of hospital stays;
- An air ambulance should cover the east of the county;
- More beds, staff (including staff with thrombolysis training) and other resources should be made available;
- A telemedicine system should be introduced that matches some models used in Europe or other remote areas, whereby more junior staff members could be upskilled to initiate investigations and treatment plans with the help of consultants, to keep patient care local; and
- Additional therapy staffing in the stroke unit and community stroke team to support more timely assessment and discharge planning, as well as discharges themselves.

4.150 As mentioned above, two more general alternative suggestions were made; firstly, that both Lincoln County Hospital and Pilgrim Hospital, Boston should be centres of excellence for stroke; and secondly, that specialist stroke services should be located in Boston to better suit the overall needs of the population.

4.151 More specifically, the following suggestions were made in relation to the hyper-acute and acute wards:

- Train teams stepping into hyper acute care in a timely way; for example, specialist strokes and registrants stepping onto Advanced Clinical Practitioner (ACP) university courses using 'learning beyond registration' (LBR) funds or apprenticeship levies;
- If there is to be a second ward at Lincoln, this should be a small hyper-acute ward (close to the stroke unit), and the current stroke unit should be used for acute care and rehabilitation as it already has several therapy rooms. Therapy teams should work across the two wards to provide consistency of care and help maintain cover during annual leave/staff absence etc.;
- It would be beneficial to have a dedicated MDT/discharge co-ordinator(s);
- Make consultants and ACPs work pan-trust and put money into ACP training for experienced stroke nurses; and
- A standard operating procedure should be in place that allows thrombolysis to be given in the emergency department if the time to transfer to a hyper-acute stroke unit (HASU) is greater than 45 minutes. Patients should then be transferred to HASU post-thrombolysis. This, it was said, is supported by NICE and there are examples of it working in practice elsewhere in the country.

Views from organisations on proposals for stroke services in Lincolnshire

4.152 Ten of the sixteen organisations agreed with the proposals for stroke services in Lincolnshire, four strongly. Four disagreed (three strongly) and two organisations did not answer the question. The comments made about the proposals are below.

Issues of concern: travel and access

4.153 While there was support for a centre of excellence for stroke services, travel and access to the proposed site at Lincoln County Hospital was a concern for some organisations. The main worries were that: the additional travel time would mean more negative patient outcomes in the event of a time-critical incident like a stroke; it would be difficult for family and friends to visit, negatively impacting patients' recovery; and EMAS and non-urgent patient transport would be placed under considerable additional pressure.

Skegness Town Council are very concerned that residents in Skegness would have to travel a significant further distance to access emergency treatment for a stroke. Especially when it is recognised that time is critical during a stroke. Patients have a much greater chance of surviving and avoiding long-term brain damage if they arrive at the hospital and receive treatment. The further distance will also put additional pressure onto East Midlands Ambulance Service and non-urgent hospital transport- to get people home. It may also mean that friends and family are unable to visit and that our most vulnerable residents are affected negatively by these changes the most.

Skegness Town Council

Visitors would not be able to go daily which in my experience is necessary to help recovery of those affected by strokes.

Organisation not named

It is acknowledged that TIA clinics at Pilgrim would be unaffected, however, the loss of hyper-acute and acute stroke services in the South of the county is causing concern. This is particularly concerning given the increased travel time required to access this treatment when time is critical for treating stroke patients. It is helpful that Peterborough City Hospital and Queen Elizabeth at King's Lynn are referenced in the document and it would be useful to understand the impact of travel time in practice to these hospitals – both for treatment and for public transport accessibility for visitors.

Boston Borough Council, East Lindsey District Council, and South Holland District Council

Always good to specialise, however, it's a long way from many parts of Lincolnshire. I wonder if I could get transported there quick enough.

Homecare

I agree a better centre is needed, however, again I just think about the people with no transport.

Lincolnshire Traveller Initiative Health Champion

System does need to be mindful though that transport times to other neighbouring specialist centres may be less than to Lincoln, so this needs to be built into any plans.

Lincolnshire Local Medical Committee

Issues of concern: rehabilitation

4.154 The Chartered Society of Physiotherapy supported the proposed centre of excellence for stroke services, while also strongly advocating for the provision of local rehabilitation beds at Pilgrim Hospital, Boston within a 'hub and spoke' model. The Society also recommended meaningful consultation and engagement with all relevant patients, staff and community service providers prior to any implementation.

> *The Chartered Society of Physiotherapy (CSP) would support a full review of stroke services which is meaningfully consulted upon with both patients that use the services as well as our members that support local service provision. Having a centre of excellence can in some cases be the appropriate way of providing high quality outcomes for patients that have had a stroke. With that said, there must be careful consideration … given to ringfencing such beds at Boston, thus creating a hub and spoke stroke rehabilitation service across Lincolnshire. This would provide the ability for highly specialist stroke provision in a centre with ongoing rehabilitation and preparation for discharge to community to be supported in Boston. CSP members that work within the current service provision must be actively engaged and their views sought for how best to reconfigure high quality service provision that links the pathway for rehabilitation across the acute and community sector. The community service provider must also be engaged to see how a push or pull system that is appropriate for patient need be able to be created in any new pathway.*
>
> ***The Chartered Society of Physiotherapy (CSP)***

4.155 Boston, East Lindsey and South Holland Councils also agreed that providing and enhancing local rehabilitation services would be beneficial.

> *The enhanced community stroke rehabilitation closer to homes is also welcome, particularly given Lincolnshire's geography.*
>
> ***Boston Borough Council, East Lindsey District Council, and South Holland District Council***

4.156 The Lincolnshire Neurological Alliance acknowledged the importance of stroke rehabilitation but felt that equal attention and resource must be given to other neurological conditions such as brain injury.

> *Rehabilitation is everyone's business and it's acknowledged effective rehabilitation delivers better outcomes, improved quality of life and has potential to reduce health inequalities, making cost savings across the health and care system (NHS England Commissioning Guidance Rehabilitation March 2016). It is imperative to have a good rehabilitation service to go with the proposed stroke service, but it needs to be equally available for other neurological conditions - especially brain injury. Over the years neurology has been a priority with CCGs and has but never improved because it is claimed there is no money. A stroke is a neurological condition and patients with other neurological conditions should have access to services. Many brain injury patients have to go out of county to acute centres for life saving treatment to return to any bed available or sent home and miss out on vital steps to recovery. It is important to have step down/step up inpatient/outpatient units where patients can get help to regain lost skills suffered with their life-threatening condition e.g., relearn to walk, talk, eat, swallow and get limbs working again after paralysis. It is important to get the right care, at the right time, in the right place and patients could have shorter hospital stays, better recovery, better quality of life and save NHS money. Integrated pathways and care plans should start on day one of the onset of the condition. Sadly, some people are suffering from neurological problems after having Covid-19 and would benefit from specialised rehabilitation. It is time to take on board the commissioning recommendations in the JSNA for neurological conditions. Also, you should bear in mind the new National Rehabilitation Centre at Stanford Hall which is due to open for the East Midlands in 2024. Lincolnshire needs representation and a foot in the door to use the facilities for worthy cases.*
>
> ***Lincolnshire Neurological Alliance***

Issues of concern: links between hospital- and community-based teams

4.157 The United Lincolnshire Hospitals NHS Trust Orthoptic Service at Pilgrim hospital supported the proposals for stroke services, with the caveat that much closer links between its team and community-based stroke services must be developed to enable seamless patient care. The Service also suggested that its work patterns and the way it is commissioned will need to be considered.

> *I tend to agree with the principal of consolidating the service at LCH, for the reasons given in the paper, however, our orthoptic team based at PHB provides excellent and seamless care and service to the stroke in-patients and the on-site medical and rehabilitation team. The patients have previously been seen on the ward within the acute phase so there will need to be a much greater link between our service and community teams for the patients to continue to benefit. Our current staffing levels are not sufficient to enable home visiting as currently the orthoptists attend the stroke unit to assess several patients in one session, so a change to the orthoptists work pattern, and possibly a change to who commissions our service would need to be considered.*
>
> ***The United Lincolnshire Hospitals NHS Trust Orthoptic Service at Pilgrim***

Issues of concern: prevention

4.158 Local councils also highlighted the importance of stroke prevention by tackling lifestyle issues such as smoking, poor diets and lack of exercise to avoid, where possible, contributory conditions such as high blood pressure and diabetes.

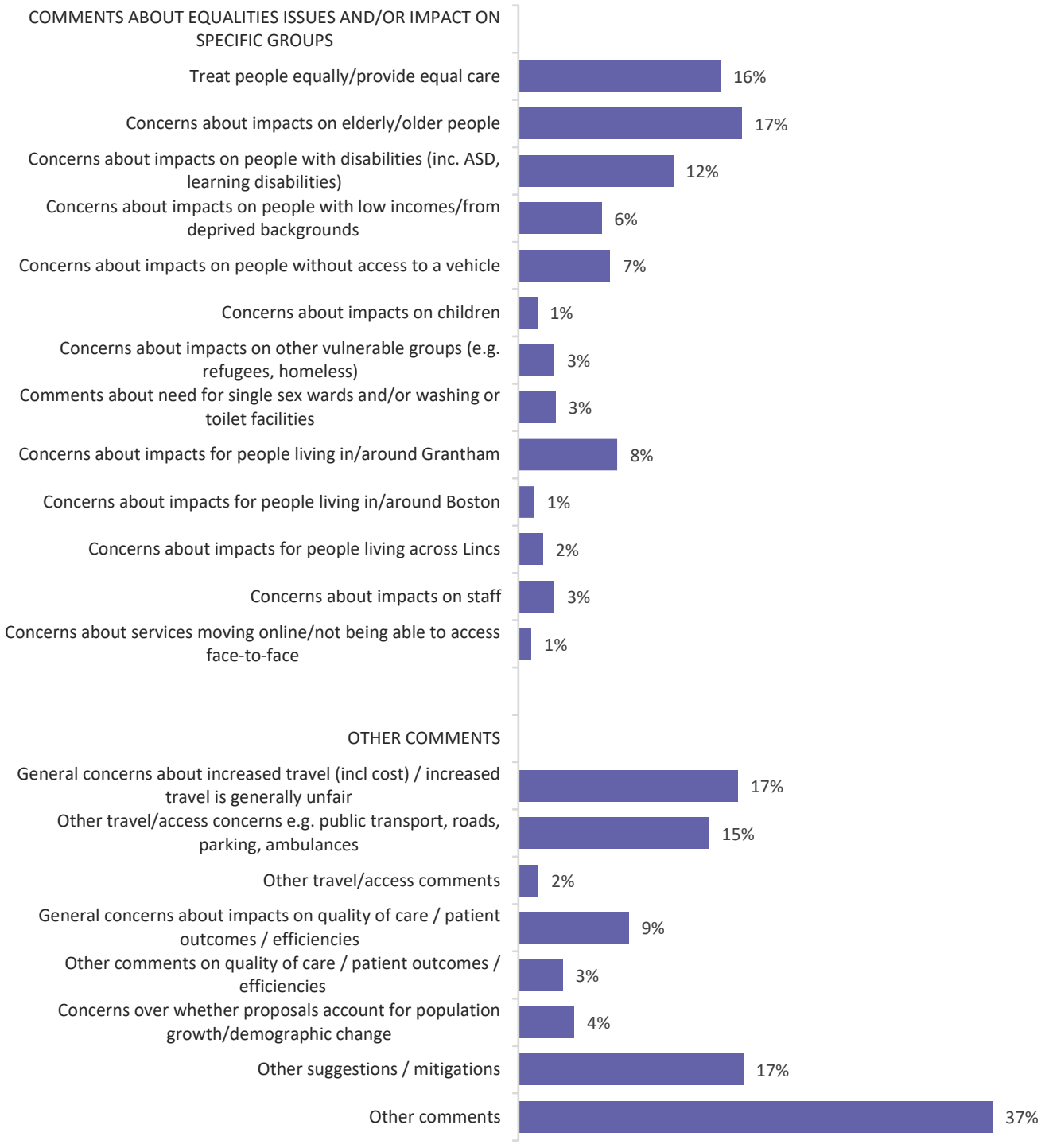
> *Although this consultation is on treatment services there is a need to consider prevention. Smoking, high blood pressure, diabetes, heavy drinking, high salt and high fat diets and lack of exercise increase the risk of stroke. These are health concerns in Boston, South Holland and East Lindsey and we would welcome further discussion on addressing these challenges holistically across the system.*
>
> ***Boston Borough Council, East Lindsey District Council, and South Holland District Council***

Views on potential equalities impacts and mitigations (across the proposals generally)

4.159 A further question encouraged respondents to identify any potential positive or negative impacts in relation to specific equalities groups, and to suggest possible mitigations for any negative impacts.

4.160 A summary is provided below. Most of the comments related to concerns or negative impacts rather than positive ones.

Figure 59: High-level summary of the further comments made in response to the text question about equalities impacts



Base: All individual respondents who provided comments (899)

4.161 Nearly a fifth of individuals who commented mentioned potential impacts on older people, and over a tenth mentioned potential impacts for those with disabilities. Other potentially affected groups included people with low incomes and/or from deprived backgrounds, people with a range of other vulnerabilities (e.g., due to homelessness etc) and people without access to personal vehicles.

4.162 Where issues were raised in relation to specific groups, these tended to be a mixture of points relating to travel and access issues (e.g., suggestions that the increased travel would disproportionately affect a particular group in terms of greater difficulty accessing services, facing increased costs, etc) and concerns around quality of care and/or the risk of more adverse outcomes for certain groups as a result of them having to travel further to access care. Some respondents spoke about a general need to ensure a particular group is treated fairly.

4.163 Although not directly relating to the main proposals, another area of concern identified by small numbers of respondents was around services potentially moving online and/or face-to-face appointments becoming more difficult to access in the future, with potential impacts for those not having internet access or being unable to use IT. A small proportion also made comments about a need to provide single sex wards and toilet and/or washing facilities.

4.164 Some of the comments identified negative impacts on residents living in particular areas (as opposed to specific demographic groups etc) – most frequently in relation to Grantham and surrounding areas. There were also some concerns about staff and their treatment and wellbeing.

4.165 There were also some suggestions that the issues might be exacerbated by population growth or other demographic changes (e.g., an increasingly older population).

4.166 Most of the suggested mitigations involved investing in and/or maintaining current services across the various hospitals. A small proportion (around 3% of those who commented) suggested that staff should undergo training in relation to equalities issues. There were a few comments advocating the provision of free transport (e.g., a shuttle bus) between sites in order to mitigate travel impacts.

Comments about equalities and health inequalities considerations from organisations responding to the consultation questionnaire

Discrimination toward the Gypsy and Traveller community

4.167 The organisations representing the views of Gypsies and Travellers in Lincolnshire made some general comments around the discrimination and exclusion they continue to face.

> *The society we live in today there should be no discrimination under any circumstances, however I have witnessed first-hand that gypsies/traveller do be discriminated against. So, it would probably be a good idea to get to know a race before you have an opinion and tell staff to talk quietly when having a chat.*
>
> ***Lincolnshire Traveller Initiative Health Champion***
>
> *Some Travellers/Gyps[ies] feel left behind with things. Working forward, being online and are unable to access this and some can't read letters, they say it all seems so un personal.*
>
> ***Lincolnshire Traveller Initiative, Well Woman Group***

Ensuring other groups are considered in decision-making

4.168 Other organisations commented on the importance of supporting and involving different communities across Lincolnshire. The elderly, disabled residents and the economically disadvantaged were considered a priority, as were those whose first language is not English, those who rely on public transport, and residents of particular geographical areas (in the east of the county for example).

> *The most vulnerable people in Lincolnshire (elderly, disabled or anyone with additional needs) are likely to be negatively impacted by services being further away from their home.*
>
> ***Skegness Town Council***
>
> *The consultation document highlights the consideration given to equalities impacts of the proposals. There is limited information about what mitigations can or will be put in place – or how addressing these concerns will be taken forward. Consideration and support to access services by older residents, lower income or economically disadvantaged residents, patients or families whose first language is not English, disabled residents and public transport challenges need to be clear. Support from partners across the system can assist with this.*
>
> ***Boston Borough Council, East Lindsey District Council, and South Holland District Council***
>
> *The current climate is making the elderly feel extremely vulnerable. They do tend to think they are being neglected over the younger population.*
>
> ***Homecare***
>
> *Lincolnshire East patients will be further away from the orthopaedic and stroke units, so transport and rehabilitation need to be adjusted to ensure these patients are not disadvantaged.*
>
> ***Lincolnshire Local Medical Committee***

Other issues raised by organisations

Importance of service user input

4.169 The Chartered Society of Physiotherapy commented on the importance of patient/service user and staff input in decision-making and implementation. They also note the need for transparency at all stages.

> *The CSP would always agree to a consultation on changes to service delivery, where it is clear that improvements to the patient pathway could lead to better quality of care and outcomes for those that receive the service locally. Users of the services involved must be actively engaged with their thoughts gained through pro-active discussion and engagement in order to ensure that they are part of the ongoing process and their voices are heard and acted upon. The premise of "Nothing about me, without me" would always seem appropriate to any proposal with the potential to alter the availability and/or quality of care provided. The Chartered Society of Physiotherapy (CSP) would also expect that CSP members working within an effected service are consulted with in a meaningful way, with clear messages provided as to why proposals are being made, the intended effects of those outlined whilst their terms and conditions of employment are supported and any implications to those terms and conditions are clearly laid out.*
>
> ***The Chartered Society of Physiotherapy***

5. Focus groups and interviews with residents

Introduction

5.1 In order to understand the views of local residents on NHS Lincolnshire's proposals, ORS was commissioned to organise and facilitate a number of focus groups and in-depth interviews. Participants were recruited by ORS' social research call centre using a mix of purchased and randomly generated telephone numbers for Lincolnshire residents[6]. The events/interviews lasted for between one and two hours and were successful in exploring and encouraging wide-ranging debate and discussion .

5.2 The focus groups and interviews were undertaken in early December 2021 and 14 residents took part: five from Grantham and District Hospital catchment area; four from Lincoln County Hospital catchment area; three from the Pilgrim hospital catchment area; and two from the County Hospital Louth catchment area.

5.3 ORS has sought – when reporting – to provide a faithful and thorough account of the feedback received during the sessions. The feedback is presented thematically in this chapter, with sections dedicated to each broad topic covered and commentary on the discussions supported by verbatim quotes. The inclusion of these quotes does not indicate that they are more or less important than what was said by other participants; rather, the quotes included are those which most vividly or clearly capture the views of several or all participants, or which relate to key aspects of the discussion around NHS Lincolnshire's proposals.

5.4 In addition to the above, quotes are included that identified differences of opinion and criticism or concern about the proposals, to ensure balance and provide NHS Lincolnshire with important insights to consider as part of the ongoing process of which this consultation is one part of. To aid this process of due consideration, we have summarised the main themes of the feedback shared at the focus groups and interviews below, before commencing the main body of the chapter.

Summary of key findings

5.5 The main findings from the focus groups and interviews were as follows:

- Residents agreed that there is a clear case for changing NHS services across Lincolnshire, expressing concern over the pressure current hospital sites are under and the negative impact of that on services and staff;
- Participants were largely supportive of the proposals, believing that they would help to tackle many of the challenges faced by NHS Lincolnshire. However, support for the proposals for acute stroke services was more mixed: in particular, residents from the Boston area were concerned about increased travel times to Lincoln for stroke patients;
- It was felt that staff would generally benefit from the proposals as a result of the relieved pressure on sites, potentially improving job satisfaction, recruitment and retention;

[6] Calls made for the purpose of research are exempt from TPS (Telephone Preference Service) which only applies to sales and marketing calls, and ORS complies fully with regulations and guidelines from all relevant regulatory bodies

- Most participants said that increased travel and transfers were minor drawbacks, outweighed by improvements to quality of care;
- Some residents expressed concern over capacity and infrastructure at Lincoln County Hospital, and questioned whether the site would be able to deliver the proposed stroke services;
- One Grantham participant rejected the proposal for an urgent treatment centre (UTC) locally, arguing that the area needs a 24/7 A&E department due to its growing population. However, the others supported the provision of a 24-hour UTC;
- It was said that patients are visiting A&E and UTCs with minor issues because it has become too difficult to get a GP appointment, contributing unnecessary pressure to acute hospital sites. Addressing this issue may, it was felt, go some way to alleviating this pressure;
- Participants suggested that the root causes of NHS Lincolnshire's difficulties are poor staff retention and/or funding issues. Therefore, while generally supporting the proposals as an appropriate response to the NHS' challenges, residents were of the view that they will not solve them completely.

Views on the need for change

5.6 Participants felt there is a clear case for changing NHS services in Lincolnshire. Hospitals were said to be under substantial pressure, resulting in frequent appointment cancellations and reduction in quality of services.

> *"I think it definitely needs to improve, just in general. I think if you can improve each hospital, like you've got Lincoln, and Boston, and Louth and Grantham... Because if everyone's trying to do everything it just makes everything a mess, doesn't it? You've got people running about all over the place, and appointments being cancelled, so I definitely think the change would be a good thing."*

5.7 In particular, Grantham participants suggested that demand for local NHS services has risen partly as a result of the area's increasing population. They agreed that there is a need to streamline services not only locally, but also across Lincolnshire, so that residents can access timely care.

> *"The population is growing ridiculously, particularly in Grantham. We've all seen how many new houses are being built everywhere. So, we do need to find a way to streamline the NHS and the services in Lincolnshire to make sure that people can get the right access to care and they're not waiting months and months and months. Also making sure the care is in the right place as well"*

5.8 Staff retention was also said to be an issue across Lincolnshire, with waiting times worsening as a result. This was of particular concern in relation to continuation of care.

> *"Obviously it does help if you have a continuation of staff… my mum was taken from Boston to Lincoln, and I carried her letter related to a vascular incident … and I must've shown it to about 15 different people who all went to photocopy it and put it in files. But when I took it next time, they'd never seen it and wanted to take it again which is a bit odd."*
>
> *"It's the retaining of staff and trying to reduce waiting times. It's an awful lot of time. I've waited weeks and my problem reduced itself naturally, but it would've been nice to have had some help."*

Views on the proposals for orthopaedic services

5.9 In summary, participants were largely supportive of the proposals for orthopaedic services, believing that the services suggested for the Louth and Grantham sites would reduce pressure on those at Lincoln and Boston, and improve the quality of orthopaedic services overall. Staff were also said to likely benefit from these improvements through a reduction in stress.

5.10 Some concern was expressed around the increased distance patients may have to travel for orthopaedic services at Louth and Grantham, but it was generally felt that the benefits to service quality would offset this.

Potential to improve orthopaedic care and reduce pressure at Boston and Lincoln

5.11 Most participants supported the provision of a centre of excellence for planned orthopaedic surgery at Grantham and District Hospital and a day case centre at County Hospital Louth. This, they felt, would reduce pressure on unplanned care at the Lincoln and Boston sites.

5.12 It was also said that the proposals would improve orthopaedic services across Lincolnshire overall through likely reductions in appointment cancellations.

> *"I think the principle of the idea is fantastic, to be honest. Prioritising planned and acute at different hospitals… will actually be a very positive step because obviously we want to reduce waiting times."*
>
> *"I think it's a brilliant idea, to be honest. I think if Lincoln and Boston don't do the day cases anymore it will … release a bit of pressure ... If Grantham and Louth do the day hospitals, and people are not getting cancelled, I would much rather travel a little bit further and not have my appointment cancelled than travelling to a nearer hospital."*

Potential to improve job satisfaction & staff retention

5.13 Some participants suggested that job satisfaction and staff retention would improve as a result of the proposed changes to orthopaedic services, since separating planned and emergency surgery would allow each site to specialise, and ease pressure on staff as a result of not having to 'do everything'.

> *"It might help with retention of staff as well because… you'll get then hopefully them actually just being able to do it and not be affected by emergencies, and actually … doing what they're supposed to be doing and being specialists in that area. So, there might be more job satisfaction and it might be less hairy, shall we say, if it's all planned and stuff."*

5.14 A reduction in appointment cancellations was also said to be potentially beneficial to administrative staff, who may be less stressed as a result of not having to deal with as many angry patients.

> *"I think another positive might be for people in the admin teams as well, just because if things aren't being cancelled, I imagine it's very stressful having to explain to people that things have been cancelled, and that something else has taken priority."*

Concern over access/travel to County Hospital Louth

5.15 The rural location of County Hospital Louth was a concern for a few participants, who felt that some patients may struggle to reach the site. Additionally, one person said that the cost of transferring orthopaedic patients to and between hospital sites could be expensive.

> *"Grantham is more accessible; you can get a bus right outside the hospital, there's train stations. But I know Louth is quite in the sticks."*
>
> *"… I have no problems about making special centres, what concerns me is that Lincolnshire is a highly rural area and the cost of transporting someone because they've got a hip problem and won't be able to drive perhaps."*

5.16 Although travel concerns were raised numerous times throughout the focus groups and interviews, most participants felt that impacts would be relatively minor, and certainly offset by increases in service quality, reduced cancellations and timely interventions.

> *"The thing is, you're not going to be able to please everybody, there's always different scenarios. But if you can release some pressure from certain services, and it means people don't get their appointment cancelled, then in the long run… People are getting those appointments that aren't being cancelled, and they aren't living with lifelong pain that probably makes them a lot worse… it's just weighing all that up."*
>
> *"… People will moan because of the travel. We know they will, because they don't want to travel a bit further to get things sorted… But at the end of the day, having the emergencies in Lincoln and Boston will then release them, which will then put Grantham and Louth at ease as well, because then they don't have to deal with the emergency ones. So, I think at the end of the day everyone's going to be happy."*

Concern over spreading staff across sites

5.17 One interviewee expressed concern about spreading staff between sites. They said that staff have been moved from one site to the other because of shortages in the past and sought assurance that this would not be the case in future.

> *"The only thing that I would be curious about is the spread of the staff. Something that has happened several times in the past is staff being called from Grantham to Lincoln or Boston because they are short staffed. So, I wonder if we would still end up in a similar position where they don't have enough specialists in Lincoln, so they have to pull them from Grantham which means surgeries still being cancelled."*

Views on equalities impacts of the orthopaedic surgery proposal

5.18 It was said that any access and travel difficulties resulting from the proposals would impact certain groups more than others, especially in the absence of easily accessible patient transport. Elderly people, people on low incomes, people without cars, and people with disabilities were all mentioned in this context.

"The elderly, I think it's not as easy for them to hop on the train or hop on the bus. Are there services that offer to pick up for appointments if they can't get there? I mean, not everybody wouldn't be able to get there. Most people have grandchildren and kids that would be able to help them out. For the people that are isolated and maybe can't, are there services offering that will pick them up and take them home?"

"Anyone who can't drive would need to have a good service attached to it. You can't do it on the buses, you can't do it on the trains so it would need quite a complex, proper bus service to bring people in. My guess is that could be very expensive…"

5.19 Once again however, it was stressed that the difficulties potentially experienced by certain groups would be outweighed by the overall benefit to service quality and timeliness – with the important caveat that those without transport options are offered assistance with accessibility.

"Most people do have somebody that would help, so obviously as long as there are services [for] people who really don't have another option then you can't do anymore… you're offering the best you can. And at the end of the day, if their appointment is not being cancelled, or they are receiving the best care, you can't really put an argument against that."

Views on the proposals for urgent and emergency care at Grantham and District Hospital

5.20 Overall, focus group and interview participants were positive about the proposals for a 24-hour Urgent Treatment Centre (UTC) at Grantham District Hospital. They stressed the importance of having a 24/7 unit in Grantham because of the area's growing population, and therefore felt that a round-the-clock UTC would be better than an A&E that is closed overnight as has been the case.

5.21 It was also felt that the proposals would relieve pressure on services in Lincoln and therefore improve the quality of urgent and emergency services overall.

Support from Grantham residents and other participants

5.22 Most participants, including those from Grantham, were supportive of the proposals, stating that while they may have preferred a full A&E service in the past, they were now more realistic about what is possible and so would be happy with a 24-hour UTC.

5.23 Indeed, residents stressed the importance of having 24/7 access to urgent care, and therefore felt that a UTC would be of more benefit than an A&E that is closed overnight as is currently the case. In addition, it was felt that whilst more serious cases would likely be moved to Lincoln, Grantham's UTC would be effective in caring for such patients prior to transfer.

"I always used to think we need an A&E. 100% Grantham cannot survive without an A&E. However, my views recently have changed… I'd rather have somewhere where you can go at two o'clock in the morning to get treatment. And yes, very serious cases may well have to go on to Lincoln and Boston or wherever, but they will be able to provide a decent level of care at Grantham."

"If we can get a 24-hour UTC in Grantham instead of an A&E, so be it. It's better than having one that's only open from 8:00am until 6:30pm."

Potential to alleviate pressure on Lincoln A&E and improve service quality

5.24 Most participants were very positive about the proposed introduction of a 24-hour UTC at Grantham and District Hospital. Generally, participants were hopeful that the facility would ease pressure on Lincoln's A&E department and other 24-hour sites and services, improving the quality and sustainability of NHS services, as well as staff retention rates, across Lincolnshire.

"I think it would put less stress on the surrounding hospitals who are doing it 24/7 as it stands because they've just been under so much strain. So, if that's the case, that's going to help with staff retention, waiting times, quality of care, I suppose. And it would be more sustainable."

"… anything to alleviate that stress on A&E is good because Lincoln isn't coping."

5.25 Participants also raised concern over the ability of Grantham's current A&E to meet the demands of the area's increasing population. The proposals for a 24-hour UTC were seen as an appropriate response to this.

"I think it's just one of those things that it's a good thing to do, because it [overnight services] should've never been taken away in the first place. All the residential areas that are growing, there's new plans for new houses all over the place, especially Grantham as well. So that's good…"

5.26 Meanwhile, the conversion of Skegness' A&E department into an UTC some years ago was mentioned, with one participant stating that they had not noticed a significant change to either the nature or quality of care there. They were thus comfortable with the proposals for a similar centre at Grantham.

"… we had something similar in Skegness. Our A&E changed to an urgent treatment centre, probably for the same reasons … because they had to limit their hours. As far as I'm aware, I've not noticed really any difference from it changing from an A&E to urgent care. You still get seen, you still get the same kind of care, the same kind of stuff. So, I can't see it being much of an issue. I think when it first happened people were panicking that we're not going to have an A&E anymore."

Defining the difference between UTCs and A&E

5.27 While Grantham residents supported a 24-hour UTC, they also said it would be important to explain the difference between UTCs and A&E to ensure others have a proper understanding of what services are provided where.

"I think as long as people know what it's for it will be a real benefit. But I do think there's a big disconnect between what people […] go to A&E and Urgent Treatment Centres for."

Concern over the capacity of a UTC to meet the needs of Grantham

5.28 Although participants were mostly supportive, one interviewee argued that an UTC would be insufficient to meet the demands of Grantham and district's large population and geographical footprint. Therefore, they suggested that their local hospital should retain its A&E with support from staff at Lincoln.

> *"Grantham actually covers quite a large geographical input area for accidents, and where it's located of course there are a number of major roads just outside Grantham. So, my personal view is that they should consider an A&E service if it's possible, maybe supported by Lincoln… it seems to me that geographically, Grantham does need a bigger service than a UTC."*

Views on equalities impacts of the urgent and emergency care proposal

5.29 It was suggested that the proposal could have a positive impact on access for elderly people in the Grantham area, as a local 24-hour service would mean less travelling for urgent care during the 'overnight' period.

> *"I think elderly [people] especially would be one of the most affected in a positive way because they wouldn't have far to travel. It would be easily accessible, and they'd be getting as much treatment as they could closer to home. So, there's no worry about if people could accompany them, or family going with them, because you know they'd only be five or ten minutes down the road…"*

Views on community/acute medical beds at Grantham and District Hospital

5.30 Proposals to establish combined acute/community medical beds at Grantham and District Hospital were supported by participants, who felt that services would become more efficient, with patients being treated and discharged back into their communities more quickly as a result. Increased travel and transfers were discussed but considered a small price to pay for improvements to care quality.

5.31 Participants also discussed how difficult it has become to get a GP appointment, meaning minor illnesses are not treated at an early stage, leading in some cases to increased severity and eventual hospitalisation. Therefore, it was suggested that the NHS could reduce the demand for hospital beds by ensuring that residents can more easily access primary care.

Potential for services to run more efficiently

5.32 Participants were generally positive about the proposal for combined acute/community medical beds at Grantham and District Hospital. They hoped that patients' needs would be clearer at an earlier stage, thereby improving patient flow.

> *"I suppose that does make sense… it's not reducing the number of beds but hopefully just making it more of a process…"*
>
> *"I think it will definitely make it easier to pinpoint exactly where a patient needs to go and the exact kind of treatment they will be given, which will then make it quicker to deal with patients and keep the flow going…"*

5.33 It was also said that if the proposal does result in staff being more aware of patients' needs at an earlier stage, there will be far less potential for patients to *"fall through the gaps"*.

> *"If it runs more smoothly and they have all the information they need and it's not… people falling through the gaps then obviously it would be beneficial. It's just hoping that would run to the best and there aren't people being forgotten."*

Potential increase in transfers is a concern, but one that would be offset by service improvements

5.34 It was noted that increased transfers as a result of the proposed changes would be seen as an inconvenience to patients. However, this inconvenience would, it was felt, be minor relative to the improvements in patient care as a result of being treated for serious illness at a specialist facility .

> *"… I think even though it might be quite frustrating if you're being transferred somewhere else… on the other hand, if I knew I was going to a hospital which was specialising in whatever I was suffering with, I think that would make me feel a little bit more at ease with it because you know that you're going to get a slightly better level of care."*

Concern that difficulty accessing GP services is resulting in increased demand for hospital beds

5.35 When discussing the proposals for integrated community/acute medical beds at Grantham and District Hospital, several participants expressed concern over how difficult it has become to access GP appointments in Lincolnshire. This, they felt, has resulted in minor illnesses going untreated and occasionally developing in seriousness, requiring hospitalisation. Therefore, participants suggested that to reduce pressure on hospitals beds, the NHS must consider means of facilitating easier access to primary care.

> *"Where I am it's so hard to get into the doctors. And then say that you had a chest infection that then turned into pneumonia… you are then having to go into hospital in Grantham because you've got pneumonia when it could've been solved at a GP surgery… If you could get the course of antibiotics a little bit quicker then maybe you wouldn't need to go to a hospital. That takes pressure off the hospitals as well, it's all linked, isn't it? If it could be sorted earlier on then that pressure wouldn't be on the hospital, then that wouldn't back them up."*

Views on equalities impacts of the community/acute medical beds proposal

5.36 Participants said that if patients (especially elderly patients) are seen in a timely and efficient manner, they would benefit by being discharged back into their communities more quickly.

> *"It might get elderly patients out of hospital quicker and back into the community and ideally close to home as well. So, I think if this helps that discharge process, that's much better and the time to return for people to go home, that would be the main focus for me."*

Views on the proposals for stroke services in Lincolnshire

5.37 Participants expressed mixed views on this proposal. They were mostly positive, suggesting that stroke services would improve as a result of increased and concentrated expertise within a centre of excellence. It was also said that the proposed centre could lead to further future investment into NHS Lincolnshire.

5.38 Some residents, especially those from the Boston area, were concerned about travel times to Lincoln in an emergency. They worried about both the time taken from the patient perspective, and the potential negative impact on ambulance availability as a result of having to travel between sites more frequently.

5.39 Residents from Grantham were concerned about infrastructure and capacity at Lincoln County Hospital, questioning the site's ability to cope with increased service provision.

Potential to improve stroke services in Lincolnshire and free up staff at other hospitals

5.40 Participants generally anticipated that the proposal for a centre of excellence for hyper-acute and acute stroke services at Lincoln County Hospital would significantly improve the quality of care offered to stroke patients, who would benefit from specialists' expertise being concentrated in one place.

> *"I like the proposal... In my opinion it's about providing the best care for patients. And if you've got all of the specialists in one place, regardless of where that is… Whether it's at Boston, Lincoln, Grantham, Louth, that doesn't really matter, to be honest. To me it's about the standard of treatment that can be provided."*
>
> *"… having them all in one place means you could give them all the attention that they need by a specific team there. So, they're not being jolted off to a different department each time, they will be there 24/7, getting the care they need."*
>
> *"I do honestly believe that [with] specialist services brought in… you actually bring in the best expertise available in the area. It is absolutely excellent."*

5.41 The next most common reason for supporting the proposal to centralise hyper-acute and acute stroke services at Lincoln was that it would relieve some pressure at other Lincolnshire hospitals as a result of no longer having to provide them.

> *"I personally think it would free up more staff in other hospitals, and they could deal with other patients like A&E or operations..."*

Potential to attract future funding to NHS services in the area

5.42 There was also hope that establishing a centre of excellence in Lincoln would attract specialists and lead to further investment into the NHS in Lincolnshire in future, which could be of further benefit to patients.

> *"The centre of excellence, I think that would hopefully attract funding and … specialists. It could even get to a point where we could do the specialist thrombectomy. I imagine a lot of money would be ploughed into it as well, and they could handle a lot of high demand."*

Concern over travel from Boston to access stroke services in Lincoln

5.43 Although most participants were positive about the proposals for stroke services, those from Boston were generally more reserved, with increased travel distance to Lincoln of concern because of the time-sensitive nature of stroke. It was also said that, in certain circumstances, patients might be unnecessarily taken from Boston to Lincoln - if their condition was mistaken for a stroke - potentially leading to a delay in their assessment and care.

> *"… it's obviously good to have everything in one place, but sometimes in an ambulance you're not actually sure the person has had a stroke, which means that people might be taken further than necessary and then still be in the waiting room to be assessed."*

5.44 Boston residents were also worried that ambulances transferring patients from Boston to Lincoln for stroke treatment would be unavailable for extended time periods – and that this would happen far more frequently than it does currently. They sought reassurance that mitigations would be put in place to ensure the Boston area has sufficient ambulance cover in future.

> *"If the ambulance picks somebody up from our area and they're taking them all the way to Lincoln because they suspect they've had a stroke, that takes an ambulance off the road from this area for the best part of four hours. Is there any sort of contingency to cover that, or is somebody going to have to be sitting around with another illness waiting to get picked up? Because you could wait a long time now for an ambulance."*

5.45 Participants from other areas, however, generally felt that they would be happy to travel further for better quality of care and specialist expertise – both as patients and as visitors to loved ones.

> *"I do think it's worthwhile. You can't have specialised equipment everywhere, so if you have to travel a little bit to make sure that family member gets the best care they'll get, in the long run it is better"*
>
> *"It weighs up, would you have a family member in the right place with the right specialists and equipment and sacrifice the travelling and travel longer, or would you go to the closest hospital where they might not be as experienced or well-equipped but then be able to see them every day? ... I think the pros outweigh the cons really."*

Concerns over existing capacity and infrastructure at Lincoln County Hospital

5.46 Some participants (particularly those from Grantham) were concerned about existing capacity and infrastructure at Lincoln County Hospital. It was said that, from their understanding, the hospital is already very busy, raising questions as to whether it would be equipped to deal with the proposed changes. Parking was also said to be difficult because of how busy the site is.

> *"Lincoln is really busy, it's very, very difficult to park. If you've got a loved one there it's not an easy hospital to get to either because the traffic in Lincoln is horrific like most towns …"*
>
> *"You always get the impression here in Grantham that Lincoln is exceptionally busy, so why put even more on them? It doesn't make sense to me."*

Views on equalities impacts of the stroke services proposal

5.47 Participants did not raise concerns about any specific equalities and health inequalities impacts as a result of the proposal for stroke services in Lincolnshire.

Additional comments and issues raised

5.48 A lack of funding was thought to be the main contributor to NHS Lincolnshire's resourcing difficulties. Therefore, whilst participants tended to support the consultation proposals as an attempt to address these difficulties, this support was tinged with concern that they will never be fully overcome without more financial investment.

> *"I think overall most of the proposals have some legitimacy and sense behind them… although I'd rather see things growing, and more investment and more staff, I understand that isn't really possible at the moment under the circumstances so it's about making best of what we've got. It seems like those first three proposals are designed to do that… And the point I keep making again about investment in staff and capacity, that's the solution."*

5.49 Poor staff retention was also said to be a significant challenge that the proposals may not fully address.

> *"It feels like we're responding incorrectly, rather than dealing with the root cause [of] a lack of resource and a lack of capacity and staffing [...] I would rather the staffing problem and the community issues [were] focused on, rather than just splitting it off like this"*

5.50 Finally, the importance of ensuring that staff have easy access to patient information was stressed by one participant, so that decisions on their care and needs can be made more quickly. An NHS app for staff that stores patient data was suggested for this purpose.

> *"Do they have access to all of the information? Is it on a file or is it something the patient would have to have? Maybe there could be like an app or something that they can access, and you can only access it by NHS numbers, and it's individually protected. Obviously, I know it's confidentiality as well, isn't it?"*

6. Public meetings and other engagement activities

Introduction

6.1 Between September and December 2021, NHS Lincolnshire CCG hosted a series of meetings for members of the public. To ensure that as many people as possible were able to attend, particularly within the context of ongoing restrictions due to COVID-19, there was a mixture of online (virtual) meetings and in-person (face-to-face) events; the latter were organised in line with UK government guidelines at the time.

6.2 In addition, NHS Lincolnshire CCG met with the Countywide Patient Participation Group (PPG) and ULHT Patient Panel, and three organisations working with groups with protected characteristics under the Equalities Act 2010.

6.3 Finally, ULHT Hosted briefings and discussions, face-to-face and online, for NHS staff members to be informed and updated about the consultation, and to give their own feedback.

Promotion of the consultation and public engagement activities

6.4 The public consultation was widely advertised and promoted across Lincolnshire[7], including:

- Delivery of a consultation leaflet was commissioned, targeting 374,193 households across Lincolnshire;
- Paper copies of consultation documents distributed to hospitals, GP surgeries, pharmacies, shops, cafes, businesses, places of worship and libraries and at events across the county;
- Posters displayed at Lincolnshire NHS buildings and distributed to 'Involvement Champions' to display in their local communities;
- Press and publicity activity which generated 93 media articles during the consultation period in over 300 separate locations across TV, print, radio and online;
- 25 advertisements were placed in county newspapers; and
- 431 social media posts and tweets by NHS Lincolnshire CCG's communications team, seen by over 260,000 people of whom over 7700 directly engaged and 784 clicked through to the consultation website, which itself attracted over 12,000 unique visitors[8].

6.5 Posters, flyers and consultation documents contained links and QR codes to guide readers to the consultation website where they could find out about the upcoming events, an email address and a telephone helpline.

6.6 During the consultation there were 2290 visits to the consultation events page; by email and telephone, there were 62 requests for information about consultation live and virtual events, including 49 booking requests.

[7] Full details of the communications programme can be found in NHS Lincolnshire CCG's Public Consultation Communications Activity and Engagement Report

[8] Social media posts were shared with partner organisations across the county, requesting that they be shared on their accounts. Examples include other NHS organisations, the local authority, and relevant voluntary and campaign groups.

Format of meetings and engagement activities

6.7 Events and meetings were hosted by senior NHS managers and clinicians, with clinicians describing the proposals either in person or via video presentations; depending on the format of the event, attendees could ask questions and give feedback in several ways: verbally; using paper feedback forms, 'Q&A cards' or paper consultation questionnaires; via text chat functions (e.g., SLIDO); by email; or via the online questionnaire

6.8 Online events were run in the same format as the face-to-face events, via Microsoft Teams. Additionally, a 24/7 'virtual event' was hosted on the consultation website which contained the same information and video presentations used at the scheduled events and enabled visitors to access the same feedback channels.

6.9 ORS provided a structured template for staff at each event to use to capture and record the feedback raised. At the close of consultation, completed forms from 28 meetings and engagement activities were returned to ORS for analysis and reporting and are summarised in this chapter.

Table 7: Public meetings and events from which feedback is reported in this chapter by location, date and attendees

Type of Event	Location	Stakeholders	Date	Approximate No. of attendees
Face-to face event	Boston	Members of the public	12/10/21	5
Face-to face event	Boston	Members of the public	18/12/21	12
Public Consultation Briefing (PCN)	Boston	Members of the public	09/12/21	12
Face-to face event	Grantham	Members of the public	14/10/21	42
Face-to face event	Grantham	Members of the public	12/12/21	13
Face-to face event	Lincoln	Members of the public	14/12/21	1
Face-to face event	Louth	Members of the public	14/12/21	3
Face-to face event	Skegness	Members of the public	11/11/21	5
Face-to face event	Skegness	Members of the public	1/12/21	19
Face-to face event	Sleaford	Members of the public	14/11/21	2
Face-to face event	Spalding	Members of the public	16/11/21	8
Virtual Event	Virtual	Members of the public	18/10/21	2
Virtual Event	Virtual	Members of the public	20/10/21	2
Virtual Event	Virtual	Members of the public	22/10/21	2
Virtual Event	Virtual	Members of the public	18/11/21	2
Virtual Event	Virtual	Members of the public	20/11/21	1
Virtual Event	Virtual	Members of the public	20/12/21	1
Staff Briefing	Virtual	NHS Staff	30/09/21	25
Staff Briefing	Virtual	NHS Staff	30/09/21	27
Staff Discussion	Grantham	NHS Staff	04/10/21	27
Staff Discussion	Virtual	NHS Staff	05/10/21	35
1 to 1 meeting	Virtual	NHS Staff	21/12/21	1
Staff Discussion	Virtual	NHS Staff	14/12/21	8

Type of Event	Location	Stakeholders	Date	Approximate No. of attendees
Virtual Event	Virtual	Countywide PPG meeting	01/11/21	26
Virtual Event	Virtual	ULHT Patient Panel	06/12/21	14
Virtual Event	Virtual	Voices for All (learning disabilities group)	01/12/21	15
Virtual Event	Virtual	Lincolnshire Sensory Service	07/12/21	18
1 to 1 meeting	Virtual	Grantham Senior Citizens Club	13/12/21	1

Feedback from public meetings and other engagement activities

6.10 As noted above, the public meetings and other engagement activities organised by NHS Lincolnshire CCG and ULHT served a dual purpose: to offer an opportunity for attendees to hear about the proposals and ask questions; and to provide some initial feedback. In contrast to the independently facilitated research activities undertaken by ORS on behalf of NHS Lincolnshire CCG, however, the meetings were not structured in such a way as to elicit feedback on each part of the proposals in turn. The questions and feedback were therefore typically focused on only those elements of the proposals which were of most interest to the particular attendees or participants at any given meeting.

6.11 This is perhaps most clearly demonstrated by the fact that the meetings held for Grantham, Boston and Skegness residents (the population centres located closest to Grantham and District Hospital and Pilgrim Hospital, Boston) had more attendees than the events in areas of Lincolnshire where residents may feel less directly impacted by the proposals. Furthermore, many attendees did not ask questions or give feedback directly, preferring to listen to those of others in the meetings.

6.12 In light of the above, it is important to bear in mind that the comments and questions summarised in this chapter cannot necessarily be viewed as representative of the population of Lincolnshire, nor even of any particular geography or demographic; they should therefore be considered alongside the feedback from other research strands contained in this report such as the consultation questionnaire - the route by which some of those attending the meetings may have submitted their considered feedback.

6.13 ORS approach to this chapter, therefore, is to represent the broad themes arising, rather than to attempt to draw definitive conclusions about any balance of opinions. For ease of reading, we have collated the comments and questions according to which proposal they related to. We recommend that readers refer to Appendix III of this report, which contains full lists of questions and comments arising from all the meetings.

6.14 Finally, it should be noted that many of the questions asked during meetings were answered by NHS managers and clinicians either during or after the meetings. ORS has not included these answers, as the purpose of this report is to focus on the views of members of the public, NHS staff and other stakeholders.

Comments on the need for change

6.15 Attendees gave some feedback relating to the challenges facing health services in Lincolnshire, including waiting times, cancelled operations, recruitment, and retention of staff, and spending on locum and temporary staff. Comments were also forthcoming around the opportunities for improvement around urgent and emergency care, care and length of hospital stays for stroke patients, quicker access to specialist clinicians, integration of acute and community care and sustainability of services.

Accessibility of the consultation document

6.16 In making comments around the need for change, a local senior citizens group commented that they felt that the consultation information provided was too lengthy for an older person. They described it as 'information overload' and said that it would be easier to understand and digest if it was 'less wordy' and clearer in general.

Orthopaedic surgery and the need for change

6.17 Members of the public commented that a challenge facing orthopaedic surgery is delays due to lack of beds. It was felt that dedicating Grantham and District Hospital to planned surgery would improve the situation. One member of the public asked whether the pilot phase for orthopaedics had made a difference to staffing levels in terms of recruitment and retention, which they felt should be a consideration going forward.

Urgent and emergency care and the need for change

6.18 The key challenge noted by members of the public in relation to urgent and emergency care is not recruiting staff, but rather retaining staff. Several from the Grantham area felt that there are opportunities to improve staff morale by increasing wages to encourage them to stay in post and, that in general, staff are 'badly treated'. One felt that uncertainties around the result of the consultation is contributing to poor staff morale.

6.19 A member of the public in Skegness stated that the Grantham area is fairly well served in terms of urgent and emergency care due to its proximity to A&Es in Nottingham, Peterborough and Lincoln; a contributor in Grantham said that, as a walk-in patient, the current services are fine but that the NHS 111 service tends to direct people away from A&E.

Acute medical beds and the need for change

6.20 No comments were made on the challenges and opportunities related to this proposal.

Stroke services and the need for change

6.21 Members of the public in Boston highlighted a number of challenges relating to stroke services in their area. The key concern was around ambulance response times which were said to not have met challenges for category one and two calls as they are seen queued outside A&E 'in large numbers'. There was also a concern that response times from near Boston to Lincoln by emergency ambulance had produced 'horror stories'.

6.22 This view was echoed by an individual in Grantham who said that '*people are dying in the back of an ambulance*', adding there is an opportunity to put a process in place where those in waiting ambulance are reviewed every 15 minutes in order of need. It was not felt that documents published on ambulance response times are sufficiently reassuring and 'pay lip service' to concerns. An individual in Skegness also felt that the pilot had not provided sufficient evidence of quicker discharge times.

6.23 There was also a concern that the Pilgrim hospital does not have 'vital' emergency services like other hospitals in the area, or indeed will not have if the proposals are implemented. An individual questioned why Boston doesn't have specialist ambulances seen in other areas and why brain and head injury rehabilitation are kept separate to stroke rehab as the two would align.

6.24 Members of the public across several locations in the county mentioned staffing of stroke services. Several said they do not feel that working for ULHT is an attractive offer at present. It was felt that unattractive contracts are being offered to staff, for example offering fixed term contracts to locums or consultants. One attendee said that Boston has had 'bad press' as a result and that this doesn't help in attracting consultants.

6.25 Some felt that although the recruitment and retention of staff is a national issue, it has been historically difficult to recruit stroke consultants and nurses in the area. A respondent from a local Sensory Service added that those with medical degrees may prefer to live in larger cities with 'more opportunities and things going on', so that recruitment will continue to be a challenge despite changes made following the consultation.

6.26 Moreover, an individual in Grantham said that many are being deterred from training as a nurse due to a lack of bursary and low wages, another national issue. Finally, a member of the public in Lincoln said that in the context of staff-related challenges, temporary staff are an expensive option and that there are opportunities to encourage people to come and live and work in the area.

Proposals for orthopaedic surgery in Lincolnshire

6.27 Some attendees gave their views on the proposed changes to orthopaedic surgery in Lincolnshire, thinking about any possible benefits and positive impacts as well as any concerns or negative impacts.

Developing a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District hospital

6.28 Several participants at the open public meetings recognised that the pilot to trial locating all planned orthopaedic surgery at Grantham and District Hospital is working well. Coupled with good feedback from clinicians, it was felt by many, including councillors, this was a positive step. A reduction in waiting times and fewer cancellations was seen to be the key potential success of this change.

6.29 Some members of the public also felt that these changes would make the services at Grantham and District Hospital more accessible. One from Sleaford felt it had preferrable road links to the area than other hospitals and a representative of a local Sensory Service said that it is not too far for people from Boston to travel either, particularly as there is a direct train route.

6.30 Several participants from the ULHT Patient Panel shared positive experiences of the care they received by the orthopaedic team at Grantham and said that hospital stays are generally short following operations, these participants supported the planned changes as a result.

> *I went to Grantham hospital in August for a full knee replacement and I cannot fault them. The service was marvellous, and I only had to spend one night in hospital. I'm going back in tomorrow to have my second one done.*
>
> ***ULHT Patient Panel participant***

6.31 However, there were also some concerns expressed other meetings, most focused on travel and access. Members of the public gave examples where travel times are a concern in the county: bus journeys from Boston to Louth takes 2.5 hours, for example and one questioned whether there is transport available from Skegness to Grantham. A representative from the Voices for All group was concerned about lack of transport options to Grantham from anywhere on the East coast and another member of the public was concerned that people in Lincoln and Boston will not be willing to travel to Grantham for a planned operation at all.

> *A decentralised service better serves the population. Some people struggle to travel all the way from the east coast for planned care.*
>
> ***Virtual meeting participant***

6.32 Others expressed concern that the transport infrastructure in Grantham is not good enough to support people who cannot drive pre- and post-procedure. Representatives from the Voices for All group said that increased travel times could cause anxiety for patients and that the location of Grantham may make it difficult for visitors to travel to see patients following their operation.

6.33 A member of the public in Grantham felt more clarity was needed on how patients with broken limbs will be transported to and from Lincoln and another, from Spalding, asked had there been more cancellations of operations during the pilot stage because of patients having to travel further for their care?

6.34 Although there were concerns, a few potential opportunities and solutions were offered. A representative from the Sensory Service suggested that follow-up appointments should be done in the local community to bring them closer to people and a representative from the senior citizens group said that it would be more effective for a consultant to travel around the county than making the patients travel. A Voices for All representative said that, in the case of planned procedures, transport options are detailed in the patient letter and so anyone eligible can use it, as well as access volunteer and community care schemes.

6.35 On the potential impact of changes on the availability and quality of care, some questions were asked about possible scenarios; some felt that more clarity was needed on the finer details of the plans:

- What if a child breaks a limb, will they be treated at Grantham?
- If you are under a consultant at Lincoln, will you still be operated on at Grantham and stay with the same consultant?
- If you have an operation at Grantham, will your aftercare and physiotherapy be offered locally or have to travel back to Grantham?
- Can pre-ops happen at Skegness and other locations?
- Does centralising planned services at Grantham and Louth mean they will not happen elsewhere?
- Where will elective surgery patients who do not meet the criteria for Grantham be placed after surgery? (Staff question)

6.36 More generally, there was a feeling that orthopaedic patients have received a good quality of care in the past and a concern that any changes may jeopardise this quality of care.

> *I know of two people who have had to have 'unplanned' emergency surgery at Grantham Hospital - hip and wrist. Both received excellent care. If they had been taken to Boston or Lincoln, what guarantee can you give that they would receive the same level and quality of care?*
>
> ***Member of the public, Grantham***

6.37 There were some concerns about impacts on staffing. A member of the public in Spalding would have liked more information on how staffing levels would be impacted in general by the changes; another in Grantham said that they thought consultants were happy with the proposals, but that other staff are not so happy. This is due, they said, to a need for the service to run 7-days per week with staff working at weekends. It is also felt that this change during the pilot has had a knock-on effect on other services within the hospital.

> *This has meant an increase in waiting times for other services as these staff were deployed. The loss of those was never back filled, leaving other areas short.*
>
> ***Member of the public, Grantham***

6.38 Some participants felt there was a high level of risk associated with this proposal. A member of the public taking part in a virtual meeting said that creating a 'centre of excellence' comes with a significant level of risk and a chance of failing.

> *Wouldn't it be better to have a de-centralised model spreading the expertise across the county?*
>
> ***Virtual meeting participant***

6.39 A ULHT Patient Panel member asked whether, by creating an orthopaedic centre of excellence at Grantham and District Hospital, there would be a lack of suitable staff left to treat emergency and unplanned cases elsewhere in the county. Finally, a member of staff said that for Grantham to become a 'centre of excellence', there would need to be some investment into the quality of the buildings on the site.

Developing a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery

6.40 Very few participants across the meetings chaired by NHS Lincolnshire had an opinion on the proposals for a dedicated day case centre at County Hospital Louth. A positive point raised by a Sensory Service representative was that it would be 'easy' for a family member to take a patient and wait for them to complete their procedure before taking them home, given they will be seeing day cases only at Louth.

6.41 However, another representative from the Sensory Service felt that Louth isn't so easy to travel to and from Boston with very few buses and poor roads. A member of the public at Louth questioned whether pre-assessments would still take place in a location local to the patient or would those happen at Louth also?

Mitigations and other comments around proposals for orthopaedic surgery

6.42 In other comments on the proposal, transport was again the most talked about issue. A ULHT Patient Panel member said that, although the group was largely in favour of the proposals, more consideration must be given to transport issues, with the CCG working in collaboration with the local authority to alleviate concerns.

> *We would not allow services to change without the CCG getting together with Lincolnshire County Council to ensure there is a transport plan in place that works. To ensure that people living in outlying areas are not disadvantaged by any changes.*
>
> ***ULHT Patient Panel member***

6.43 A member of the public in Skegness mentioned a transport model that they had seen work in Leicestershire, where a roving bus was provided to take patients to hospitals across the county. There was also a flat rate for taxi journeys taken to access healthcare, something that they would support in Lincolnshire. A representative from the Voices for All group stated that there must be a plan to ensure carers can get to Grantham to support vulnerable patients.

6.44 Another factor mentioned was the ongoing bed pressures at Lincoln. Some participants felt that Lincoln hospital is still too busy to justify these proposed changes with the senior citizens group sharing an example of an elderly lady waiting over 10 hours for a bed there. The increased pressure of the proposals on other services was also a concern, a participant in one of the virtual meetings said that transferring more emergency patients to Lincoln must be increasing the strain on the ambulance service.

6.45 Finally, a member of the public at Grantham said that a bigger picture view is needed and that only with better investment in the NHS from Westminster will positive change be seen.

Proposal for urgent and emergency care in Grantham

6.46 Meeting attendees shared views on the specifics of the planned changes to urgent and emergency care at Grantham and District Hospital, including possible benefits as well as any concerns or negative impacts.

Provision of a 24/7 walk-in UTC at Grantham and District Hospital

6.47 Many participants in meetings recognised the challenges to providing a full A&E service at Grantham and District Hospital and were therefore supportive of offering an UTC on a 24/7 basis. The ability to access the service at any hour was considered a positive and widely supported. It was said that this allows people to access services locally which would largely meet their needs.

> *This is brilliant – I can take my child up there in the middle of the night. We need to know what is available.*
>
> ***Member of the public, Grantham***

6.48 Although several said that ultimately, they would prefer an A&E department, it was felt that the proposed 24/7 UTC was the 'best prospect' given the challenges. A member of the public said that a good offering would include a 24/7 walk-in with doctors, advanced practitioners and diagnostics available, and another said that a UTC would need to be promoted to improve public understanding of what can be treated there.

6.49 A member of the public taking part in a virtual meeting shared a previous positive experience:

> *When Grantham was an Urgent Treatment Centre, I used it on a number of occasions and was happy with it - the wait [time] was very low.*
>
> ***Virtual meeting participant***

6.50 Another said they had used the A&E at Grantham in the past and had a good experience there. However, they recognised that a UTC would have met their needs in the same way. A few members of the public from Lincoln and those taking part in virtual meetings felt that a UTC at Grantham could reduce pressure from other A&Es at night.

6.51 Also in support of this proposal was the local senior citizens group who said they want to access as many services as possible locally and the fact it will be a walk-in was also considered positive. Several participants in different groups also recognised that, if an emergency required an ambulance, the patient would be taken to the most appropriate treatment centre; the status of emergency and urgent care at Grantham and District Hospital is therefore less important in those circumstances.

> *I understand that it's better to travel to a centre where patient will receive the best care leading to the best outcomes.*
>
> ***Member of the public, Lincoln***

6.52 Despite many positive views on the availability of the service over a 24-hour basis, there was also a significant volume of concerns about the proposal. The most prominent concern was the potential impact on ambulance response and journey times for trauma patients. A few members of the public who had suffered heart attacks in the past shared their concerns that if they were to suffer another one, their chances of survival would be reduced by having to travel 45-60 minutes from Grantham to Lincoln.

6.53 There was a view that ambulance response times would be increased by the proposal and that it would also increase the burden on the ambulance service due to longer journey times. There was also a concern among members of the public from different areas that there is poor public transport in the south of the county, meaning that anyone discharged from Lincoln may have difficulties travelling home.

6.54 Many meeting participants felt there are several factors making it difficult to justify a change from an A&E to a UTC. The first is the potential growth in population in Grantham due to a proposal to build 8,000 homes over the next 20 years. For some, it was felt this would justify a demand for a full A&E.

> *Has this proposal considered the estimated population growth in Grantham and surrounding areas? There are lots of building works and new housing springing up so anticipate larger number of people in the community that will then need to access local services. Has this been considered?*
>
> ***Virtual meeting participant***

6.55 The second was a feeling that Grantham residents want a full A&E service and are being left without emergency care. This proposed change is not seen to be leading to improved patient outcomes and there is a view among members of the public in Grantham that A&E services have been allowed to 'run down' to the point they are no longer available. A participant in a virtual meeting did not feel this proposal reflects strategic thinking and that it puts the area's population at risk.

> *Car crashes happen anytime & anywhere. I need to see the strategic thinking across the trust to demonstrate this risk is being considered. I understand that more people live in Lincoln but it's important to the people in South Lincs to have A&E. The level of risk to the public doesn't seem to be considered in this conversation. Why does the trust consider the current level of cover to be safe?*
>
> ***Virtual meeting participant***

6.56 There was also concern from a member of staff that they have not been given an option to put forward an alternative proposal to keep the current A&E provision as it is, or indeed make it a 24/7 A&E.

6.57 There are also concerns that issues with other services would need to be addressed in order to make this proposal successful. GP surgeries were described as 'swamped', with members of the public feeling residents may start using the UTC instead of visiting their GP which would increase waiting times. It was also felt demand might increase on other hospitals, with those in Lincoln, Boston and Peterborough all mentioned.

6.58 NHS staff also shared concerns about issues with other services that would need to be addressed. One was a potential increase in ambulance handover times, and another was an impact on communication with other hospitals that had happened when a UTC was trialled at Grantham previously.

> *When we had the temporary UTC in place at Grantham, there was a disconnect between LCHS and ULHT in terms of safeguarding oversight and IT systems not working together. How will that be resolved in a permanent model?*
>
> ***Member of staff***

6.59 Several members of the public mentioned a 'lack of trust' between the public and NHS Lincolnshire caused by loss of services in the past and a feeling that these proposals will lead to a 'continual drain' and further downgrading of Grantham and District Hospital, e.g., dropping to a 12-hour UTC at a later date. It is felt there needs to be a 'show of faith' to ensure that the proposed services remain in place for many years.

6.60 Some other members of the public felt that what is being proposed is not different to what has been available in the past; some were unsure what is currently available, and others felt the proposal does not reflect the wishes of the people of Grantham. A member of the public in Sleaford asked why a service like the UTC is not available there, as there is a smaller-scale service happening in a local GP surgery with good levels of demand.

6.61 A small number of participants also expressed concern about staff retention and recruitment, with one member of ULHT staff saying they were concerned that they would have to move employer as a result.

6.62 Finally, some questions were asked, and comments made about what services would be at a UTC:

- What care is given at an Urgent Treatment Centre?
- Can you categorically state that the UTC will treat an emergency stroke victim?
- What is the exact difference between a UTC and an A&E? Can you give an example or cases of each?
- Would the proposed model have blood tests in the UTC, rather than referring to Lincoln A&E?
- Will there still be middle grade doctors, and will it be 24/7 walk-in permanently?
- Is anything else changing – fracture clinic? Do we lose anything else?

Mitigations and other comments around proposals for urgent and emergency care

6.63 Travel and access was raised in meetings with members of the public. At Grantham, a participant said that Lincolnshire is a large county with a poor transport infrastructure and that A&Es must be spread out. Another participant mentioned a vulnerable 70-year-old who was taken to Lincoln in an ambulance and discharged in the early hours of the morning. As there were no transport options, a taxi had cost £50.

6.64 Other participants at Sleaford agreed there should be some kind of shuttle bus available and said that there used to be a voluntary transport option in the area run by an individual, but this is no longer running meaning there are not transport options available. At Skegness, there was a concern that there is no contingency plan in place if there is an accident on the railway line which allows people to travel to Grantham.

6.65 It is considered important that the UTC works on a walk-in basis as members of the public in Grantham reported issues with the previous 'talk before you walk' system run by 111. They felt the service was turning patients away that could have been treated effectively at Grantham and District Hospital.

6.66 Members of the public, patients representatives and the senior citizens group felt that there needs to be more clarity provided to the public on the purpose of the UTC and who can be treated there. The senior citizens group in particular mentioned that older people are concerned they are putting pressure on services by using them and are concerned about the pressures at Lincoln, more explanation about the benefits of this proposal may alleviate some of this worry.

> *We need to speak much more clearly to the public – terminology is difficult. People would use it if they knew what was there. This service looks fantastic, but people of GDH are being talked down to.*
>
> ***Member of the public, Grantham***

Proposal for acute medical beds at Grantham and District Hospital

6.67 Some attendees shared their views on the specifics of the planned changes to acute medical beds at Grantham and District Hospital, thinking about any possible benefits and positive impacts as well as any concerns or negative impacts. It is worth noting that less feedback was provided on this proposal than the other three, suggesting there may be less strength of feeling around this proposal.

Introducing integrated community/acute medical beds at Grantham and District Hospital

6.68 Any positive comments made were quite general, with members of the public feeling the proposal was a 'good idea' and a positive step to getting people rehabilitated close to home. Senior citizens group representatives felt that retaining services at Grantham is good for the elderly population in the area as many will be familiar with the surroundings and indeed the staff.

> *Lincoln and Boston are too impersonal and do not receive the same attention. They can be intimidating.*
>
> ***Senior citizens group***

6.69 For representatives of the Voices for All group, keep some acute medical beds open and services working together to allow follow-up appointments in the community were viewed positively.

6.70 In terms of concerns or potential negative impacts, the feedback largely focused on needing clarity on the proposal and how it will be carried out. Several members of the public asked about the numbers of beds overall in Grantham, they felt more information was needed on whether there will be a reduction or increase in the number of beds currently at Grantham and District Hospital.

6.71 Another concern was that different services would need to work together to realise this proposal and how this would happen. A member of the public at Grantham asked whether, in integrating community and acute beds, adult social care services provided by the local authority would be involved? A meeting attendee in Spalding echoed this and was concerned that there is not enough capacity in social care to support this move.

6.72 Indeed, several participants in the various groups were concerned about how this change would impact on other services that are already overstretched. A member of the public in Spalding shared a story of a family member who had spent 10 days unnecessarily in a home while waiting for discharge, but support wasn't there from either the NHS or the local authority.

6.73 ULHT Patient Panel members felt that this model would need more involvement from primary care but felt that GPs are already under too much pressure; they felt strongly that GPs should be given the opportunity to give feedback on the proposal. They also felt that there is a lack of support available in the area for patients post-discharge and this proposed model could increase the demand for these services further.

6.74 Crucially, it was felt that for this proposal to be successful, services would have to work collaboratively, with concerns that wider pressures could be a barrier to this.

> *They need to make sure it is all joined up properly – a lot of the time patient notes cannot be accessed.*
>
> ***Sensory Service***

6.75 Another concern for members of the public was logistics; one asked how will the 'expensive' logistical challenge of delivering acute care in the community be realised? And another questioned why someone would travel to Lincoln to be treated and then moved back to Grantham for acute care?

6.76 Other members of the public shared concerns about staffing. One, from Grantham, was concerned that not enough staff with the skills to provide high dependency care would be available and another, from Spalding, asked where the number of community nurses needed to staff the model would come from?

6.77 There were some questions from the various groups around whether the model was suitable. Representatives from the senior citizens groups felt that there are not enough beds for geriatrics in Grantham at the moment and said three wards, used for other purposes, are underutilised. They also felt that paramedics are being told not to take patients to Grantham and District Hospital, which concerned them.

6.78 It was felt by a member of the public in Grantham that some strategic thinking is needed around the types of services that coexist in the hospital, to ensure they complement each other.

> *As Grantham has no higher dependency beds, it is important that patients are cared for in the most appropriate setting, unless these higher dependency service are reinstated then acute beds are not appropriate at Grantham – these plans must work hand in hand.*
>
> ***Member of the public, Grantham***

6.79 At one of the NHS staff briefings, questions were asked about what specialists would be available to Grantham inpatients under the proposed model, with one staff member expressing alarm that the proposal seems to suggest that the frail elderly service at Grantham is going to be a *'glamourised nursing home'*. Another said that there needs to be assurance that some specialists will remain at Grantham, with a focus on acute and geriatric medicine as specialisms in their own right.

Mitigations and other comments around proposals for community/acute medical beds

6.80 A few meeting participants shared factors they consider to be important considerations for decision makers. For the senior citizens group, these were practical considerations. They suggested that blood tests should always be offered at Grantham and gave an example of someone taken from Grantham to Lincoln for a blood test late in the evening, then discharged in their pyjamas with no money or phone to find their way home.

6.81 The Voices for All group said that NHS 111 need to be well informed and clear on the proposals to ensure that patients who can be appropriately treated are sent to Grantham, as opposed to one of the A&E departments at Pilgrim Hospital, Boston or Lincoln County Hospital. A member of the public at Grantham felt it was important to consider how food and drinks would be supplied for any increase in patients.

6.82 Staff participants and ULHT Patient Panel members would support extending this model to other hospitals in the trust. It was felt that a whole-system approach would bring an effective solution to 'bed blocking' issues. Staff asked whether there would be similar integrated models at Lincoln and Boston to avoid admissions there, and a patient representative asked whether the model might be extended.

> *As those people using these acute medical beds are those who often end up blocking beds in the system for those with other medical requirements. Is there a strategy to work across the county with other agencies to provide money and assets for these beds as a countywide stream across the area?*
>
> ***ULHT Patient Panel member***

6.83 Finally, another of the ULHT Patient Panel members suggested that a district nurse type-role should be introduced to do things such as go into people's homes and administer daily injections they cannot do themselves, to ease the pressure on hospital services.

Views on the proposal for stroke services in Lincolnshire

6.84 Some meeting attendees shared views on the proposed changes to stroke services in Lincolnshire, thinking about possible benefits as well as any concerns or negative impacts.

A 'centre of excellence' for hyper-acute and acute stroke services at Lincoln County Hospital

6.85 Positive comments on this proposal were supportive of the creation of a centre of excellence with members of the public in Grantham, Skegness and in one of the virtual groups saying they now better understand the reasons behind the proposed changes. However, a participant from Louth felt that there should be better communication of the proposal to members of the public, despite feeling it is a 'fantastic development'.

6.86 Representatives of the senior citizens group feel that a good quality of care is given at Lincoln Council Hospital and those representing the Sensory Service said that Deaf people in particular, are given good care there. They are also eligible for free NHS transport meaning that the travel distance isn't an issue.

> *I would much rather travel to a centre of excellence and get the best care possible.*
>
> ***Sensory Service representative***

6.87 In terms of benefits to staffing, a representative from the senior citizen group acknowledged that because procedures are becoming increasingly advanced, it makes sense to keep staff trained in a central location and a member of the public in Lincoln recognised that temporary staff are expensive, so this procedure could encourage more long-term staff to live and work in Lincoln.

6.88 However, there were some concerns raised far, the biggest area of concern was travel time to Lincoln from other parts of the county. Participants said that with stroke services, 'time is of the essence' and that people living outside the 'Golden hour' of travel time to Lincoln, will be disadvantaged by these proposals.

> *Lincoln is too far and not easy to get to in a timely manner. TIME is crucial for stroke patients.*
>
> ***Member of the public, Grantham***

6.89 A key area of concern was ambulance response times. Several attendees said that response time targets are not consistently met in the area, with several factors making the situation worse at certain times of year.

> *The poor roads in Lincolnshire, and rurality will not help with the response times, examples given of journeys from the coast to Lincoln can take up to 2 hours in winter.*
>
> ***Countywide PPG representative***

6.90 Members of the public, patients and special interest group representatives all shared examples of long ambulance waiting times in the area and felt that Lincoln was not geographically ideal as a location for the centre of excellence due to its distance from the more rural parts of the county and the east coast.

> *Pilgrim in better position to centralise services for the county. No one talks about the Centre of excellence that used to be at Boston.*
>
> ***Member of the public, Boston***

6.91 Participants also explained the difficulties locating the centre in Lincoln would cause for families and carers of patients. A participant in one of the staff meetings said that patients had told them they were worried about travelling from Boston to Lincoln and a patient representative said that those who depend on their family members to support their rehabilitation could find the Lincoln location difficult.

> *When we are talking about travel and transport and communication across the county we need to think about family as well. I don't drive, and if my husband was unwell, I wouldn't be able to get to Lincoln.*
>
> ***ULHT Patient Panel member***

6.92 Representatives of the senior citizens group and the Sensory Service felt the need to travel to Lincoln would cause a lot of anxiety for elderly patients and felt it could be costly for family members to visit their loved ones. A member of the public in Skegness felt that being in hospital further from home would have a negative impact on patients' mental health.

6.93 Apart from specific concerns around ambulance response times and travel distance to Lincoln, many of the comments focused on general public opinion and the viability of the proposals. Participants in several groups said there was public unease about the changes proposed with many questioning why locating the centre of excellence in Boston was not an option?

> *Why can't we have the centre of excellence at Boston, especially as the data shows most strokes happen on the East Coast?*
>
> ***Member of the public, Skegness***

6.94 In terms of viability, a Countywide PPG representative felt that Lincoln hospital is already under too much pressure to facilitate this change and staff echoed the fact that there is public unease about having to travel to Lincoln for this kind of treatment, even though that is what currently happens.

6.95 A member of the public at Louth felt that there is poor communication with the public around stroke care in the area, meaning that people do not generally understand what kind of treatment is offered where.

6.96 Another member of staff felt that Boston is being put at a disadvantage by the developments at Lincoln.

> *For too long Boston has been held back by the development of Lincoln. This is clearly leading to a postcode lottery of care...*
>
> ***Staff representative***

6.97 A member of the public in Spalding felt that these changes were being proposed because they benefit the trust and its staff but not the patients, and asked why are nurses not able to do extra hours instead of employing agency staff?

6.98 Finally, a number of comments and questions were raised about the specific details of the proposals, with requests for a little more detail around the following issues:

- » Will there be mechanical thrombectomy provided at Lincoln 24/7?
- » Will there be follow-up services required after the acute episode has concluded available in the community, e.g., OT, Physio support?
- » Does the change that is being proposed mean the closure of stroke services at Boston?
- » Does this mean that there will continue to be no acute stroke service available for local people including inpatients who are unfortunate enough to suffer a stroke? A phone call to LCH is clearly not the same level of care as a physician seeing the Patient. (NHS Staff question/comment)
- » Do we have any figures for how many 'strokes' are missing the 1st vital 48hr care? Why close an 'A' rated on SSNSP (which is the standard for stroke care) performing ward? Surely if we are to move forward pan-trust, we owe it to patients in our catchment area to share stroke services across the county. (NHS Staff question/comment)

Views on the removal of hyper-acute and acute stroke services from Pilgrim Hospital, Boston

6.99 Only two comments around positive impacts or opportunities from this aspect of the proposal were offered. The first was from a member of the public in Boston, suggesting it could be an opportunity to open mobile stroke units across the county. The second, from a Sensory Service representative, was that because 'ambulances are always queuing up at Boston', the proposal could alleviate some of this pressure.

6.100 A key concern was the impact of removing hyper-acute and acute stroke services from Boston on ambulance response times and travel distance for those living in the area.

6.101 Several members of the public said that having a centralised model is a risk in England's second largest county where there are infrastructure issues, particularly when treatment time is so crucial for stroke patients. A member of the public in Skegness said that concern about travel times to hospitals in an emergency situation could have a negative impact on the mental health of patients.

6.102 Members of the public in Skegness felt that locating stroke services in Boston would suit the overall needs of the population better than Lincoln. It was said that residents in Boston feel their services are under threat and that they are not supported as a result – they would appreciate clarity on what the future plans for Pilgrim hospital are. Another said that if Boston receives city status, it will need more services, not less. Finally, one participant in the Skegness meeting suggested the proposals are not based on the data.

> *The data suggests the status quo would be better. It would be better to be closer to home in local hospital.*
>
> ***Member of the public, Skegness***

6.103 A member of the public at Boston felt that the proposal would widen health inequalities and patient access as services would be taken away from a deprived area; with a participant at Skegness suggesting that to combat some of these issues, an air ambulance should be deployed to cover the East coast of the county.

6.104 As with the other proposals, a few participants across the various meetings had questions on the exact details of the proposals, which were:

- » What happens if someone presents at Boston while having a stroke?

» Is vital stroke medication administered in the ambulance?

» Will a UTC treat a stroke patient? If not, how can an additional 28 mile journey to Lincoln be justified?

Factors and impacts and/or mitigation measures that decision makers should consider

6.105 A key factor members of the public felt should be considered by decision makers are the impact of these plans on the carers and family members of patients accessing stroke services. With the difficulties already mentioned with poor road infrastructures, and a lack of public transport in many parts of the county, there is a concern that they are being disadvantaged by concentrating services in Lincoln. This was echoed by a representative from the Voices for All group.

> *Patients need support from their families and need to demonstrate that the community model will support that – maybe utilise cottage hospitals as a step-down to get patients out of hospital quicker.*
>
> ***Member of the public, Skegness***

6.106 Members of the public in Boston were concerned that the population is set to increase there – it has increased by 30% in the last three years. Removing stroke services from the area is a concern given that retirees account for some of the population increase.

6.107 Another factor suggested was staffing and recruitment issues. Members of the public in Grantham felt that low staff wages are a factor in recruitment struggles, coupled with a feeling they are not valued. They also said that many are put off nurse training due to a lack of bursary and the pay prospects once they qualify.

6.108 As mentioned previously, the impact of the proposals on ambulance response times were a key concern across all groups. Several people said that the ambulance service is not routinely meeting targets, and that this would further increase the pressure.

> *Given the Geography and transport problems we cannot meet the NICE guidelines of 1 hour to get acute stroke scanned and, if indicated, administered treatment. Outcomes will be poor. This area has seen great advances; I don't see how your proposal complies to guidelines.*
>
> ***Member of the public, Grantham***

6.109 There were also other concerns about the potential implications of the proposals on the ambulance service. It was felt that the costs associated with ambulance maintenance would increase if these changes were implemented. A member of the public in Louth questioned whether East Midlands Ambulance Service are equipped to stabilise stroke patients and a member of the Countywide PPG felt that representatives from the ambulance service ought to have been present to answer questions and respond to concerns.

6.110 Finally, several wider issues were flagged as important considerations:

» A member of the public in Boston said that a lack of social care resource in the county would lead to difficulties in putting the proposals in place;

» A member of the public in Skegness questioned what would be done to combat the environmental issues potentially caused by the proposals, e.g., due to further journeys being taken to hospitals further away); and

» It was felt by a ULHT Patient Panel member that a transport plan is needed, particularly as 30% of Lincolnshire residents do not have access to a car.

Equalities and health inequalities impacts

6.111 A Grantham senior citizens group representative said they were pleased overall with the plans for orthopaedic care and acute and community beds at Grantham hospital as, historically, older people have been treated well there.

6.112 However, there were some concerns about how the other elements of the proposals could negatively impact older people. The same representative from the senior citizens group was concerned that ambulances are now 'allowed' to drop patients at Grantham hospital on some occasions and questioned why older patients from the Grantham area would be taken to Lincoln, Boston or Peterborough to be treated when there is a hospital that is familiar to them on their doorstep?

6.113 At the Voices for All group, concern was also raised about people with mental health issues or disabilities who might need support to travel and might find it harder to deal with longer journeys.

Other comments and feedback

6.114 Some participants shared specific comments relating to experiences of using the services in Lincolnshire, thinking about things such as waiting times and cancelled operations.

6.115 Most feedback on planned orthopaedic surgery was positive, with patients having experienced a good service. A ULHT Patient Panel member said they volunteer in a surgical unit in the county and regularly observe patients having a good experience of treatment and aftercare, with most sent home the next day.

6.116 However, one member of the public from Louth shared their experience of being an orthopaedic patient where they had some communication issues when attempting to make an appointment:

> *When I called to arrange another appointment with the consultant, the appointment service called me back to offer me an appointment with another consultant. When I explained my need to see the original consultant, I was put through to another person at Lincoln who said exactly the same as the first person I spoke to. Again, I wasn't given the option of making an appointment with my original consultant. I still haven't managed to arrange the appointment with this consultant, and I am deeply concerned as I am on medication for conditions relating to cancer I have suffered. He knows my history and medication needs and I'm worried that another consultant won't.*
>
> ***Member of the public (patient), Louth***

6.117 A few experiences were also shared in relation to stroke services. A member of the public in Boston was concerned that when you call 999, you don't get given an ETA for the ambulance; another from Louth said that when they took their daughter to Grimsby Hospital with a suspected stroke, they were told they had to wait for an ambulance to take her to Lincoln. Finally, a member of the public in Skegness shared their concern about those who are discharged without access to transport:

> *My husband was blue lighted to Lincoln – he was able to be collected at 9pm on a December evening. Luckily, our daughter was able to support to collect him but what about those without support and transport?*
>
> ***Member of the public, Skegness***

6.118 At the public meetings, several individuals made comments and asking questions about the cost of the consultation programme itself.

Other questions asked during public meetings and other engagement events organised by NHS Lincolnshire CCG

6.119 As described earlier in this chapter, a large number of questions, comments and request for information were made at the public meetings and other engagement activities undertaken by NHS Lincolnshire CCG during the course of the consultation, with many being responded to by NHS managers and clinicians during the meetings.

6.120 While not necessarily constituting feedback on the proposals, these questions and comments are helpful in highlighting more general concerns and points of interest around acute health services in Lincolnshire. Therefore, in addition to the summary in this chapter, full lists of questions and comments have been included in Appendix III for reference.

7. Written submissions

Introduction

7.1 In addition to the organisational responses to the consultation questionnaire covered in Chapter 4 of this report, 18 written or emailed submissions were received from residents, staff, organisations and stakeholders. The table below shows the breakdown of contributors by type.

Figure 60: Summary of written submissions received

NHS TRUSTS AND PROFESSIONAL GROUPS	
Stroke Therapy Services, Pilgrim Hospital, Boston	
LOCAL AUTHORITIES AND POLITICAL GROUPS	
Health Scrutiny Committee for Lincolnshire	South Kesteven District Council
CHARITIES AND SPECIAL INTEREST/COMMUNITY GROUPS	
Healthwatch Lincolnshire	Fulbeck Over 60s Club
INDIVIDUAL RESIDENTS	
13 individual responses from residents	

7.2 ORS has read all the written submissions and reported them in this chapter. Most have been reviewed in a thematic, summary format in order to identify the range of views and issues as well as common themes, though some that have presented unique or distinctive arguments, that refer to different evidence or were submitted on behalf of organisations and individuals representing groups of people, have been summarised individually for accessibility and to highlight their main arguments and any alternative proposals.

7.3 It is important to note that the views expressed by submission contributors may, in some cases, run contrary to available evidence. Nonetheless, ORS has not sought to highlight or correct any potentially incorrect statements or assumptions when summarising the views expressed; nonetheless, this should be borne in mind when considering the submissions.

7.4 The detailed written submissions in particular do not lend themselves to easy summary and so readers are encouraged to consult the remainder of the chapter below for an account of the views expressed. However, the following overview gives a sense of the types of issues raised: a 'summary of the summaries'.

Summary of main findings

7.5 Much of the feedback received (from individual residents, Kesteven District Council and the Fulbeck Over 60s Club) related to the proposals for, and service provision more generally at, Grantham and District Hospital. The main issues raised were that:

- The hospital has suffered from under-investment and service reductions for many years despite its strategic location, and the proposals represent further 'downgrading';
- Service provision should be at least maintained at Grantham: respondents particularly wished to see the retention of unplanned orthopaedic services, and the restoration of a full 24/7 A&E department;

- » Consideration could be given to providing acute stroke services in the area, for patients must currently travel significant distances for specialist care;
- » Increasing stroke rehabilitative provision and offering it locally (not just in Grantham and District, but in all areas) is essential;
- » The distance from the Grantham area to other hospitals is a concern, particularly in terms of access to full A&E services;
- » Travel difficulties (and costs) are particularly acute for the elderly, those on low incomes and those without access to a private car, especially if they are having to access follow-up care and/or rehabilitation some distance from home;
- » Patients being treated away from their local areas is challenging and expensive for visitors, adding to patients' stress and hindering their recovery;
- » Housing growth in Grantham means that health provision is a material planning consideration;
- » There are climate change implications when patients have to travel to and from hospitals; and
- » A lack of local hospital-based facilities may affect tourism.

7.6 The Stroke Therapy Team at Pilgrim Hospital, Boston wrote to say it understands the reasoning for developing a centre of excellence at Lincoln, but has concerns around:

- » An increase in the number of patients at Lincoln;
- » The lack of additional specialist staffing proposed for the Lincoln site;
- » An increase in stroke patients out-lied[9] to non-specialist wards who do not receive timely and effective specialised rehabilitation;
- » The management of more complex patients who require more intensive input; and
- » The availability (or lack thereof) of community beds and specialist stroke management within community hospitals.

7.7 Healthwatch Lincolnshire raised wider concerns around the impact of service changes on what it saw as the 'most affected' groups, namely: people living in rural and isolated communities; people living with disabilities and co-morbidities; public transport users; and people who are geographically impacted because of changes to current provision.

7.8 Healthwatch strongly urged the CCG to fully consider all negative and positive impacts on people and communities when reviewing the results of the public consultation and its Equality Impact Assessments.

Response from the Health Scrutiny Committee for Lincolnshire

7.9 The Health Scrutiny Committee for Lincolnshire submitted a wide-ranging response to the consultation which combined feedback on the proposals with suggestions and requests to Lincolnshire CCG and ULHT.

7.10 Given the level of detail of this submission, it has not been included in this brief 'summary of summaries' It has, however, been précised at the end of this chapter and is included in full in Appendix IV of this report alongside the written submissions from the other four organisations.

[9] Being placed on a non-stroke ward

Summary tables of themes from residents' written submissions

7.11 To ensure anonymity, submissions from individuals are summarised rather than reported verbatim. Below and overleaf are summary tables of the main themes emerging from these submissions received from residents. All of the feedback related to the proposed service changes at Grantham and District Hospital.

Figure 61: Summary of main themes raised in written submissions – service provision at Grantham and District Hospital

Sub-Theme	Example Comments/Points made
Grantham and District Hospital needs more investment	*"My views are it's about time they stopped these idiots from trying to close Grantham hospital and took some of the money from Boston and Lincoln and spent it in our hospital"*
Grantham and District Hospital should have a full A&E department	*"We need an A&E"* *"Please get a 24-hour A&E, just as it used to be. Your temporary measures were supposed to be just that (not six years)"* *"I am particularly concerned about A&E provision for Grantham, a rapidly growing town with a major railway line. It takes time to get to Lincoln or Boston and much is demanded of the ambulance service"* *"… we had five hours to wait for an Ambulance then had to go all the way to Lincoln from Grantham so [my mum] died because we are all aware it's that first hour. Maybe if we'd had A&E at Grantham, she might have been alright"*
Orthopaedic services should remain at Grantham and District Hospital	*"I do think that orthopaedic surgery should stay at Grantham Hospital"* *"In the 20 years that we have lived in Grantham, both of us have suffered fractures due to falls, which required theatre surgery. The treatment we received was outstanding at Grantham"* *"With the size of our local population, it is essential that Grantham retains a comprehensive orthopaedic service … "*
Acute stroke services should be provided at Grantham and District Hospital	*"Stroke services should take place at Grantham and District Hospital. After having a stroke myself, it really is not in order to be taken to Nottingham"* *"Does this mean that there will continue to be no acute stroke service available for local people including inpatients who are unfortunate enough to suffer a stroke? A phone call to LCH is clearly not the same level of care as a physician seeing the patient"* *"As a healthcare worker, I find it difficult to explain to myself how acute stroke care can be denied to this area. As the nearest provider is at least one hour away with the decision-making being done about which patient to be shifted to Lincoln and which not, it appears like a lottery system. I feel that if I or a family member or friend requires the acute stroke services, it would not be of the standard expected as the time to thrombolysis will be a struggle to achieve"*
Stroke rehabilitation provision must be enhanced	*"It is important that when reconfiguration is implemented, there is significant additional investment in inpatient rehabilitation (including speech and language therapy, physiotherapy, occupational therapy, psychological and emotional support, orthoptist services and dieticians) to ensure that people affected by stroke have the support they need to rebuild their lives. It's also important that inpatient rehabilitation beds are protected so that patients requiring longer hospital stays are cared for in an appropriate therapeutic setting"*

7.12 There was a shared view that overall service provision should be at least maintained at Grantham and District Hospital, and that investment is needed in local health services. Those submitting written feedback wished to see unplanned orthopaedic services retained, and a full 24/7 A&E department restored.

7.13 There was also some support for the provision of acute stroke services in the area, as patients must currently travel significant distances for specialist care. The importance of increasing rehabilitative provision and offering it locally (not just in Grantham and District, but in all areas) was also stressed.

7.14 The distance from the Grantham area to other hospitals was a concern, particularly in terms of access to full A&E services. Travel difficulties (and costs) were said to be particularly acute for the elderly and those without access to a private car, especially if they are having to access follow-up care and/or rehabilitation some distance from home.

7.15 Patients being treated away from their local areas was also said to be challenging and expensive for visitors, adding to patients' stress and hindering their recovery.

Figure 62: Summary of main themes raised in written submissions – distances to alternative hospitals

Sub-Theme	Example Comments/Points made
Distance to other hospitals could be detrimental to the patient experience	*"The distances patients will have to travel when they need urgent care are totally unacceptable"* *"You make people travel an hour away from villages taking them further on red routes. Over 50 people a year have lost their lives, could they have been saved if they had been allowed to go to Grantham Hospital, a fraction of the travel time?"* *"… one aspect that does worry and frighten me is when I do need medical attention, will I have to travel to Lincoln, Boston, Nottingham or Peterborough to get it?"* *"Lincoln, Boston and Peterborough are far away. When you are not well, then you have to stay in the ambulance for a long time until they can take you in"* *"Follow up to acute care involving travelling to centralised acute care outpatient appointments is difficult and increasingly unaffordable to some without cars"* *"It … ignores travel problems for the 15%-25% without cars, whether to acute centres or for rehabilitation. You need to solve this"*
Distance to other hospitals is challenging for visitors	*"… Longer travel times for families and carers which could place a financial burden on them and restrict how often they can visit their loved one in hospital"* *"It also adds stress to the person who is being visited, because their family have to make such a long journey to come as see them, not helping their recovery"* *"I'm a frequent user of NHS services [and am] concerned for my wife visiting. We're both in our 80s, both still drive, but I'm worried about having to go to hospital in Lincoln and the travel involved. The travel from Grantham to Lincoln; not good roads"*
Distance to other hospitals is challenging for elderly residents	*"Elderly people along the coast are getting very frightened as they feel they are losing services closer to home and ambulances are taking longer to get to them"* *"The few occasions we have sought hospital treatment as OAPs have regrettably necessitated the most awful of journeys to Lincoln County Hospital (and back) … "*
Travel to other hospitals is particularly challenging and costly by public transport	*"When you can't drive yourself, and there's not buses in the middle of the night, by the time you get to Boston (which doesn't have a good rep), or Lincoln, you are dead"* *"Public transport as it is does not facilitate 60-mile round trips"* *"Public transport is a real issue along the coast … "* *"Patients discharged in the early hours having to pay £60 for a taxi home"*

7.16 Other issues raised by individual residents were that: Grantham and District is a growing area that requires appropriate levels of healthcare provision locally; and that centralised services do not fit with the Government's 'zero carbon' aims.

Figure 63: Summary of main themes raised in written submissions – other issues

Sub-Theme	Example Comments/Points made
A growing population requires appropriate healthcare services	*"Grantham is a massively growing town"* *"Not only are more homes going up in Grantham, the villages are growing in size as well. When you phone for an ambulance, you can wait for two hours"*
Centralised services do not fit with the Government's emissions policy	*"Centralisation undermines government policy on 'zero-carbon' transport which will mean that fewer of the poor and vulnerable will have electric cars"*

Summaries of submissions from stakeholder organisations

7.17 Response from organisations have been summarised individually as they are more detailed than the shorter responses from individual residents, or have been written to represent the views of larger groups of people. Some of the submissions point to additional or alternative sources of evidence. As noted above, it is not ORS role to assess the validity this evidence or the accuracy of the statements made. We recommend that readers also refer to Appendix IV of this report, which contains the full verbatim submissions.

The Stroke Therapy Team, Pilgrim Hospital, Boston

The team understands the reasoning for developing a centre of excellence at Lincoln but feels that the full pathway has not been considered in terms of the wide range of complex patients' needs. Their main concerns are around:

- An increase in the number of patients at Lincoln;
- An increase in stroke patients out-lied[10] to non-specialist wards who do not receive timely and effective specialised rehabilitation;
- The lack of additional specialist staffing at the Lincoln Site; and
- The management of slower stream, more complex patients who require more intensive input.

The team accepts that patients need to be discharged home quickly and receive stroke support from the Lincolnshire Stroke Service. However, it says that a percentage of patients are unable to go home, requiring more specialist rehabilitation on their sitting ability and/or having non-oral feeding requirements – and that there is evidence to suggest that these patients would benefit from further multi-disciplinary team (MDT) input to prevent longer-term seating problems, contractures, pressure sore development, reduced mobility, management of swallowing problems and, possibly, risk of death. This group of patients also need expert input including the use of special equipment which is not available in the community.

The team feels that beds in community hospitals are rarely available and there is lack of specialist stroke management, meaning patients do not reach their full potential/outcomes. When working with the Lincolnshire Stroke Service on best discharge outcomes, the Service often advises that referring to a community bed will not provide the necessary specialist rehabilitation for these patients. This apparently results in patients being referred to a new placement despite the fact that if they had further rehabilitation, they could have returned home in certain cases.

[10] Being placed on a non-stroke ward

The team recommends that funding is maintained for the number of beds at Pilgrim Hospital, Boston to enable patient flow. It also believes that stroke-specific inpatient rehabilitation beds are key to the success of the proposal should it be taken forward.

South Kesteven District Council

South Kesteven District Council supports a fully-functioning, 24/7 A&E Department for Grantham and District Hospital.

At a recent meeting, Members highlighted concern over continued service reductions at Grantham and District Hospital and the consultation itself, which, it was felt, is "*not a meaningful consultation but a tick box exercise with a bias against Grantham Hospital"*.

Furthermore, an individual councillor made the following points:

- Previous consultations have recognised Grantham as a strategic location, and proposals have changed accordingly;
- The services offered at Grantham and District Hospital affect every single resident, as no-one is immune to accidents and the need for urgent treatment at A&E or a UTC;
- Housing growth in Grantham means that health provision is a material planning consideration;
- There are climate change implications when patients have to travel to and from hospitals; and
- A lack of local hospital-based facilities may affect tourism.

Reference was made to the closure of the hospital in June 2020, and the Judicial Review that had been brought in connection with the closure of the acute care services for a period of time, and how the level of services had been downgraded and eroded.

Members also stated that the information ULHT had given during the closure period due to Covid-19 was flawed, as they had failed to mention that 33,000 residents had signed a petition for the 24/7 restoration of emergency services at Grantham hospital under the Healthy Conversation 2019 engagement exercise.

Healthwatch Lincolnshire

Healthwatch Lincolnshire acknowledges the significance of the four service areas as they "*affect so many patients across the county."* It believes that any changes to these services will impact people in various ways, and that the most affected groups will be:

- People living in rural and isolated communities;
- People living with disabilities and co-morbidities;
- Public transport users; and
- People who are geographically impacted because of changes to current provision.

Healthwatch Lincolnshire strongly believes that the CCG must fully consider all negative as well as positive impact on people and communities when reviewing the results of the public consultation and its Equality Impact Assessments.

In terms of the consultation, Healthwatch Lincolnshire acknowledges the significant amount of effort the CCG has made to invite people to respond to their public consultation and is encouraged to note the large and diverse number of responses. It is also reassured by the fact that the CCG will be using Opinion Research Services to collate the feedback received.

Fulbeck Over 60s Club

The Fulbeck Over 60s Club, which has 26 members, submitted a letter that did not refer specifically to the proposals under consultation, but did refer to concerns around travel and access to receive healthcare.

The submission stated that full ear and eye treatment should be available at Grantham and District Hospital. It notes that some of the club members are having to travel to Boston (70 miles) and Louth (100 miles) for cataract operations and appointments previously undertaken/held at Grantham, with transport costing up to £100.

The Club is concerned that, in future, the elderly and low-income residents will be unable to afford these transport costs due to the rise in the cost of living and will have no choice but to cancel appointments.

Health Scrutiny Committee for Lincolnshire

7.18 Although the Health Scrutiny Committee (henceforth the HSC or the Committee) fully accepts the evidence underpinning the need for change, it is not completely convinced that the proposal is right for the people of Lincolnshire.

The HSC's views on the proposal for Orthopaedic Surgery

The HSC tends to disagree with the proposal to introduce a centre of excellence for orthopaedic surgery. Although it understands the concept and intentions, the Committee disagrees for the following reasons:

- Concerns around accessibility for patients across Lincolnshire, particularly those in the east where age, deprivation, and public transport usage is higher than average. The HSC requests further details on the support proposed for these patients;
- It is not convinced that the proposal would improve the recruitment and retention of staff; and
- It is not clear how many patients would choose to have their elective orthopaedic surgery at a hospital outside Lincolnshire. This could potentially impact on neighbouring healthcare systems, the continued use of the independent sector, and funding for the Lincolnshire healthcare system.

However, the Committee strongly supports the continuation and expansion of day case orthopaedic surgery at County Hospital, Louth.

The HSC's views on the proposals for Urgent and Emergency Care

The HSC strongly disagrees with the proposal for an UTC at Grantham and District Hospital because:

- Recruiting and retaining staff to the proposed UTC will not be straightforward, and there may be times in future whereby staff are re-allocated from the UTC to support A&E departments, thus reducing the capacity of the proposed Centre; and
- It has not yet been assured that the 3% of patients who cannot be treated at the proposed UTC will not be discharged from another A&E department without transport or a means of returning home when public transport is unavailable.

The HSC recommends that:

- There should be clear publicity around what is provided at the Grantham UTC, as the term is a relatively new concept within the NHS;
- The modest capital investment for the expansion of the proposed UTC into unused parts of the hospital should be identified, and the development planned and implemented, immediately.

The HSC's views on the proposals for Acute Medical Beds

The HSC tends to agree with the proposal to provide integrated community/acute medical beds at Grantham and District Hospital because:

- It is likely to improve the recruitment and retention of consultants and middle-grade doctors; and
- It supports the concept of integrating health and social care services, and the potential for Grantham to become a centre of excellence for multi-disciplinary care and a template for other similar centres.

The Committee also made the following additional comments:

- There are concerns that if the proposed UTC is developed, with an extended range of services compared to other similar centres, there is a risk that withdrawing any of these services would impact on the arrangements for acute and community beds;
- As the integration agenda develops, there may be discussions on where the funding for services is held. If budgets are to be held by local authorities, 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 Council's finances; and
- The HSC would wish to be made aware of any changes to the proposed community bed provision detailed in Chapter 11 of the pre-consultation business case.

The HSC's views on Stroke Services

The Committee tends to disagree with the proposal for a Stroke centre of excellence at Lincoln County Hospital. It is not convinced by all the arguments put forward, and disagrees for the following reasons:

- The proposal is another example of services being consolidated at Lincoln County Hospital and, in this case, the displacement of 497 patients each year. This leads to the perception that services at Pilgrim Hospital, Boston are gradually being downgraded;
- The east coast of Lincolnshire has a large population with high levels of deprivation. Withdrawal of acute hospital services is likely to have a significant impact on wellbeing;
- The pre-consultation business case does not consider the capacity of the North West Anglia NHS Foundation Trust to treat as many as an extra 250 stroke patients a year;
- It is important to recognise how the proposed changes affect the availability of the East Midlands Ambulance Service; and
- The Committee is not convinced that the proposals will lead to improvements in the recruitment and retention of staff.

The Committee also urges that clinics for the treatment and follow-up of transient ischaemic attacks should continue at Pilgrim hospital.

Equalities impacts

The HSC urges the NHS in Lincolnshire to take full account of equalities assessments prior to making decisions on service changes.

Travel and transport

The HSC does not believe it is the County Council's role to facilitate changes to public transport provision, solely and directly in response to changes to NHS services. Furthermore, the Committee has concerns over evening and overnight discharges when public transport does not operate.

The Committee notes the references in the pre-consultation business case to non-emergency patient transport services as means of mitigating the impact of the withdrawal of services from certain locations. It considers it 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.

Staff recruitment and retention

The Committee is not convinced that the proposed service changes alone will address staffing challenges. They note that the supply of medical and nursing staff is a national issue, thus not solely the responsibility of the NHS in Lincolnshire. A difficulty is that many medical and nursing staff are more attracted to a flexible agency style of working.

Links to neighbouring health systems

The HSC seeks reassurance that neighbouring health systems will be able to cope with any increased demand on their services from the displacement of Lincolnshire patients. Furthermore, there is concern that there may be proposals to withdraw some acute hospital services from either the 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"*.

The HSC's views on the consultation

The HSC would like to see the full consultation report to provide an assessment on how well the delivery of leaflets to households has worked as "*anecdotal evidence suggests that many households did not receive a consultation leaflet*".

The Committee understands that there has been some very low attendance at the in-person consultation events and feels that the pre-booking system "*might have deterred people from coming forward with their views*".

The Committee feels that although there were 2,495 online responses at the time of writing, the reach of the consultation could have been "*more extensive and elicited more responses*". It acknowledges, though, that this reach has been constrained in part by the Covid-19 pandemic.

8. Petitions and standardised submissions

Introduction

8.1 Two petitions were submitted during the consultation period and are summarised below.

Petition 1 (organised by SOS Grantham) – 1,302 signatures

8.2 SOS Grantham organised the petition below on behalf of 'United GDH Campaigners', which also includes two other groups: 'Is Anyone Listening? Lincolnshire' and 'Fighting 4 Life Lincolnshire'. ORS received **818** signed paper copies of the standardised letter and petition statement.

8.3 Although not notified by the petition organisers, ORS is also aware that **484** individuals supported the same petition online at the Care2 Petitions website; while it is not clear whether some of the same people may have also submitted paper copies, they have nonetheless been included to give a total of **1,302** signatures.

8.4 The petition statement can be seen overleaf. It was preceded by some contextual text in the form of an 'open letter', as summarised below and included verbatim in the appendices to this report.

Petition introduction

- Grantham and District Hospital is located on busy rail and road routes. The area attracts many visitors and is a Growth Town with plans for at least 7,000 more homes, new business parks and retail developments;
- Grantham is approximately 45 minutes by car from the next nearest A&E Department. Downgrading acute care services at Grantham & District Hospital will put lives at risk, and cause pain, suffering and stress to patients and/or their visitors;
- Grantham area patients will not have parity with those in the Lincoln or Boston areas;
- The changes will not make services safer but less so. Local patient resuscitation, intubation and stabilisation will be undermined;
- The plans will result in little more than a cottage hospital unable to handle emergency patients and non-planned surgery, or care for acutely ill elderly patients. Of particular concern are the low income, elderly and disabled residents likely to be most affected.

Orthopaedic Services

- Complex fractures require urgent specialist treatment, but those with less serious fractures could incur further injury on route to other hospitals via poor roads. As such, simple fractures should be treated at Grantham & District Hospital;
- The majority of patients requiring surgery would prefer it to be completed locally, with the exception of complex cases.

Stroke services county wide

- Lincolnshire CCG has ignored Grantham and District residents in its emergency stroke plans, despite the significant distance to alternative provision;
- A clear plan indicating how Grantham emergency stroke patients will be stabilised in the absence of a local A&E unit and without an emergency stroke unit or ACU is required.

Urgent and emergency care at Grantham Hospital

- Lincolnshire CCG's plans will result in 120,000 residents having to travel between 15-45 miles to their next alternative A&E units at Lincoln, Peterborough and Nottingham;
- The plan puts lives at risk and will affect many patients;
- Other A&E departments are too busy, and Grantham patients going elsewhere affects those hospitals too;
- Grantham & District A&E staff had the skills and equipment, supported by consultants in the ACU, to be able to handle a wide range of acute medical conditions.

Acute Medicine at Grantham Hospital

- The CCG's proposal for integrated community/acute medical beds will result in fewer patients being admitted into Grantham and District Hospital;
- The CCG proposes to remove elderly patients with complex needs from the secure and supportive hospital environment and move them to alternative hospital sites requiring risky journeys, or into community care which is known to be fragmented and where monitoring patient progress and outcomes will become much more challenging.

Consultant training and staff

- Grantham and District Hospital was popular among doctors training as specialist consultants and had training equipment available;
- Proposals for consultants to work mainly between Lincoln and Boston will lead to dissatisfied staff and will make hospital services across the county less sustainable.

In view of the concerns raised I OPPOSE the recommendations in the Lincolnshire Clinical Commissioning Group Acute Service Review 2021. I call for a full restoration of acute services at Grantham & District Hospital and consider if the changes are implemented that the CCG will not have fully reflected my concerns in their Public Consultation. I would also consider what is left of our District Hospital to be little more than a cottage hospital and that future development plans for the area should take this into consideration.

Earlier SOS Grantham petition

8.5 ORS was also notified that, prior to the development of proposals and the formal consultation period, SOS Grantham organised an online petition calling for the restoration of a full A&E department at Grantham and District Hospital. The petition, which was first established in 2016 and updated several times since, was signed by 63,507 people and has previously been submitted to NHS Lincolnshire CCG.

Petition 2 (organiser unknown) - 517 signatures

8.6 The following petition, of unknown origin, was signed by **517** people and submitted to ORS.

> *Do you think the residents of Grantham and surrounding villages need*
>
> *a) An Urgent Treatment Centre*
>
> *b) A 24/7 Level 1 Accident & Emergency Service (A&E)*
>
> *Please sign below and tick your preference*

8.7 516 of the 517 signatories chose to support option b: a 24/7 'Level 1' A&E Service.

Note on petitions

8.8 Petitions are clearly important in indicating public anxiety about important aspects of the 'Acute Services Review' (previously known as ASR) proposals, and so those leading the consultation must treat them seriously. Petitions should never be disregarded, for they indicate strong local feelings on specific issues. These observations are not included to undermine the sentiments expressed, but rather to provide a context within which petitions might be interpreted.

8.9 Nonetheless, it should also be noted that petitions seldom provide detailed information about the specific proposals under consultation; nor do they tend to direct potential signatories toward available sources of information to consider before deciding whether or not to sign. Petitions can therefore exaggerate general public sentiments if organised by motivated opponents to change.

8.10 It is also notable in this particular case, that neither petition submitted in response to the formal consultation opposes the proposals *in favour* of the status quo. Rather, they support *alternative proposals* for the full restoration of acute services, including a 24-hour A&E, which are not currently in place in Grantham. This is, of course, a viewpoint also expressed by some respondents in the other consultation strands and covered elsewhere in this report.

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Appendix II: Detailed tables of questionnaire text comments

The tables below provide a more detailed account of the text comments provided by individuals responding to the five open-ended questions in the consultation questionnaire (summarised in Figure 37, Figure 44, Figure 51, Figure 58 and Figure 59 in the main body of the report). It should be noted that some respondents made broader comments or raised concerns about other proposals than those address directly by each of the questions. Nonetheless, those responses are also included in the tables below for completeness.

Comments in relation to the proposals for orthopaedic surgery

Supportive/positive comments made in response to the proposals for orthopaedic surgery.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,684)

Summary of supportive comments		Number of respondents	%
General agreement with the proposal	General agreement with proposal	271	16%
	Agree with centre of (orthopaedic) excellence (no location specified)	121	7%
	Agree with location of centre of (orthopaedic) excellence at Grantham Hospital	134	8%
Positive comments about quality of care	Will improve quality of care (general comment)	59	4%
	Will improve quality of urgent care/alleviate pressure	1	*
	Will improve quality of emergency care/alleviate pressure	10	1%
	Fewer cancellations of services	108	6%
	It will make sure services are future proofed/more sustainable	4	*
Positive comments about staffing / waiting times	Will have positive impact on efficiency of service/reduce waiting times	133	8%
	Will have positive impact on ability to attract/retain staff	24	1%

Concerns/negative comments made in relation to the proposals for orthopaedic surgery.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,684)

Summary of concerns		Number of respondents	%
General disagreement with the proposal	General disagreement with proposal	49	3%
	Disagree with location of centre of (orthopaedic) excellence (no location specified)	6	*
	Disagree with location of centre of (orthopaedic) excellence at Grantham Hospital	25	1%
	Centre of (orthopaedic) excellence should be at Lincoln County Hospital	10	1%
	Centre of (orthopaedic) excellence should be at Pilgrim Hospital, Boston	15	1%
	Maintain unplanned surgery at Grantham and District Hospital	51	3%
	Maintain planned surgery/services at Lincoln County Hospital/ Pilgrim Hospital, Boston	20	1%
	Maintain planned surgery/services at County Hospital Louth	13	1%

	Maintain emergency services at Grantham and District Hospital	23	1%
General concerns about travel/access (incl access to specific hospitals)	Concerns about access i.e., poor transport links/increased travel times/distance	320	19%
	Concerns about access to Lincoln County Hospital	67	4%
	Concerns about access to Grantham and District Hospital	124	7%
	Concerns about access to Pilgrim Hospital, Boston	29	2%
	Concerns about access to County Hospital Louth	138	8%
	People should not have to travel/keep services local	164	10%
	Too much travelling would be required/Travelling too far under difficult circumstances	32	2%
Concerns about travel/access practicalities	Concerns about cost, i.e., too expensive, not having access to money at the time	73	4%
	Concerns about frequency i.e., not enough buses, not running at certain times of day	19	1%
	Concerns about transport routes, i.e., not direct enough, doesn't cover all areas	60	4%
	Concerns about state of public transport generally	83	5%
	Concerns about road infrastructure/quality of roads (general comment)	9	1%
	Concerns about road infrastructure/quality of roads to Lincoln County Hospital	5	*
	Concerns about road infrastructure/quality of roads to Pilgrim Hospital, Boston	3	*
	Concerns about road infrastructure/quality of roads to County Hospital Louth	8	*
	Concerns about traffic congestion/road closures affecting travel times	4	*
	Concerns about parking/need to improve/more parking (general comment)	5	*
	Concerns about parking facilities at Grantham and District Hospital	1	*
	Concerns about parking facilities at County Hospital Louth	1	*
Concerns about access for particular groups	Concerns about access for older people/the elderly	98	6%
	Concerns about access for people with disabilities (inc. ASD, learning disabilities)	14	1%
	Concerns about access for people from a deprived background/low income	11	1%
	Concerns about access for people without access to a vehicle	120	7%
	Concerns about access for people unable to drive, i.e., after surgery	29	2%
	Concerns about access for people who are in a lot of pain or discomfort/ unwell	21	1%
	Concerns about access for people who have had a stroke	1	*
	Concerns about access for children	2	*
	Concerns about people needing to get home afterwards	17	1%
	Concerns about other vulnerable groups e.g., refugees, experiencing homelessness	6	*
	Concerns about access for family members, e.g., to visit	97	6%
Concerns about ambulances/PT	Concerns about Patient Transport, i.e., not able to cope with demand	20	1%
	Concerns about impact on Ambulance service	19	1%
	Concerns about Ambulance response times, taking too long to reach patient/hospital.	9	1%
Concerns about impact on quality of care	Won't improve quality of care (general comment)	11	1%
	Concerned about negative impact on quality of care/additional pressure (general)	27	2%
	Concerned about negative impact on quality of care/additional pressure at Lincoln	2	*
	Concerned about negative impact on quality of care/additional pressure at Grantham	3	*
	Concerned about negative impact on quality of care/additional pressure at Pilgrim	3	*
	Concerned about negative impact on quality of care/additional pressure at Louth	1	*
	Concerned about negative impact on quality of emergency care	4	*
	Concerns about access to the right staff if at the wrong hospital in an emergency	1	*
	Concerns about time to transfer from one hospital to another in an emergency	1	*
	Poor quality of care provided/already under pressure/can't cope (general)	9	1%
	Poor quality of care provided/already under pressure/can't cope at Lincoln	18	1%
	Poor quality of care provided/already under pressure/can't cope at Grantham	6	*
	Poor quality of care provided/already under pressure/can't cope at Pilgrim	11	1%
	Poor quality of care provided/already under pressure/can't cope at Louth	5	*

Concerns about patient outcomes	Concerns about outcomes where time really matters/missing 'golden hour' (general)	1	*
	Concerns about outcomes where time really matters (for people in/around Grantham)	1	*
	Concerns about outcomes where time really matters (for people in/around Boston)	1	*
	Concerns about outcomes where time really matters (for people further from Lincoln)	1	*
	Concerns people will die as a result of having to travel further for care	11	1%
Concerns about impact on staffing/waiting times	Will have a negative impact on efficiency of service/increase waiting times	13	1%
	Won't improve ability to attract/retain staff	8	*
	Concerns about negative impact on ability to attract/retain staff/ staff shortages	14	1%
	Concerns about negative impact on ability to attract/retain staff at smaller sites	2	*
Concerns about population growth / demographic change	Does not take into account/properly address growing population (general)	6	*
	Does not take into account/properly address growing population in Grantham	22	1%
	Does not take into account/properly address growing population in Boston	1	*
	Does not take into account/properly address growing population across Lincolnshire	7	*
	Does not take into account/properly address aging population (general)	5	*
	Does not take into account/properly address aging population in Grantham	3	*
	Does not take into account/properly address aging population in Boston	1	*
	Does not take into account/properly address aging population across Lincolnshire	4	*
	There is a growing population (in general)	11	1%
	There is a growing population in Grantham	38	2%
	There is a growing population in Boston	5	*
	There is a growing population across Lincolnshire	7	*
Other concerns about the proposal	Environmental impact due to increased journeys i.e., increased carbon footprint etc.	15	1
	Will negatively affect local residents: more people in area/traffic/pollution/noise	2	*
	Concerns given increasing number of accidents on the roads	2	*
	Grantham is at high risk of a major incident due to location (A1, rail, flight paths)	5	*
	This is very short sighted	3	*
	This is about cutting costs/not about providing best service	23	1%
	Not good value for money	5	*
	Grantham and District Hospital is/has been downgrading over a period of time	15	1%
	This will lead to Grantham and District Hospital closing	4	*

Other comments made in relation to the proposals for orthopaedic surgery.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,684)

Summary of other comments		Number of respondents	%
Other travel/access comments	Generally good access to services/facilities: good transport links/close/easy to reach	15	1%
	Good access to Lincoln County Hospital	7	*
	Good access to Grantham and District	26	2%
	Good access to Pilgrim hospital	9	1%
	Good access to County Hospital Louth	10	1%
	Pre- and post op appointments should be local	13	1%
	Free transport service between sites should be provided	11	1%
	Good road infrastructure/quality of roads (general comment)	4	*
	Good road infrastructure/quality of roads to Grantham and District Hospital	4	*
	Good road infrastructure/quality of roads to County Hospital Louth	2	*
	Good parking/easier to park at Grantham and District Hospital	1	*

Other comments about quality of care	Need facilities to stabilise patients/provide appropriate treatment before transfer	2	*
	Need facilities to stabilise patients/provide appropriate treatment during transit	1	*
	All hospitals should be able to provide initial care	10	1%
	There is good quality of care (general comment)	4	*
	There is good quality of care at Lincoln County Hospital	4	*
	There is good quality of care at Grantham and District Hospital	28	2%
	There is good quality of care at Pilgrim Hospital, Boston	5	*
	There is good quality of care at County Hospital Louth	8	*
Other staffing /efficiency comments	We need to improve efficiency/reduce waiting times	44	3
	It will be the same surgeons who work at all sites	4	*
	Need staff to meet a range of conditions (general comment)	8	*
	Need staff to deal with the medical condition admitted	1	*
Comments about possible alternatives / other suggestions	Improve/Invest in facilities/services (general comment)	29	2%
	Improve/Invest in facilities/services at Lincoln County Hospital	10	1%
	Improve/Invest in facilities/services at Grantham and District Hospital	41	2%
	Improve/Invest in facilities/services at Pilgrim Hospital, Boston	7	*
	Improve/Invest in facilities/services at County Hospital Louth	12	1%
	Restore Grantham and District Hospital to what it was before	4	*
	Make Grantham and District Hospital a fully serviced hospital	34	2%
	Restore the A&E at Grantham and District Hospital fully (24/7), to what it was before	39	2%
	Improve wages/benefits/think of innovative ways to recruit/retain staff e.g., housing	4	*
	Staffing issues need to be addressed at a national level	3	*
	Have teams of staff that move across sites	6	*
	Community nursing should be done in local centres such as nursing homes, hospices	2	*
	Other alternative/suggestion	22	1%
Criticism of the consultation	More information needed	20	1%
	Proposals aren't clear/are confusing	10	1%
	Minds already made up/this is a paper exercise	2	*
	Consultation is biased/flawed/leading questions	7	*
	Not enough ground level/on-site consultation/ask the people who live here	3	*
	Other criticism of consultation	14	1%
Other comments	Agree with provision of a 24/7 UTC at Grantham and District Hospital	5	*
	Agree with better integration between services in the community and hospital	1	*
	Agree with provision of Acute medical beds at Grantham and District Hospital	2	*
	Agree there should be a dedicated centre for Stroke/Heart problems at Lincoln	1	*
	Leave services as they are (general comment)	12	1%
	Leave services as they are at Lincoln County Hospital	4	*
	Leave services as they are at Pilgrim Hospital, Boston	9	1%
	Leave services as they are at Grantham and District Hospital	12	1%
	Leave services as they are at Lincoln County Hospital/ Pilgrim hospital	1	*
	Hospitals should be multi-purpose/no sites for a specific reason/reasons	27	2%
	Acute medical beds should be available at all hospitals	2	*
	Stroke services should be available at all hospitals	1	*
	Stroke services should be available at Grantham and District Hospital/Grantham	1	*
	Stroke services should be available at Pilgrim Hospital, Boston/Boston	2	*
	There needs to be follow up care	4	*
	The NHS has been deteriorating over a period of time	4	*

	Having family and friends to visit/there as support is important	28	2%
	Depends on where you live (general comment)	6	*
	Depends on where you live (good for me/good for others)	3	*
	Depends on where you live (not good for me/not good for others)	2	*
	Understand the need to save money/improve finances	10	1%
	This is what is happening in practice anyway	2	*
	Professionals know best/take on board their opinion/judgement	3	*
	Personal anecdote	32	2%
	Don't reduce beds / more beds needed at Grantham and District Hospital	1	*
	Specific comment about COVID-19	17	1%
	Equality comment	2	*
	Other	95	6%

Comments in relation to the proposal for urgent and emergency care

Supportive/positive comments made in relation to the proposal for urgent and emergency care.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,829)

Summary of supportive comments		Number of respondents	%
General agreement with the proposal	General agreement with proposal	160	9%
	Agree with provision of a 24/7 UTC at Grantham and District Hospital	318	17%
Positive comments about quality of care	Will improve quality of care (general comment)	25	1%
	Will improve quality of urgent care/alleviate pressure	7	*
	Will improve quality of emergency care/alleviate pressure	23	1%
	It will make sure services are future proofed/more sustainable	5	*
Positive comments about staffing / waiting times	Will have positive impact on efficiency of service/reduce waiting times	55	3%
	Will have positive impact on ability to attract/retain staff	6	*

Concerns/negative comments in relation to the proposal for urgent and emergency care
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,829)

Summary of concerns		Number of respondents	%
General disagreement with the proposal	General disagreement with proposal	40	2%
	Maintain emergency services at Grantham and District Hospital	176	10%
	Leave services as they are (general comment)	9	*
	Leave services as they are at Grantham and District Hospital	3	*
General concerns about travel/access (incl access to specific hospitals)	Concerns about access i.e., poor transport links/increased travel times/distance	259	14%
	Concerns about access to Lincoln County Hospital	225	12%
	Concerns about access to Grantham and District Hospital	21	1%
	Concerns about access to Pilgrim Hospital, Boston	142	8%
	Concerns about access to County Hospital Louth	5	*
	People should not have to travel/keep services local	135	7%
	Too much travelling would be required/Travelling too far under difficult circumstances	41	2%

Concerns about travel/access practicalities	Concerns about cost, i.e., too expensive, not having access to money at the time	35	2%
	Concerns about frequency i.e., not enough buses, not running at certain times of day	12	1%
	Concerns about transport routes, i.e., not direct enough, doesn't cover all areas	34	2%
	Concerns about state of public transport generally	30	2%
	Concerns about road infrastructure/quality of roads (general comment)	32	2%
	Concerns about road infrastructure/quality of roads to Lincoln County Hospital	14	1%
	Concerns about road infrastructure/quality of roads to Grantham and District Hospital	5	*
	Concerns about road infrastructure/quality of roads to Pilgrim Hospital, Boston	10	1%
	Concerns about traffic congestion/road closures affecting travel times	3	*
	Concerns about parking/need to improve/more parking (general comment)	1	*
	Concerns about parking facilities at Lincoln County Hospital	1	*
	Concerns about parking facilities at Pilgrim Hospital, Boston	1	*
Concerns about access for particular groups	Concerns about access for older people/the elderly	30	2%
	Concerns about access for people with disabilities (inc. ASD, learning disabilities)	3	*
	Concerns about access for people from a deprived background/low income	3	*
	Concerns about access for people without access to a vehicle	53	3%
	Concerns about access for people unable to drive, i.e., after surgery	3	*
	Concerns about access for people who are in a lot of pain or discomfort/ unwell	10	1%
	Concerns about access for people who have had a stroke	1	*
	Concerns about access for children	10	1%
	Concerns about people needing to get home afterwards	17	1%
	Concerns about other vulnerable groups e.g., refugees, experiencing homelessness	2	*
	Concerns about access for family members, e.g., to visit	21	1%
Concerns about ambulances/PT	Concerns about Patient Transport, i.e., not able to cope with demand	2	*
	Concerns about impact on Ambulance service	77	4%
	Concerns about Ambulance response times, taking too long to reach patient/hospital.	128	7%
Concerns about impact on quality of care	Won't improve quality of care (general comment)	12	1%
	Concerned about negative impact on quality of care/additional pressure (general)	40	2%
	Concerned about negative impact on quality of care/additional pressure at Lincoln	36	2%
	Concerned about negative impact on quality of care/additional pressure at Grantham	4	*
	Concerned about negative impact on quality of care/additional pressure at Pilgrim	23	1%
	Concerned about negative impact on quality of care/additional pressure at Louth	3	*
	Concerned about negative impact on quality of emergency care	20	1%
	Concerns about access to the right staff if at the wrong hospital in an emergency	6	*
	Concerns about time to transfer from one hospital to another in an emergency	26	1%
	Poor quality of care provided/already under pressure/can't cope (general)	51	3%
	Poor quality of care provided/already under pressure/can't cope at Lincoln	85	5%
	Poor quality of care provided/already under pressure/can't cope at Grantham	9	*
	Poor quality of care provided/already under pressure/can't cope at Pilgrim	50	3%
	Poor quality of care provided/already under pressure/can't cope at Louth	2	*
	Will put additional pressure on GPs	5	*
Concerns about patient outcomes	Concerns about outcomes where time really matters/missing 'golden hour' (general)	63	3%
	Concerns about outcomes where time really matters (for people in/around Grantham)	19	1%
	Concerns about outcomes where time really matters (for people in/around Boston)	5	*
	Concerns about outcomes where time really matters (for people further from Lincoln)	13	1%
	Concerns people will die as a result of having to travel further for care	174	10%

Concerns about impact on staffing/waiting times	Will have a negative impact on efficiency of service/increase waiting times	38	2%
	Won't improve ability to attract/retain staff	5	*
	Concerns about negative impact on ability to attract/retain staff/ staff shortages	24	1%
	Concerns about negative impact on ability to attract/retain staff at smaller sites	1	*
Concerns about population growth / demographic change	Does not take into account/properly address growing population (in general)	7	*
	Does not take into account/properly address growing population in Grantham	108	6%
	Does not take into account/properly address growing population across Lincolnshire	7	*
	Does not take into account/properly address aging population (in general)	1	*
	Does not take into account/properly address aging population in Grantham	7	*
	Does not take into account/properly address aging population across Lincolnshire	2	*
	There is a growing population (in general)	55	3%
	There is a growing population in Grantham	234	13%
	There is a growing population in Boston	1	*
	There is a growing population across Lincolnshire	5	*
Other concerns about the proposal	Environmental impact due to increased journeys i.e., increased carbon footprint etc.	5	*
	Concerns given increasing number of accidents on the roads	13	1%
	Grantham is at high risk of a major incident due to location (A1, rail, flight paths)	180	10%
	This is very short sighted	13	1%
	This is about cutting costs/not about providing best service	20	1%
	Not good value for money	2	*
	Grantham and District Hospital is/has been downgrading over a period of time	49	3%
	This will lead to Grantham and District Hospital closing	4	*

Other comments made in relation to the proposal for urgent and emergency care
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,829)

Summary of other comments		Number of respondents	%
Other travel/access comments	Generally good access to services/facilities: good transport links/close/easy to reach	6	*
	Good access to Lincoln County Hospital	5	*
	Good access to Grantham and District Hospital	41	2%
	Good access to Pilgrim Hospital, Boston	3	*
	Free transport service between sites should be provided	3	*
	Good road infrastructure/quality of roads (general comment)	1	*
	Good road infrastructure/quality of roads to Lincoln County Hospital	2	*
	Good road infrastructure/quality of roads to Grantham and District Hospital	2	*
	Good road infrastructure/quality of roads to Pilgrim Hospital, Boston	2	*
	Good parking/easier to park at Grantham and District Hospital	1	*
Other comments about quality of care	Need facilities to stabilise patients/provide appropriate treatment before transfer	16	1%
	Need facilities to stabilise patients/provide appropriate treatment during transit	2	*
	All hospitals should be able to provide initial care	9	*
	There is good quality of care (general comment)	4	*
	There is good quality of care at Lincoln County Hospital	4	*
	There is good quality of care at Grantham and District Hospital	21	1%
	There is good quality of care at Pilgrim Hospital, Boston	2	*
	There is good quality of care at County Hospital Louth	7	*

Other staffing /efficiency comments	We need to improve efficiency/reduce waiting times	58	3%
	Need staff to meet a range of conditions (general comment)	16	1%
	Need staff to meet a range of conditions at Grantham and District Hospital	6	*
	Need staff to meet a range of conditions at County Hospital Louth	1	*
	Need staff to deal with the medical condition admitted	4	*
Comments about possible alternatives / other suggestions	Improve/Invest in facilities/services (general comment)	50	3%
	Improve/Invest in facilities/services at Lincoln County Hospital	7	*
	Improve/Invest in facilities/services at Grantham and District Hospital	54	3%
	Improve/Invest in facilities/services at Pilgrim Hospital, Boston	8	*
	Improve/Invest in facilities/services at County Hospital Louth	5	*
	Restore Grantham and District Hospital to what it was before	9	*
	Make Grantham and District Hospital a fully serviced hospital	14	1%
	Restore the A&E at Grantham and District Hospital fully (24/7), to what it was before	484	26%
	Improve wages/benefits/think of innovative ways to recruit/retain staff e.g., housing	41	2%
	Staffing issues need to be addressed at a national level	10	1%
	Have teams of staff that move across sites	3	*
	Other alternative/suggestion	12	1%
Criticism of the consultation	More information needed	43	2%
	Proposals aren't clear/are confusing	19	1%
	Minds already made up/this is a paper exercise	12	1%
	Consultation is biased/flawed/leading questions	3	*
	Not enough ground level/on-site consultation/ask the people who live here	5	*
	Other criticism of consultation	7	*
Other comments	Agree with centre of (orthopaedic) excellence (no location specified)	1	*
	Agree with location of centre of (orthopaedic) excellence at Grantham	3	*
	Agree with better integration between services in the community and hospital	1	*
	Agree with provision of Acute medical beds at Grantham and District Hospital	1	*
	Agree there should be a dedicated centre for Stroke/Heart problems at Lincoln	1	*
	Disagree with location of centre of (orthopaedic) excellence at Grantham	1	*
	Centre of (orthopaedic) excellence should be at Lincoln County Hospital	1	*
	Centre of (orthopaedic) excellence should be at Pilgrim Hospital, Boston	1	*
	Maintain unplanned surgery at Grantham and District Hospital	1	*
	Maintain planned surgery/services at County Hospital Louth	1	*
	Leave services as they are at Pilgrim Hospital, Boston	2	*
	Hospitals should be multi-purpose/no sites for a specific reason/reasons	5	*
	Hospitals should not be used for community nursing	1	*
	Stroke services should be available at Grantham and District Hospital/Grantham	1	*
	The NHS has been deteriorating over a period of time	6	*
	Having family and friends to visit/there as support is important	1	*
	Depends on where you live (general comment)	12	1%
	Depends on where you live (good for me/good for others)	4	*
	Depends on where you live (not good for me/not good for others)	4	*
	Understand the need to save money/improve finances	3	*
	This is what is happening in practice anyway	11	1%
	Professionals know best/take on board their opinion/judgement	3	*
	Personal anecdote	60	3%
	Comments about COVID-19	16	1%

	Other	135	7%

Comments in relation to the proposal for community/acute medical beds

Supportive/positive comments made in relation to the proposal for community/acute medical beds.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,045)

Summary of supportive comments		Number of respondents	%
General agreement with the proposal	General agreement with proposal	74	7%
	Agree with better integration between services in the community and hospital	29	3%
	Agree with provision of Acute medical beds at Grantham and District Hospital	201	19%
Positive comments about quality of care	Will improve quality of care (general comment)	29	3%
	Will improve quality of urgent care/alleviate pressure	3	*
	Will improve quality of emergency care/alleviate pressure	4	*
	Fewer cancellations of services	1	*
	Will improve integration between services in the community and hospital	5	*
	Quality of care: It will make sure services are future proofed/more sustainable	3	*
Positive comments about staffing / waiting times	Will have positive impact on efficiency of service/reduce waiting times	29	3%
	Availability of staff: Will have positive impact on ability to attract/retain staff	10	1%

Concerns/negative comments made in relation to the proposal for community/acute medical beds.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,045)

Summary of concerns		Number of respondents	%
General disagreement with the proposal	General disagreement with proposal	41	4%
	Leave services as they are (general comment)	5	*
	Leave services as they are at Grantham and District Hospital	17	2%
	Acute medical beds should be available at all hospitals	14	1%
General concerns about travel/access (incl access to specific hospitals)	Concerns about access i.e., poor transport links/increased travel times/distance	74	7%
	Concerns about access to Lincoln County Hospital	28	3%
	Concerns about access to Grantham and District Hospital	16	2%
	Concerns about access to Pilgrim Hospital, Boston	14	1%
	Concerns about access to County Hospital Louth	1	*
	People should not have to travel/keep services local	63	6%
	Too much travelling would be required/Travelling too far under difficult circumstances	2	*
Concerns about travel/access practicalities	Concerns about cost, i.e., too expensive, not having access to money at the time	14	1%
	Concerns about frequency i.e., not enough buses, not running at certain times of day	5	*
	Concerns about transport routes, i.e., not direct enough, doesn't cover all areas	3	*
	Concerns about state of public transport generally	11	1%
	Concerns about road infrastructure/quality of roads (general comment)	4	*
	Concerns about road infrastructure/quality of roads to Lincoln County Hospital	1	*
	Concerns about road infrastructure/quality of roads to Pilgrim Hospital, Boston	1	*
	Concerns about parking/need to improve/more parking (general comment)	1	*

	Concerns about parking facilities at Grantham and District Hospital	1	*
Concerns about access for particular groups	Concerns about access for older people/the elderly	15	1%
	Concerns about access for people with disabilities (inc. ASD, learning disabilities)	2	*
	Concerns about access for people from a deprived background/low income	2	*
	Concerns about access for people without access to a vehicle	15	1%
	Concerns about access for people unable to drive, i.e., after surgery	3	*
	Concerns about access for people who are in a lot of pain or discomfort/ unwell	2	*
	Concerns about access for children	2	*
	Concerns about people needing to get home afterwards	6	1%
	Concerns about other vulnerable groups e.g., refugees, experiencing homelessness	2	*
	Concerns about access for family members, e.g., to visit	38	4%
Concerns about ambulances/PT	Concerns about Patient Transport, i.e., not able to cope with demand	2	*
	Concerns about impact on Ambulance service	10	1%
	Concerns about Ambulance response times, taking too long to reach patient/hospital.	6	1%
Concerns about impact on quality of care	Won't improve quality of care (general comment)	6	1%
	Concerned about negative impact on quality of care/additional pressure (general)	16	2%
	Concerned about negative impact on quality of care/additional pressure at Lincoln	4	*
	Concerned about negative impact on quality of care/additional pressure at Grantham	4	*
	Concerned about negative impact on quality of care/additional pressure at Pilgrim	4	*
	Concerned about negative impact on quality of emergency care	1	*
	Concerns about access to the right staff if at the wrong hospital in an emergency	3	*
	Concerns about time to transfer from one hospital to another in an emergency	3	*
	Poor quality of care provided/already under pressure/can't cope (general)	8	1%
	Poor quality of care provided/already under pressure/can't cope at Lincoln	18	2%
	Poor quality of care provided/already under pressure/can't cope at Grantham	1	*
	Poor quality of care provided/already under pressure/can't cope at Pilgrim	18	2%
	Will put additional pressure on GPs	1	*
Concerns about patient outcomes	Concerns about outcomes where time really matters/missing 'golden hour' (general)	6	1%
	Concerns about outcomes where time really matters (for people in/around Boston)	1	*
	Concerns about outcomes where time really matters (for people further from Lincoln)	2	*
	Concerns people will die as a result of having to travel further for care	10	1%
Concerns about impact on staffing/waiting times	Will have a negative impact on efficiency of service/increase waiting times	14	1%
	Won't improve ability to attract/retain staff	14	1%
	Concerns about negative impact on ability to attract/retain staff/ staff shortages	28	3%
	Concerns about negative impact on ability to attract/retain staff at smaller sites	1	*
Concerns about population growth / demographic change	Does not take into account/properly address growing population (general comment)	4	*
	Does not take into account/properly address growing population in Grantham	22	2%
	Does not take into account/properly address growing population in Boston	1	*
	Does not take into account/properly address growing population across Lincolnshire	3	*
	Does not take into account/properly address aging population (general comment)	2	*
	Does not take into account/properly address aging population across Lincolnshire	2	*
	There is a growing population (general comment)	6	1%
	There is a growing population in Grantham	33	3%
	There is a growing population across Lincolnshire	4	*
Other concerns about the proposal	Environmental impact due to increased journeys i.e., increased carbon footprint etc.	2	*
	Grantham is at high risk of a major incident due to location (A1, rail, flight paths)	2	*
	This is very short sighted	3	*
	This is about cutting costs/not about providing best service	15	1%

	Not good value for money	6	1%
	Grantham and District Hospital is/has been downgrading over a period of time	41	4%
	This will lead to Grantham and District Hospital closing	10	1%

Other comments made in relation to the proposal for community/acute medical beds.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,045)

Summary of other comments		Number of respondents	%
Other travel/access comments	Generally good access to services/facilities: good transport links/close/easy to reach	12	1%
	Good access to Lincoln County Hospital	1	*
	Good access to Grantham and District Hospital	24	2%
	Good access to Pilgrim Hospital, Boston	2	*
	Free transport service between sites should be provided	2	*
	Good parking/easier to park at Grantham and District Hospital	2	*
Other comments about quality of care	Need facilities to stabilise patients/provide appropriate treatment before transfer	3	*
	All hospitals should be able to provide initial care	2	*
	There is good quality of care (general comment)	2	*
	There is good quality of care at Grantham and District Hospital	8	1%
	There is good quality of care at Pilgrim Hospital, Boston	3	*
	There is good quality of stroke care at Pilgrim Hospital, Boston	1	*
Concerns about staffing (incl waiting times)	We need to improve efficiency/reduce waiting times	16	2%
	Need staff to meet a range of conditions (general comment)	10	1%
	Need staff to meet a range of conditions at Grantham and District Hospital	9	1%
	Need staff to deal with the medical condition admitted	8	1%
Criticism of the consultation	More information needed	63	6%
	Proposals aren't clear/are confusing	26	2%
	Minds already made up/this is a paper exercise	8	1%
	Consultation is biased/flawed/leading questions	6	1%
	Not enough ground level/on-site consultation/ask the people who live here	6	1%
	Other criticism of consultation	8	1%
Comments about possible alternatives / other suggestions	Improve/Invest in facilities/services (general comment)	25	2%
	Improve/Invest in facilities/services at Grantham and District Hospital	28	3%
	Improve/Invest in facilities/services at Pilgrim Hospital, Boston	1	*
	Restore Grantham and District Hospital to what it was before	7	1%
	Make Grantham and District Hospital a fully serviced hospital	54	5%
	Restore medical beds at Grantham and District Hospital to what they were before	6	1%
	Restore the A&E at Grantham and District Hospital fully (24/7), to what it was before	44	4%
	Improve wages/benefits/think of innovative ways to recruit/retain staff e.g., housing	58	6%
	Staffing issues need to be addressed at a national level	7	1%
	Have teams of staff that move across sites	2	*
	Community nursing should be done in a local centres such as nursing homes, hospices	2	*
Other comments	Agree with centre of (orthopaedic) excellence (no location specified)	2	*
	Agree with location of centre of (orthopaedic) excellence at Grantham	2	*
	Agree with a dedicated centre for Stroke/Heart problems (no location specified)	1	*
	Agree with a dedicated centre for Stroke/Heart problems at Lincoln	1	*
	Maintain unplanned surgery at Grantham and District Hospital	1	*
	Maintain emergency services at Grantham and District Hospital	15	1%

	Leave services as they are at Lincoln County Hospital	1	*
	Leave services as they are at Pilgrim Hospital, Boston	1	*
	Hospitals should be multi-purpose/no sites for a specific reason/reasons	9	*
	Hospitals should not be used for community nursing	7	*
	Stroke services should be available at Grantham and District Hospital/Grantham	1	*
	There needs to be follow up care	2	*
	The NHS has been deteriorating over a period of time	4	*
	Having family and friends to visit/there as support is important	32	3%
	Depends on where you live (general comment)	7	1%
	Depends on where you live (good for me/good for others)	2	*
	Depends on where you live (not good for me/not good for others)	1	*
	Understand the need to save money/improve finances	5	*
	This is what is happening in practice anyway	3	*
	Professionals know best/take on board their opinion/judgement	3	*
	Personal anecdote	12	1%
	Don't reduce beds / more beds needed at Grantham and District Hospital	32	3%
	Specific comment about COVID-19	6	1%
	Equalities-related comment	1	*
	Other	59	6%

Comments in relation to the proposal for stroke services

Supportive/positive comments made in relation to the proposals for stroke services.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,540)

Summary of supportive comments		Number of respondents	%
General agreement with the proposal	General agreement with proposal	95	6%
	Agree with a dedicated centre for Stroke/Heart problems (no location specified)	193	13%
	Agree with a dedicated centre for response to Stroke/Heart problems at Lincoln	85	6%
Positive comments about quality of care	Will improve quality of care (general comment)	53	3%
	Will improve quality of emergency care/alleviate pressure	1	*
	It will make sure services are future proofed/more sustainable	2	*
Staffing (incl waiting times)	Will have positive impact on efficiency of service/reduce waiting times	9	1%
	Will have positive impact on ability to attract/retain staff	25	2%

Concerns/negative comments made in relation to the proposal for stroke services.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,540)

Summary of concerns		Number of respondents	%
General disagreement with the proposal	General disagreement with proposal	35	2%
	Leave services as they are (general comment)	4	*
	Leave services as they are at Pilgrim Hospital, Boston	7	*
	Leave services as they are at Lincoln County Hospital/ Pilgrim	1	*
	Stroke services should be available at all hospitals	53	3%

	Stroke services should be available at Grantham and District Hospital/Grantham	99	6%
	Stroke services should be available at Pilgrim Hospital, Boston/Boston	91	6%
Concerns about travel and access (general)	Concerns about access i.e., poor transport links/increased travel times/distance	152	10%
	Concerns about access to Lincoln County Hospital	187	12%
	Concerns about access to Grantham and District Hospital	4	*
	Concerns about access to Pilgrim Hospital, Boston	29	2%
	Concerns about access to County Hospital Louth	1	*
	People should not have to travel/keep services local	81	5%
	Too much travelling required/Travelling too far under difficult circumstances	3	*
Concerns about travel/access practicalities: public transport, roads, parking, cost etc.	Concerns about cost, i.e., too expensive, not having access to money at the time	23	1%
	Concerns about frequency i.e., not enough buses, not running at certain times of day	3	*
	Concerns about transport routes, i.e., not direct enough, doesn't cover all areas	15	1%
	Concerns about state of public transport generally	33	2%
	Concerns about road infrastructure/quality of roads (general comment)	31	2%
	Concerns about road infrastructure/quality of roads to Lincoln County Hospital	14	1%
	Concerns about road infrastructure/quality of roads to Grantham Hospital	1	*
	Concerns about road infrastructure/quality of roads to Pilgrim Hospital, Boston	1	*
	Concerns about traffic congestion/road closures affecting travel times	11	1%
	Concerns about parking/need to improve/more parking (general comment)	3	*
	Concerns about parking facilities at Lincoln County Hospital	4	*
	Concerns about parking facilities at Grantham and District Hospital	1	*
Concerns about travel/access for specific groups or people	Concerns about access for older people/the elderly	32	2%
	Concerns about access for people with disabilities (inc. ASD, learning disabilities)	1	*
	Concerns about access for people from a deprived background/low income	6	*
	Concerns about access for people without access to a vehicle	28	2%
	Concerns about access for people unable to drive, i.e., after surgery	1	*
	Concerns about access for people who are in a lot of pain or discomfort/ unwell	1	*
	Concerns about access for people who have had a stroke	22	1%
	Concerns about getting home afterwards	2	*
	Concerns about other vulnerable groups e.g., refugees, experiencing homelessness	3	*
	Concerns about access for family members, e.g., to visit	120	8%
Impact on ambulance service, patient transport etc	Concerns about Patient Transport, i.e., not able to cope with demand	5	*
	Concerns about impact on Ambulance service	28	2%
	Concerns about Ambulance response times, taking too long to reach patient/hospital.	138	9%
Concerns about impact on quality of care	Won't improve quality of care (general comment)	8	1%
	Concerned about negative impact on quality of care/additional pressure (general)	16	1%
	Concerned about negative impact on quality of care/additional pressure at Lincoln	26	2%
	Concerned about negative impact on quality of care/additional pressure at Grantham	2	*
	Concerned about negative impact on quality of care/additional pressure at Pilgrim	4	*
	Concerns about access to the right staff if at the wrong hospital in an emergency	2	*
	Concerns about time to transfer from one hospital to another in an emergency	7	*
	Poor quality of care provided/already under pressure/can't cope (general)	18	1%
	Poor quality of care provided/already under pressure/can't cope at Lincoln	66	4%
	Poor quality of care provided/already under pressure/can't cope at Pilgrim	8	1%
Concerns about impact on patient outcomes	Concerns about outcomes where time really matters/missing 'golden hour' (general)	218	14%
	Concerns about outcomes where time really matters for people in/around Grantham	47	3%
	Concerns about outcomes where time really matters for people in/around Boston	58	4%
	Concerns about outcomes where time really matters for people further from Lincoln	169	11%

	Concerns people will die as a result of having to travel further for care	131	9%
	There needs to be follow up care	1	*
	There needs to be follow up care after a stroke	42	3%
Concerns about staffing (incl waiting times)	Will have a negative impact on efficiency of service/increase waiting times	12	1%
	Won't improve ability to attract/retain staff	9	1%
	Concerns about negative impact on ability to attract/retain staff/ staff shortages	33	2%
	Concerns about negative impact on ability to attract/retain staff at smaller sites	3	*
Concerns over whether the proposals account for population growth/demographic change	Does not take into account/properly address growing population (general comment)	2	*
	Does not take into account/properly address growing population in Grantham	10	1%
	Does not take into account/properly address growing population in Boston	3	*
	Does not take into account/properly address growing population across Lincolnshire	4	*
	Does not take into account/properly address aging population (general comment)	1	*
	Does not take into account/properly address aging population in Grantham	2	*
	Does not take into account/properly address aging population in Boston	4	*
	Does not take into account/properly address aging population across Lincolnshire	3	*
	There is a growing population (general comment)	2	*
	There is a growing population in Grantham	7	*
	There is a growing population in Boston	5	*
Other concerns about the proposal	Environmental impact due to increased journeys i.e., increased carbon footprint etc.	2	*
	Will negatively affect local residents: more people in area/traffic/pollution/noise	1	*
	Concerns given increasing number of accidents on the roads	3	*
	This is very short sighted	8	1%
	This is about cutting costs/not about providing best service	9	1%
	Not good value for money	4	*

Other comments made in relation to the proposal for stroke services.
Base: All individual respondents who provided comments in response to the question inviting views on this proposal (1,540)

Summary of other comments		Number of respondents	%
Other travel/access comments	Generally good access to services/facilities: good transport links/close/easy to reach	3	*
	Good access to Lincoln County Hospital	10	1%
	Good access to Grantham and District Hospital	4	*
	Good access to Pilgrim Hospital, Boston	16	1%
	Free transport service between sites should be provided	2	*
	Good road infrastructure/quality of roads (general comment)	4	*
	Good road infrastructure/quality of roads to Lincoln County Hospital	1	*
Other comments about quality of care	Need facilities to stabilise patients/provide appropriate treatment before transfer	26	2%
	Need facilities to stabilise patients/provide appropriate treatment during transit	16	1%
	All hospitals should be able to provide initial care	4	*
	There is good quality of care (general comment)	2	*
	There is good quality of care at Lincoln County Hospital	12	1%
	There is good quality of care at Grantham and District Hospital	3	*
	There is good quality of care at Pilgrim Hospital, Boston	12	1%
	There is good quality of stroke care at Lincoln County Hospital	5	*
	There is good quality of stroke care at Pilgrim Hospital, Boston	33	2%
	We need to improve efficiency/reduce waiting times	21	1%

Other staffing /efficiency comments	Need staff to meet a range of conditions (general comment)	8	1%
	Need staff to meet a range of conditions at Lincoln County Hospital	7	*
	Need staff to meet a range of conditions at Grantham and District Hospital	2	*
	Need staff to meet a range of conditions at Pilgrim Hospital, Boston	2	*
	Need staff to deal with the medical condition admitted	2	*
Criticism of the consultation	More information needed	37	2%
	Proposals aren't clear/are confusing	2	*
	Minds already made up/this is a paper exercise	8	1%
	Consultation is biased/flawed/leading questions	6	*
	Not enough ground level/on-site consultation/ask the people who live here	4	*
	Other criticism of consultation	8	1%
Comments about possible alternatives / other suggestions	Improve/Invest in facilities/services (general comment)	29	2%
	Improve/Invest in facilities/services at Lincoln County Hospital	13	1%
	Improve/Invest in facilities/services at Grantham and District Hospital	8	1%
	Improve/Invest in facilities/services at Pilgrim Hospital, Boston	11	1%
	Improve/Invest in facilities/services at County Hospital Louth	4	*
	Make Grantham and District Hospital a fully serviced hospital	14	1%
	Restore the A&E at Grantham and District Hospital fully (24/7), to what it was before	9	1%
	Improve wages/benefits/think of innovative ways to recruit/retain staff e.g., housing	57	4%
	Staffing issues need to be addressed at a national level	12	1%
	Have teams of staff that move across sites	8	1%
	Community nursing should be done in a local centres such as nursing homes, hospices	1	*
	Alternative proposal	11	1%
Other comments	Agree with centre of (orthopaedic) excellence (no location specified)	7	*
	Agree with provision of a 24/7 UTC at Grantham and District Hospital	1	*
	Agree with better integration between services in the community and hospital	12	1%
	Centre of (orthopaedic) excellence should be at Lincoln County Hospital	1	*
	Centre of (orthopaedic) excellence should be at Pilgrim Hospital, Boston	1	*
	Maintain emergency services at Grantham and District Hospital	2	*
	Leave services as they are at Grantham and District Hospital	1	*
	Hospitals should be multi-purpose/no sites for a specific reason/reasons	4	*
	Grantham is at high risk of a major incident due to location (A1, rail, flight paths)	1	*
	Grantham and District Hospital is/has been downgrading over a period of time	6	*
	This will lead to Grantham and District Hospital closing	4	*
	The NHS has been deteriorating over a period of time	2	*
	Having family and friends to visit/there as support is important	45	3%
	Depends on where you live (general comment)	14	1%
	Depends on where you live (good for me/good for others)	10	1%
	Depends on where you live (not good for me/not good for others)	24	2%
	Understand the need to save money/improve finances	5	*
	This is what is happening in practice anyway	4	*
	Professionals know best/take on board their opinion/judgement	2	*
	Personal anecdote	53	3%
	Don't reduce beds / more beds needed at Grantham and District Hospital	3	*
	Specific comment about COVID-19	16	1%
	Other	42	3%

Comments in relation to equalities impacts of the proposals

As well as questions about each of the proposals, the consultation questionnaire gave respondents the opportunity to address any wider issues related to potential equalities and health inequalities impacts.

Comments made in relation to equalities impacts of the proposals on particular groups
Base: All individual respondents who provided comments in response to the question inviting views on potential impacts and mitigation measures (899)

Summary of comments		Number of respondents	%
General	Generally important to treat people equally/provide equal care	141	16%
Comments/concerns about impacts on elderly/older people	Concerns about access for older people/the elderly	77	9%
	Older people/the elderly should not have to travel/travel so far	25	3%
	Travel costs would be unfair for older people/the elderly	3	*
	Concerns about cost, i.e., too expensive for older people/the elderly	7	1%
	Must treat all people equally including older people/the elderly	27	3%
	Concerns about patient outcomes for older people/the elderly	6	1%
	Concerns older people/the elderly will die as a result of travelling further for care	4	*
	Unfair to/discriminates against older people/the elderly (in general)	39	4%
Comments/concerns about impacts on people with disabilities (inc. ASD, learning disabilities)	Concerns about access for people with disabilities (inc. ASD, learning disabilities)	58	6%
	People with disabilities should not have to travel/travel so far	17	2%
	Concerns about cost, i.e., too expensive for people with disabilities	6	1%
	Travel costs would be unfair for people with disabilities	2	*
	Must treat all people equally including people with disabilities	21	2%
	Concerns about patient outcomes for people with disabilities	7	1%
	Unfair to/discriminates against people with disabilities (in general)	26	3%
Comments/concerns about impacts on people with low incomes/from deprived backgrounds	Concerns about access for people from a deprived background/low income	25	3%
	People from low-income backgrounds should not have to travel/travel so far	5	1%
	Travel costs would be unfair for people from a deprived background/low income	5	1%
	Concerns about cost for people from a deprived/low-income background	8	1%
	Must treat all people equally including people from a low-income background	1	*
	Concerns about outcomes for people from low income/ deprived backgrounds	3	*
	Concerns people from low-income backgrounds will die due to travelling further	1	*
	There are many on low incomes (in general)	4	*
	There are many on low incomes across Lincolnshire	1	*
	Unfair to/discriminates against people from a deprived background/low income (in general)	12	1%
Comments/concerns about impacts on people without access to a vehicle	Concerns about access for people without access to a vehicle	51	6%
	People without access to a vehicle should not have to travel/travel so far	4	*
	Must treat all people equally including people without access to a vehicle	2	*
	Unfair to/discriminates against people without access to a vehicle (in general)	9	1%
Comments/concerns about impacts on children	Concerns about access for children	3	*
	Children should not have to travel/travel so far	4	*
	Must treat all people equally including children	2	*
	Concerns about outcomes for children	1	*
	Concerns children will die as a result of having to travel further for care	1	*
	Unfair to/discriminates against children (general comment)	2	*

Comments/concerns about impacts on other vulnerable groups (e.g., refugees, people experiencing homelessness/rough sleeping, other complex needs etc)	Concerns about access for other vulnerable groups	7	1%
	Other vulnerable groups should not have to travel/travel so far	2	*
	Concerns about cost, i.e., too expensive for other vulnerable groups	2	*
	Must treat all people equally including other vulnerable groups	13	1%
	Concerns about outcomes for other vulnerable groups	1	*
	Concerns individuals from other vulnerable groups may die due to travelling further	1	*
	Unfair to /discriminates against other vulnerable groups	1	*
Single-sex facilities	Keep/there should be single sex areas on wards	26	3%
	Keep/there should be single sex toilets/washing facilities	6	1%
Comments/concerns about impact on people in/around Grantham	Travel time would be unfair for those living in Grantham	22	2%
	Travel costs would be unfair for those living in Grantham	7	1%
	Quality of care not fair for those living in Grantham	9	1%
	Concerns about outcomes where time really matters for people in/around Grantham	6	1%
	Unfair to/discriminates against those living in Grantham (in general)	41	5%
Comments/concerns about impact on people in/around Boston	Travel time would be unfair for those living in Boston	1	*
	Travel costs would be unfair for those living in Boston	1	*
	Quality of care not fair for those living in Boston	2	*
	Concerns about outcomes where time really matters (for people in/around Boston)	4	*
	Would be unfair /discriminate against those living in Boston (in general)	3	*
Comments/concerns about impact on people across Lincs	Travel time would be unfair for those living across Lincolnshire	4	*
	Travel costs would be unfair for those living across Lincolnshire	1	*
	Quality of care not fair for those living across Lincolnshire	1	*
	Unfair to/discriminates against those living across Lincolnshire (in general)	12	1%
Comments/concerns about impact on NHS staff	Proposals will have negative impact on wellbeing of staff	3	*
	There is poor wellbeing/staff are not treated well (general comment)	6	1%
	There is poor staff wellbeing /staff are not treated well at Grantham Hospital	2	*
	There is poor staff wellbeing /staff are not treated well at County Hospital Louth	1	*
	Need to listen to and support staff	17	2%
Comments/concerns about services moving online, lack of face-to-face	Face to face appointments should be available	5	1%
	Concerns about only having access to services/being able to contact hospitals and staff online	4	*
	Access is unfair for people without a computer/internet access	2	*

Other comments made in relation to equalities impacts of the proposals.
Base: All individual respondents who provided comments in response to the question inviting views on potential impacts and mitigation measures (899)

Summary of other comments		Number of respondents	%
General concerns about increased travel (incl cost) / increased travel is generally unfair	Concerns about access i.e., poor transport links/increased travel times/distance	76	8%
	People should not have to travel/keep services local	67	7%
	Travel times would be unfair in general	4	*
	Concerns about cost, i.e., too expensive, not having access to money at the time	25	3%
	Travel costs would be unfair	5	1%
Other travel/access concerns e.g., public transport, roads, parking, ambulances	Concerns about access to Lincoln County Hospital	41	5%
	Concerns about access to Grantham and District Hospital	4	*
	Concerns about access to Pilgrim Hospital, Boston	22	2%
	Concerns about access to County Hospital Louth	6	1%
	Concerns about frequency i.e., not enough buses, not running at certain times of day	11	1%

	Concerns about transport routes, i.e., not direct enough, doesn't cover all areas	5	1%
	Concerns about state of public transport generally	38	4%
	Concerns about Patient Transport, i.e., not able to cope with demand	6	1%
	Concerns about Ambulance service	13	1%
	Concerns about Ambulance response times, taking too long to reach patient/hospital	17	2%
	Concerns about road infrastructure/quality of roads	21	2%
	Concerns about parking/need to improve/more parking	4	*
	Concerns people will decide not to seek out treatment/services	10	1%
Other travel/access comments	Good access to services/facilities i.e., good transport links/close/easy to get to etc.	1	*
	Pre- and post op appointments should be local	2	*
	Free transport service between sites should be provided	12	1%
General concerns about impacts on quality of care / patient outcomes / efficiencies	Poor quality of care provided/already under pressure/can't cope	30	3%
	Won't improve quality of care	2	*
	Concerned about negative impact on quality of care provided/ additional pressure	5	1%
	Concerns about outcomes where time really matters/missing 'golden hour' (general)	15	2%
	Concerns about outcomes where time really matters for people too far from Lincoln	6	1%
	Concerns people will die as a result of having to travel further for care	27	3%
	Will have a negative impact on efficiency of service/increase waiting times	2	*
Other comments on quality of care / patient outcomes / efficiencies	Quality of care would be better at Grantham Hospital (than somewhere else)	4	*
	Quality of care would be better at Pilgrim Hospital, Boston (than somewhere else)	2	*
	Quality of care will not be as good at Lincoln County Hospital (than somewhere else)	2	*
	There is good quality of care	8	1%
	Will improve quality of care	5	1%
	There needs to be follow up care	3	*
	There needs to be follow up care after a stroke	1	*
	Will have positive impact on efficiency of service/reduce waiting times	3	*
	Efficiency of services: We need to improve efficiency/reduce waiting times	9	1%
Concerns over whether proposals account for population growth/demographic change	Does not take into account/properly address growing population	15	2%
	Does not take into account/properly address aging population (general comment)	10	1%
	Does not take into account/properly address aging population in Grantham	5	1%
	Does not take into account/properly address aging population in Boston	3	*
	Does not take into account/properly address aging population across Lincolnshire	3	*
	Other comments: There is a growing population	3	*
Other suggestions / mitigations	Improve/Invest in facilities/services	46	5%
	Restore/Maintain services at Lincoln County Hospital	1	*
	Restore/Maintain services at Grantham and District Hospital	69	8%
	Restore/Maintain services at Pilgrim Hospital, Boston	12	1%
	Restore/Maintain services at County Hospital Louth	3	*
	Services should be available at all hospitals	9	1%
	Staff should undergo equality training	25	3%
Other comments	Environmental impact due to increased journeys i.e., increased carbon footprint etc.	1	*
	Having family and friends to visit/there as support is important	42	5%
	Depends on where you live	30	3%
	I don't think there is any discrimination	42	5%
	Personal anecdote	48	5%
	Criticism of consultation incl. issues with this question (equalities or human rights)	80	9%
	Specific comment about COVID-19	14	2%
	Other	89	10%

Appendix III - Additional comments and questions from meetings

In addition to the feedback covered in Chapter 6 of this report, a number of other questions, comments and request for information were made at the public meetings and other engagement activities undertaken by NHS Lincolnshire CCG during the course of the consultation. While not necessarily constituting feedback on the proposals, these questions and comments are helpful in highlighting more general concerns and points of interest around acute health services in Lincolnshire and they have therefore been included below.

Abbreviations used:

PPG	Countywide Patient Participation Group
PP	ULHT Patient Panel

Changes to orthopaedic surgery in Lincolnshire

The following clarification questions were asked by attendees of the various meetings having considered the proposed changes to orthopaedic care:

	Question / comment	Group
1	How is a service that only offers level 1 (minor) surgery, a "Centre of Excellence?"	Grantham 1
2	Where do orthopaedic spinal cases get managed, currently most seem to be moved out of county to be managed?	Grantham 1
3	Is this going to set up Grantham to never be able to have an A&E in the future?	Grantham 2
4	What were the levels of cancellations pre pilot?	Grantham 2
5	What about BMI Hospital?	Grantham 2
6	Can we promote GDH as centre of excellence to other areas?	Grantham 2
7	How can we encourage patients to choose Grantham for elective surgery when the NHS is still buying services from the private sector?	Grantham 2
8	What is happening to the planned orthopaedic surgery already currently offered at Lincoln County Hospital?	Louth
9	What if I break my arm (and live in or around Louth)?	Louth
10	Does Louth becoming a centre for orthopaedic surgery day cases mean that there will be changes to other surgery provision at the hospital?	Louth
11	How many beds will be available at Grantham and what is the current number available for planned operations across the system?	Skegness 1
12	Will it be unchanged in Boston? Can you have the choice to have your operation in Boston?	Skegness 1
13	What is the relationship with hot and cold surgery at Louth Hospital?	Skegness 1
14	Where is the money coming from?	Skegness 1
15	Will planned ortho all go to Grantham?	Skegness 2
16	Grantham for orthopaedics = 2 hrs, no public transport VS. Boston = 1 hr – how can we expect people to go?	Skegness 2
17	For the options being considered, is there any data of those people who would be travelling for operations from Sleaford?	Sleaford

	Question / comment	Group
18	Before you did the pilot, what was the situation for unplanned at Grantham or would it be a new service?	Sleaford
19	What is the lead time for current surgery?	Spalding
20	Why can't we build a bigger, better facility in the South of the county?	Spalding
21	What are the best times for successful orthopaedic treatment?	Virtual 1
22	What is 'joined up' between unplanned operations and social care, regarding discharges and how they are handled?	Virtual 1
23	How has the service been improved?	PPG
24	How has the pilot shortened hospital length of stay for planned orthopaedics at Grantham?	PPG
25	Will the day case unit at Louth be for planned or unplanned surgery? What is the situation if I break a bone in the Louth area, where will I go?	PP
26	How long did the pilot run? And was it impacted by the COVID pandemic?	PP
27	Will Grantham have the capacity to cope with this influx of patients?	Voices for All
28	Will patients get follow up appointments in the local community or have to go to Grantham?	Voices for All

Changes to urgent and emergency care at Grantham and District Hospital

The following clarification questions were asked, and general comments made by attendees of the various meetings having considered the proposed changes to urgent and emergency care at Grantham:

	Question / comment	Group
1	How can you consult on a temporary closure? You should be consulting on the service we had prior to the overnight closure	Grantham 1
2	At the Health Scrutiny meeting yesterday, it stated that if patients attend a UTC and was found to be ill, they would be transferred to another hospital?	Grantham 1
3	What is a UTC +? - no such thing nationally but will still accept ambulance / trauma.	Grantham 2
4	We have had a campaign for years – seems like you are not listening to our comments. Is that fair?	Grantham 2
5	Simple UTI – patient was sent to Stamford not Grantham – why not happening?	Grantham 2
6	Will a CT scan etc will be available? And why are people from Grantham being sent to Lincoln for simple bloods?	Grantham 2
7	Would a leaflet through every door at point of decision being made help?	Grantham 2
8	How long will it take to implement? When do we get 24/7 UTC?	Grantham 2
9	Low staff morale is because of this uncertainty.	Grantham 2
10	You've made the case for Grantham A&E – can present with anything then	Grantham 2
11	There are over 60k signatures on a petition – you aren't listening to these people / comments	Grantham 2
12	We need reassurance about what we are going to get - Too much mis-information / rumours	Grantham 2
13	The community wants an A&E due to growing town, major road links however it would need the back up of the acute services within the hospital.	Grantham 2
14	Grantham are fairly well served in their local area as there are other A&Es nearby in Nottingham, Peterborough and Lincoln	Skegness
15	Is Sleaford seen as part of the Grantham area?	Sleaford

16	It does seem that if you cut down the service from A&E, once you start losing services in hospital, the recruitment of doctors etc tend to go down	Sleaford
17	Why is the UTC at Grantham proposed to be open 24/7 and this is not at Spalding? This is discrimination.	Spalding
18	Consultant oversight - what does it meant at the UTC?	Virtual 1
19	There is uncertainty around A&E services in Grantham!	Staff 3
20	Are there any planned age restrictions for the UTC?	Staff 3
21	If the new Grantham UTC staff are going to be employed by a community health service provider, and not ULHT, will they still have a ULHT computer login username/password as they need these to open the blood fridge, which they may still require access to?	Staff 4
22	Will Grantham staff have the option whether they are employed by LCHS or ULHT?	Staff 5
23	This is the first Grantham staff have heard of any changes, even though campaigners seem to know already. Were ULHT aware that a consultation was being launched?	Staff 6
24	People were concerned about having to travel to outpatient appointments	PPG
25	A question was asked as to why an Urgent Treatment Centre was not being considered in the South of the county	PPG
26	You gave one example of a heart attack, what other ambulance cases would not go to Grantham now and be transferred to Peterborough or Nottingham?	PP
27	As far as the UTC is concerned, will ambulances go there ever? Is there any reason why an ambulance would ever go to Grantham?	PP
28	My understanding was that UTCs would all provide the same service level. Whilst I accept that there may not be a significant enough call for it, I do wonder why we have not run a pilot to see if the same level (24-hour) should be provided at Spalding.	PP
29	Grantham is a cottage hospital and a good cottage hospital – it always has been. We don't want it to be top notch but able to deal with most of our ailments as an old people.	Senior Citizens Group

Changes to acute medical beds at Grantham and District Hospital

The following clarification questions were asked, and general comments made by attendees of the various meetings having considered the proposed changes to acute medical beds at Grantham:

	Question / comment	**Group**
1	I find it strange that GPs don't know what has happened to their patients as on discharge electronic discharge documents are sent directly to the GP. Is it a problem with the IT systems used?	Grantham 1
2	GPs receive electronic discharge documents automatically when patients are discharge so why are you suggesting GPs don't know what has happened to the patient?	Grantham 1
3	Will medical staff attend the homes and not volunteers?	Grantham 1
4	Wiring people to a machine at home is not health care – how long will it take staff to attend if an emergency occurred?	Grantham 1
5	Care at home not always an option	Grantham 1
6	Not sure what is changing? What is a community health provider?	Grantham 2
7	Would Grantham be TUPE-d over if LCHS took over?	Grantham 2

	Question / comment	Group
8	It is a shame the services have been lost, we as a community have lost the hospital – we must provide safe services for local residents	Grantham 2
9	Has this proposal for acute medical beds been trialled elsewhere?	Lincoln
10	We're aware of the Grantham campaign groups and demonstrations.	Louth
11	Do we have community beds in Louth and Skegness?	Skegness
12	Is this going to be GP led? Is this idea not going back 50 years to what it was before?	Skegness
13	For frail/elderly patients, it is the support that they need to receive when they get out of hospital. Negative experience of 1 lady once had been discharged and there were not sufficient staff to support her in her own home.	Sleaford
14	With the combining of social care, in terms of the budget and control, do you think this will be an advantage?	Sleaford
15	Are we looking into other hospitals once this has been established	Spalding
16	Why does a decentralised model work for this but not A&E? Why are the approaches different?	Virtual 3
17	I question the strategy - stroke and orthopaedic is centralised but the medical beds is different. Why is this?	Virtual 3
18	How many acute beds are at Grantham now and how will that change & how do you decide how many beds you require?	Virtual 3
19	Will it be possible to be referred into an acute bed from the UTC?	Virtual 3
20	Why will this change make services more sustainable?	Virtual 3
21	What kind of conditions do you expect to treat/to present at Grantham? What's difference between community hospitals and what you'd treat at Grantham?	Virtual 4
22	Will ULHT still be working with people in those acute medical beds, or will they be supported as LCHS?	Virtual 5
23	There is a rumour that all inpatient beds at Grantham will move over to LCHS from ULHT, is that true?	Staff 6
24	Would it be fair to say that this is the modern-day version of a cottage hospital?	PP
25	What we lost a number of years ago were the convalescence homes- low dependency, had physios, for people who don't necessarily need doctors but do need support before they are ready to home. If that is more the role that is intended for areas at Grantham hospital, is there going to be sufficient space?	PP
26	Grantham is an excellent cottage hospital. We do not expect all the latest technology as we understand that the NHS cannot provide 'excellence' everywhere but provide good 'adequate' services to the population.	Senior Citizens Group

Changes to stroke services in Lincolnshire

The following clarification questions were asked by attendees of the various meetings having considered the proposed changes to stroke services:

	Question / Comment	Group
1	Promised two years ago that we wouldn't shut stroke services without consultation to LCC, but already shut down.	Boston 2
2	Every household hasn't received a leaflet through the door – not fair consultation process, people aren't aware	Boston 2
3	Until EMAS can prove they can meet those response times and travel times – can't make decision to move those services now.	Boston 2

	Question / Comment	Group
4	Can you get more people to write more positive reviews on working for the trust and reviews on the town?	Boston 2
5	This is a financially led decision to cut stroke services	Boston 2
6	Manipulated stroke patient figures.	Boston 2
7	Complaint about EMAS, response time to son knocked over by drink driver. Son deteriorated in process.	Boston 2
8	General perception is that this is already a done deal	Boston 3
9	Why is everything being moved to Lincoln? Feels like a done deal	Boston 3
10	Unsure how 7-day discharge will happen as patients are already struggling to see core community nursing teams	Boston 3
11	Greyfriars PPG has great concerns around visiting patients	Boston 3
12	Are you suggesting we can treat patients with strokes at the UTC?	Grantham 1
13	When calling 999 what proportion of the population would accurately be able to describe that they are having/had a stroke. Sadly, many are not articulate and they will receive a lesser service.	Grantham 1
14	Were patients going to Boston and getting wrong care?	Grantham 2
15	How long will a take ambulance to get to a person in Grantham with suspected stroke & are the crew qualified?	Grantham 2
16	Are jigsaw ambulances equally trained?	Grantham 2
17	How many beds are in the new model? Are you combining number of Lincoln and Boston beds?	Grantham 2
18	Capital expenditure being used for stroke service?	Lincoln
19	Unaware there were so many stroke patients	Lincoln
20	Do you work with the new Medical School / are we encouraging people to train in stroke?	Lincoln
21	How time critical is a stroke?	Louth
22	England as a whole has a lot of catching up to do with Stroke service in Scotland	Louth
23	Suggestion: Develop a centre of excellence at Peterborough, Grimsby or Nottingham and don't have anything in Lincolnshire at all	Skegness 1
24	What will happen if there is no transport to get a loved one from Lincoln County Hospital to Skegness?	Skegness 1
25	Can transport be improved?	Skegness 1
26	Why is there specialist stroke surgery in Nottingham but not in Boston? - Only 1 hospital per region where specialist procedure can be done.	Skegness 1
27	How many beds are you proposing to increase to in Lincoln? - Work to 7 day or 10 day discharges	Skegness 1
28	Husband was blue lighted to Lincoln – was able to be collected at 9pm on a December evening. Luckily daughter was able to support to collect but what about those without support and transport? What about the visitors and family who can't get there? Could result in patient and family isolation	Skegness 2
29	What difference does the extra 30 mins travel time make to a stroke victim?	Skegness 2
30	Skegness services are under more strain, ambulance takes so much longer to get to a call, how is this going to be possible?	Skegness 2
31	As ambulances are taking longer at hospital, there is less available – how will this be fixed?	Skegness 2
32	The maths is simple – 25mins vs 45mins – explain?	Skegness 2
33	Ambulance services and the response times and the length of time for ambulances to arrive was discussed.	Sleaford
34	How many people treated at the Lincoln and Boston sites	Virtual 3

	Question / Comment	Group
35	What links do you have with the medical training centre at the Lincoln University and how does this help with sustainability?	Virtual 3
36	Will there be any stroke beds at Pilgrim in future?	Staff 5
37	These changes, if implemented make a mockery of the “FAST” campaign regarding stroke care and intervention is time critical.	PPG
38	I live in the Boston area. Are there any stroke facilities still at Boston, or have they already gone over to Lincoln? If I had a stroke, would I go to Boston, or would I rely on an ambulance?	PP
39	Understand the need to consolidate resource where it is most effective. Patients in the South probably won’t go to Lincoln, they will probably go to Peterborough. So, what level of service can those of us in the South of the county expect to get?	PP
40	It might have been helpful for EMAS to send a rep to the consultation meetings to give reassurance on their ability to get to stroke patients in time.	PP
41	If EMAS category is now level 2, then we are not classed as urgent.	PP
42	I was blue lighted to the heart centre in Lincoln and got there in well under an hour – the heart centre was amazing – if Stroke is going to be the same it can only be a good thing	Sensory Service
43	Not surprised people don’t want to work in Boston and would rather work in Lincoln	Sensory Service

Comments related to particular protected characteristics groups and other groups, and other questions

The following feedback was given, and questions asked in relation to the potential impacts on protected characteristic and other groups:

	Question / Comment	Group
1	What are the ULHT doing in order to train and keep their staff?	Grantham 1
2	Why not rotate staff over different sites in order to allow them to treat enough patients and keep up their skills?	Grantham 1
3	How is Lincoln going to cope and they can’t cope now?	Grantham 1
4	Why no suggestion of new buildings at site of Prince William of Gloucester Barracks?	Grantham 1
5	Do we have funding for service changes? Is there one pot of money being split into four?	Lincoln
6	Glad I attended. Very well explained and good presentation. Disappointing that more people didn’t attend to hear because it’s very positive.	Lincoln
7	Why has the range of services offered by Louth Hospital reduced?	Louth
8	Won’t EMAS need at least 50 more ambulances to cope with the demand?	Louth
9	Are you considering bringing more services back to Louth hospital?	Louth
10	Are there plans to address the transport issues around healthcare access in the county?	Louth
11	LIVES have launched a new vehicle. Charity feels a need to create that service. Great service. (LIVES are part funded by NHS, FALLS service funded by LCC)	Skegness
12	Suggestion: Formalisation of charity funded/voluntary services to support stroke patients:	Skegness

	Question / Comment	Group
	○ Integration and linking in with third sector is a priority ○ Use collective expertise to serve community ○ ICS comms could be improved by including what CCG supports – primary care/community services – ensure all of the public are aware of what is available to them all	
13	With the increase in National Insurance contributions, do you see changes will benefit Lincolnshire?	Sleaford
14	There has been a demand post covid of GP services – do we know what is causing this demand?	Sleaford
15	It was felt that Spalding and Holbeach hospitals are not being used to their full potential. The hospitals are empty why can't we fill the hospitals with services.	Spalding
16	It was mentioned about the provision of a shuttle bus that would go between all of the three sites would help those with financial difficulty or who would not have a means of getting to the hospital. Would help for those who are discharged from the hospital in the early hours of the morning – they could be on a bus and then back at their local hospital. It could have a nominal £1 charge – however people when admitted to hospital don't always think to take money with them.	Virtual 1
17	What are the timescales for implementation of any changes?	Staff 2
18	At the end of the consultation, what will be the priority to happen first?	Staff 5
19	Is there a date of any change proposed?	Staff 5
20	What are the timescales for implementation of any changes?	Staff 6
21	The pilots are done deals, and the outcome of the consultation won't influence decisions. What will happen if the consultation results do not show acceptance of the proposals?	PPG
22	transport concerns where people travel further for treatment.	PPG
23	There aren't alternative arrangements made for rural areas around the number of patients a hospital must treat to be considered safe; relating to the figure of 600 strokes to be considered safe.	PPG
24	Over the delivery of these models when Lincolnshire has recruitment issues for key clinical staff.	PPG
25	Over the lack of follow up care via the District Nurses if people are being treated further from home.	PPG
26	Far too much information provided. "Information overload!"	Senior Citizens Group
27	All the staff at the hospitals do a wonderful job! The medical side of Grantham hospital works very well.	Senior Citizens Group
28	It has been very difficult during the pandemic for deaf people when going to the doctors or hospital. I lip read and the staff refused to take off their masks, I was frightened and confused, I didn't understand what was happening. All it would have taken was one person to take off their mask and explain.	Sensory Service
29	Antenatal clinic – "I missed out on a lot of information because I was deaf and not treated very nicely. My Health Visitor had to find out the information for me. However, the care in the maternity ward and labour ward was fantastic, they were brilliant	Sensory Service
30	Several questions requesting information about the cost of the public consultation process	Public meetings

Appendix IV: Written submissions and petition statement

Written submissions received during the consultation are summarised in the main body of this report. Verbatim copies of responses from organisations are included here for reference.

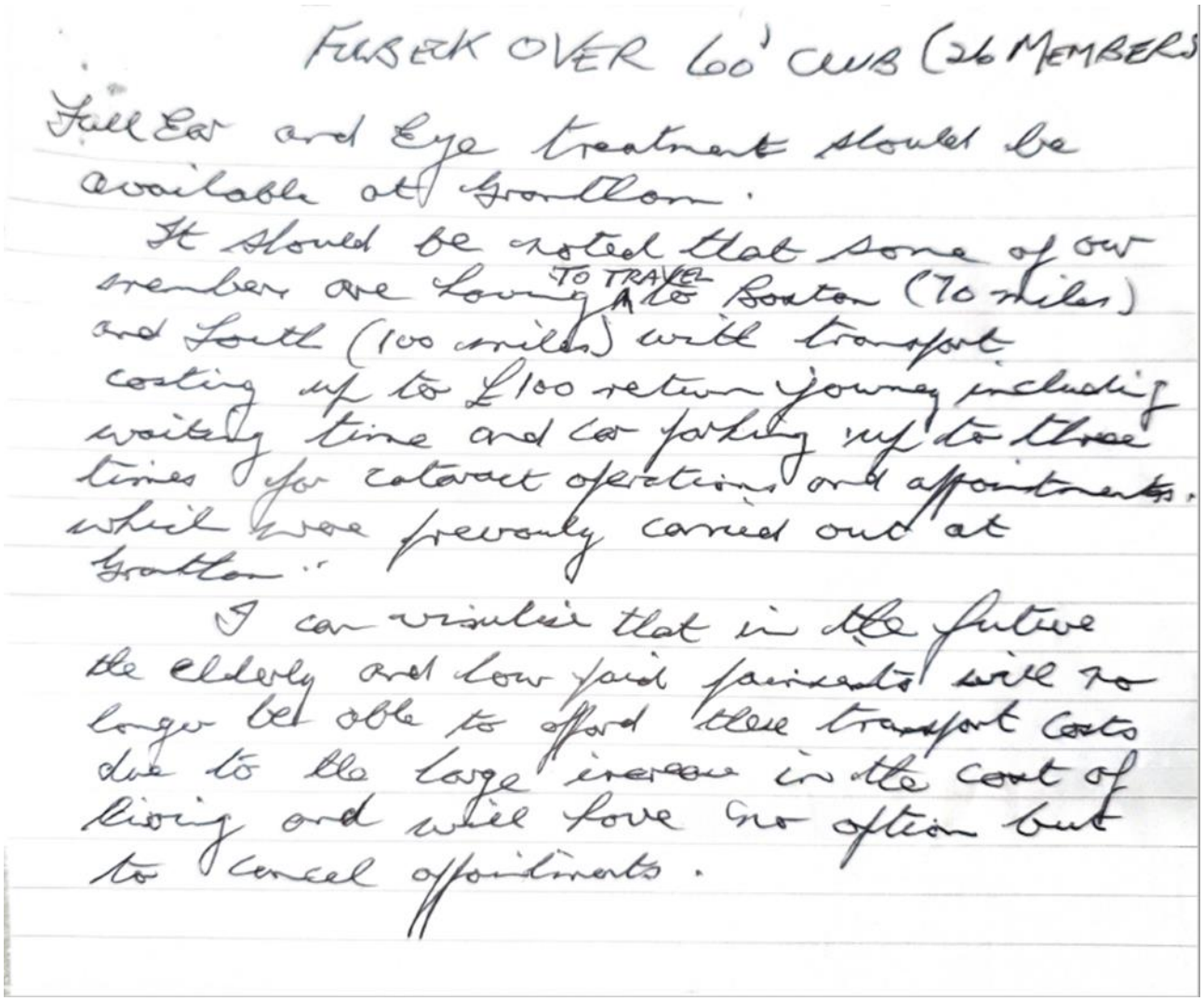
Written submissions

1. Fulbeck Over 60s Club
2. Health Scrutiny Committee for Lincolnshire
3. Healthwatch Lincolnshire
4. South Kesteven District Council
5. Stroke Therapy Services, Pilgrim Hospital, Boston

Standardised responses

1. Open letter submitted as a petition by SOS Grantham on behalf of 'United GDH Campaigners'

Fulbeck Over 60s Club



FULBECK OVER 60's CLUB (26 MEMBERS)

Full Ear and Eye treatment should be available at Grantham.

It should be noted that some of our members are having TO TRAVEL to Boston (70 miles) and South (100 miles) with transport costing up to £100 return journey including waiting time and car parking up to three times for cataract operations and appointments which were previously carried out at Grantham.

I can visualise that in the future the elderly and low paid patients will no longer be able to afford these transport costs due to the large increase in the cost of living and will have no option but to cancel appointments.

Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

RESPONSE OF HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE TO THE LINCOLNSHIRE ACUTE SERVICES REVIEW CONSULTATION

PART A – INTRODUCTION

The Health Scrutiny Committee for Lincolnshire is grateful to the NHS in Lincolnshire for providing an introduction and presentations on each element of the Lincolnshire Acute Services Review, at meetings on 13 October, 10 November and 15 December 2021, which included clinicians.

The Committee would also like to record its thanks to the Clinical Commissioning Group 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 response of the Health Scrutiny Committee for Lincolnshire is based on the information in the consultation document, the pre-consultation business case, and the information presented to the Committee at the three meetings between October and December 2021.

In this response, Part B sets out the Committee's response to the questions in the consultation document, in each case indicating the Committee's position on a particular proposal. Although the Committee has followed the template of the consultation survey form, it has included a 'free text' box in the *Need for Change* section, in which the Committee explains its answer to the question on this topic.

Part C of this response focuses on the themes that have arisen during the course of the consultation.

PART B – RESPONSE TO SURVEY QUESTIONS

The Need for Change

This consultation is focused on these four NHS services because we believe that significant and permanent improvement is required to them. Such change would ensure that the highest possible standards of patient care are provided in line with clinical evidence and best practice, giving the best possible outcomes for patients. We are consulting to understand the potential impact of these changes on you before we make a decision.

We believe that the benefits of changing will include:

- Improved quality of care
- Reduced waiting times
- Better outcomes for patients
- Increased availability of staff to care for patients
- Better use of NHS funds, reducing spend on temporary staff

✓	**Strongly Agree**
	Tend to Agree
	Neither Agree nor Disagree
	Tend to Disagree
	Strongly Disagree

The Health Scrutiny Committee for Lincolnshire fully accepts the arguments put forward on page 5 of the consultation document and in chapter 4 of the pre-consultation business case as evidence for the need for change in the provision of acute hospital services in Lincolnshire. However, as indicated in the following answers on each specifical proposal, the Committee is not completely convinced in three instances out of four that the proposal, as detailed, is right for the people of Lincolnshire. In each case, reasons are put forward for the Committee's conclusion.

Orthopaedic Surgery

Our current model combines planned and unplanned surgery on the same sites. Unplanned emergency admissions into hospitals must be prioritised. This often leads to planned surgery across the NHS being cancelled on the same day, meaning patients wait a long time for it.

Our proposal is to separate planned and unplanned orthopaedic surgery by:

- Creating a 'centre of excellence' for planned orthopaedic surgery for Lincolnshire at Grantham and District Hospital.

- Creating a dedicated day case centre at County Hospital Louth.
- Performing only unplanned orthopaedic surgery at Lincoln County Hospital or Pilgrim Hospital, Boston (apart from some complex planned surgery which will be better managed at these large acute hospitals).

Please tell us how much you agree or disagree with the proposal to create a 'Centre of Excellence' at Grantham and District Hospital for Lincolnshire's patients to receive planned and day case surgery, with a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery.

	Strongly Agree
	Tend to Agree
	Neither Agree nor Disagree
✓	**Tend to Disagree**
	Strongly Disagree

Please tell us why you agree or disagree with the proposal to change orthopaedic surgery and if you have any other suggested proposals to address the identified challenges.

Whilst the concept of a centre of excellence for orthopaedic surgery and the intention for a significant reduction in the cancellation rate of 30% for planned operations are understood, the Health Scrutiny Committee tends to disagree with the proposal for the following reasons:

(1) The Committee has concerns on the overall accessibility of Grantham and District Hospital for patients across Lincolnshire, but particularly for residents in the east of county where they rely on public transport. Furthermore, the age profile of the population and levels of deprivation in the east of the county are higher than average. Whilst the pre-consultation business case makes reference to the criteria for the non-emergency patient transport service and a contingency sum of £1 million to support this service, further details of how patients would be supported in practice would be needed to satisfy the Committee that this potential negative impact had been addressed.

(2) The local NHS would like to see the Grantham orthopaedic centre of excellence become a showcase, and the pilot was previously highlighted as a good practice nationally. However, the Committee is not convinced that the proposal would necessarily improve the recruitment and retention of staff.

(3) 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 have the potential to impact on neighbouring healthcare systems, and the continued use of the independent sector. These in turn have funding impacts on the Lincolnshire healthcare system.

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

Urgent and Emergency Care at Grantham and District Hospital

Our current model offers restricted A&E services between the hours of 8am and 6.30pm at Grantham and District Hospital. Just as in the rest of the country, we struggle to recruit enough specialist staff to run three full A&Es across the county, and this means the services are fragile. For some time the model in Grantham has been similar to that of an Urgent Treatment Centre (UTC), and this has been able to appropriately manage the types of injury and illness patients come to Grantham and District Hospital with.

Our proposal is to establish a 24/7 walk in Urgent Treatment Centre (UTC) at Grantham and District Hospital, in place of the current Accident and Emergency (A&E) department.

Please tell us how much you agree or disagree with the proposal to provide 24/7 walk in urgent care services in Grantham via an Urgent Treatment Centre at Grantham and District Hospital.

- [ ] **Strongly Agree**
- [ ] **Tend to Agree**
- [ ] **Neither Agree nor Disagree**
- [ ] **Tend to Disagree**
- [x] **Strongly Disagree**

Please tell us why you agree or disagree with the proposal to change urgent and emergency care services and if you have any other suggested proposals to address the identified challenges.

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.

Since 2016 many residents in Grantham have been campaigning to restore an overnight A&E service at Grantham, which has included a petition of 60,000 signatures in support of its retention. After six years, many residents in Grantham have concluded that their views have been overlooked.

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

over the last twenty years or so. The Committee is not re-assured that further changes to the services provided at Grantham will be avoided.

In view of the above long-standing concerns of residents, the Committee strongly disagrees with the proposal for an urgent treatment centre at Grantham. In addition to the above, the Committee cites the following reasons for this conclusion:

(1) The Committee is not convinced that recruiting and retaining staff to the proposed urgent treatment centre will be straightforward, 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 permanent.

(2) 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.

If the proposal for an urgent treatment centre at Grantham and District Hospital is implemented by the NHS in Lincolnshire, the Committee would make the following recommendations:

(a) 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. (The pre-consultation business case and other supporting documentation referred to the term 'urgent treatment centre plus', although it is understood this would not be used as it would cause more confusion.)

(b) The modest capital investment for the expansion of the proposed urgent treatment into unused parts of the hospital should be identified, planned and implemented immediately.

Acute Medical Beds at Grantham and District Hospital

Our current model is delivered by an 'acute' (hospital) provider, and cares for less complex patients than at Lincoln County Hospital and Pilgrim Hospital, Boston, in line with the restricted A&E service at Grantham and District Hospital. Like our A&E services and the rest of the country, we struggle to recruit enough specialist staff to the service.

Our proposal is to establish integrated community/ acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.

Please tell us how much you agree or disagree with the proposal to provide integrated community/acute medical beds at Grantham and District Hospital.

- [ ] **Strongly Agree**
- [x] **Tend to Agree**
- [ ] **Neither Agree nor Disagree**
- [ ] **Tend to Disagree**
- [ ] **Strongly Disagree**

Please tell us why you agree or disagree with the proposal to provide acute medical beds at Grantham Hospital and if you have any other suggested proposals to address the identified challenges.

The Health Scrutiny Committee for Lincolnshire tends to agree with the proposal for the establishment of integrated medical and community beds at Grantham and District Hospital, for the following reasons.

(1) 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 consultants and middle grade doctors.

(2) 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. This model could become a template for other urgent treatment centres in the county, for example, in Louth and Skegness, subject to funding and the appropriate levels of patient volumes and acuity.

The Committee would also like to record the following additional comments:

(a) 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.

(b) 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.

(c) 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.

Stroke Services

Our current model has hyper-acute hospital stroke services at Lincoln County Hospital and Pilgrim Hospital, Boston. We need more doctors and nurses to deliver the existing hospital stroke services, but there aren't enough locally and nationally, which has caused temporary closures of the services. Because patients in the county are dispersed across these two hospitals, the clinicians in them struggle to care for enough patients per year to retain and improve their skills. These issues reflect in the service performance in national audits.

Our proposal is to establish a 'centre of excellence' for hyper-acute and acute stroke services at Lincoln County Hospital, which would be supported by increasing the capacity and capability of the community stroke rehabilitation service. Outpatient TIA ('mini stroke') clinics would be unaffected at Pilgrim Hospital, Boston.

Please tell us how much you agree or disagree with the proposal to provide a centre of excellence at Lincoln County Hospital offering both a hyperacute stroke unit and an acute stroke unit to deliver care for the county's patients, supported by an enhanced community stroke rehabilitation service.

☐	**Strongly Agree**
☐	**Tend to Agree**
☐	**Neither Agree nor Disagree**
☑	**Tend to Disagree**
☐	**Strongly Disagree**

Please tell us why you agree or disagree with the proposal to change stroke services and if you have any other suggested proposals to address the identified challenges.

The Health Scrutiny Committee for Lincolnshire is not convinced by the all the arguments put forward in support of this proposal, and this tends to disagree for the following reasons:

(1) The proposal represents another example of service 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.

(2) Further to (1) 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.

(3) As stated in the pre-consultation business case (page 202, paragraph 12.2.30), 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.

(4) 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.

(5) The Committee is not completely convinced that the proposals will lead to improvements in the recruitment and retention of both medical and nursing staff.

The Committee would also like to record the following additional comments:

(a) During the discussion on this item reference was made to the possibility of introducing a mobile stroke unit, which would in particular be able to support people in the east of the county. The Committee was advised that this suggestion would be considered in further detail.

(b) The Committee was advised that the clinics for the treatment and follow-up of transient ischaemic attacks would continue at Pilgrim Hospital, Boston, and would urge that this should continue.

Equalities Impact

Protected characteristics are specific aspects of a person's identity defined by the Equality Act 2010. It is against the law to discriminate against someone because of the nine protected characteristics which are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Are there any positive or negative impacts that you believe the CCG should take into account in relation to equalities or human rights? If so, are you able to provide any supporting evidence and suggest any ways in which the organisations could reduce or remove any potential negative impacts and increase any positive impacts?

Please enter your response below:

The Committee notes that appendix J to the pre-consultation consultation business case details the assessment of the equalities impact for each of the four proposals. In each case the assessment states that the combination of an ageing population, a rural geography and areas of high socio-economic deprivation defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire. The Health Scrutiny Committee for Lincolnshire highlights this statement and urges the NHS in Lincolnshire to take full account of these assessments prior to making a decision on any service changes.

PART C – THEMES AND GENERAL COMMENTS

Travel and Transport

The pre-consultation business case makes numerous references to public transport; and in several instances refers to consultations being ongoing with Lincolnshire County Council about public transport provision. 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.

There are also references in the pre-consultation business case to non-emergency patient transport services as means of mitigating the impact of the withdrawal of services from certain locations, 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.

Recruitment and Retention of Staff

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.

Links to Neighbouring Health Systems

There are two parts to this theme, firstly the impact of service changes at United Lincolnshire Hospitals NHS Trust on other health systems; and secondly the impact of any changes outside Lincolnshire in

Impact on Other Health Systems

These four proposals will impact on neighbouring health systems, as acknowledged by the detail in 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.

Impact of Other Health Systems on Lincolnshire

An update from the Humber Acute Services Programme team to the Health Scrutiny Committee for Lincolnshire on 15 December 2021 again highlighted how changes to health provision in one location can have a wider impact. 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.

Consultation Arrangements

The Committee would like to record the following comments on the consultation arrangements:

(1) The Committee was advised that leaflets on the consultation would be delivered to every household, as a means 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.

(2) 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.

(3) 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.

(4) 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.

Conclusion

As stated above, the Health Scrutiny Committee for Lincolnshire would again record its thanks to the NHS in Lincolnshire for its engagement at Committee meetings, and for allowing the Committee's response to be submitted to the NHS in Lincolnshire by 31 January 2022.

The Committee understands that there is an intention that the Lincolnshire Clinical Commissioning Group Board will make a decision on these four proposals by 31 March 2022. The Committee would like to continue its dialogue with the NHS in Lincolnshire on the decision making process.

The Health Scrutiny Committee for Lincolnshire has been appointed by Lincolnshire County Council to fulfil its functions as set out in Section 244 of the National Health Service Act 2006 and Regulations 20 – 34 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Healthwatch Lincolnshire response to NHS Lincolnshire Clinical Commissioning Group Public Consultation

On behalf of Lincolnshire people who now, or in the future access NHS healthcare services in the county, Healthwatch Lincolnshire is providing NHS Lincolnshire Clinical Commissioning Group (CCG) this formal response relevant to their recent public consultation on the future of four NHS services in the county. The four services include:

1. Orthopaedic surgery across Lincolnshire
2. Urgent and emergency care at Grantham and District Hospital
3. Acute medical beds at Grantham and District Hospital
4. Stroke services across Lincolnshire

The above service areas are significant as they affect so many patients across the county. Changes to any of these services will impact people in different ways. For example, the needs of people that live in rural and isolated communities, people who are living with disabilities and co-morbidities, people who use public transport, people who are geographically impacted because of any change to the current provision need to be understood. Healthwatch Lincolnshire strongly believes that the CCG must fully consider all negative as well as positive impact on our people and communities when reviewing the results of the public consultation and their Equality Impact Assessments.

Healthwatch Lincolnshire acknowledges the significant amount of effort the CCG has made to invite people to respond to their public consultation and thanks them for this. It is encouraging to note the range of methods of engagement delivered by the CCG has resulted in a large and diverse number of responses.

Healthwatch Lincolnshire is also reassured by the fact that the CCG will be using an independent body, Opinion Research Services to collate the feedback they have received from their public consultation. However, as a health and care watchdog Healthwatch Lincolnshire is keen once made, to scrutinise the CCGs final decisions which we assume will be based around the public consultation data it receives from Opinion Research Services.

Whilst we recognise this public consultation is not a public ‘vote’ on the outcome of the four services. Out of respect to the public, including both those who have responded and those who have not, but will still need to access them, the next important question will be ‘how open and transparent NHS Lincolnshire is going to be with the public when it comes to final decisions about the future of these four services.’

Healthwatch Lincolnshire looks forward to liaising with the CCG in the spring of 2022 with regards to their outcomes and next steps.

Healthwatch Lincolnshire Contract Co-ordinator

Date: January 2022

Minutes from South Kesteven District Council meeting

Motion as reflected in the minutes for 25.11.21 Council

Motion put by Cllr Ian Selby:

South Kesteven District Council supports a fully functioned Level 1, 24/7 Accident and Emergency Department for Grantham Hospital.

Members were circulated with an amended motion at the meeting:

"It is vital that the residents of the Grantham area have access to Emergency Healthcare which is accessible 24/7. Grantham Hospital is a vital facility for our community and I would like the Chairman to write to the Chief Executive of the United Lincolnshire Hospital Trust, saying that South Kesteven District Council wishes to thank all the staff at this hospital for their continued hard work and service, especially over the last 2 years.

The motion highlighted the concern over the continued reduction in services at Grantham Hospital and the current consultation being undertaken by NHS Lincolnshire Clinical Commission Group, which, it was felt, was not a meaningful consultation but a tick box exercise with a bias against Grantham Hospital".

In presenting the motion, Councillor Selby made the following points:

- The former consultation undertaken by the East Midlands Ambulance Service (EMAS) had recognised that Grantham was a strategic location and had changed their proposals accordingly.
- The services that Grantham hospital offered affected every single resident, no-one was immune to accidents and the need for urgent treatment as provided by an Accident and Emergency service or an Urgent Treatment Centre.
- A massive housing growth was happening in Grantham and health provision was a material planning consideration.
- Climate change implications when patients had to travel to and from hospitals.
- Tourists were encouraged to come to the district but the lack of local hospital facilities may impact their plans.
- Thanks were given to the work of the ambulance service, paramedics and first responders and the work of the NHS staff and all Key Workers.
- Credit was given to the campaigners and those that had attended the Wednesday vigils to try and help save Grantham's A & E department.

The motion was seconded by the Leader of the Council.

Further discussion ensued on how the services at Grantham Hospital had been reduced over the last five years and the levels of services downgraded. Reference was made to the closure of the hospital in June 2020 and the Judicial Review that had been brought in connection with the closure of the acute care services for a period of time and how the level of services had been downgraded and eroded over the last five years. Elected Members and members of the public were urged to complete the NHS

Lincolnshire Clinical Commissioning Groups consultation questionnaire on urgent and emergency care which closed on 23 December 2021.

It was noted that the information that the ULHT had given during the closure period due to Covid was flawed as they had failed to mention that 33,000 residents had signed a petition for the 24/7 restoration of emergency services at Grantham Hospital under the Healthy Conversation consultation.

Further discussion on the motion followed with Members thanking the NHS Staff for all their hard work following the impact of Covid-19 and the campaigners over the last five years in keeping the closure of services at Grantham Hospital in the public domain.

The Chairman referred to the extraordinary meeting of Council that had taken place 1 July 2020 on Grantham Hospital services.

On being put to the vote the motion circulated by Councillor Selby was unanimously **AGREED**.

DECISION

That the Chairman of the Council writes to the Chief Executive of the United Lincolnshire Hospital Trust, saying that South Kesteven District Council wishes to thank all the staff at this hospital for their continued hard work and service, especially over the last two years.

Stroke Therapy Services, Pilgrim Hospital, Boston

To whom it may concern,

We would like to provide our opinions about the Public Consultation Document with specific reference to the stroke service. The stroke service at Pilgrim Hospital Boston provides a comprehensive rehabilitation approach. Patients are admitted from Boston and surrounding areas and are transferred from the hyper-acute service at Lincoln. The team is made up of occupational therapists, physiotherapists, speech and language therapist, neuro-psychologists, dieticians and specialist nursing staff who have specific skills, knowledge, competencies and experience built up over many years in the area of stroke management. For many years we have provided good patient care and scored well on SSNAP targets when providing hyper-acute and acute services.

With regards to the proposed changes we understand the reasoning for having a centre of excellence at Lincoln but feel that the full pathway has not been considered for the wide range of complex patients' needs in the stroke pathway. The following are our main concerns:

- An increase in the number of patients at Lincoln
- The increase in stroke patients out-lied to non-specialist wards who do not receive timely and effective specialised rehabilitation. Appendix 1 shows the SSNAP Data for Domain 2 (Length of stay on stroke unit) is not reaching the correct standard and has dropped from 92.7% to 37.1% when there were no stroke beds at Pilgrim Hospital Boston.
- No additional stroke specialist staffing has been added to Lincoln Site
- The management of slower stream more complex patients who require more intensive input

We accept that patients need to be discharged home quickly and have stroke support from Lincolnshire Stroke Service, however there are a percentage of patients that are unable to go home who require more specialist rehabilitation on their sitting ability and who have non-oral feeding requirements. There is evidence to say that these patients will benefit from further MDT input to prevent longer term seating problems, contractures, pressure sore development, reduced mobility, management of swallowing problems and possibly the risk of death. This group of patients also need expert input including the use of special equipment which is not available in the community.

There are beds in community hospitals but they are very rarely available and there is a lack of specialist stroke management which means these patients do not reach their full potential or outcomes. We work very closely with the Lincolnshire Stroke Service and discuss patients regularly to decide on best discharge outcome. However, they often advise that referring to a community bed will not provide the necessary specialist rehab for these patients. This often results in patients being referred to a new placement despite the fact that if they had further rehabilitation they could have returned home in certain cases.

Therefore, we would like to propose that a number of beds are continued to be funded at Pilgrim Hospital Boston to enable patient flow for the hospital and to enable a small number of patients to be able to access slower stream rehabilitation with specialised staffing. Appendix 2 shows that from April 2020 when the beds were shut at Boston the Lincoln length of stay rose rapidly. Appendix 3 details the number of patients discharged from Pilgrim Hospital in 2019 with a severe or moderately severe disability, there is an average of 10 patients per month needing slower stream rehabilitation which is unable to be provided in the community. Over 12 months 110 patients were transferred from Lincoln County Hospital to Pilgrim Hospital for further specialised rehabilitation (Please see

appendix 4). They were also unable to be discharged home as they needed complex discharge planning.

We have gathered a number of patient stories over the past few months which also support the need for our proposal. These include patients that have been admitted directly to Pilgrim Hospital and therefore with the specialist staff still present at Pilgrim have managed to be supported for specialised rehabilitation and post stroke care. There are also a number of patients who have returned to Pilgrim Hospital for longer/slower stream rehabilitation to improve flow over at Lincoln. When this flow is available we notice an improvement in Domain 2 of SSNAP data, however the periods where our unit has been closed due to COVID19 we have noticed a decline in number of patients getting a 90% stay on the stroke unit in Lincoln as well as a deterioration in all other domains due to increased demand on staff and resources at Lincoln. This is shown in the most recent SSNAP data for the last quarter where Lincoln Stroke Unit scored a D overall with an E in domain 2.

Therefore, we would be grateful if you could consider the overall impact of the proposal put to the public in the acute service review and consider looking at the greater pathway. We truly believe that stroke specific inpatient rehab beds are key to the success if the proposal goes through.

Yours sincerely,

Stroke Therapy Team, Pilgrim Hospital Boston

On Behalf of the physiotherapy Team
Team Lead Physiotherapist – Stroke

On behalf of the Occupational Therapy Team
Senior Occupational Therapist - Stroke

SOS Grantham on behalf of 'United GDH Campaigners'

Open letter to Lincolnshire CCG in response to Acute Service Review (2021) Public Consultation

2021 Stop the cuts to Grantham & District Hospital NOW!!

Rural Grantham & District Hospital is located in the heart of England at the crossroads between the North and South, East and West on both rail and busy A1/A52 routes. The area attracts visitors from across the country and overseas many visiting the large out of town retail park. It is a Growth Town with plans for 7000 more homes at least, new business parks and new retail developments. Grantham is approximately 45 minutes car journey from the next nearest A&E Department. Significant and potentially irreversible downgrade of acute care services at Grantham & District Hospital will put lives at risk, and cause undue pain, suffering and stress to patients and/or their visitors. The proposals do not amount to an improvement in service and will not generally improve patient care nor make it safer as the CCG suggest. Grantham area patients will not have parity with those in Lincoln or Boston areas. The changes will not make services more safe but less so**.** Local patient resuscitation, intubation and stabilisation will be undermined. We call upon Lincolnshire Clinical Commissioning Group (CCG) to review their Acute Service Review (ASR) plans published: https://lincolnshireccg.nhs.uk/ currently in Public Consultation due to end **23 December 2021.**

If the latest plans go ahead Grantham & District Hospital will become little more than a 'cottage hospital' unable to handle emergency patients and non-planned surgery nor care for acutely ill elderly patients in their local area. Of particular concern are the low income, elderly and disabled residents likely to be most affected. **The changes will not make services safer but less so.**

The Lincolnshire CCG Acute Service Review includes a review of:

- Orthopaedics (elective and non-elective) county wide
- *Lincolnshire CCG are proposing to remove all emergency/non elective fracture surgery from Grantham & District Hospital.*

We appreciate complex fractures require urgent specialist treatment however those with less serious fractures will be required to travel to other hospitals potentially incurring further injury en route cross country on poor roads and in pain. We believe that simple fractures should be treated at Grantham & District Hospital and that the majority of patients requiring surgery would prefer them to be completed locally with the exception of complex cases.

Stroke services county wide

Lincolnshire CCG have totally ignored Grantham & District residents in their emergency stroke plans despite the significant distance to any other alternative hospital A&E/emergency stroke site. They only refer to the needs of Boston residents in their emergency stroke plans.

Grantham residents experiencing a stroke have the same concerns and needs as Boston residents being a similar distance to the next nearest emergency stroke unit. A clear plan indicating how Grantham emergency stroke patients will be stabilised in the absence of a local A&E unit and without an emergency stroke unit or ACU is required.

Urgent and emergency care at Grantham & District Hospital

Lincolnshire CCG propose to downgrade Grantham & District Hospital Accident and Emergency Unit currently available during the day and replaced with a UTC and drop-in GP service at night with a 24/7 Urgent Treatment Centre. Lincolnshire. CCG also state at Grantham & District Hospital there were "limited range of presenting conditions dealt with by A&E department since 2007/8." (pg 20)

Local people have persistently called for the restoration of a 24/7 A&E department after the service was closed at night on a temporary basis by United Lincolnshire Hospital Trust in August 2016.Lincolnshire CCG plans will result in 120,000 residents in the Grantham Hospital catchment area, currently relying on Grantham & District Hospital A&E, in an acute emergency, being forced to travel between 15-45 miles to their next alternative A&E units at Lincoln, Peterborough and Nottingham QMC. The plan puts lives at risk and the number of patients affected estimated by the CCG to be 700 a year is not 'a few'. The CCG have underestimated the impact on emergency patients. Prior to night closure 4400 patients were admitted via A&E. We know 1574 emergency patients were admitted from the Grantham area between 1 July 2020 - 1 September 2021 at Lincoln & Boston Hospitals alone. We must assume the remainder were forced to travel elsewhere. Not all Emergency patients with potentially life-threatening time critical conditions require admission e.g. severe allergy, some heart conditions and breathing difficulties. A&E departments elsewhere are too busy now. East Midlands Ambulance crews are forced to wait hours outside these hospitals on a regular basis. *Note: Tragically on 6 October 2021 a local young man died whilst waiting to be seen outside Lincoln County.* Grantham patients going elsewhere affect those hospitals too.

Open letter to Lincolnshire CCG in response to Acute Service Review (2021) Public Consultation

Contrary to misleading CCG comments, Grantham & District A&E staff had the skills and equipment supported by consultants in the ACU to be able to handle a wide range of acute medical conditions up to the highest severity as evidenced by ULHT responses to SOSGH Freedom of Information requests in 2018. *Only recently repeatedly resuscitating a local woman and saving her life after a 2hr wait for an ambulance.*

Acute Medicine at Grantham & District Hospital

Lincolnshire CCG propose not to replace the Acute Service Unit which provided vital medical expertise to critically ill patients and included beds commissioned by the East Midlands Critical Care network. The CCG propose to leave a minimum number of 'integrated community/acute medical beds' shared with other non-medical departments. This will result in fewer patients being admitted into Grantham Hospital.

The CCG proposes to place elderly patients with complex needs out of a secure hospital environment supported by specialist consultants and either move them to alternative hospital sites requiring considerable journeys with associated risks, or, place them into community care which is known to be fragmented and where monitoring patient progress and outcomes will become much more challenging. They will not receive the level of medical care they would get in hospital until they make a recovery and will be at greater risk of non-recovery.

Consultant training and staff

Lincolnshire CCG omit reference to Grantham & District Hospital as a training hospital in their new plans

Grantham & District Hospital was popular among doctors training as specialist consultants. Elderly patients with chronic complex conditions were supported locally by respiratory, cardio and gastro specialists who provided training support for new Consultants. The site also had training equipment available. Lincolnshire CCG & ULHT the consultants should work mainly between Lincoln and Boston. Dissatisfied staff and consultants will make the future of hospital services across the county less sustainable.

In view of the concerns raised I OPPOSE the recommendations in the Lincolnshire Clinical Commissioning Group Acute Service Review 2021. I call for a full restoration of acute services at Grantham & District Hospital and consider if the changes are implemented that the CCG will not have fully reflected my concerns in their Public Consultation. I would also consider what is left of our District Hospital to be little more than a cottage hospital and that future development plans for the area should take this into consideration.

Your signature:	
Print your first name(s):	
Print your last name(s):	
Your Address:	
Your Postcode:	

🔵 Tick to confirm that I am over 18 years old , or,

🔵 Tick to confirm that I am under 18 years old and have parental consent to sign this document. Children and young adults will be affected by the changes planned too.

Please feel free to share this petition.







Working together – United Grantham District Hospital Campaigners

An online version is available at:
https://www.thepetitionsite.com/en-gb/191/529/732/2021-stop-the-cuts-to-grantham-hospital-now/

Please return completed forms to:
United GDH Campaigners, c/o SOSGH, 45 Harrowby Road, Grantham, NG31 9ED by

20 December 2021.

They may be left sealed in the porch.

Can you help? Please **contact 07398 156296** re petition enquiries or email Charmainemorgan50@gmail.com

Appendix D

Themed detailed consultation feedback

ORTHOPAEDICS PROPOSAL - THEMED CONSULTATION FEEDBACK

Theme	Comment / Message / Concern	In Support of Proposal	In Opposition of Proposal	Additional Consideration	Mitigation	Alternative Option	Source
Quality / Workforce	Ongoing improvements in quality of care	✓					ORS Public Consultation Feedback Report
	Negative impacts on quality and timeliness of emergency orthopaedic care, with increased pressure on services at Lincoln County Hospital, as well as on the ambulance service if more or longer transfers needed		✓				ORS Public Consultation Feedback Report
	Ongoing improvements in staff recruitment and retention	✓					ORS Public Consultation Feedback Report
	Could staffing two separate centres for orthopaedic services present challenges to recruitment? Need to ensure NHS staff are included in any ongoing consultation	✓	✓				ORS Public Consultation Feedback Report
	Chartered Society of Physiotherapy (CSP) raised concerns that lack of funding for weekend rehabilitation services is resulting in increasing patient length of stay, and sought confirmation that high quality care and best practice rehabilitation for orthopaedic discharged patients would be put in place under the proposed changes			✓			ORS Public Consultation Feedback Report
	Confirmation of high quality care and best practice rehabilitation for orthopaedic patients with 'either a pull or push system in place' for early discharge. Patients should be provided with their choice of provider at point of referral.			✓			ORS questionnaire key comments
	Communication between care facilities, including hospital departments and GPs, needs to be addressed urgently to ensure the timely flow of information on patient care and treatment			✓			ORS Public Consultation Feedback Report
	The NHS Lincolnshire should work with and learn from private hospitals to improve patient care and assist with the crisis; and			✓			ORS Public Consultation Feedback Report
	Has the T&O pilot demonstrated an improvement or not on staffing levels in terms of both recruitment and/ or retention? It (Health Scrutiny Committee for Lincolnshire) is not convinced that the proposal would improve the recruitment and retention of staff; Skegness Town Council believe the issues around staff recruitment and retention need to be addressed rather than cutting local services.		✓				Boston f2f event 12 Oct ORS questionnaire key comments Questionnaire - Organisation responses: Skegness Town Council (01/12/2021)
	Proposal includes no provision for unforeseen emergencies arising from routine surgery and when patients older and/or frail patients need high dependency care. Assurance is needed that safe immediate care and transfer will be available. Where will such patients receive support during recovery?			✓			ORS questionnaire key comments
	Concern generally over metrics used and factual inaccuracies in the documentation			✓			ORS Public Consultation Feedback Report
	Concerns whether Grantham will be able to cope with increased demand			✓			ORS questionnaire key comments
	Ensure policies and pathways are robust and clear for continuous improvements are made and filtered throughout the organisation.			✓			ORS questionnaire key comments
	This is a short term contingency plan to cope with deep rooted problems not being addressed by NHS and governments – beds, staff recruitment and retention and quality of care.		✓				ORS questionnaire key comments
	Lack of evidence and information in relation to changes at Grantham. How will performance at the centre of excellence be measured and reported to give reassurance of the planned changes?			✓			ORS questionnaire key comments
	It is not clear how many patients would choose to have their elective orthopaedic surgery at a hospital outside Lincolnshire. This could potentially impact on neighbouring healthcare systems, the continued use of the independent sector, and funding for the Lincolnshire healthcare system.			✓			Written submissions - Health Scrutiny Committee for Lincolnshire
Access	All acute hospital services / orthopaedic surgery should be delivered close to patients' homes – or specialist orthopaedic services should be rotated between sites All sites should be available for planned and unplanned care		✓			✓	ORS Public Consultation Feedback Report ORS questionnaire key comments
	Reassurance about whether pre-operative assessments and post-operative care, as well as related services such as fracture clinics, would be available at local hospitals or in the community Has targeted support has been considered to improve access, with outpatient and diagnostics being provided close to patients' homes in the community?	✓	✓				ORS Public Consultation Feedback Report ORS questionnaire key comets
	Benefits of access to specialist Centre of Excellence would outweigh increases in travel time	✓					ORS Public Consultation Feedback Report
Interdependency with Urgent and Emergency Care	Orthopaedic proposal linked to proposed changes to urgent and emergency care provision in Grantham		✓				ORS Public Consultation Feedback Report
	Complex fractures require urgent specialist treatment. However those with less serious fractures will be required to travel to other hospitals potentially incurring further injury en route cross country on poor roads and in pain. Simple fractures should be treated at			✓		✓	Stop the cuts to Grantham & District Hospital NOW! Letter
	Emergency orthopaedic surgery should be retained at Grantham and District General Hospital			✓		✓	ORS Public Consultation Feedback Report
	Unplanned orthopaedic procedures should remain at hospitals with A&E departments and intensive care to reduce the cost of transfer to the proposed new centres and to reduce risk for patients with underlying health conditions			✓		✓	ORS questionnaire key comments
	Grantham Hospital should be a centre of excellence for all services.			✓		✓	ORS questionnaire key comments
Travel & Transport	Concerns about travel and transport to County Hospital Louth	✓	✓				ORS Public Consultation Feedback Report
	Concerns about travel and transport to Grantham and District Hospital	✓	✓				ORS Public Consultation Feedback Report
	Measure which might mitigate against challenges some service users might face around travelling to more distant or unfamiliar hosoital sites e.g. Increased provision of patient transport services Working with local authorities to explore improvements to public transport links More follow-up appointments provided in community				✓		ORS Public Consultation Feedback Report
	It is not the County Council's role to facilitate changes to public transport provision, solely and directly in response to changes to NHS services. Furthermore, the Committee has concerns over evening and overnight discharges when public transport does not			✓			Written submissions - Health Scrutiny Committee for Lincolnshire
Equalities & Health Inequalities	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/more expensive journeys to hospitals Patients with comorbidities were also mentioned, including those who might require access to kidney dialysis while in hospital.			✓			ORS Public Consultation Feedback Report
	Review of eligibility criteria for patient transport services to address any potential barriers to access – particularly for most deprived communities in rural and inner city areas or frail or older people who might find travel stressful/difficult			✓			ORS Public Consultation Feedback Report
	Challenge of ensuring equitable access in large, rural county, especially for localities where health service provision and public transport services were described already as being poor (e.g. East Coast)			✓			ORS Public Consultation Feedback Report
	People with disabilities who are used to attending particular hospitals where additional support is available if needed, might find that the same support not available elsewhere			✓			ORS Public Consultation Feedback Report
	ability of carers being able to travel to Grantham to support vulnerable patient, specifically if an overnight stay is needed			✓			Voices for All virtual meeting
	The continuing, planned run down of Grantham and Louth Hospitals is endangering the care and safety of populations living at a distant from Pilgrim and Lincoln hospitals.			✓			ORS Public Consultation Feedback Report
	Some Travellers/Gypsys feel left behind with things working forward, being on line and are unable to access this and some can not read letters, they say it all seems so unpersonal,			✓			Questionnaire organisation responses: Lincolnshire Traveller initiative, Well Woman group.
	The cost to the NHS in transport for patients without own means of transport could outweigh the benefits of the proposal.			✓			Questionnaire - Organisation responses: Lincolnshire traveller initiative Health champion (Grantham)
	Concern by a disabled, deaf person over potential loss of appointments and operations at valued local Pilgrim Hospital and belief that this support would be unavailable elsewhere - is there any specific extra service for hard of hearing here?			✓			ORS Public Consultation Feedback Report
Facilities	That Grantham and District Hospital is poor state of maintenance, and that it would be more cost effective in the long run to build a brand new centre for orthopaedic services.			✓		✓	ORS Public Consultation Feedback Report

URGENT AND EMERGENCY CARE PROPOSAL - THEMED CONSULTATION FEEDBACK

Theme	Comment / Message / Concern	In Support of Proposal	In Opposition of Proposal	Additional Consideration	Mitigation	Alternative Option	Source
Conditions that would be treated at 24/7 Grantham and District Hospital UTC	There was acknowledgement a high percentage of evening and overnight visitors to the A&E departments at Lincoln County Hospital or Peterborough City Hospital could actually be treated at a more local UTC	✓					ORS Public Consultation Feedback Report
	24-hour access to walk-in UTC might relieve pressure on Lincoln County Hospital's A&E, as well as benefiting those living in and near to Grantham if the majority of them would not need to travel to Lincoln to receive out of hours urgent care	✓					ORS Public Consultation Feedback Report
	Recognition of issues such as Grantham's growing and aging population, and travel to Lincoln County Hospital – for respondents and residents that supported the proposals they represent a reasonable 'real world' compromise to these issues that could be mitigated against – not least by ensuring that local residents are made fully aware of what services a UTC would be able to provide	✓					ORS Public Consultation Feedback Report
	Reassurances that a 24-hour Urgent Treatment Centre would be appropriate for the vast majority of patients requiring out-of-hours assessment and treatment and might therefore lead to shorter waiting times and less pressure on A&E services in other locations in Lincolnshire, were accepted by many of those who agreed with the proposals.	✓	✓				ORS Public Consultation Feedback Report
	There was also recognition that most people who would require full A&E services, such as trauma patients, would in any case be transported by ambulance to the nearest appropriate site.	✓	✓				ORS Public Consultation Feedback Report
	Concerns about quality of care provided at A&E departments at Lincoln County Hospital and Pilgrim Hospital in Boston, as well as the long wait times some respondents had experienced – these might become worse without A&E services at Grantham and District Hospital	✓	✓				ORS Public Consultation Feedback Report
	Vital that a UTC at Grantham and District Hospital should always operate as a walk-in service, rather than requiring people to contact NHS 111 first to ensure that people use of the service and do not travel elsewhere unnecessarily			✓			ORS Public Consultation Feedback Report
	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. 'How does this compare to the level of service that would be provided from the proposed 'urgent Treatment Centre'.		✓				Information submitted by member of the public
	Some people were worried that opening times would drop later to 12 hour opening from 24/7			✓			PPG meeting 1 Nov
	Assurance that 111 refer to Grantham Hospital and they are on their database and that ambulances are 'allowed' to transport patients to Grantham directly			✓			Various meetings
Full A&E and hospital service provision at Grantham and District Hospital	For many respondents, a 24-hour UTC was viewed as preferable to the current limited services A&E department operating from 8.00am-6.30pm.	✓					ORS Public Consultation Feedback Report
	The vast majority of those who rejected the proposals for a 24-hour UTC at Grantham and District Hospital did so, not on the basis that they favour the status quo of current service provision, but rather because they want a full, 24/7 A&E department in place of the current 8:00am to 6:30pm service.		✓				ORS Public Consultation Feedback Report
	Grantham and District Hospital should have a full 24/7 A&E Department - Any changes to acute services at the hospital in Grantham were viewed as unacceptable and, in many cases, seen as a continuation of under-investment and a process of service reduction at Grantham and District Hospital over a period of a number of years		✓				ORS Public Consultation Feedback Report
	Services at Grantham and District Hospital need to be protected and expanded/more services delivered with reference made to emergency orthopaedic surgery and stroke services in particular		✓				ORS Public Consultation Feedback Report
	Lack of trust in the case for change and strong concern the proposal is another step in a deliberate 'downgrading' of Grantham and District Hospital		✓				ORS Public Consultation Feedback Report
	Proximity of the A1, major railway links and airports increases the risk of major incident that might overwhelm remaining A&E services without Grantham and District Hospital being able to provide support		✓				ORS Public Consultation Feedback Report
	The strength of feeling from some members of the public was further evidenced by the submission of two petitions with a combined total of 1,818 signatures or online indications of support calling for a 24-hour A&E department at Grantham and District Hospitals.		✓				ORS Public Consultation Feedback Report
	Population of Grantham is growing The variety of patient ailments, growth of Grantham and large rural catchment area of patients deserve a better quality of service than the UTC offers		✓				ORS Public Consultation Feedback Report
	Additional Nurse ACPs be trained to compensate for the shortage of consultants				✓		
	Current part-time limited A&E department at Grantham and District Hospital to be replaced by (or 'restored to') a full Type 1 Accident and Emergency Department					✓	ORS Public Consultation Feedback Report
	A&E services should continue to be offered at Grantham and District Hospital during the day, with a UTC in operation only overnight					✓	ORS Public Consultation Feedback Report
	Lincoln Pilgrim A&E departments are often stretched and prolonged ambulance handover delays. ULHT should build the A&E capabilities at Grantham to cut transfer times, reduce risk for patients, make it attractive for staff. "The challenge for ULHT is to see		✓				
	Maintain A&E service at Grantham and provide dedicated, separate walk in services, run by nurse specialists, in addition to A&E services for emergency / ambulance admissions in Lincoln and Boston.					✓	ORS questionnaire key comments
Ambulance conveyance	Concerns of risk to life as a result of increased travel times in life-threatening emergencies – concerns about ambulance conveyance times to more distant Accident and Emergency Departments at Lincoln County Hospital and other locations	✓	✓				ORS Public Consultation Feedback Report
	The rural geography of much of Lincolnshire led to concerns about acute and emergency health service provision becoming more 'spread out' at a time when the population of is growing, particularly around Grantham	✓	✓				ORS Public Consultation Feedback Report
	NHS 111 needs to be informed that this is being proposed so that patients if needing treatment here are transferred there rather than being taken to the 2 x A&E departments at Pilgrim / Lincoln County			✓			Voices for all 01 Dec
Workforce and Organisational Integration	Recruiting and retaining staff to the proposed UTC will not be straightforward, and there may be times in future whereby staff are re-allocated from the UTC to support A&E departments, thus reducing the capacity of the proposed Centre		✓	✓			Written submissions - Health Scrutiny Committee for Lincolnshire
	The issue of staff recruitment is not just specific to A&E doctors; UTCs experience staff shortages mean there are barely enough to safely staff the existing UTCs. There is concern over where the experienced ACPs will be found to fill these vacancies.			✓			ORS questionnaire key comments
	When we had the temporary UTC in place at Grantham, there was a disconnect between LCHS and ULHT in terms of safeguarding oversight and IT systems not working together. How will that be resolved in a permanent model?			✓			ULHT staff briefing 30 Sept
Travel & Transport	Impact on members of the public who might find it difficult to travel to and from Lincoln County Hospital and other locations due to poor transport links to Lincoln County Hospital and increased costs and journey times, particularly for those who rely on public transport or are discharged late at night	✓	✓				ORS Public Consultation Feedback Report
	Visitors if patients admitted to hospitals, both in terms of their own journeys and the potential impacts on patient recovery and wellbeing if they are isolated from family and carers.	✓	✓				ORS Public Consultation Feedback Report
	More patient transport options be offered between hospital sites, and to help patients to return home following discharge if they were transferred from the UTC to an A&E at a different hospital				✓		ORS Public Consultation Feedback Report
	If proposal for 24/7 UTC goes ahead, ULHT should provide their own emergency and non-emergency transfer service to local A&E departments, so that East Midlands Ambulance Services are not affected				✓		ORS Public Consultation Feedback Report
	There are climate change implications when patients have to travel to and from hospitals - Centralisation undermines government policy on 'zero-carbon' transport which will mean that fewer of the poor and vulnerable will have electric cars"			✓			Written submissions - Kesteven District Council
Equalities & Health Inequalities	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.			✓			ORS Public Consultation Feedback Report
Similar UTC provided at Stamford and Spalding	A similar urgent treatment service be provided at Stamford to cover areas south of Grantham			✓			ORS Public Consultation Feedback Report
	Why have we not run a pilot to see if the same level (24hour) should be provided at Spalding UTC			✓			ULHT patient panel 06 Dec
New Specialist Hospital	Suggestion of a more radical approach – a new specialist hospital be built near Sleaford to deal with all emergency care, leaving other hospitals in Lincolnshire to deal with routine and planned care					✓	ORS Public Consultation Feedback Report

ACUTE MEDICINE PROPOSAL - THEMED CONSULTATION FEEDBACK

Theme	Comment / Message / Concern	In Support of Proposal	In Opposition of Proposal	Additional Consideration	Mitigation	Alternative Option	Source
Quality / Workforce	Would provide benefits such as more efficient care, with patient being discharged more quickly while continuing to receive treatment and care in their communities	✓					ORS Public Consultation Feedback Report
	The proposal for integrated community/acute medical beds at Grantham and District Hospital is likely to improve the recruitment and retention of consultants and middle-grade doctors	✓					Written submissions - Health Scrutiny Committee for Lincolnshire
	Concerns expressed that other services need to be involved to facilitate the change e.g. adult social care and primary care, and these services are already overwhelmed	✓	✓				ORS Public Consultation Feedback Report
	Concerns about costs of implementing the changes and increased workload required	✓	✓				ORS Public Consultation Feedback Report
	Community staff are in sort supply as well as hospital staff so relying on care in the community is not necessarily the solution. A huge recruitment drive is needed for clinicians, care workers and therapists.	✓	✓				ORS Public Consultation Feedback Report
	The CSP would support the integration of acute/community medical beds at Grantham and District Hospital. This is with the proviso that the required workforce across the whole pathway can be attained, with any required training needs met prior to the service	✓					Questionnaire _organisation responses: Chartered Society of Physiotherapy
	Adequate staffing and resources must be provided for a comprehensive seven-day service with all professions having the full resources they require to enable a high level of quality of care that facilitates better outcomes for the population of Lincolnshire			✓			Questionnaire _organisation responses: Chartered Society of Physiotherapy
	The CCG proposes to place elderly patients with complex needs out of a secure hospital environment supported by specialist consultants and either move them to alternative hospital sites requiring considerable journeys with associated risks, or, place them into community care which is known to be fragmented and where monitoring patient progress and outcomes will become much more challenging. They will not receive the level of medical care they would get in hospital until they make a recovery and will be at greater risk of non-recovery.		✓				Stop the cuts to Grantham & District Hospital NOW! Letter
	Lincolnshire CCG omit reference to Grantham & District Hospital as a training hospital in their new plans Grantham & District Hospital was popular among doctors training as specialist consultants. Elderly patients with chronic complex conditions were supported locally by respiratory, cardio and gastro specialists who provided training support for new Consultants. The site also had training equipment available. Lincolnshire CCG & ULHT the consultants should work mainly between Lincoln and Boston. Dissatisfied staff and consultants will make the future of hospital services across the county less sustainable.		✓				Stop the cuts to Grantham & District Hospital NOW! Letter
	Difficulty accessing GPs means minor illnesses are not treated, leading some to increase in severity resulting in hospitalisation – NHS could reduce the demand for hospital beds by ensuring residents can more easily organise appointments with their GP				✓		ORS Public Consultation Feedback Report
	A huge recruitment drive is needed for clinicians, care-workers and therapists				✓		ORS Public Consultation Feedback Report
Conditions that would be treated at 24/7 Grantham and District Hospital UTC	NHS 111 needs to be fully informed of who they can send to Grantham instead of an A&E department and further afield				✓		ORS Public Consultation Feedback Report
	There are concerns that if the proposed UTC is developed, with an extended range of services compared to other similar centres, there is a risk that withdrawing any of these services would impact on the arrangements for acute and community beds;			✓			Written submissions - Health Scrutiny Committee for Lincolnshire
Full A&E and hospital service provision	Grantham and District Hospital should be a fully serviced hospital with acute medical beds		✓				ORS Public Consultation Feedback Report
	Proposal does not take into account or properly address the growing and aging population in Grantham		✓				ORS Public Consultation Feedback Report
	Concerns about negative impacts on the quality of care being provided, and the potential for increased pressure on other hospital sites		✓				ORS Public Consultation Feedback Report
Acute Care Unit (ACU)	What has happened to the ACU? Why has the ACU been closed?		✓				ORS Public Consultation Feedback Report Information submitted by member of the public
	Lincolnshire CCG propose not to replace the Acute Service Unit which provided vital medical expertise to critically ill patients and included beds commissioned by the East Midlands Critical Care network. The CCG propose to leave a minimum number of 'integrated community/acute medical beds' shared with other non-medical departments. This will result in fewer patients being admitted into Grantham Hospital.		✓				
	specific concerns about lack of provision of Level 2 Respiratory beds at Grantham and District Hospital and suggested that respiratory ACPs could manage respiratory beds with support from anaesthetists and additional funding for recruitment and training.					✓	ORS Public Consultation Feedback Report
Ambulance conveyance	There will also be an additional impact put onto East Midlands Ambulance Service to transfer people to the nearest hospital with an acute bed.			✓			Questionnaire _organisation responses: Skegness Town Council
Facilities	Further clarity sought on impact of the proposals on overall bed space at Grantham and District Hospital	✓	✓				ORS Public Consultation Feedback Report
Equalities & Health Inequalities	Patients would be seen to quicker, resulting in more efficient care; patients will benefit by being discharged back into their community more quickly. Elderly or frail patients were highlighted as particularly benefiting from this			✓			ORS Public Consultation Feedback Report
	Reducing pressure on acute hospital sites at Lincoln and Boston – specifically in relation to 'frail' population is sensible and the integrated multi-disciplinary care team for frail patients is positive. Where else in the County will this specialism for frailty be available –			✓			Questionnaire _organisation responses: Boston Borough Council, ELDC, SHDC
Travel & Transport	Non urgent hospital transfer may also be affected, as people live further away from the hospital they are admitted to.			✓			Questionnaire _organisation responses: Skegness Town Council
Alternative Suggestions	If acute and community beds are available at Grantham, blood tests should be available there too					✓	ORS Public Consultation Feedback Report
	Establish acute and rehab pathways: · Acute pathway (for acutely/medically unstable patients) that would be EAU (assessment unit) and one more medical ward to allow patient flow with MDT discharge facilitation; · Rehabilitation pathway: step down from acute beds and step up from community. The Rehab Ward should include stroke rehab beds and general rehab beds for patients with any other conditions including frail elderly and post-Covid patients. · Establishing a rehabilitation ward in Grantham and District Hospital would allow service provision for patients closer to their home and access for visitors.					✓	ORS Public Consultation Feedback Report
	Provide 'half way house' care wards for those who are medically well but unable to cope with going home at present, offering convalescence and low dependency beds. Occupational therapy could be an added service.					✓	ORS Public Consultation Feedback Report
	Acute medical beds should not be provided at Grantham, given the limited support and other services there. Grantham should be an elective surgery and community hospital providing high quality care outside an acute setting.					✓	ORS Public Consultation Feedback Report
	Hospital and ongoing social care should be staffed by fully integrated multidisciplinary teams to facilitate seamless transfer of patients into the community. This would involve integrated social services and hospital financial structures to end delayed discharge.					✓	ORS Public Consultation Feedback Report
	Desperately need to develop a district nurse type role to go into people in their homes, so for example the person who needs daily injections may not need to be in hospital but may not be able to do it themselves.					✓	ULHT patient panel 06 Dec
Criticism over lack of detail	Criticism over lack of detailed information on the integrated model in the consultation document 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.			✓			ORS Public Consultation Feedback Report
Additional considerations	Staff and PPG representatives would like to see this kind of model replicated across the trust			✓			ORS Public Consultation Feedback Report
	Mental health beds should be treated as a priority in future planning			✓			ORS Public Consultation Feedback Report
	Develop research and development linked to university and attracted graduates by asking them what they need			✓			ORS Public Consultation Feedback Report
	Patients with chronic health conditions and co-morbidities e.g. obesity, should be centralised in one location in the county to allow staff to develop specialisms			✓			ORS Public Consultation Feedback Report

STROKE PROPOSAL - THEMED CONSULTATION FEEDBACK

Theme	Comment / Message / Concern	In Support of Proposal	In Opposition of Proposal	Additional Consideration	Mitigation	Alternative Option	Source
Outcomes / Quality	Supporters of the proposals agree with the principles of a specialist centre for hyper-acute and acute stroke services	✓					ORS Public Consultation Feedback Report
	Proposal would likely tackle many of the challenges that NHS Lincolnshire services currently face	✓					ORS Public Consultation Feedback Report
	Increased expertise and quality of care	✓					ORS Public Consultation Feedback Report
	Could lead to future investment into NHS Lincolnshire as a result	✓					ORS Public Consultation Feedback Report
	Examples such as the Heart Centre at Lincoln illustrate that having specialist services concentrated leads to better outcomes. System does need to be mindful though that transport times to other neighbouring specialist centres may be less than to Lincoln so this needs to be built into any plans.	✓					ORS org responses - LMC
	If the population of Boston is to increase at its current trajectory, stroke services would be required		✓				ORS Public Consultation Feedback Report
	Basing figures on the last two years will provide false data as prior to COVID Pilgrim saw a spike in admissions over the summer months with increased holiday makers at the coast. Therefore, having only one unit will lead to patients being on wards without specialist nurses or therapists.		✓				ORS Public Consultation Feedback Report
	Until 18 months ago Pilgrim ran a safe and high quality stroke service, achieving higher targets than Lincoln. Lincoln is not a centre of excellence. This will lead to a loss in experienced nurses and therapists, and put the people of Lincolnshire at further risk.		✓				ORS Public Consultation Feedback Report
	This proposal will lead to worsened rehabilitation outcomes as patients requiring longer periods of inpatient specialist rehab will not receive it due to the lack of specialist therapists and nursing staff in existing community beds.		✓				ORS Public Consultation Feedback Report
	Removal of life-saving local services - changes are being made to the detriment of Boston, with many feeling Boston was being placed at a disadvantage as a result and that there would be a threat to other services at Pilgrim Hospital.		✓				ORS Public Consultation Feedback Report
	Integrated pathways and care should start from day 1 of the condition			✓			ORS questionnaire key comments
	Social care provision needs to be strengthened in order to reduce length of stay				✓		ORS Public Consultation Feedback Report
	Clarification of pre- hospital treatment of stroke			✓			Various meetings
Workforce	Presumption that specialist stroke staff will be able to move from Pilgrim to Lincoln is unrealistic owing to personal circumstances and lack of transport	✓	✓				ORS Public Consultation Feedback Report
	Stroke Therapy Team at Pilgrim Hospital identified concerns around: An increase in the number of patients at Lincoln; The lack of additional specialist staffing proposed for the Lincoln site; An increase in stroke patients out-lied to non-specialist wards who do not receive timely and effective specialised rehabilitation; The management of more complex patients who require more intensive input; and The availability (or lack thereof) of community beds and specialist stroke management within community hospitals.	✓	✓				ORS Public Consultation Feedback Report
	Improve recruitment with higher wages/benefits. Are low staff wages and a feeling they are not valued impacting on recruitment and retention?				✓		ORS Public Consultation Feedback Report
	Increase staff numbers and ensure there are enough staff, with thrombolysis training. Increase bed numbers and resources.				✓		ORS Public Consultation Feedback Report
	Introduce a telemedicine system that matches some models used in Europe or other remote areas whereby other staff members could be upskilled to initiate investigations and treatment plans with the help of consultants to keep patient care local.				✓		ORS Public Consultation Feedback Report
	Additional therapy staffing in the community stroke team would help support more timely discharges if it enabled urgent therapy follow-up. However, the stroke unit would also require sufficient qualified therapy staffing to allow for timely assessment and discharge planning. At present the stroke community team are struggling to hire therapists at some locations. Has the impact of this been considered regarding the proposal?				✓		ORS Public Consultation Feedback Report
	The (HOSC) Committee is not convinced that the proposals will lead to improvements in the recruitment and retention of staff		✓				Written submissions - Health Scrutiny Committee for Lincolnshire
Travel Time / Ambulance Conveyance	Increased travel times that Boston residents would have to travel to Lincoln in the event of a stroke	✓	✓				ORS Public Consultation Feedback Report
	Travel times, including by ambulance, to reach Lincoln are too long - 'Time is of the essence' and people living in places outside the 'Golden hour' of travel time to Lincoln, will be disadvantaged by these proposals.		✓				ORS Public Consultation Feedback Report
	Concerns about centralised model is a risk in England's second largest county where there are infrastructure issues, particularly when treatment time is so crucial for stroke patients.	✓	✓				ORS Public Consultation Feedback Report
	Less availability of ambulance in Boston if they are having to make the journey between sites	✓	✓				ORS Public Consultation Feedback Report
	In terms of alleviating concerns, the availability of an air ambulance to cover the East of the county would be supported				✓		ORS Public Consultation Feedback Report
	With current waiting times for ambulance services, the people in Grantham and Boston will be severely disadvantaged because of a substandard access to emergency care.		✓				ORS Public Consultation Feedback Report
Travel & Transport	Travelling to Lincoln to visit patients would be difficult for many families and carers which was seen to be a cause of anxiety for many. poor infrastructure and a lack of public transport options make travelling to Lincoln difficult	✓	✓				ORS Public Consultation Feedback Report
Facilities	Concern over capacity and infrastructure at Lincoln County Hospital and questioned whether the site would be able to work effectively and deal with increased demand with proposed stroke services	✓	✓				ORS Public Consultation Feedback Report
Equalities & Health Inequalities	Proposal could widen health inequalities and patient access could be taken away from a deprived area			✓			ORS Public Consultation Feedback Report
	A number of patients have elderly spouses/family who will be unable to visit due to increased travel distance. The impact of this on patients' mental health and recovery may have been overlooked in this proposal.			✓			
	The stroke figures for the whole of the area served by Pilgrim Hospital are higher owing to an ageing population. It makes more sense, therefore, to have a centre of excellence in Boston. This would reduce travel times for the majority			✓			
	Where concerns were raised that did not relate directly to travel, they tended to focus on issues around lack of familiarity with 'new' or different locations. For example, there were concerns that older people from Grantham might be taken by ambulance to Lincoln, Boston or Peterborough to be treated in an emergency. The unfamiliar setting, it was felt, could cause additional distress. Furthermore, there was a concern that increased travel times for care would have a negative impact on the mental health of the older population in particular.			✓			
	Similarly, the needs of people with sensory disabilities who might be used to accessing certain hospitals and were therefore confident that they would receive any additional support they might require at those locations, were also raised as an issue for consideration.			✓			
Alternative Suggestions Hyper-acute and acute wards	Both Lincoln County Hospital and Pilgrim Hospital, Boston should be a centres of excellence for stroke, attracting good staff to manage them. There should be a focus on recommended speed for treatment rather than numbers of patients.					✓	ORS Public Consultation Feedback Report
	Locating stroke services in Boston was seen by some to suit the overall needs of the population better than Lincoln.					✓	
	Train teams stepping into hyper acute care in a timely way; for example Specialist Strokes and Registrants stepping onto ACP University courses using LBR funds or Apprenticeship Levy. Also HCAs have upskilled using Stroke.org.					✓	
	If there is to be a second ward at Lincoln this should be a small hyperacute ward (close to the stroke unit), and use the current stroke unit for acute/rehab as this already has several therapy rooms. Therapy teams would work across the two wards to provide consistency of care and help maintain cover during annual leave/staff absence etc. It would also be beneficial to have a dedicated MDT/discharge coordinator(s).					✓	
	Keep the hyperacute at site; make consultants and ACPs work pan-trust and put money into ACP training for experienced stroke nurses.					✓	
	A standard operating procedure should be in place that allows thrombolysis to be given in the emergency department if time to transfer to HASU is >45 minutes (in the same manner Major Trauma patients divert to local TUs if an MTC cannot be reached in 45 minutes). Patients should then be transferred to HASU post thrombolysis. This is supported by NICE and there are examples of this working in practice elsewhere in the country.					✓	
	There is concern over lack of capacity to cope with patients with more complex needs, leading to patients being outlined to non-specialist wards. This was a significant impact arising from the loss of the stroke unit at Boston					✓	
	Develop a centre of excellence at Peterborough, Grimsby or Nottingham and don't have anything in Lincolnshire at all					✓	Skegness f2f event 11 Nov

Alternative Suggestions Rehabilitation	As time is critical for stroke patients, Grantham should have the rehabilitation service but only have an acute service if there is an A&E unit there.					✓	ORS Public Consultation Feedback Report
	Ringfence specialist beds at Boston to create a hub and spoke stroke rehabilitation service across Lincolnshire. This would provide a highly specialist stroke provision in a centre with ongoing rehabilitation and preparation for discharge to the community. High quality service provision should link the pathway for rehabilitation across acute and community sectors.					✓	
	An appropriate stroke rehab ward would ensure throughput sufficient to allow new patients to be admitted and longer term patients to receive the stroke rehabilitation they require.					✓	
	Community rehabilitation services need to be in place for stroke and other neurological conditions, especially brain injury. Also, a step up/step down inpatient/outpatient unit where all patients can go to regain lost skills: able to learn to walk again, talk, eat, swallow etc.					✓	
	Provide step down beds in Pilgrim and GDH to allow a manageable caseload for LCH and so that patients receive specialist stroke rehabilitation closer to home. ADSS/community stroke services will not be able to provide an effective service to all patients as stroke rehabilitation requires specialist facility and equipment. The recovery of patients who are more dependent and require more than two people to treat them will be compromised and their outcomes will be poorer. Pre- covid GDH had five beds for stroke rehabilitation. Those beds were always occupied and patients had the opportunity to have treatment near home.					✓	
	There is no mention regarding the link to community rehab beds within care homes or community hospitals. Is there a risk for those patients with dysphagia etc, as a result of a stroke, will be 'stuck' in Lincoln acute stroke beds?					✓	
	Why do we still keep brain and head injury rehab separate to stroke rehab- should align better			✓		✓	
	The team understands the reasoning for developing a centre of excellence at Lincoln but feels that the full pathway has not been considered in terms of the wide range of complex patients' needs. A percentage of patients are unable to go home, requiring more specialist rehabilitation on their sitting ability and/or having non-oral feeding requirements – and that there is evidence to suggest that these patients would benefit from further multi-disciplinary team (MDT) input. This group of patients also need expert input including the use of special equipment which is not available in the community. The team feels that beds in community hospitals are rarely available and there is lack of specialist stroke management, meaning patients do not reach their full potential/outcomes. When working with the Lincolnshire Stroke Service on best discharge outcomes, the Service often advises that referring to a community bed will not provide the necessary specialist rehabilitation for these patients. This apparently results in patients being referred to a new placement despite the fact that if they had further rehabilitation, they could have returned home in certain cases. The team recommends that funding is maintained for the number of beds at Pilgrim Hospital Boston to enable patient flow. It also believes that stroke-specific inpatient rehabilitation beds are key to the success of the proposal should it be taken forward.					✓	Written submission - Stroke Therapy Team, Pilgrim Hospital Boston
Additional Consideration	Although this consultation is on treatment services there is a need to consider prevention. Smoking, high blood pressure, diabetes, heavy drinking, high salt and high fat diets and lack of exercise increase the risk of stroke. These are health concerns in Boston, South Holland and East Lindsey and we would welcome further discussion on addressing these challenges holistically across the system.			✓			Questionnaire _organisation responses: Boston Borough Council, ELDC, SHDC

Appendix E

Health Scrutiny Committee for Lincolnshire response to public consultation

Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

RESPONSE OF HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE TO THE LINCOLNSHIRE ACUTE SERVICES REVIEW CONSULTATION

PART A – INTRODUCTION

The Health Scrutiny Committee for Lincolnshire is grateful to the NHS in Lincolnshire for providing an introduction and presentations on each element of the Lincolnshire Acute Services Review, at meetings on 13 October, 10 November and 15 December 2021, which included clinicians.

The Committee would also like to record its thanks to the Clinical Commissioning Group 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 response of the Health Scrutiny Committee for Lincolnshire is based on the information in the consultation document, the pre-consultation business case, and the information presented to the Committee at the three meetings between October and December 2021.

In this response, Part B sets out the Committee's response to the questions in the consultation document, in each case indicating the Committee's position on a particular proposal. Although the Committee has followed the template of the consultation survey form, it has included a 'free text' box in the *Need for Change* section, in which the Committee explains its answer to the question on this topic.

Part C of this response focuses on the themes that have arisen during the course of the consultation.

PART B – RESPONSE TO SURVEY QUESTIONS

The Need for Change

This consultation is focused on these four NHS services because we believe that significant and permanent improvement is required to them. Such change would ensure that the highest possible standards of patient care are provided in line with clinical evidence and best practice, giving the best possible outcomes for patients. We are consulting to understand the potential impact of these changes on you before we make a decision.

We believe that the benefits of changing will include:

- Improved quality of care
- Reduced waiting times
- Better outcomes for patients
- Increased availability of staff to care for patients
- Better use of NHS funds, reducing spend on temporary staff

✓	**Strongly Agree**
	Tend to Agree
	Neither Agree nor Disagree
	Tend to Disagree
	Strongly Disagree

The Health Scrutiny Committee for Lincolnshire fully accepts the arguments put forward on page 5 of the consultation document and in chapter 4 of the pre-consultation business case as evidence for the need for change in the provision of acute hospital services in Lincolnshire. However, as indicated in the following answers on each specifical proposal, the Committee is not completely convinced in three instances out of four that the proposal, as detailed, is right for the people of Lincolnshire. In each case, reasons are put forward for the Committee's conclusion.

Orthopaedic Surgery

Our current model combines planned and unplanned surgery on the same sites. Unplanned emergency admissions into hospitals must be prioritised. This often leads to planned surgery across the NHS being cancelled on the same day, meaning patients wait a long time for it.

Our proposal is to separate planned and unplanned orthopaedic surgery by:

- Creating a 'centre of excellence' for planned orthopaedic surgery for Lincolnshire at Grantham and District Hospital.

- Creating a dedicated day case centre at County Hospital Louth.
- Performing only unplanned orthopaedic surgery at Lincoln County Hospital or Pilgrim Hospital, Boston (apart from some complex planned surgery which will be better managed at these large acute hospitals).

Please tell us how much you agree or disagree with the proposal to create a 'Centre of Excellence' at Grantham and District Hospital for Lincolnshire's patients to receive planned and day case surgery, with a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery.

☐	**Strongly Agree**
☐	**Tend to Agree**
☐	**Neither Agree nor Disagree**
☑	**Tend to Disagree**
☐	**Strongly Disagree**

Please tell us why you agree or disagree with the proposal to change orthopaedic surgery and if you have any other suggested proposals to address the identified challenges.

Whilst the concept of a centre of excellence for orthopaedic surgery and the intention for a significant reduction in the cancellation rate of 30% for planned operations are understood, the Health Scrutiny Committee tends to disagree with the proposal for the following reasons:

(1) The Committee has concerns on the overall accessibility of Grantham and District Hospital for patients across Lincolnshire, but particularly for residents in the east of county where they rely on public transport. Furthermore, the age profile of the population and levels of deprivation in the east of the county are higher than average. Whilst the pre-consultation business case makes reference to the criteria for the non-emergency patient transport service and a contingency sum of £1 million to support this service, further details of how patients would be supported in practice would be needed to satisfy the Committee that this potential negative impact had been addressed.

(2) The local NHS would like to see the Grantham orthopaedic centre of excellence become a showcase, and the pilot was previously highlighted as a good practice nationally. However, the Committee is not convinced that the proposal would necessarily improve the recruitment and retention of staff.

(3) 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 have the potential to impact on neighbouring healthcare systems, and the continued use of the independent sector. These in turn have funding impacts on the Lincolnshire healthcare system.

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

Urgent and Emergency Care at Grantham and District Hospital

Our current model offers restricted A&E services between the hours of 8am and 6.30pm at Grantham and District Hospital. Just as in the rest of the country, we struggle to recruit enough specialist staff to run three full A&Es across the county, and this means the services are fragile. For some time the model in Grantham has been similar to that of an Urgent Treatment Centre (UTC), and this has been able to appropriately manage the types of injury and illness patients come to Grantham and District Hospital with.

Our proposal is to establish a 24/7 walk in Urgent Treatment Centre (UTC) at Grantham and District Hospital, in place of the current Accident and Emergency (A&E) department.

Please tell us how much you agree or disagree with the proposal to provide 24/7 walk in urgent care services in Grantham via an Urgent Treatment Centre at Grantham and District Hospital.

- [ ] **Strongly Agree**
- [ ] **Tend to Agree**
- [ ] **Neither Agree nor Disagree**
- [ ] **Tend to Disagree**
- [x] **Strongly Disagree**

Please tell us why you agree or disagree with the proposal to change urgent and emergency care services and if you have any other suggested proposals to address the identified challenges.

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.

Since 2016 many residents in Grantham have been campaigning to restore an overnight A&E service at Grantham, which has included a petition of 60,000 signatures in support of its retention. After six years, many residents in Grantham have concluded that their views have been overlooked.

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

over the last twenty years or so. The Committee is not re-assured that further changes to the services provided at Grantham will be avoided.

In view of the above long-standing concerns of residents, the Committee strongly disagrees with the proposal for an urgent treatment centre at Grantham. In addition to the above, the Committee cites the following reasons for this conclusion:

(1) The Committee is not convinced that recruiting and retaining staff to the proposed urgent treatment centre will be straightforward, 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 permanent.

(2) 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.

If the proposal for an urgent treatment centre at Grantham and District Hospital is implemented by the NHS in Lincolnshire, the Committee would make the following recommendations:

(a) 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. (The pre-consultation business case and other supporting documentation referred to the term 'urgent treatment centre plus', although it is understood this would not be used as it would cause more confusion.)

(b) The modest capital investment for the expansion of the proposed urgent treatment into unused parts of the hospital should be identified, planned and implemented immediately.

Acute Medical Beds at Grantham and District Hospital

Our current model is delivered by an 'acute' (hospital) provider, and cares for less complex patients than at Lincoln County Hospital and Pilgrim Hospital, Boston, in line with the restricted A&E service at Grantham and District Hospital. Like our A&E services and the rest of the country, we struggle to recruit enough specialist staff to the service.

Our proposal is to establish integrated community/ acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.

Please tell us how much you agree or disagree with the proposal to provide integrated community/acute medical beds at Grantham and District Hospital.

	Strongly Agree
✓	**Tend to Agree**
	Neither Agree nor Disagree
	Tend to Disagree
	Strongly Disagree

Please tell us why you agree or disagree with the proposal to provide acute medical beds at Grantham Hospital and if you have any other suggested proposals to address the identified challenges.

The Health Scrutiny Committee for Lincolnshire tends to agree with the proposal for the establishment of integrated medical and community beds at Grantham and District Hospital, for the following reasons.

(1) 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 consultants and middle grade doctors.

(2) 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. This model could become a template for other urgent treatment centres in the county, for example, in Louth and Skegness, subject to funding and the appropriate levels of patient volumes and acuity.

The Committee would also like to record the following additional comments:

(a) 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.

(b) 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.

(c) 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.

Stroke Services

Our current model has hyper-acute hospital stroke services at Lincoln County Hospital and Pilgrim Hospital, Boston. We need more doctors and nurses to deliver the existing hospital stroke services, but there aren't enough locally and nationally, which has caused temporary closures of the services. Because patients in the county are dispersed across these two hospitals, the clinicians in them struggle to care for enough patients per year to retain and improve their skills. These issues reflect in the service performance in national audits.

Our proposal is to establish a 'centre of excellence' for hyper-acute and acute stroke services at Lincoln County Hospital, which would be supported by increasing the capacity and capability of the community stroke rehabilitation service. Outpatient TIA ('mini stroke') clinics would be unaffected at Pilgrim Hospital, Boston.

Please tell us how much you agree or disagree with the proposal to provide a centre of excellence at Lincoln County Hospital offering both a hyperacute stroke unit and an acute stroke unit to deliver care for the county's patients, supported by an enhanced community stroke rehabilitation service.

☐	**Strongly Agree**
☐	**Tend to Agree**
☐	**Neither Agree nor Disagree**
☑	**Tend to Disagree**
☐	**Strongly Disagree**

Please tell us why you agree or disagree with the proposal to change stroke services and if you have any other suggested proposals to address the identified challenges.

The Health Scrutiny Committee for Lincolnshire is not convinced by the all the arguments put forward in support of this proposal, and this tends to disagree for the following reasons:

(1) The proposal represents another example of service 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.

(2) Further to (1) 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.

(3) As stated in the pre-consultation business case (page 202, paragraph 12.2.30), 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.

(4) 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.

(5) The Committee is not completely convinced that the proposals will lead to improvements in the recruitment and retention of both medical and nursing staff.

The Committee would also like to record the following additional comments:

(a) During the discussion on this item reference was made to the possibility of introducing a mobile stroke unit, which would in particular be able to support people in the east of the county. The Committee was advised that this suggestion would be considered in further detail.

(b) The Committee was advised that the clinics for the treatment and follow-up of transient ischaemic attacks would continue at Pilgrim Hospital, Boston, and would urge that this should continue.

Equalities Impact

Protected characteristics are specific aspects of a person's identity defined by the Equality Act 2010. It is against the law to discriminate against someone because of the nine protected characteristics which are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Are there any positive or negative impacts that you believe the CCG should take into account in relation to equalities or human rights? If so, are you able to provide any supporting evidence and suggest any ways in which the organisations could reduce or remove any potential negative impacts and increase any positive impacts?

Please enter your response below:

The Committee notes that appendix J to the pre-consultation consultation business case details the assessment of the equalities impact for each of the four proposals. In each case the assessment states that the combination of an ageing population, a rural geography and areas of high socio-economic deprivation defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire. The Health Scrutiny Committee for Lincolnshire highlights this statement and urges the NHS in Lincolnshire to take full account of these assessments prior to making a decision on any service changes.

PART C – THEMES AND GENERAL COMMENTS

Travel and Transport

The pre-consultation business case makes numerous references to public transport; and in several instances refers to consultations being ongoing with Lincolnshire County Council about public transport provision. 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.

There are also references in the pre-consultation business case to non-emergency patient transport services as means of mitigating the impact of the withdrawal of services from certain locations, 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.

Recruitment and Retention of Staff

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.

Links to Neighbouring Health Systems

There are two parts to this theme, firstly the impact of service changes at United Lincolnshire Hospitals NHS Trust on other health systems; and secondly the impact of any changes outside Lincolnshire in

Impact on Other Health Systems

These four proposals will impact on neighbouring health systems, as acknowledged by the detail in 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.

Impact of Other Health Systems on Lincolnshire

An update from the Humber Acute Services Programme team to the Health Scrutiny Committee for Lincolnshire on 15 December 2021 again highlighted how changes to health provision in one location can have a wider impact. 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.

Consultation Arrangements

The Committee would like to record the following comments on the consultation arrangements:

(1) The Committee was advised that leaflets on the consultation would be delivered to every household, as a means 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.

(2) 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.

(3) 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.

(4) 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.

Conclusion

As stated above, the Health Scrutiny Committee for Lincolnshire would again record its thanks to the NHS in Lincolnshire for its engagement at Committee meetings, and for allowing the Committee's response to be submitted to the NHS in Lincolnshire by 31 January 2022.

The Committee understands that there is an intention that the Lincolnshire Clinical Commissioning Group Board will make a decision on these four proposals by 31 March 2022. The Committee would like to continue its dialogue with the NHS in Lincolnshire on the decision making process.

The Health Scrutiny Committee for Lincolnshire has been appointed by Lincolnshire County Council to fulfil its functions as set out in Section 244 of the National Health Service Act 2006 and Regulations 20 – 34 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Appendix F1

Consideration of public feedback by subject matter expert working groups

ORTHOPAEDICS

Public consultation on four NHS services

Addressing public consultation feedback comments, messages, and concerns

Change proposal(s)	**Orthopaedic Services** *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*
Common theme	Quality & Workforce
Feedback working group	Mark Lacey – Managing Director Surgery Kulandaivel Sakthivel – Consultant Orthopaedics Catherine O'Dwyer – Divisional Clinical Director for Surgery Catherine Capon – Deputy Divisional Nurse Surgery Lisa Pim – Divisional Nurse Surgery
Date feedback working group signed off response	Version 4.4 - 22 April 2022 22 4 22 – VS & ML
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	28 April 2022

Orthopaedic proposal consultation feedback – Quality and Workforce

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of orthopaedic services:

- 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

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to orthopaedics there was feedback in support of the proposals relating to quality and workforce in terms of:

- Ongoing improvements in quality of care; and

- Ongoing improvements in staff recruitment and retention

Feedback in opposition to the proposal relating to quality and workforce identified concerns around:

- The negative impacts on quality and timeliness of emergency orthopaedic care, with increased pressure on services at Lincoln County Hospital

- Impact on ambulances if more or longer transfers are needed

- The proposal includes no provision for unforeseen emergencies rising from routine surgery and when patient's older and/or frail need high dependency care. Assurance is needed that safe immediate care and transfer will be available. Where will such patients receive support during recovery?

In addition, the following feedback was provided:

- Could staffing two separate centres for orthopaedic services present challenges for recruitment?

- Has the pilot demonstrated an improvement in staffing or not?

- The issues around staff recruitment and retention need to be addressed rather than cutting local services

- This is a short-term contingency plan to cope with deep rooted problems not being addressed by NHS and governments – beds, staff recruitment and retention, and quality of care.

More broadly in relation to workforce, feedback identified a need to ensure NHS staff are included in any ongoing consultation.

A number of additional considerations were also put forward in the feedback received during the public consultation relating to quality and workforce. These were:

- The Chartered Society of Physiotherapy (CSP) raised concerns that lack of funding for weekend rehabilitation services is resulting in increasing patient length of stay, and sought confirmation that high quality care and best practice rehabilitation for orthopaedic discharged patients would be put in place under the proposed changes

- Confirmation of high quality care and best practice rehabilitation for orthopaedics patients with 'either a pull or push system in place'

- Patients should be provided with their choice of provider at point of referral

- Concerns over a lack of evidence and information in relation to the proposed changes, questions over how performance at the centre of excellence will be measured and reported to give reassurance of the planned changes, and a need to ensure policies and pathways are robust and clear for continuous improvements and filtered through the organisation

- Concerns whether Grantham will be able to cope with increased demand and the impact on neighbouring health systems and use of the independent sector

- Communication between care facilities, including hospital departments and GPs, needs to be addressed urgently to ensure the timely flow of information on patient care and treatment

- The NHS in Lincolnshire should work with and learn from private hospitals to improve patient care and assist with the crisis

This paper aims to provide a concise evidence-based summary of the situation in relation to the feedback received through the public consultation relating to quality and workforce to ensure conscientious consideration of the issues raised.

Quality of care and length of stay – including evidence for change proposals and performance measurement

In August 2018 ULHT commenced a pilot on the way it provided orthopaedic services which focussed on creating a 'centre for 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.

This 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 (national Getting It Right First Time programme – GIRFT), and input from local acute, primary and community based health professionals. When this model was presented to the East Midlands Clinical Senate as part of the options appraisal process, the panel recommended that the Lincolnshire STP (Sustainability & Transformation Partnership) proceeded with it.

Due to the Covid-19 pandemic the pilot was suspended, along with all other elective surgery in February 2020, however up to this point the pilot showed very positive results. The detail of this was

set out in the Pre-Consultation Business Case in the chapter on Orthopaedics and was reported to the United Lincolnshire Hospitals NHS Trust Board.

Since the start of the orthopaedic pilot in August 2018 the ward at Grantham Hospital which looks after the elective orthopaedic patients has consistently received extremely positive feedback. In January and February 2020, a score of 95% achieved in the Friends and Family Test against a target of 90% (as evidenced in orthopaedic pilot evaluation ULHT Trust board paper July 2021).

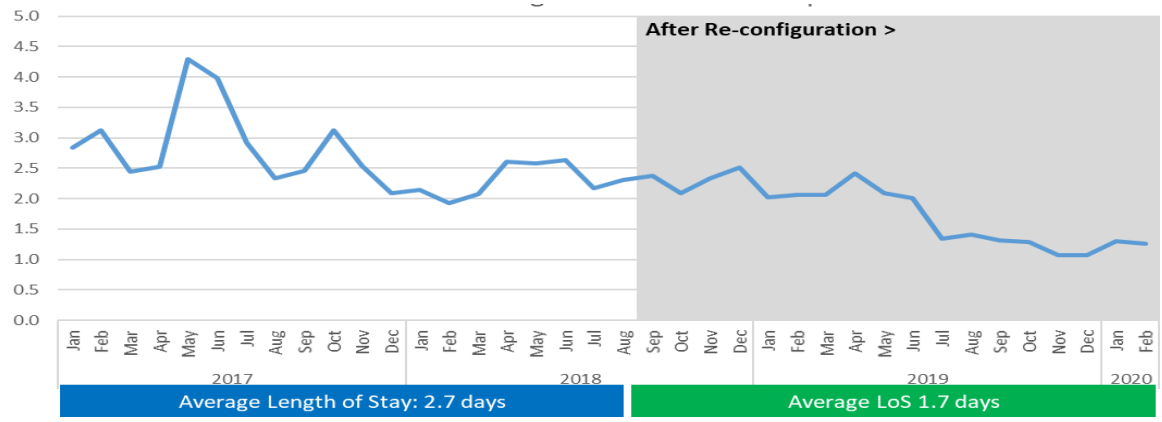
The overwhelming theme from the patient experience feedback was how impressed and happy patients were with the level of care and treatment received from all staff involved.

> *An excellent experience, cannot fault my treatment and procedures.*
>
> *The team are amazing, so friendly, informative, caring.*
>
> *Nothing is too much trouble for them. My stay has been really 'enjoyable'.*
>
> *My experience since referral has been excellent. Fast tracked from consultation on 28/11/18 to surgery on 18/01/2019. Amazing, surprised, and happy. Again my whole experience from check in at 07.30 (a little early for surgery at 2pm) to surgery, then overnight on Ward 2 was fantastic and little unexpected. All staff were very caring, professional. 100%, 10/10++*
>
> *Wow certainly 'Enhanced Recovery'. Impressed lovely staff very friendly. Ward so clean and nothing any trouble. Comfortable stay. Well done everyone.*

The evaluation of the orthopaedic pilot also identified a reduction in the average length of stay for elective orthopaedics at Grantham Hospital from 2.7 days to 1.7 days, demonstrating strong operational performance. A marginal increase in length of stay was seen in January 2020, this was due to hip and knee revision surgery commencing at Grantham Hospital.

An enabler to the reduced length of stay is the commencement of total hip and total knee replacements being undertaken at Grantham Hospital as day-case procedures. Undertaking orthopaedic procedures as a day case is facilitated by ensuring that the appropriate pre-operative optimisation and post-operative support is available, and this can be achieved with a consolidation of specialist support staff onto one site. Patients having these procedures as day-cases are followed up by telephone to ensure their outcome is as planned.

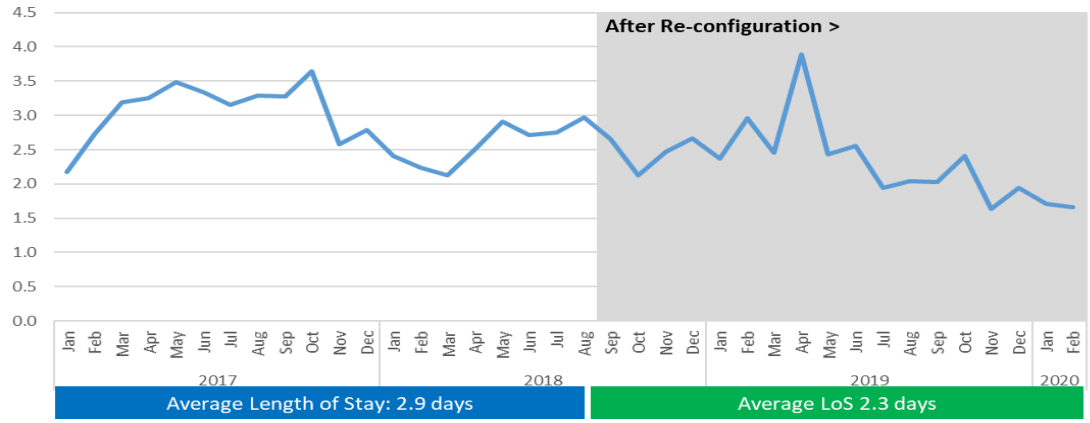
Grantham Hospital elective orthopaedic inpatient average length of stay



(Data source: Orthopaedic pilot evaluation ULHT Trust Board paper July 21)

A reduction in the Trust-wide orthopaedic elective length of stay has been achieved from 2.9 days to 2.3 days.

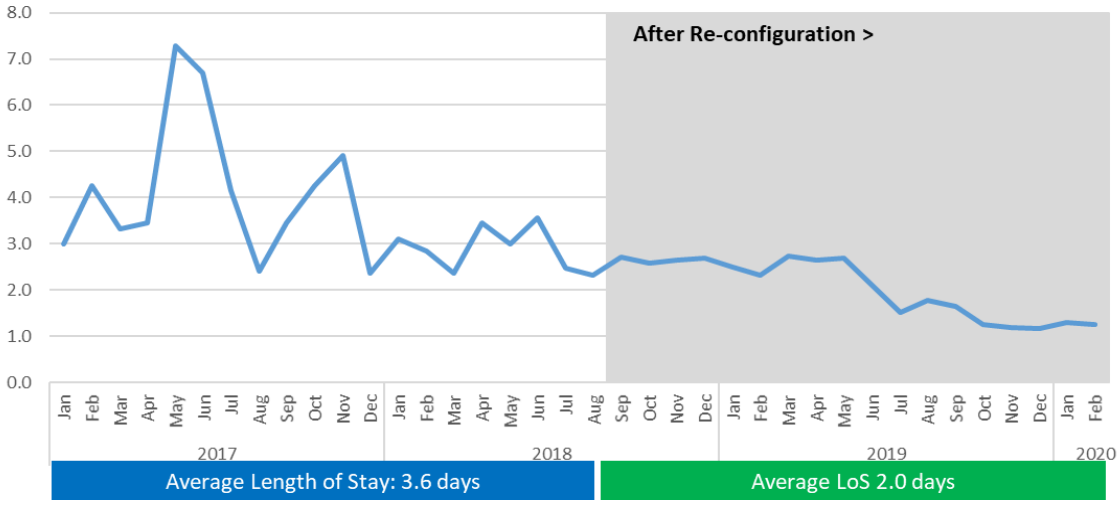
ULHT wide elective orthopaedic inpatient average length of stay



(Data source: Orthopaedic pilot evaluation ULHT Trust Board paper July 21)

The length of stay for primary hip replacements at Grantham Hospital has reduced to an average of 2.0 days compared to 3.6 days before the pilot commenced. In February 2020 the average length of stay was reported as 1.3 days.

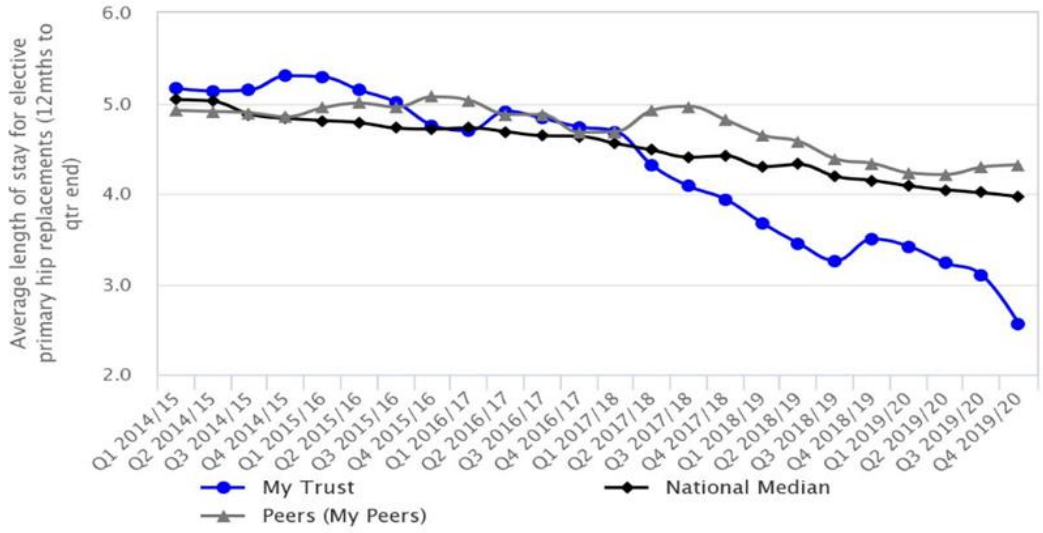
Grantham Hospital primary hip replacement average length of stay



(Data source: Orthopaedic pilot evaluation ULHT Trust Board paper July 21)

As the graph below demonstrates, ULHT is performing significantly better than both its peer Trusts and the national median for primary total hip replacements length of stay.

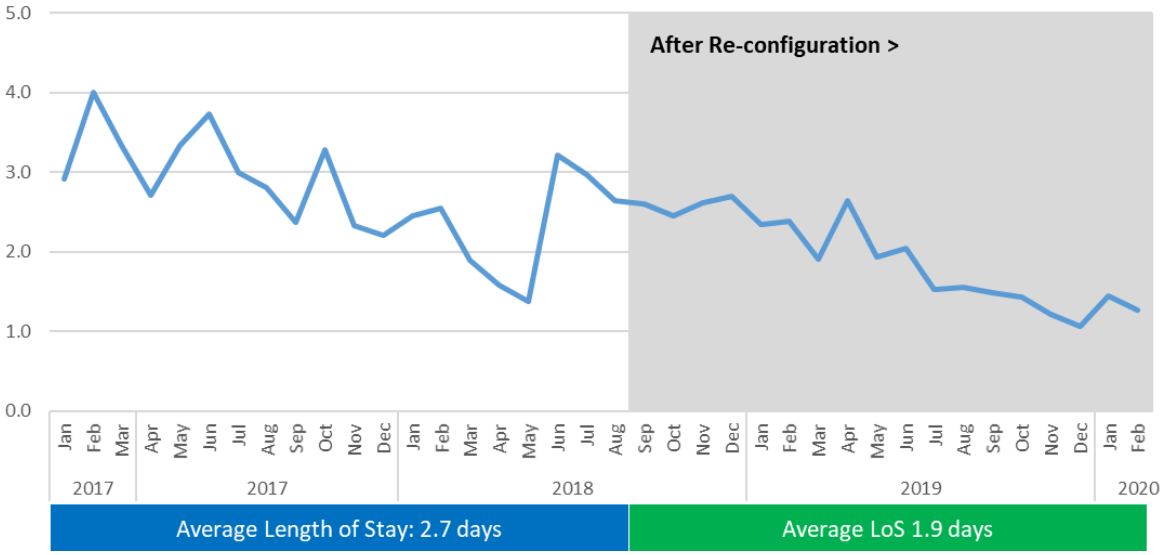
Primary hip replacement average length of stay performance comparison (12 months to quarter end) –



(Data source: Orthopaedic pilot evaluation ULHT Trust Board paper July 21)

The length of stay for primary knee placements at Grantham Hospital has also reduced to an average of 1.9 days compared to 2.7 days before the pilot commenced. Length of stay at Grantham Hospital has outperformed all other pilot Trusts within the GIRFT programme.

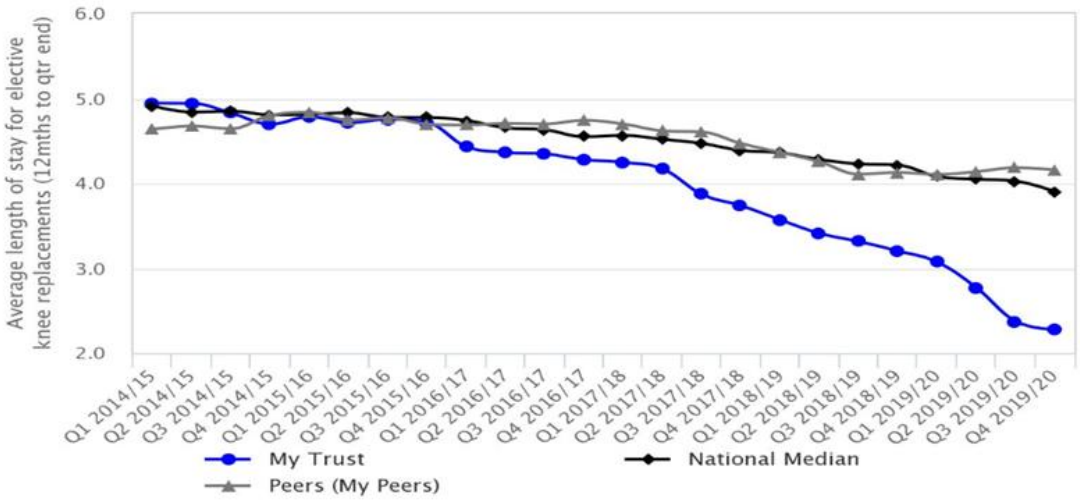
Grantham Hospital primary knee replacement average length of stay



(Data source: Orthopaedic pilot evaluation ULHT Trust Board paper July 21)

As the graph below evidences, the length of stay for total knee replacements is far better than the national median and ULHT peer Trusts, mirroring the achievement in the reduction of length of stay for total hip replacements.

Knee replacement average length of stay performance comparison (12 months to quarter end)



(Data source: Orthopaedic pilot evaluation ULHT Trust Board paper July 21)

ULHT being able to deliver (and beyond) the quality and performance levels achieved through the orthopaedics pilot at Grantham would provide critical support to the recovery and restoration programme 'post-Covid' to reduce elective 'back logs'.

At the beginning of the reconfiguration, success factors were agreed upon to ensure it was easily identifiable whether the changes implemented had the desired impact and drove performance improvements in terms of quality, safety, patient experience and use of resources.

Performance against these key performance indicators have been regularly monitored, a number of which are reflected above and have been used when reporting progress to the ULHT Board. Moving forward the intention is to present them in the form of a reporting dashboard.

The reason for the length of stay reduction is multifactorial. It starts with pre-operative optimisation of the patient, improved practices during the intra operative/pre-operative period, and the post-operative support being robust.

The improved length of stay is managed by good and improved education of the patient, enhanced recovery protocols, and post-operative Occupational therapist (OT) and Physiotherapist (PT) support. All this is more effective if the expertise is focused in one area rather than it being thinly distributed around all the sites in the trust. This was made possible by the hot (emergency/unplanned non-elective care) and cold (elective/planned care) split reconfiguration. It enabled the Trust to focus services in one area thereby enabling improved effectiveness of the service.

The challenge, however, was the requirement of the increased OT and PT personnel but this had been identified and addressed. The more recent challenge has been trying to deliver a similar service over the weekend. This requires extra funding. This could be funded by the savings created by the reduced length of stay and a business case has been developed detailing these benefits.In order to improve

and develop the service further we need to ensure the Physiotherapy and Occupational therapy support staff required for elective surgery are aligned to provide seven day per week cover to support the delivery of high quality clinical outcomes with the minimum length of stay. The proposal would deliver this workforce model and recruitment and retention will improve as the belief is that these posts would be attractive to physiotherapy, occupational therapy, and associated staff as this model of care would support role development and development of specialist interests.
There is additional funding available for a physiotherapy support worker (Band 4). This is required for the service outside of the decision to proceed with the Orthopaedic Proposal. This post will be recruited over the coming few weeks. In addition, a business case has been developed to enhance physiotherapy and occupational therapy support over the weekend period. This would further improve the service, and support the protocol led nurse & physiotherapy discharge process over the weekend. This will further improve patient experience, outcomes, reduced length of stay and efficiency.

The service aspires to develop a community care model with community providers to support earlier discharge and to reduce the length of stay even further.

Staffing of orthopaedic services - could staffing two separate centres for orthopaedic services present challenges to recruitment?

Prior to the implementation of the ULHT orthopaedics pilot in August 2018, the service faced a number of workforce challenges, including high nursing and medical vacancies across the Trust in the Orthopaedic service (elective and non-elective) (c.15% of nursing posts and c.10% of medical posts vacant). The workforce is in an improved position, the Trust has effectively reconfigured the Medical Staff so there is no longer any need for agency staff.

Through the orthopaedics pilot the workforce model has changed and demonstrated an improved staffing position which has been sustained in several areas:

- The consultant on-call model at Grantham has been removed. The on-call function is now provided by a core of middle tier orthopaedic doctors and consultants based at Pilgrim and Lincoln (hot-sites). The receiving sites alternate on a daily basis.
- The middle tier and consultants who work at Grantham for orthopaedics are now part of the ULHT wide (Lincoln, Pilgrim and Grantham Hospitals) orthopaedic rota.
- The number of orthopaedic junior doctors has reduced at Grantham from 7 to 3 with effect from April 2020.
- Orthopaedic consultants now operate across multiple sites as part of the ULHT wide orthopaedic team.
- The pilot workforce model has successfully removed all orthopaedic agency doctor usage ULHT wide. Before the pilot, agency doctors were used at all levels of orthopaedic medical staff.
- The current workforce in the pilot model still carries one consultant vacancy, two middle tier vacancies and two junior doctor vacant posts, however all these vacancies are covered through the new workforce model without the need to bring in agency doctors.

This positive impact in relation to the orthopaedic workforce was set out in the Pre-Consultation Business Case.

Following a review of the change proposal by the East Midlands Clinical Senate, who recommended the Lincolnshire health system progress with the proposed change, the Clinical Senate recommended that Health Education England were involved early in the process with regards to the training experience of junior surgeons.

The pilot has shown no detriment with regards to middle tier training because when a surgeon from Lincoln or Pilgrim goes to Grantham they also take their middle tier with them to give that exposure. The view is this is better for training as ULHT is cancelling fewer patients and trainees are seeing more patients. Junior doctor training hasn't changed.

This has created a stronger more robust workforce, the Trust, having effectively reconfigured the medical staff, now has no requirement for agency staff to regularly fill vacant positions.

The issues around staff recruitment and retention needs to be addressed rather than cutting local services.

This is a short-term contingency plan to cope with deep rooted problems not being addressed by NHS and governments – beds, staff recruitment and retention and quality of care.

Prior to the pilot in orthopaedics, where a 'hotter' (emergency/unplanned non-elective care) and 'colder' (elective/planned care) site model was trialled, analysis showed that approximately 30% of planned orthopaedic patients (circa.900 patients) had their activity cancelled every year. Around half of these (circa.450 patients) had their surgery cancelled on the day. On average, around 10 patients each month had their surgery cancelled on the day due to a lack of beds. Cancellation of surgery at any time leads to poor patient experience and satisfaction, moreover, being cancelled on the day of surgery is extremely distressing for patients and their families.

A mismatch between elective capacity and demand across ULHT means patients are already treated at hospital sites that may not be their closest geographically or choose to go to the independent sector (over 3,000 per year) to access elective orthopaedic services.

Patients going to the independent sector, in or out of county, for elective orthopaedic surgery has financial implications for the health system as a whole as funding allocated to the Lincolnshire Clinical Commissioning Group is not being spent on local NHS services.

The new NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate 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.

ULHT volunteered to be involved with the national Getting It Right First Time (GIRFT) 'hot and cold site pilot' given the high level of patient benefits and improved clinical outcomes which best practice evidence suggests could be achieved. A hot and cold site model refers to the undertaking emergency/unplanned non-elective (hot) activity at a different site to elective/planned (cold) activity. The Trust was part of Phase 2, which included three other trusts (King's College London, East Kent and Royal Cornwall).

We have seen a significant reduction in length of stay, reduced on the day cancellations due to bed issues to zero, and supported the introduction of new techniques such as partial knee replacements, keyhole surgical approach to hip replacements and day case primary joint replacements. There has been no reduction to service, the service has been appropriately reconfigured to support best practice and improved care for patients.

Ensuring staff are involved in any ongoing consultation

Staff within ULHT were engaged in face to face consultation groups in August 2018, some running until late at night to discuss all the challenges that would be faced. All issues were discussed, and agreements reached prior to the pilot implementation. Staff agreed with the pilot.

Following the consultations prior to the start of the pilot, staff had the opportunity to feedback any further ideas or concerns to the Medical and management team.

Whilst there has been on-going engagement throughout the pilot, the changes are well received, and supportive. The plan going forward is a targeted piece of work looking at staff satisfaction.

Patients should be provided with their choice of provider at point of referral

Patients are given a choice of provider at the time a decision is made to refer them to the acute hospital. Some patients choose to go out of area as wait times may be shorter or they prefer to receive their care at a different hospital. The choice is for an alternative NHS acute provider or an independent sector provider. The referral may be made direct or via a physiotherapy service at the point where a referral to secondary care is required. Patients will continue to be offered a choice of provider, however if this proposal is approved the choice of hospital site for patients referred to ULHT will be more limited.

Concerns whether Grantham will be able to cope with increased demand and the impact on neighbouring health systems and use of the independent sector

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.
The pilot has demonstrated that Grantham site has the capacity to undertake this work. 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. The Grantham site is investing in two new modular laminar flow (suitable for orthopaedic surgery) theatres, which are due to open in July 2022. The Grantham site also has bed capacity and day ward capacity to undertake this activity.

A mismatch between elective capacity and demand across ULHT meant that prior to the pilot patients were sometimes treated at hospitals that may not be their closest geographically site or chose the independent sector to access elective orthopaedic services.

Patients going to the independent sector, in or out of county, for elective orthopaedic surgery also has financial implications for the local health system as funding allocated to the Lincolnshire Clinical Commissioning Group is not being spent on local NHS services.
The orthopaedic pilot has demonstrated:

- Reductions in the number of patients who have their planned orthopaedic surgery cancelled due to a lack of beds

- Care provided in line with national best practice and care standards
- A reduction in the amount of time patients wait for their planned orthopaedic surgery
- A reduction in the amount of time patients spend in hospital after their planned surgery
- An improvement in patient satisfaction and experience
- A reduction in the number of patients receiving their care in the private sector, funded by the NHS

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.

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).

Patients are given a choice of provider at the point of referral either by the GP direct or through the Physiotherapy referral process. Patients make their choice for many reasons such as waiting times or proximity of the provider to their home. It is anticipated that if the proposal is approved the improvements in efficiency and reduced cancellations will improve the patient experience and more patients will choose to have their surgery at ULHT.

The Lincolnshire CCG (Clinical Commissioning Group) covers a large geographic area and many patient's local hospital will fall outside of the natural ULHT catchment area. On this basis some patients choose to be treated at other NHS Acute providers NHS funded independent providers.

Communication between care facilities, including hospital departments and GPs, to ensure timely flow of information on patient care and treatment

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. Any x-rays are available automatically through PACS (Picture Archiving & Communication System) with images and reports available to be viewed by all clinicians for each patient on all the systems used across the health system. There are plans across the system for further integration of information systems to ensure even greater sharing of information.

Working with and learning from private hospitals

There is continuous learning from Private Hospitals and a number of surgeons at ULHT work in the independent sector. The independent sector provides elective activity separately from the non-elective activity. This ensures that the elective work is not impacted by unplanned emergencies. It is more controlled and, in this way, the model at Grantham hospital is a similar elective only model. The private hospitals provide out of hours ward cover through a resident medical officer. A Junior Doctor covers the orthopaedic ward at the Grantham hospital. This is similar to the resident medical officer model that is used within the private sector.

Negative impacts on quality and timeliness of emergency orthopaedic care, with increased pressure on services at Lincoln County Hospital, as well as on the ambulance service if more or longer transfers needed

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 have been admitted to Grantham and District Hospital for unplanned orthopaedic surgery would receive care at an alternative hospital. These patients would receive the specialist input they need at the right time, in the right setting.
This modelling estimated that of those receiving unplanned orthopaedic surgery at an alternative hospital site, none will travel more than 60 minutes by car for their surgery, the threshold agreed by the local health system for this type of activity.

The current trauma and orthopaedic serviced (including fracture clinics) has been running since 2018 as a pilot and therefore is now embedded with positive patient feedback and has been developed with involvement from service users. The impacts on the service in the Trust is mostly positive during the pilot.

There was more pressure on the emergency orthopaedic theatre lists at Lincoln and Boston. However, this was offset and theatre time freed up by the elective orthopaedic care going to Grantham and Louth. As such the Lincoln and Boston sites have been able to absorb the increase in non-elective demand.

It should also be noted that under the proposed changes, Grantham and District Hospital would still treat:

- 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 subsequent transfer after assessment)
- Children's suspected fractures – if confined to one area and child haemodynamically stable (may require subsequent transfer after assessment)

Prior to the start of the orthopaedic pilot a consultation process with staff was undertaken. There was some staff feedback that Grantham should have trauma lists on a weekend and slots over the weekdays. The pilot model was changed to include these suggested lists (no non-elective lists were

originally planned for the pilot). At the start of the pilot, the orthopaedic service therefore included trauma lists in place on a Saturday and Sunday and a designated trauma slot on an elective list each weekday. During the first six weeks of this model, only one patient required an operation over the weekend. This was a minor case (removal of a foreign body) and therefore the provision of weekend trauma lists and weekday trauma slots at Grantham was not necessary and they were ceased. Presently the orthopaedic service has found that there is capacity to accommodate the planned minor trauma cases that are appropriate for the Grantham site.

With respect to the ambulance service, as well as confirming their support, the East Midlands Clinical Senate recommended that the service should work with EMAS to ensure the impact on emergencies is factored in.

When the pilot started, a dialogue was had with East Midlands Ambulance Services NHS Trust (EMAS) about fractured neck of femur and 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 with EMAS during this pilot and there are no anticipated issues going forward.
Given the existing exclusion criteria and the acuity of patients who would no longer be seen at Grantham and District Hospital under the change proposal, it was identified most are likely to travel by ambulance to an alternative site and therefore their travel time would be less than 45 minutes. The independent analysis completed by ORH set out above supports this, with an average travel time to a hospital other than GDH from the wards closest to it being 00:41:29 (maximum average travel time from a ward 00:50:58).

Two key foundations of the proposed care model are to:

- Make sure patients get to the definitive treatment, first time whether that be Grantham 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 receiving their operation when it is booked with a minimal chance of being cancelled and the improved outcomes associated with this are seen to out-weigh the potential increases in ambulance travel time.

The proposal includes no provision for unforeseen emergencies rising from routine surgery and when patients are older and/or frail patients need high dependency care. Assurance is needed that safe immediate care and transfer will be available. Where will such patients receive support during recovery?

During the review of the change proposal by the East Midlands Clinical Senate the question around on-call arrangements and clinical responsibility was posed.
Under the pilot the on-call pattern at Grantham is hospital at night which looks after all patients. There is a Junior-tier (Core Trainee level) 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 patient 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.

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.
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.

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

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 comorbidities will have their operation planned for the Lincoln or Boston sites where there is suitable post-operative care and access to the ICU.

Conclusions and actions

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

- Performance against these key performance indicators have been regularly monitored, several of these are reflected above and have been used when reporting progress to the ULHT Board. Moving forward the intention is to present them in the form of a reporting dashboard.

- 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.

- At the start of the orthopaedic pilot weekend trauma lists and weekday trauma slots lists 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 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.

- 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.

- 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.

- 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.

- 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 SystemOne.

- 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 form unplanned work and the medical cover required to support patients out of hours is a similar model to that used on the Grantham site.

- 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.

- 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.

- 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.

- 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.

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

- 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.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Change proposal(s)	**Orthopaedic Services** *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*
Common theme	Access
Feedback working group	Mark Lacey – Managing Director Surgery Kulandaivel Sakthivel – Consultant Orthopaedics Catherine O'Dwyer – Divisional Clinical Director for Surgery Catherine Capon – Deputy Divisional Nurse Surgery Lisa Pim – Divisional Nurse Surgery
Date feedback working group signed off response	Version 4.1 dated 22 April 2022 Signed off – ML
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	28 April 2022

Orthopaedic proposal consultation feedback - Access

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of orthopaedic services:

- 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.

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to orthopaedics there was feedback in support of the proposals relating to access in terms of the benefits of access to a specialist centre of excellence that would outweigh increases in travel time.

Feedback in opposition to the proposal relating to access put forward that all acute hospital services / orthopaedic surgery (planned and unplanned) should be delivered at all sites close to patient's home – or specialist orthopaedic services should be rotated between sites.

There was also a common view that reassurance was required in relation to pre-operative assessments and post-operative care (including outpatients and diagnostics), as well as related services such as fracture clinics, would be available at local hospitals or in the community.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the facilities at Grantham and District Hospital feedback through the public consultation. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Benefits of access to a specialist centre of excellence

In August 2018 ULHT commenced a pilot on the way it provided orthopaedic services, which focussed on creating a 'centre for 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.

This 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 (national Getting It Right First Time programme – GIRFT), and input from local acute, primary and community based health professionals. When this model was presented to the East Midlands Clinical Senate the panel recommended that the Lincolnshire STP (Sustainability & Transformation Partnership) proceeded with it.

Due to the Covid-19 pandemic the pilot ended in February 2020, however up to this point the pilot showed very positive results (the detail of this was set out in the Pre Consultation Business Case in the orthopaedics chapter).

An overview of the benefits of the orthopaedics pilot is set out below:

- Reduced trust-wide cancellation rate on the day due to a lack of beds (from 10 to 3 patients a month on average) – cancellations on the day due to a lack of beds reduced to 0 at Grantham Hospital
- Reduced waiting times for operations / procedures
- Improved overall patient experience and satisfaction, including reduced length of stay
- Reduction in average length of stay at Grantham Hospital from 2.7 days to 1.7 days
- ULHT performing significantly better than peer trusts and national median for primary total hip replacement length of stay
- Increased theatre utilisation at Grantham Hospital
- Length of stay at Grantham Hospital for primary knee replacements has outperformed all other pilot Trusts within the GIRFT programme
- Reduced number of patients going out of county to receive treatment
- Established a centre of excellence – thereby improving patient care and increasing appeal to doctors and nurses to work at the site
- On-call is reduced and surgeons spend more time operating and treating patients making jobs more attractive
- The Orthopaedic pilot workforce model has successfully removed all agency and doctor usage ULHT wide

These benefits were set out in detail in the Pre Consultation Business Case (PCBC) and 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.

All acute hospital services / orthopaedic surgery should be delivered close to patient's home – or specialist orthopaedic services should be rotated between sites

The NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate 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.

The current orthopaedic pilot which is being proposed to make permanent, very much follows this national model. This 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 (national Getting It Right First Time programme – GIRFT), and input from local acute, primary and community based health professionals. When this model was presented to the East Midlands Clinical Senate as part of the options appraisal process the panel recommended that the Lincolnshire STP proceeded with it.

Prior to the orthopaedic pilot starting, which would be made permanent under the service change proposals consulted with the public, 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.

The model of delivery for orthopaedics faced a number of challenges:

- Declining performance against 18-week target
- Limited separation of elective and non-elective activity makes attainment/sustainment of 18-week target a challenge
- There is a need for ring fenced orthopaedic beds across all sites, given the high volumes of medical emergencies all year round is placing significant pressures on elective beds
- On average 10 patients a month cancelled on the day due to a lack of beds
- Distance between sites and the poor transport infrastructure limits opportunities for economies of scale and networked working
- Over 3,000 patients each year receive their procedure in the independent sector (funded by the NHS)
- NHS Long Term Plan supports split of urgent and planned care work on different sites
- High medical (c.10%) and nursing (c.15%) vacancies exist in Orthopaedics

The proposed model for orthopaedics, which is being piloted, was identified as the preferred option for this specialty following the completion of an options appraisal process. Options were included in the original long list of options that was developed at the start of this appraisal process that kept the provision of all orthopaedic services at each of ULHT hospital sites 'as is'.

However, following an assessment of the long list of options by a Lincolnshire Clinical Summit held on the 1st February 2018, using a criteria focussed on Quality, Access, Affordability/Sustainability and Deliverability. The proposal of no changes to the current configuration of orthopaedic services did not progress to the short-list for further analysis as this group of clinical leaders did not see the current situation improving without change.

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, 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, therefore we 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 the acute site and this has the disadvantage of the high cancellation rate.

As we are able to concentrate services on the one site. This helps us immensely improve services. The results of the pilot are testament to that belief and supports us to create this 'Centre of Excellence' at Grantham. This will help the people of Lincolnshire receive this high quality service.

Pre-operative assessments and post-operative care, as well as related services such as fracture clinics, would be available at local hospitals or in the community

Outpatient clinics prior to the introduction of the orthopaedic pilot were held at Lincoln, Pilgrim, Grantham and Louth Hospitals, with further outpatient lists held at John Coupland Hospital, Gainsborough.

During the pilot and under the proposed service change it was made explicit that outpatient clinics would remain across all sites (ULHT and others). This is set out in the Pre Consultation Business Case, it remains the case and there are no plans to change this.

Opportunities also exist through 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. This form is filled in either by the patient directly or using a telephone assessment with a health care support worker. The questions are designed to identify the patients' anaesthetic and operative risk and therefore determine what level of assessment is required pre-operatively. Depending upon the scoring the patient will either require no further assessment, a telephone assessment with a registered nurse or a face to face assessment or a face to face assessment with an anaesthetist. The need for this has been accelerated due to COVID and most assessments are done over the phone now.

In addition, eConsultations and video consultations between hospital sites and between specialists and the patients' home for follow-up care can support local access. The Lincolnshire health system's capability in this has been accelerated through COVID-19 as more virtual clinics have been run than 'pre-covid'.

Pre-operative care, pre-operative assessments and post-operative care is provided locally and is still in practice at the four hospital sites, including Louth for follow up and initial consultations. Virtual consultations are available so make it now even more accessible for patients, there are no plans for this service to change.

Under the proposed changes, Grantham and District Hospital would still treat:

- 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 subsequent transfer after assessment)
- Children's suspected fractures – if confined to one area and child haemodynamically stable (may require subsequent transfer after assessment)

There are also no planned changes to the provision of a fracture clinic at Grantham and District Hospital, however in this and all fracture clinics across Lincolnshire there is increased opportunity for virtual fracture clinics and telemedicine. Fracture Clinics are undertaken at all of the four hospital sites, and new fracture patient clinics are undertaken as part of the orthopaedic on-call provision.

The service is more centralised at Lincoln and Boston due to these being the 2 hot sites (emergency/unplanned non-elective care) and for the patients who require surgery. This improves the patient care and availability for the service. Grantham and Louth will still have elective surgery available.

Conclusions and actions

- 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.

- 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.

- Rotating the Elective IP and Day Case Orthopaedic Services provision across the sites would spread the service and resources too thin and therefore we would not be able to provide the best quality of care at any of the sites. Undertaking elective orthopaedic activity on acute (hot) sites significantly increases the risk of delays and cancellations and a poor patient experience.

- 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.

- 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

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 1.0: 08 April 2022

Change proposal	**Orthopaedics** *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* **Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre* **Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Conditions that would be treated at 24/7 Grantham and District Hospital UTC
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care Yvonne Owen - Senior Partner Minster Medical Practice LCHS David Baker - GP Neil Scott - EMAS
Date feedback working group signed off response	Version 1.0: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022 and 28 April 2022

Orthopaedics, Urgent & Emergency Care and Acute Medicine proposal consultation feedback – Conditions that would be treated at 24/7 Grantham and District Hospital UTC

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, three of which related to the provision of services from Grantham and District Hospital:

- 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;
- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre; and
- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to Grantham and District Hospital there was feedback in support of the proposals relating to:

- Acknowledgement that evening and overnight visitors to the A&E departments at Lincoln County Hospital or Peterborough City Hospital could be treated at a more local UTC
- 24-hour access to walk-in UTC might relieve pressure on Lincoln County Hospital's A&E, as well as benefiting those living in and near to Grantham if the majority of them would not need to travel to Lincoln to receive out of hours urgent care
- Recognition of issues such as Grantham's growing and aging population and travel to Lincoln County Hospital, for respondents and residents that supported the proposals they represent a reasonable 'real world' compromise to these issues that could be mitigated against, not least by ensuring that local residents are made fully aware of what services a UTC would be able to provide

Some concerns expressed about the proposal, in terms of the conditions that would be treated at the 24/7 UTC, 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:

- Reassurances that a 24-hour Urgent Treatment Centre would be appropriate for the vast majority of patients requiring out-of-hours assessment and treatment and might therefore lead to shorter waiting times and less pressure on A&E services in other locations in Lincolnshire, were accepted by many of those who agreed with the proposals.

- There was also recognition that most people who would require full A&E services, such as trauma patients, would in any case be transported by ambulance to the nearest appropriate site.

In addition, public feedback identified that it is vital that a UTC at Grantham and District Hospital should always operate as a walk-in service, rather than requiring people to contact NHS 111 first to ensure that people use of the service and do not travel elsewhere unnecessarily.

Other feedback identified that NHS 111 needs to be fully informed of who they can send to Grantham instead of an A&E department further afield, and that ambulances are 'allowed' to transport patients to Grantham directly. Some people were also worried that opening times would drop later to 12 hour opening from 24/7.

Feedback in opposition to the proposal linked the proposal for orthopaedic surgery to changes in urgent and emergency care provision.

Concerns about quality of care provided at A&E departments at Lincoln County Hospital and Pilgrim Hospital in Boston, as well as the long wait times some respondents had experienced (which might become worse without A&E services at Grantham and District Hospital) were expressed by those in support and opposition of the proposal.

In addition to this feedback from the consultation, a member of the public submitted information that they felt showed statements in the public consultation that Grantham and District Hospital did not have a Level 1 A&E from 2007/08 as inaccurate, as every level of severity across a wide range of critical conditions were treated and stabilised at the hospital. A question was posed around 'how does this compare to the level of service that would be provided from the proposed Urgent Treatment Centre?'.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the conditions that are currently treated at Grantham and District Hospital and those that would not be if the proposed changes were implemented. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

It is due to these clinical interdependencies that the feedback set out above relating to Urgent and Emergency Care and Acute Medical beds has been brought together and considered as one.

Orthopaedics

Current situation

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 Hospitals Lincolnshire NHS Trust (ULHT) has been part of a national orthopaedic pilot to look at how service quality and patient outcomes could be improved.

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.

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.

The Pre Consultation Business Case (PCBC) that was made publicly available at the start of the public consultation described this situation in more detail.

Proposed changes

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.

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.

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 (See Appendix 1 of this document).

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

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)

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 proposed 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.

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.

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 Hospitals Lincolnshire NHST Trust and Lincolnshire Community Health Services NHS Trust.

Urgent and Emergency Care and Acute Medicine

Current situation

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.

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.

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.

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.

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 (see Appendix 2). 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.

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.

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).

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.

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.

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.

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.

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.

<u>Proposed changes</u>

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.

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.

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)

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.

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.

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 Hospital site.

Within the PCBC the Grantham and District Hospital Acuity Model to underpin the proposed changes was outlined as follows:

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.

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 the Appendix of the PCBC (see Appendix 1 of this document).

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 proposed 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.

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.

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 Hospitals Lincolnshire NHST Trust and Lincolnshire Community Health Services NHS Trust.

Reassurances that a 24-hour Urgent Treatment Centre would be appropriate for the vast majority of patients requiring out-of-hours assessment and treatment and might therefore lead to shorter waiting times and less pressure on A&E services in other locations in Lincolnshire

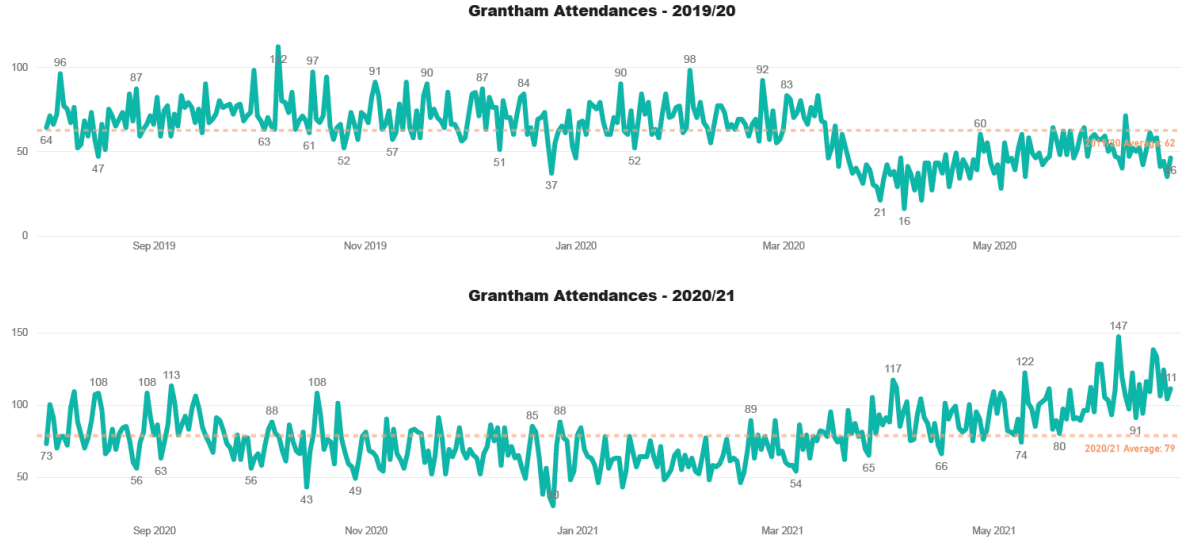
Activity modelling completed to assess the change proposal estimated that with the proposed change and refinement of the exclusions criteria, around 3% of those patients currently attending the Grantham and District Hospital A&E. This is equivalent to 2 patients a day, on average. These are patients 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.

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.

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 Hospital in response to the pandemic, the temporary changes do provide useful insights.

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.

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.



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.

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

Conclusions and actions

- 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 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.
- However, it is important to note that having the skills and experience to manage patients who initially attend with this level of acuity, as well as those who attend with a lower acuity but deteriorate to this level whilst on site, before transferring does not define the Grantham and District Hospital A&E department as 'Level 1'. This has been confirmed by independent external reviews.
- Under the proposed service change for a 24/7 Urgent Treatment Centre (UTC) at Grantham & District Hospital in place of the current A&E department, the UTC would be 24/7, walk-in and 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.
- Activity modelling completed to assess the change proposal 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. This is equivalent to 2 patients a day, on average. These are patients who require onward transfer for immediate specialist care. If the proposed change is implemented the activity modelling will be kept under ongoing review.
- Those additional patients who would be seen at a different site under the proposal 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. The refined exclusion criteria that would underpin the proposed 24/7 UTC at Grantham and District Hospital if it went ahead was included in the PCBC.
- 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. If the proposed change is implemented this analysis will be kept under ongoing review.
- 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. This will include 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.
- The communication plan will be rolled out using NHS Lincolnshire CCG's well established communication channels as well as those of all local health and care providers, including ULHT and LCHS.
- In addition, 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 proposed 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.

Appendix 1

United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust

Grantham and District Hospital
Urgent Treatment Centre, Ambulatory Care Unit and Emergency Assessment Unit exclusion criteria

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital Urgent Treatment Centre, Ambulatory Care Unit & Emergency Assessment Unit

- News ≥ 7 WITH frailty score of < 5
- A patient requiring immediate airway management and/ or resuscitation
- Status epilepticus
- Fast Positive Stroke / high risk TIA
- STEMI
- Acute coronary syndrome- Ongoing ischaemic chest pain with 1mm ST depression in more than one limb lead or in two or more consecutive chest leads
- CONFIRMED NSTEMI- Once diagnosis made In UTC or Ambulatory Care- transfer to LCH
- Post cardiac arrest
- Significant bradycardia < 40bpm, 2nd or 3rd degree AV block, Ventricular tachycardia
- Suspected acute heart failure WITH frailty score < 5
- Reduced conscious level (not alert) – Glasgow Coma Score <13- or PU on AVPU WITH frailty score < 5
- Acute respiratory distress with an oxygen saturation < 91% on room air WITH frailty score < 5 "unless" the patient has known significant chronic lung disease
- Gastro-intestinal haemorrhage (fresh blood or melaena).
- Severe abdominal pain and acute abdomen (refer patient directly to Lincoln County.)
- A female of childbearing age with lower abdominal pain
- A male with testicular pain
- A patient with suspected AAA or ischaemic limb needs admission to the on-call vascular unit (Pilgrim Hospital)
- All Obstetric and Gynaecological patients
- Neutropenic sepsis
- Patients requiring dialysis
- Patients with renal transplants
- Ophthalmological emergencies e.g. acute glaucoma, trauma
- All Major trauma is excluded from this site in line with the East Midlands Trauma Network Triage Tool, including all suspected femoral fractures.
- Fractures/ dislocations with evidence of distal neurovascular compromise. See over page for trauma that can be treated on the Grantham Hospital site
- Open lower limb fractures of femur, tibia/fibula, ankle or forefoot

Note: Patients who are house bound OR from a nursing/care home OR where RESPECT form has limitations of care in place that would make escalation of care inappropriate should normally continue to be brought to Grantham for assessment for medical conditions

Paediatric Exclusions

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital Urgent Treatment Centre

- Children with a POPS score of 5 or more
- Children requiring immediate airway management and/ or resuscitation
- Children requiring Paediatric assessment / Review
- Children with biphasic stridor
- Children with DKA
- Children with Status epilepsy
- Children who have self-harmed
- Children requiring Mental health assessment

Trauma that can be treated in 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 subsequent transfer after assessment)
- Children's suspected fractures- if confined to one area and child is haemodynamically stable(may require subsequent transfer after assessment)

Appendix 2

Count of PASID		Years	DateofObservation
		2017	Grand Total
LocationDesc	newsscore	Nov	
A&E	5	35	35
	6	34	34
	7	22	22
	8	23	23
	9	9	9
	11	4	4
	14	1	1
A&E Total		128	128
Grand Total		128	128



United Lincolnshire Hospitals NHS Trust

2014/15 - Total and Diagnosis description of patients admitted to Grantham Hospital wards as 'Emergency'

FIN_YEAR	HOSPITAL_AT_START	WARD_CODE_AT_START	ADMISSION_METHOD	DIAG_PRIMARY_NAME
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Lobar pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Viral infection, unspecified
2014/15	Grantham Hospital	GK-HDU	Emergency - GP	Lobar pneumonia, unspecified
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Infection following a procedure, not elsewhere classified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Other giant cell arteritis
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Left ventricular failure
2014/15	Grantham Hospital	GK-2	Emergency - GP	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Effusion of joint Lower leg
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Unspecified acute lower respiratory infection
2014/15	Grantham Hospital	GK-1	Accident and Emergency	Other and unspecified abnormalities of gait and mobility
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Type 2 diabetes mellitus Without complications
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Cellulitis of other parts of limb
2014/15	Grantham Hospital	GK-HDU	Accident and Emergency	Congestive heart failure
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Dyspnoea
2014/15	Grantham Hospital	GK-GAEC	Accident and Emergency	Chest pain, unspecified
2014/15	Grantham Hospital	GK-GKSU	Accident and Emergency	Cerebral infarction, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Mental and behavioural disorders due to use of alcohol Acute intoxication
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Chronic obstructive pulmonary disease with acute lower respiratory infection
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Acute transmural myocardial infarction of anterior wall
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Sepsis, unspecified
2014/15	Grantham Hospital	GK-CARD	Accident and Emergency	Acute myocardial infarction, unspecified
2014/15	Grantham Hospital	GK-2	Emergency - GP	Urinary tract infection, site not specified
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Pleural effusion, not elsewhere classified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Congestive heart failure
2014/15	Grantham Hospital	GK-GAEC	Accident and Emergency	Hypotension due to drugs
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Gastro-oesophageal reflux disease without oesophagitis
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Other specified soft tissue disorders Lower leg
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-CARD	Accident and Emergency	Other ill-defined heart diseases
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Open wound of other parts of head
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Poisoning: 4-Aminophenol derivatives
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Multiple fractures of ribs closed
2014/15	Grantham Hospital	GK-1	Accident and Emergency	Urinary tract infection, site not specified
2014/15	Grantham Hospital	GK-1	Emergency - GP	Sepsis, unspecified
2014/15	Grantham Hospital	GK-6	Emergency - GP	Cellulitis of other parts of limb
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Other and unspecified abdominal pain
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Chronic obstructive pulmonary disease with acute lower respiratory infection
2014/15	Grantham Hospital	GK-1	Emergency - GP	Acute myocardial infarction, unspecified

Note: This is the first page of 142

Public consultation on four NHS services

Addressing common themes, alternative options and additional information

Version 1.1: 08 April 2022

Change proposal (s)	**Orthopaedics** *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* **Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre* **Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme *Note: the two themes arising across different change proposals have been considered together given the interdependencies*	Full A&E and hospital service provision at Grantham and District Hospital
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care David Baker - GP Yvonne Owen - Senior Partner Minster Medical Practice LCHS Neil Scott - EMAS
Date feedback working group signed off response	Version 1.1: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022 and 28 April 2022

Orthopaedics, Urgent & Emergency Care and Acute Medicine proposal consultation feedback –

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

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, three of which related to the provision of services from Grantham and District Hospital:

- 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;
- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre; and
- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For many respondents, a 24-hour UTC was viewed as preferable to the current limited services A&E department operating from 8.00am-6.30pm

The vast majority of those who rejected the proposals for a 24-hour UTC at Grantham and District Hospital did so, not on the basis that they favour the status quo of current service provision, but rather because they want a full, 24/7 A&E department in place of the current 8:00am to 6:30pm service. Feedback included:

- Grantham and District Hospital should have a full 24/7 A&E Department - Any changes to acute services at the hospital in Grantham were viewed as unacceptable and, in many cases, seen as a continuation of under-investment and a process of service reduction at Grantham and District Hospital over a period of a number of years
- Services at Grantham and District Hospital need to be protected and expanded/more services delivered with reference made to emergency orthopaedic surgery and stroke services in particular
- Lack of trust in the case for change and strong concern the proposal is another step in a deliberate 'downgrading' of Grantham and District Hospital
- Proximity of the A1, major railway links and airports increases the risk of major incident that might overwhelm remaining A&E services without Grantham and District Hospital being able to provide support
- The strength of feeling from some members of the public was further evidenced by the submission of two petitions with a combined total of 1,818 signatures or online indications of support calling for a 24-hour A&E department at Grantham and District Hospitals.

- Proposals do not take into account or properly address the growing and ageing population in Grantham – The variety of patient ailments, growth of Grantham and large rural catchment are patients deserve a better quality of service than the UTC offers
- Grantham and District Hospital should be a fully services hospital with acute medical beds
- Concerns about negative impacts on the quality of care being provided, and the potential for increased pressure on other hospital sites

In the contest of the above alternative options were put forward in the consultation feedback:

- Current part-time limited A&E department at Grantham and District Hospital to be replaced by (or 'restored to') a full Type 1 Accident and Emergency Department
- A&E services should continue to be offered at Grantham and District Hospital during the day, with a UTC in operation only overnight
- Lincoln and Pilgrim A&E departments are often stretched and prolonged ambulance handover delays. ULHT should build the A&E capabilities at Grantham to cut transfer times, reduce risk for patients, make it attractive to staff.
- Maintain A&E services at Grantham and provide dedicated, separate walk in services, run by nurse specialists, in addition to A&E services for emergency / ambulance admissions in Lincoln and Boston.

A mitigation was also put forward which was to train additional Advanced Care Practitioners (ACPs) to compensate for the shortage of consultants.

The purpose of this paper is to provide a concise summary of the key evidence-based points relating to provision of A&E services at Grantham and District Hospital as well as those services with clinical interdependencies required to deliver a 'full service', to ensure conscientious consideration of the feedback received during the public consultation.

It is due to these clinical interdependencies that the feedback set out above relating to Urgent and Emergency Care and Acute Medical beds has been brought together and considered as one.

This paper reflects and builds upon the significant scrutiny that has been placed upon the A&E department at Grantham Hospital over recent years, including that by the Independent Reconfiguration Panel (IRP) and the East of England Clinical Senate.

A&E department provision in Lincolnshire

When considering the provision of Accident and Emergency (A&E) departments it is important to consider the definition of the services.

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

- Type 1 – 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.

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.

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.

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 & 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).

Major trauma cases go to Queens Medical Centre in Nottingham.

The Grantham and District Hospital A&E department 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 & District Hospital has for some time only dealt with a limited range of presenting conditions.

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.

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.

In addition to the three A&E departments provided by ULHT, six Urgent Treatment Centres (UTC) are provided by Lincolnshire Community Health Services NHS Trust (LCHS).

These are located at:

- Lincoln; co-located with the A&E department at Lincoln County Hospital
- Boston; co-located with the A&E department at Pilgrim, Boston Hospital
- Louth
- Skegness
- Gainsborough
- Spalding

The staffing challenge faced by A&E departments

Nationally

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)[1], 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[2].

In one of its reports into the challenges facing A&E departments the Kings Fund[3] highlight that the Royal College of Emergency Medicine identify that emergency medicine has a high attrition rate from doctors in training, high early retirement rates for experienced clinicians, and significant reliance on temporary locum clinical staff. The report goes on to identify that in a General Medical Council survey in 2020, nearly three-quarters of emergency medicine trainees rated the intensity of their workload as heavy or very heavy, substantially more than any other specialty.

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.

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

[1] Health Education England, NHS England, NHS Improvement and RCEM (2017) *Securing the future workforce for Emergency Departments in England*
[2] Health Education England (2017) *Facing the facts, Shaping the Future: A draft health and care workforce strategy for England to 2027*
[3] The Kings Fund *What's going on with A&E waiting times?*

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.

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.

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.

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.

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

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.

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.

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).

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.

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

Locally

In 2016, in light of the pressures being faced by ULHT's A&E departments as a whole (a national shortage of emergency medicine doctors, insufficient doctors in training choosing to work at ULHT, an increasing reliance on locums and difficulty in securing the number of locums required to fill gaps in rotas consistently), the ULHT Board agreed to implement a temporary overnight service closure at Grantham & District Hospital to support the staffing at Lincoln County and Boston, Pilgrim A&E departments, as releasing middle-grade doctors to work at these two sites would provide safer services for the Lincolnshire population as a whole.

At the time there were four substantive consultants in post out of 15 funded whole time equivalent (wte) posts, with vacancies being filled by locums. Furthermore, there were 11.6 wte middle-grade doctors against the 28 funded posts. The reduced emergency staffing levels, combined with a reduction in skill mix of substantive staff, compromised the on-going provision of safe 24 hours, seven days per week A&E care across three sites. Although efforts were continuing to recruit additional staff, and various steps had been taken to mitigate staff shortages it was felt further action was required.

In August 2016 an initial three-month overnight closure of the Grantham and District Hospital A&E Department was introduced by ULHT taking it from a 24/7 service to 09.00-18.30 seven days a week. The closure of the A&E was initially between 18.30 and 09.00. The exclusion criteria did not change with the changes in opening times.

The Lincolnshire Health Scrutiny Committee concluded that the closure of A&E services between 18.30 and 09.00 at Grantham and District Hospital represented a substantial variation in the provision of health services in the area. The Committee decided that the matter should be referred to the Secretary of State, who passed the matter onto the Independent Review Panel (IRP).

Since the review by the East Midlands Clinical Senate, ULHT has continued to work hard to improve medical staffing levels in its A&E departments and had significant success with a wide range of initiatives (including securing significant external clinical support to coordinate its recruitment programme, refreshing its offer to new recruits, revising the approach to in-house training and rotations, reviewing relocation packages and providing a highly supportive onboarding programme), however recruitment continues to be a real challenge both locally and nationally.

The current staffing position at ULHT is described later in this paper.

Independent clinical advice on the closure of Grantham and District A&E department over night

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 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 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 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 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.

The IRP concluded that in the interests of safety the A&E service at Grantham 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 Hospital and more widely across Lincolnshire.

Following the referral to the IRP, ULHT continued its effort to recruit staff and the closure of A&E services between 18.30 and 09.00 at Grantham Hospital was reviewed. A review in February 2017 concluded that the threshold to re-open the service full time had not been met but acknowledged there had been significant improvement in staffing levels.

To inform the ULHT's Board decision on re-opening the A&E at Grantham and District Hospital, NHS Improvement commissioned a review to allow for an independent, expert, evaluation on the staffing levels across the three A&E departments and recommendations about extending the opening hours of the Grantham A&E departments.

The report produced by the East of England Clinical Senate 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 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.

In addition to the above and in summary the key recommendations coming out of the review from the Clinical Senate panel include:

Recommendation 1:

- The panel does not support the reopening of the 24/7 A&E department at Grantham Hospital on the grounds of potential adverse impact on patient safety at A&E Departments at all three United Lincolnshire NHS Trust Hospitals.
- The panel strongly recommends, on the grounds of patient safety, United Lincolnshire Hospitals NHS Trust Board reconsider its proposal to extend the current A&E service opening hours at Grantham and District Hospital.
- The Panel recommends that the Trust should continue to provide an A&E service at Grantham and District Hospital on the current opening hours of 08.00-18.30, seven days a week until a more definitive long term urgent and emergency care plan was developed and agreed.

Recommendation 2:

- The panel recommends that in order to make it clear for patients and the public the type of service available at GDH 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 GDH in any further model.

Recommendation 3:

- The panel recommended that the Trust should move to a single A&E team with a focus on standardised clinical pathways and processes across the three sites, removing any unnecessary variation and providing enhanced training opportunities.

Recommendation 4:

- The panel recommended that the Trust and CCG have clear alignment with the Lincolnshire STP, developing a system approach to urgent and emergency care, and planned care for patient and the public. The Trust and STP should move to public consultation on an agreed future model as quickly as possible.

Recommendation 5:

- The panel recommended that the United Lincolnshire Hospitals NHS Trust works with the local the CCG and STP to develop an enhanced communication and engagement strategy to ensure that all stakeholders, the public, patients and local elected representatives have an opportunity to input on the development and decision regarding the final model for urgent and emergency care across the Trust’s three sites, and not only for the Grantham site.

- The panel recommends that the communication and engagement strategy develop plans to ensure that any changes to the designation, opening times and pathways related to emergency care provision are clearly communicated with the public, patients, stakeholders and staff both within the STP footprint and with surrounding STP footprints.

Subsequent advice from NHS Improvement in a letter to the CEO of ULHT following the review by the clinical senate stated:

"The Report produced following the review was detailed and outlined 4 clear recommendations, most notably that the A&E Department at Grantham should remain closed overnight and to not extend the current opening hours. One of the key reasons for the recommendation is on the grounds of patient safety. Due to the ongoing concerns around the delivery of A&E services at Lincoln County and Pilgrim Hospital and specifically the sustainability of your staffing model, NHS Improvement strongly advises that the Trust Board follow the recommendations in the report".

Following consideration of the findings, the ULHT Trust Board agreed to accept the conclusions reached by the East of England Clinical Senate panel, and follow their recommendations, which were supported by NHS Improvement.

Within its report the East of England Clinical Senate panel advised using the Royal College of Emergency Medicine 'rule of thumb' guide for 'Medical and Practitioner Staffing in Emergency Department. Using that guide would indicate that ideally 36 middle-grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover. The number of middle-grades at the time of the review was 22 with a heavy proportion of locums amongst them which meant it was a relatively unstable position.

Current position of ULHT A&E department staffing and requirement to operate 3 'full' A&Es

As previously described 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.

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.

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

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."

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.

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"[4].

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

A&E department clinical interdependencies and scale

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.

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.

The table below provides an overview of the guidance available on the explicit and implicit scale requirements of the core specialties that need to be co-located with a Type 1 A&E, together with an estimate of the additional workforce that would be required in each area to safely and sustainably support an A&E of this type at Grantham and District Hospital. This is in addition to the additional workforce requirement described in the previous section for the A&E department itself.

[4] Goudie, R and Goddard, M. (2011) Centre for Health Economics, University of York, *Review of Evidence on What Drives Economies of Scope and Scale in the Provision of NHS Services, Focusing on A&E and Associated Hospital Services, A report for the OHE Commission on Competition in the NHS*

Guidance	Source	Estimate of additional workforce required
Critical Care / Intensive Care		
Fewer than eight level 3 beds may not be sustainable because of the need for adequate numbers of staff at all times There are no economies of scale in small units and, with limited patient exposure (that is 'case mix'), such units would not be recognised for training by the IBTICM 24/7 intensive care cover by consultants, trained medical practitioner and staff capable of managing an airway in under 3 minutes	Academy of Medical Royal Colleges, 2007	Currently major trauma into Lincoln and pilgrim is stabilised and transferred to major trauma centre. Would need full ITU, number of level 2 and 3 critical care beds and consultants and nursing workforce. ITU trained nurses on a 24/7 rota. Beds for Emergency urology, Gen surg, vascular, head and neck. If 6 beds of each, specialist nurses for each spec would be needed. Consultant cover and on-site cover all those specialties. Stand-by theatre team for each spec for emergency surgery (ODPs, recovery staff, scrub practitioner, consultant) Significant increase in infrastructure for blood provision and for theatre kit and equipment to support a 24/7 full take for anything other than major trauma 5 ITU consultants 12 ITU Nurses This would cover all emergency surgery 'takes' require for a 24/7 A&E.
Acute Medicine		
Consultant lead in acute medicine per site and larger units will require several consultants in acute medicine. All units to have SpRs (ST3) and above 24/7. Multidisciplinary team; min 2 ward rounds per day.	Academy of Medical Royal Colleges, 2007	Acute medical beds currently available at Grantham, no additional staff required
Speciality Medicine **Healthcare of older person / respiratory / gastroenterology / stroke / cardiology**		
Clearly defined contact pathways for named senior clinical opinion (speciality trainee or consultant) are on a rota for all specialties likely to require regular interaction with the AMU. These include cardiology, gastroenterology, geriatric medicine.	The Royal College of Surgeons of England, 2011	**Health care of older person / Respiratory / Gastroenterology** If an on-call team is provided from the site would mean approximately an additional 7 Gastroenterology and 5 Respiratory Consultants **Cardiology** ACU needed 1in 6 rota for consultants, 2 middle grades, 6 juniors, full nursing staffing ward **Stroke** Minimum 6 consultants, 2 middle grades and 6 juniors
600 confirmed stroke admission per year in order to sustain expert consultant-led services	British Association of Stroke Physicians (2011)	

General Surgery		
Hospitals accepting undifferentiated patients via the ED must have access to 24-hour on site surgical opinion (at ST3 level or above or a trust doctor with equivalent ability, i.e. MRCS with ATLS provider status) Staffing levels required to deliver an effective emergency general surgery service will comprise a consultant surgeon (CCT holder), middle grade (MRCS holder), core trainee and foundation Major procedures may require three surgeons. Requirement for cover arrangements during busy periods.	The Royal College of Surgeons of England, 2011	See above under critical care
Paediatrics		
Small and medium sized hospitals (Paediatric attendees =15,000, Paediatric admissions = 3,000) – rota of 8 consultants, middle grade rota of 9 and junior rota of 6	Academy of Medical Royal Colleges, 2007	For a PAU: • 8 consultants 16 senior decision-makers • 5.46 Band 6 nurses • 10.92 band 5 nurses • 5.46 HCSW
All general acute paediatric rotas are made up of at least ten WTEs, all of whom are EWTD compliant Minimum of two registered children's nurses must be in the inpatient unit at all times	Royal College of Paediatrics and Child Health, 2011	
Orthopaedics		
An Acute General Hospital taking surgical emergencies should have 24-hour, fully staffed Intensive Treatment Unit beds, provided in a ratio of 1:40,000 population as well as high dependency unit beds".	British Orthopaedic Association, 2007	See above under critical care
Obstetrics and Gynaecology		
60-hour consultant presence for units of 2,500-4,000 births per year 98 hours for 4,000-5,000 births per year	Safer Childbirth: (2007) The reconfiguration of clinical services: What	Pathways would be developed to support safe transfer of labouring mothers to Pilgrim or Lincoln, but a gynaecology acute ward would be needed: • 6 consultants • 12 senior decision-makers • 1 Band 7 nurse

168 hours for more than 5,000 births per year RCOG has argued that centralising obstetric services so that units have at least 6,000 births per years would enable the current workforce to support 24/7 consultant presence in all units. But it does not recommend centralisation in all cases Neonatal support: 24-hour availability (within 30 minutes) of consultants and 24-hour resident cover by a ST1/2 or an advanced neonatal nurse practitioner (ANNP), who is trained and assessed as competent in neonatal life support and whose only responsibility is to the neonatal and maternity service	is the evidence? Kings Fund 2014	• 1 Band 6 nurse • 15 band 5 nurses • 10 HCSW

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

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.

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."

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".[5]

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."

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.

Activity modelling by the local health system has estimated that under the service change proposal to establish a 24/7 walk in Urgent Treatment Centre (UTC) at Grantham and District Hospital (in place of the current Accident and Emergency (A&E) department) the vast majority of patients currently seen at the A&E service would continue to be seen by the proposed UTC. It is estimated that around 2 patients a day who are seen by the current service wouldn't be able to have their care needs met by the proposed 24/7 UTC and would need to have their care needs met at an alternative site with a full A&E service.

Forecast growth in Grantham and South Kesteven

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.

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.

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

[5] The Royal College of Surgeons of England. Provision of Acute General Hospital Services. London: The Royal College of Surgeons of England; July 1998 (cited in March 2006 in *Delivering High-quality Surgical Services for the Future*)

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

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.

The current catchment population of Grantham and District hospital is estimated to be c.100,000-120,000 people (see Appendix 1). 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).

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 can not be provided on site.

Catchment populations for five Accident and Emergency Departments that have been reorganised and the rationale for change

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, the table below highlights the catchment population, rationale for reorganisation, the 'new' service and year of change for the reorganisation of five Accident and Emergency departments in England[6].

Site	Catchment Population	Rationale for reorganisation	The 'new' service	Year of change
Bishop Auckland ***a market town in the north-east of England***	145,000	• A risk that safe care (including A&E, acute and critical care) could not be sustained at the hospitals in Bishop Auckland	• Urgent Care Centre (UCC) led by general practitioners open 24/7 • It was expected that many patients would use the ED services at either Darlington Memorial Hospital or the University Hospital of North Durham	2009
Hemel Hempstead ***a large town situated in southern England***	231,000	• Concerns from local clinicians that unless acute and emergency hospital services in Hertfordshire were consolidated onto fewer hospital sites, services would become substandard, unsustainable, unattractive to clinical staff and, ultimately, unsafe	• Urgent Care Centre (UCC) led by general practitioners open 24/7 • It was perceived the UCC would care for 65% of those patients who had previously visited the ED in Hemel Hempstead	2009
Newark ***a market town in the East Midlands***	125,000	• The A&E department at Newark Hospital was not sustainable in terms of staffing or in the maintenance of skills among A&E doctors	• 24/7 Minor Injury Unit (MIU) and Urgent Care Centre (UCC) • It was perceived 85% of patient who were treated in the A&E would continue to receive their care at the new MIU and UCC and there would be a reduction in the number of emergency ambulance transfers from Newark Hospital to other hospitals, as patients would receive their care in the right place first time	2011

[6] *E. Knowles et al.* Closing five Emergency Departments in England between 2009 and 2011: the closed controlled interrupted time –series analysis

Rochdale ***a market town in the north-west of England***	154,000	• To ensure that health services maintained a safe and sustainable approach to care and that care would be better situated in fewer hospital sites where resources and expertise could be concentrated • Local access to urgent care would be maintained	• Urgent Care Centre open 24/7, with services being delivered by experienced nurses, nurse practitioners and a GP • It was perceived that the UCC at Rochdale Infirmary would care for an estimated 85% of those patients who had previously used the ED in Rochdale	2011
Hartlepool ***A coastal town in the north-east of England***	155,000	• Local NHS managers and doctors supported the closure of the A&E at Hartlepool because of safety concerns, citing (1) insufficient numbers of medical staff to cover two rotas in North Tees Hospital and Hartlepool Hospital and (2) limited overnight supervision of junior medical staff at Hartlepool Hospital	• Urgent Care Centre (UCC), not based on the existing hospital site and located approximately 2 miles away from where the A&E was. • The centre provides a 24-hour Minor Injury Unit, a walk-in centre that is open for 12 hours each day (08.00 to 20.00) and out-of-hours GP medical services.	2011

As can be seen from this table, 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.

In addition, 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:

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

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

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."

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. Which 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.

Conclusions

- 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.
- 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.
- 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.

Appendix 1

The Lincolnshire health system estimated the catchment size for Grantham and District Hospital A&E department by identifying any Lower Super Output Area (LSOA) where 50% or more of the activity (not arriving by ambulance) arriving at and A&E occurs in Grantham.

Any ambulance arrivals were excluded from the activity defining the catchment since the site is unlikely to have been the choice of the patient.

All activity available in the data set was used irrespective of commissioner.

The catchment was defined using the last 12 months prior to Covid-19 (March 2019 – February 2020).

A summary of the estimated catchment size for Grantham and District Hospital A&E based on this methodology is set out below.

District Authority	Population	%
E07000133: Melton	9,401	9%
E07000139: North Kesteven	17,412	18%
E07000141: South Kesteven	68,520	69%
E07000175: Newark and Sherwood	1,569	2%
E07000176: Rushcliffe	2,312	2%
Grand Total	**99,214**	**100%**

Local campaign groups have previously identified the catchment population of Grantham and District Hospital as 120,000. However the basis for this is unknown.

In light of the above, a catchment population of c.100,000 – 120,000 for Grantham and District Hospital A&E department has been used in the consideration of the public feedback.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Change proposal(s)	**Orthopaedic Services** *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*
Common theme	Facilities
Feedback working group	Mark Lacey – Managing Director Surgery Kulandaivel Sakthivel – Consultant Orthopaedics Catherine O'Dwyer – Divisional Clinical Director for Surgery Catherine Capon – Deputy Divisional Nurse Surgery Lisa Pim – Divisional Nurse Surgery
Date feedback working group signed off response	Version 4.1 - 22 April 2022 Signed off – (ML 21-4-22)
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	28 April 2022

Orthopaedic proposal consultation feedback- Facilities

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of orthopaedic services:

- 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

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to orthopaedic services there was feedback that consideration should be given to the facilities at Grantham and District Hospital:

- That Grantham and District Hospital is poor state of maintenance, and that it would be more cost effective in the long run to build a brand new centre for orthopaedic services.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the facilities at Grantham and District Hospital feedback through the public consultation. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

The Grantham and District Hospital is poor state of maintenance, and that it would be more cost effective in the long run to build a brand new centre for orthopaedic services.

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. For example, patient environment improvements such as decoration and flooring, 2 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.

Conclusions and actions

The estates strategy is to enhance and maintain the buildings and estate to support the delivery of hospital services.

Appendix F2

Consideration of public feedback by subject matter expert working groups

URGENT AND EMERGENCY CARE

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 1.0: 08 April 2022

Change proposal	**Orthopaedics** *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* **Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre* **Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Conditions that would be treated at 24/7 Grantham and District Hospital UTC
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care Yvonne Owen - Senior Partner Minster Medical Practice LCHS David Baker - GP Neil Scott - EMAS
Date feedback working group signed off response	Version 1.0: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022 and 28 April 2022

Orthopaedics, Urgent & Emergency Care and Acute Medicine proposal consultation feedback – Conditions that would be treated at 24/7 Grantham and District Hospital UTC

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, three of which related to the provision of services from Grantham and District Hospital:

- 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;
- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre; and
- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to Grantham and District Hospital there was feedback in support of the proposals relating to:

- Acknowledgement that evening and overnight visitors to the A&E departments at Lincoln County Hospital or Peterborough City Hospital could be treated at a more local UTC
- 24-hour access to walk-in UTC might relieve pressure on Lincoln County Hospital's A&E, as well as benefiting those living in and near to Grantham if the majority of them would not need to travel to Lincoln to receive out of hours urgent care
- Recognition of issues such as Grantham's growing and aging population and travel to Lincoln County Hospital, for respondents and residents that supported the proposals they represent a reasonable 'real world' compromise to these issues that could be mitigated against, not least by ensuring that local residents are made fully aware of what services a UTC would be able to provide

Some concerns expressed about the proposal, in terms of the conditions that would be treated at the 24/7 UTC, 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:

- Reassurances that a 24-hour Urgent Treatment Centre would be appropriate for the vast majority of patients requiring out-of-hours assessment and treatment and might therefore lead to shorter waiting times and less pressure on A&E services in other locations in Lincolnshire, were accepted by many of those who agreed with the proposals.

- There was also recognition that most people who would require full A&E services, such as trauma patients, would in any case be transported by ambulance to the nearest appropriate site.

In addition, public feedback identified that it is vital that a UTC at Grantham and District Hospital should always operate as a walk-in service, rather than requiring people to contact NHS 111 first to ensure that people use of the service and do not travel elsewhere unnecessarily.

Other feedback identified that NHS 111 needs to be fully informed of who they can send to Grantham instead of an A&E department further afield, and that ambulances are 'allowed' to transport patients to Grantham directly. Some people were also worried that opening times would drop later to 12 hour opening from 24/7.

Feedback in opposition to the proposal linked the proposal for orthopaedic surgery to changes in urgent and emergency care provision.

Concerns about quality of care provided at A&E departments at Lincoln County Hospital and Pilgrim Hospital in Boston, as well as the long wait times some respondents had experienced (which might become worse without A&E services at Grantham and District Hospital) were expressed by those in support and opposition of the proposal.

In addition to this feedback from the consultation, a member of the public submitted information that they felt showed statements in the public consultation that Grantham and District Hospital did not have a Level 1 A&E from 2007/08 as inaccurate, as every level of severity across a wide range of critical conditions were treated and stabilised at the hospital. A question was posed around 'how does this compare to the level of service that would be provided from the proposed Urgent Treatment Centre?'.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the conditions that are currently treated at Grantham and District Hospital and those that would not be if the proposed changes were implemented. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

It is due to these clinical interdependencies that the feedback set out above relating to Urgent and Emergency Care and Acute Medical beds has been brought together and considered as one.

Orthopaedics

Current situation

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 Hospitals Lincolnshire NHS Trust (ULHT) has been part of a national orthopaedic pilot to look at how service quality and patient outcomes could be improved.

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.

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.

The Pre Consultation Business Case (PCBC) that was made publicly available at the start of the public consultation described this situation in more detail.

Proposed changes

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.

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.

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 (See Appendix 1 of this document).

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

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)

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 proposed 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.

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.

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 Hospitals Lincolnshire NHST Trust and Lincolnshire Community Health Services NHS Trust.

Urgent and Emergency Care and Acute Medicine

Current situation

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.

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.

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.

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.

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 (see Appendix 2). 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.

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.

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).

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.

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.

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.

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.

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.

<u>Proposed changes</u>

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.

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.

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)

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.

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.

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 Hospital site.

Within the PCBC the Grantham and District Hospital Acuity Model to underpin the proposed changes was outlined as follows:

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.

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 the Appendix of the PCBC (see Appendix 1 of this document).

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 proposed 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.

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.

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 Hospitals Lincolnshire NHST Trust and Lincolnshire Community Health Services NHS Trust.

Reassurances that a 24-hour Urgent Treatment Centre would be appropriate for the vast majority of patients requiring out-of-hours assessment and treatment and might therefore lead to shorter waiting times and less pressure on A&E services in other locations in Lincolnshire

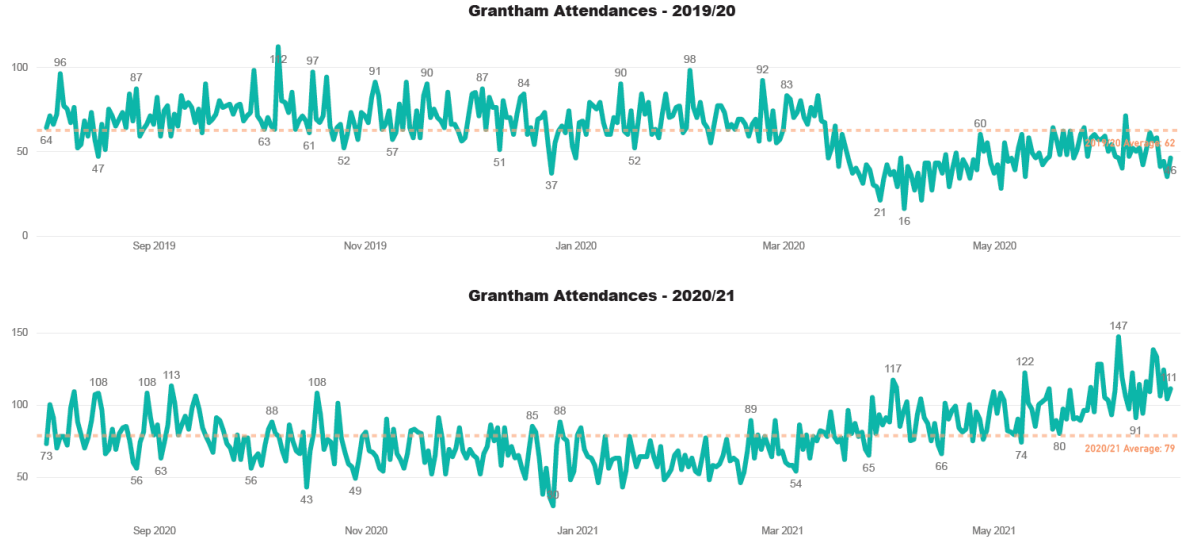
Activity modelling completed to assess the change proposal estimated that with the proposed change and refinement of the exclusions criteria, around 3% of those patients currently attending the Grantham and District Hospital A&E. This is equivalent to 2 patients a day, on average. These are patients 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.

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.

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 Hospital in response to the pandemic, the temporary changes do provide useful insights.

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.

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.



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.

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

Conclusions and actions

- 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 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.
- However, it is important to note that having the skills and experience to manage patients who initially attend with this level of acuity, as well as those who attend with a lower acuity but deteriorate to this level whilst on site, before transferring does not define the Grantham and District Hospital A&E department as 'Level 1'. This has been confirmed by independent external reviews.
- Under the proposed service change for a 24/7 Urgent Treatment Centre (UTC) at Grantham & District Hospital in place of the current A&E department, the UTC would be 24/7, walk-in and 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.
- Activity modelling completed to assess the change proposal 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. This is equivalent to 2 patients a day, on average. These are patients who require onward transfer for immediate specialist care. If the proposed change is implemented the activity modelling will be kept under ongoing review.
- Those additional patients who would be seen at a different site under the proposal 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. The refined exclusion criteria that would underpin the proposed 24/7 UTC at Grantham and District Hospital if it went ahead was included in the PCBC.
- 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. If the proposed change is implemented this analysis will be kept under ongoing review.
- 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. This will include 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.
- The communication plan will be rolled out using NHS Lincolnshire CCG's well established communication channels as well as those of all local health and care providers, including ULHT and LCHS.
- In addition, 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 proposed 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.

Appendix 1

United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust

Grantham and District Hospital
Urgent Treatment Centre, Ambulatory Care Unit and Emergency Assessment Unit exclusion criteria

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital Urgent Treatment Centre, Ambulatory Care Unit & Emergency Assessment Unit

- News ≥ 7 WITH frailty score of < 5
- A patient requiring immediate airway management and/ or resuscitation
- Status epilepticus
- Fast Positive Stroke / high risk TIA
- STEMI
- Acute coronary syndrome- Ongoing ischaemic chest pain with 1mm ST depression in more than one limb lead or in two or more consecutive chest leads
- CONFIRMED NSTEMI- Once diagnosis made In UTC or Ambulatory Care- transfer to LCH
- Post cardiac arrest
- Significant bradycardia < 40bpm, 2nd or 3rd degree AV block, Ventricular tachycardia
- Suspected acute heart failure WITH frailty score < 5
- Reduced conscious level (not alert) – Glasgow Coma Score <13- or PU on AVPU WITH frailty score < 5
- Acute respiratory distress with an oxygen saturation < 91% on room air WITH frailty score < 5 "unless" the patient has known significant chronic lung disease
- Gastro-intestinal haemorrhage (fresh blood or melaena).
- Severe abdominal pain and acute abdomen (refer patient directly to Lincoln County.)
- A female of childbearing age with lower abdominal pain
- A male with testicular pain
- A patient with suspected AAA or ischaemic limb needs admission to the on-call vascular unit (Pilgrim Hospital)
- All Obstetric and Gynaecological patients
- Neutropenic sepsis
- Patients requiring dialysis
- Patients with renal transplants
- Ophthalmological emergencies e.g. acute glaucoma, trauma
- All Major trauma is excluded from this site in line with the East Midlands Trauma Network Triage Tool, including all suspected femoral fractures.
- Fractures/ dislocations with evidence of distal neurovascular compromise. See over page for trauma that can be treated on the Grantham Hospital site
- Open lower limb fractures of femur, tibia/fibula, ankle or forefoot

Note: Patients who are house bound OR from a nursing/care home OR where RESPECT form has limitations of care in place that would make escalation of care inappropriate should normally continue to be brought to Grantham for assessment for medical conditions

Paediatric Exclusions

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital Urgent Treatment Centre

- Children with a POPS score of 5 or more
- Children requiring immediate airway management and/ or resuscitation
- Children requiring Paediatric assessment / Review
- Children with biphasic stridor
- Children with DKA
- Children with Status epilepsy
- Children who have self-harmed
- Children requiring Mental health assessment

Trauma that can be treated in 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 subsequent transfer after assessment)
- Children's suspected fractures- if confined to one area and child is haemodynamically stable(may require subsequent transfer after assessment)

Appendix 2

Count of PASID		Years	DateofObservation
		2017	Grand Total
LocationDesc	newsscore	Nov	
A&E	5	35	35
	6	34	34
	7	22	22
	8	23	23
	9	9	9
	11	4	4
	14	1	1
A&E Total		128	128
Grand Total		128	128



United Lincolnshire Hospitals NHS Trust

2014/15 - Total and Diagnosis description of patients admitted to Grantham Hospital wards as 'Emergency'

FIN_YEAR	HOSPITAL_AT_START	WARD_CODE_AT_START	ADMISSION_METHOD	DIAG_PRIMARY_NAME
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Lobar pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Viral infection, unspecified
2014/15	Grantham Hospital	GK-HDU	Emergency - GP	Lobar pneumonia, unspecified
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Infection following a procedure, not elsewhere classified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Other giant cell arteritis
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Left ventricular failure
2014/15	Grantham Hospital	GK-2	Emergency - GP	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Effusion of joint Lower leg
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Unspecified acute lower respiratory infection
2014/15	Grantham Hospital	GK-1	Accident and Emergency	Other and unspecified abnormalities of gait and mobility
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Type 2 diabetes mellitus Without complications
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Cellulitis of other parts of limb
2014/15	Grantham Hospital	GK-HDU	Accident and Emergency	Congestive heart failure
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Dyspnoea
2014/15	Grantham Hospital	GK-GAEC	Accident and Emergency	Chest pain, unspecified
2014/15	Grantham Hospital	GK-GKSU	Accident and Emergency	Cerebral infarction, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Mental and behavioural disorders due to use of alcohol Acute intoxication
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Chronic obstructive pulmonary disease with acute lower respiratory infection
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Acute transmural myocardial infarction of anterior wall
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Sepsis, unspecified
2014/15	Grantham Hospital	GK-CARD	Accident and Emergency	Acute myocardial infarction, unspecified
2014/15	Grantham Hospital	GK-2	Emergency - GP	Urinary tract infection, site not specified
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Pleural effusion, not elsewhere classified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Congestive heart failure
2014/15	Grantham Hospital	GK-GAEC	Accident and Emergency	Hypotension due to drugs
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Gastro-oesophageal reflux disease without oesophagitis
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Other specified soft tissue disorders Lower leg
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-CARD	Accident and Emergency	Other ill-defined heart diseases
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Open wound of other parts of head
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Poisoning: 4-Aminophenol derivatives
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Multiple fractures of ribs closed
2014/15	Grantham Hospital	GK-1	Accident and Emergency	Urinary tract infection, site not specified
2014/15	Grantham Hospital	GK-1	Emergency - GP	Sepsis, unspecified
2014/15	Grantham Hospital	GK-6	Emergency - GP	Cellulitis of other parts of limb
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Other and unspecified abdominal pain
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Chronic obstructive pulmonary disease with acute lower respiratory infection
2014/15	Grantham Hospital	GK-1	Emergency - GP	Acute myocardial infarction, unspecified

Note: This is the first page of 142

Public consultation on four NHS services

Addressing common themes, alternative options and additional information

Version 1.1: 08 April 2022

Change proposal (s)	**Orthopaedics** *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* **Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre* **Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme *Note: the two themes arising across different change proposals have been considered together given the interdependencies*	Full A&E and hospital service provision at Grantham and District Hospital
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care David Baker - GP Yvonne Owen - Senior Partner Minster Medical Practice LCHS Neil Scott - EMAS
Date feedback working group signed off response	Version 1.1: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022 and 28 April 2022

Orthopaedics, Urgent & Emergency Care and Acute Medicine proposal consultation feedback –

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

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, three of which related to the provision of services from Grantham and District Hospital:

- 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;
- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre; and
- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For many respondents, a 24-hour UTC was viewed as preferable to the current limited services A&E department operating from 8.00am-6.30pm

The vast majority of those who rejected the proposals for a 24-hour UTC at Grantham and District Hospital did so, not on the basis that they favour the status quo of current service provision, but rather because they want a full, 24/7 A&E department in place of the current 8:00am to 6:30pm service. Feedback included:

- Grantham and District Hospital should have a full 24/7 A&E Department - Any changes to acute services at the hospital in Grantham were viewed as unacceptable and, in many cases, seen as a continuation of under-investment and a process of service reduction at Grantham and District Hospital over a period of a number of years
- Services at Grantham and District Hospital need to be protected and expanded/more services delivered with reference made to emergency orthopaedic surgery and stroke services in particular
- Lack of trust in the case for change and strong concern the proposal is another step in a deliberate 'downgrading' of Grantham and District Hospital
- Proximity of the A1, major railway links and airports increases the risk of major incident that might overwhelm remaining A&E services without Grantham and District Hospital being able to provide support
- The strength of feeling from some members of the public was further evidenced by the submission of two petitions with a combined total of 1,818 signatures or online indications of support calling for a 24-hour A&E department at Grantham and District Hospitals.

- Proposals do not take into account or properly address the growing and ageing population in Grantham – The variety of patient ailments, growth of Grantham and large rural catchment are patients deserve a better quality of service than the UTC offers
- Grantham and District Hospital should be a fully services hospital with acute medical beds
- Concerns about negative impacts on the quality of care being provided, and the potential for increased pressure on other hospital sites

In the contest of the above alternative options were put forward in the consultation feedback:

- Current part-time limited A&E department at Grantham and District Hospital to be replaced by (or 'restored to') a full Type 1 Accident and Emergency Department
- A&E services should continue to be offered at Grantham and District Hospital during the day, with a UTC in operation only overnight
- Lincoln and Pilgrim A&E departments are often stretched and prolonged ambulance handover delays. ULHT should build the A&E capabilities at Grantham to cut transfer times, reduce risk for patients, make it attractive to staff.
- Maintain A&E services at Grantham and provide dedicated, separate walk in services, run by nurse specialists, in addition to A&E services for emergency / ambulance admissions in Lincoln and Boston.

A mitigation was also put forward which was to train additional Advanced Care Practitioners (ACPs) to compensate for the shortage of consultants.

The purpose of this paper is to provide a concise summary of the key evidence-based points relating to provision of A&E services at Grantham and District Hospital as well as those services with clinical interdependencies required to deliver a 'full service', to ensure conscientious consideration of the feedback received during the public consultation.

It is due to these clinical interdependencies that the feedback set out above relating to Urgent and Emergency Care and Acute Medical beds has been brought together and considered as one.

This paper reflects and builds upon the significant scrutiny that has been placed upon the A&E department at Grantham Hospital over recent years, including that by the Independent Reconfiguration Panel (IRP) and the East of England Clinical Senate.

A&E department provision in Lincolnshire

When considering the provision of Accident and Emergency (A&E) departments it is important to consider the definition of the services.

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

- Type 1 – 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.

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.

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.

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 & 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).

Major trauma cases go to Queens Medical Centre in Nottingham.

The Grantham and District Hospital A&E department 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 & District Hospital has for some time only dealt with a limited range of presenting conditions.

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.

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.

In addition to the three A&E departments provided by ULHT, six Urgent Treatment Centres (UTC) are provided by Lincolnshire Community Health Services NHS Trust (LCHS).

These are located at:

- Lincoln; co-located with the A&E department at Lincoln County Hospital
- Boston; co-located with the A&E department at Pilgrim, Boston Hospital
- Louth
- Skegness
- Gainsborough
- Spalding

The staffing challenge faced by A&E departments

Nationally

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)[1], 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[2].

In one of its reports into the challenges facing A&E departments the Kings Fund[3] highlight that the Royal College of Emergency Medicine identify that emergency medicine has a high attrition rate from doctors in training, high early retirement rates for experienced clinicians, and significant reliance on temporary locum clinical staff. The report goes on to identify that in a General Medical Council survey in 2020, nearly three-quarters of emergency medicine trainees rated the intensity of their workload as heavy or very heavy, substantially more than any other specialty.

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.

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

[1] Health Education England, NHS England, NHS Improvement and RCEM (2017) *Securing the future workforce for Emergency Departments in England*
[2] Health Education England (2017) *Facing the facts, Shaping the Future: A draft health and care workforce strategy for England to 2027*
[3] The Kings Fund *What's going on with A&E waiting times?*

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.

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.

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.

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.

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

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.

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.

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).

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.

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

Locally

In 2016, in light of the pressures being faced by ULHT's A&E departments as a whole (a national shortage of emergency medicine doctors, insufficient doctors in training choosing to work at ULHT, an increasing reliance on locums and difficulty in securing the number of locums required to fill gaps in rotas consistently), the ULHT Board agreed to implement a temporary overnight service closure at Grantham & District Hospital to support the staffing at Lincoln County and Boston, Pilgrim A&E departments, as releasing middle-grade doctors to work at these two sites would provide safer services for the Lincolnshire population as a whole.

At the time there were four substantive consultants in post out of 15 funded whole time equivalent (wte) posts, with vacancies being filled by locums. Furthermore, there were 11.6 wte middle-grade doctors against the 28 funded posts. The reduced emergency staffing levels, combined with a reduction in skill mix of substantive staff, compromised the on-going provision of safe 24 hours, seven days per week A&E care across three sites. Although efforts were continuing to recruit additional staff, and various steps had been taken to mitigate staff shortages it was felt further action was required.

In August 2016 an initial three-month overnight closure of the Grantham and District Hospital A&E Department was introduced by ULHT taking it from a 24/7 service to 09.00-18.30 seven days a week. The closure of the A&E was initially between 18.30 and 09.00. The exclusion criteria did not change with the changes in opening times.

The Lincolnshire Health Scrutiny Committee concluded that the closure of A&E services between 18.30 and 09.00 at Grantham and District Hospital represented a substantial variation in the provision of health services in the area. The Committee decided that the matter should be referred to the Secretary of State, who passed the matter onto the Independent Review Panel (IRP).

Since the review by the East Midlands Clinical Senate, ULHT has continued to work hard to improve medical staffing levels in its A&E departments and had significant success with a wide range of initiatives (including securing significant external clinical support to coordinate its recruitment programme, refreshing its offer to new recruits, revising the approach to in-house training and rotations, reviewing relocation packages and providing a highly supportive onboarding programme), however recruitment continues to be a real challenge both locally and nationally.

The current staffing position at ULHT is described later in this paper.

Independent clinical advice on the closure of Grantham and District A&E department over night

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 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 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 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 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.

The IRP concluded that in the interests of safety the A&E service at Grantham 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 Hospital and more widely across Lincolnshire.

Following the referral to the IRP, ULHT continued its effort to recruit staff and the closure of A&E services between 18.30 and 09.00 at Grantham Hospital was reviewed. A review in February 2017 concluded that the threshold to re-open the service full time had not been met but acknowledged there had been significant improvement in staffing levels.

To inform the ULHT's Board decision on re-opening the A&E at Grantham and District Hospital, NHS Improvement commissioned a review to allow for an independent, expert, evaluation on the staffing levels across the three A&E departments and recommendations about extending the opening hours of the Grantham A&E departments.

The report produced by the East of England Clinical Senate 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 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.

In addition to the above and in summary the key recommendations coming out of the review from the Clinical Senate panel include:

Recommendation 1:

- The panel does not support the reopening of the 24/7 A&E department at Grantham Hospital on the grounds of potential adverse impact on patient safety at A&E Departments at all three United Lincolnshire NHS Trust Hospitals.
- The panel strongly recommends, on the grounds of patient safety, United Lincolnshire Hospitals NHS Trust Board reconsider its proposal to extend the current A&E service opening hours at Grantham and District Hospital.
- The Panel recommends that the Trust should continue to provide an A&E service at Grantham and District Hospital on the current opening hours of 08.00-18.30, seven days a week until a more definitive long term urgent and emergency care plan was developed and agreed.

Recommendation 2:

- The panel recommends that in order to make it clear for patients and the public the type of service available at GDH 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 GDH in any further model.

Recommendation 3:

- The panel recommended that the Trust should move to a single A&E team with a focus on standardised clinical pathways and processes across the three sites, removing any unnecessary variation and providing enhanced training opportunities.

Recommendation 4:

- The panel recommended that the Trust and CCG have clear alignment with the Lincolnshire STP, developing a system approach to urgent and emergency care, and planned care for patient and the public. The Trust and STP should move to public consultation on an agreed future model as quickly as possible.

Recommendation 5:

- The panel recommended that the United Lincolnshire Hospitals NHS Trust works with the local the CCG and STP to develop an enhanced communication and engagement strategy to ensure that all stakeholders, the public, patients and local elected representatives have an opportunity to input on the development and decision regarding the final model for urgent and emergency care across the Trust’s three sites, and not only for the Grantham site.

- The panel recommends that the communication and engagement strategy develop plans to ensure that any changes to the designation, opening times and pathways related to emergency care provision are clearly communicated with the public, patients, stakeholders and staff both within the STP footprint and with surrounding STP footprints.

Subsequent advice from NHS Improvement in a letter to the CEO of ULHT following the review by the clinical senate stated:

"The Report produced following the review was detailed and outlined 4 clear recommendations, most notably that the A&E Department at Grantham should remain closed overnight and to not extend the current opening hours. One of the key reasons for the recommendation is on the grounds of patient safety. Due to the ongoing concerns around the delivery of A&E services at Lincoln County and Pilgrim Hospital and specifically the sustainability of your staffing model, NHS Improvement strongly advises that the Trust Board follow the recommendations in the report".

Following consideration of the findings, the ULHT Trust Board agreed to accept the conclusions reached by the East of England Clinical Senate panel, and follow their recommendations, which were supported by NHS Improvement.

Within its report the East of England Clinical Senate panel advised using the Royal College of Emergency Medicine 'rule of thumb' guide for 'Medical and Practitioner Staffing in Emergency Department. Using that guide would indicate that ideally 36 middle-grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover. The number of middle-grades at the time of the review was 22 with a heavy proportion of locums amongst them which meant it was a relatively unstable position.

Current position of ULHT A&E department staffing and requirement to operate 3 'full' A&Es

As previously described 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.

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.

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

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."

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.

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"[4].

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

A&E department clinical interdependencies and scale

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.

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.

The table below provides an overview of the guidance available on the explicit and implicit scale requirements of the core specialties that need to be co-located with a Type 1 A&E, together with an estimate of the additional workforce that would be required in each area to safely and sustainably support an A&E of this type at Grantham and District Hospital. This is in addition to the additional workforce requirement described in the previous section for the A&E department itself.

[4] Goudie, R and Goddard, M. (2011) Centre for Health Economics, University of York, *Review of Evidence on What Drives Economies of Scope and Scale in the Provision of NHS Services, Focusing on A&E and Associated Hospital Services, A report for the OHE Commission on Competition in the NHS*

Guidance	Source	Estimate of additional workforce required
Critical Care / Intensive Care		
Fewer than eight level 3 beds may not be sustainable because of the need for adequate numbers of staff at all times There are no economies of scale in small units and, with limited patient exposure (that is 'case mix'), such units would not be recognised for training by the IBTICM 24/7 intensive care cover by consultants, trained medical practitioner and staff capable of managing an airway in under 3 minutes	Academy of Medical Royal Colleges, 2007	Currently major trauma into Lincoln and pilgrim is stabilised and transferred to major trauma centre. Would need full ITU, number of level 2 and 3 critical care beds and consultants and nursing workforce. ITU trained nurses on a 24/7 rota. Beds for Emergency urology, Gen surg, vascular, head and neck. If 6 beds of each, specialist nurses for each spec would be needed. Consultant cover and on-site cover all those specialties. Stand-by theatre team for each spec for emergency surgery (ODPs, recovery staff, scrub practitioner, consultant) Significant increase in infrastructure for blood provision and for theatre kit and equipment to support a 24/7 full take for anything other than major trauma 5 ITU consultants 12 ITU Nurses This would cover all emergency surgery 'takes' require for a 24/7 A&E.
Acute Medicine		
Consultant lead in acute medicine per site and larger units will require several consultants in acute medicine. All units to have SpRs (ST3) and above 24/7. Multidisciplinary team; min 2 ward rounds per day.	Academy of Medical Royal Colleges, 2007	Acute medical beds currently available at Grantham, no additional staff required
Speciality Medicine **Healthcare of older person / respiratory / gastroenterology / stroke / cardiology**		
Clearly defined contact pathways for named senior clinical opinion (speciality trainee or consultant) are on a rota for all specialties likely to require regular interaction with the AMU. These include cardiology, gastroenterology, geriatric medicine.	The Royal College of Surgeons of England, 2011	**Health care of older person / Respiratory / Gastroenterology** If an on-call team is provided from the site would mean approximately an additional 7 Gastroenterology and 5 Respiratory Consultants **Cardiology** ACU needed 1in 6 rota for consultants, 2 middle grades, 6 juniors, full nursing staffing ward **Stroke** Minimum 6 consultants, 2 middle grades and 6 juniors
600 confirmed stroke admission per year in order to sustain expert consultant-led services	British Association of Stroke Physicians (2011)	

General Surgery		
Hospitals accepting undifferentiated patients via the ED must have access to 24-hour on site surgical opinion (at ST3 level or above or a trust doctor with equivalent ability, i.e. MRCS with ATLS provider status) Staffing levels required to deliver an effective emergency general surgery service will comprise a consultant surgeon (CCT holder), middle grade (MRCS holder), core trainee and foundation Major procedures may require three surgeons. Requirement for cover arrangements during busy periods.	The Royal College of Surgeons of England, 2011	See above under critical care
Paediatrics		
Small and medium sized hospitals (Paediatric attendees =15,000, Paediatric admissions = 3,000) – rota of 8 consultants, middle grade rota of 9 and junior rota of 6	Academy of Medical Royal Colleges, 2007	For a PAU: • 8 consultants 16 senior decision-makers • 5.46 Band 6 nurses • 10.92 band 5 nurses • 5.46 HCSW
All general acute paediatric rotas are made up of at least ten WTEs, all of whom are EWTD compliant Minimum of two registered children's nurses must be in the inpatient unit at all times	Royal College of Paediatrics and Child Health, 2011	
Orthopaedics		
An Acute General Hospital taking surgical emergencies should have 24-hour, fully staffed Intensive Treatment Unit beds, provided in a ratio of 1:40,000 population as well as high dependency unit beds".	British Orthopaedic Association, 2007	See above under critical care
Obstetrics and Gynaecology		
60-hour consultant presence for units of 2,500-4,000 births per year 98 hours for 4,000-5,000 births per year	Safer Childbirth: (2007) The reconfiguration of clinical services: What	Pathways would be developed to support safe transfer of labouring mothers to Pilgrim or Lincoln, but a gynaecology acute ward would be needed: • 6 consultants • 12 senior decision-makers • 1 Band 7 nurse

168 hours for more than 5,000 births per year RCOG has argued that centralising obstetric services so that units have at least 6,000 births per years would enable the current workforce to support 24/7 consultant presence in all units. But it does not recommend centralisation in all cases Neonatal support: 24-hour availability (within 30 minutes) of consultants and 24-hour resident cover by a ST1/2 or an advanced neonatal nurse practitioner (ANNP), who is trained and assessed as competent in neonatal life support and whose only responsibility is to the neonatal and maternity service	is the evidence? Kings Fund 2014	• 1 Band 6 nurse • 15 band 5 nurses • 10 HCSW

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

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.

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."

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".[5]

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."

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.

Activity modelling by the local health system has estimated that under the service change proposal to establish a 24/7 walk in Urgent Treatment Centre (UTC) at Grantham and District Hospital (in place of the current Accident and Emergency (A&E) department) the vast majority of patients currently seen at the A&E service would continue to be seen by the proposed UTC. It is estimated that around 2 patients a day who are seen by the current service wouldn't be able to have their care needs met by the proposed 24/7 UTC and would need to have their care needs met at an alternative site with a full A&E service.

Forecast growth in Grantham and South Kesteven

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.

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.

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

[5] The Royal College of Surgeons of England. Provision of Acute General Hospital Services. London: The Royal College of Surgeons of England; July 1998 (cited in March 2006 in *Delivering High-quality Surgical Services for the Future*)

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

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.

The current catchment population of Grantham and District hospital is estimated to be c.100,000-120,000 people (see Appendix 1). 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).

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 can not be provided on site.

Catchment populations for five Accident and Emergency Departments that have been reorganised and the rationale for change

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, the table below highlights the catchment population, rationale for reorganisation, the 'new' service and year of change for the reorganisation of five Accident and Emergency departments in England[6].

Site	Catchment Population	Rationale for reorganisation	The 'new' service	Year of change
Bishop Auckland ***a market town in the north-east of England***	145,000	• A risk that safe care (including A&E, acute and critical care) could not be sustained at the hospitals in Bishop Auckland	• Urgent Care Centre (UCC) led by general practitioners open 24/7 • It was expected that many patients would use the ED services at either Darlington Memorial Hospital or the University Hospital of North Durham	2009
Hemel Hempstead ***a large town situated in southern England***	231,000	• Concerns from local clinicians that unless acute and emergency hospital services in Hertfordshire were consolidated onto fewer hospital sites, services would become substandard, unsustainable, unattractive to clinical staff and, ultimately, unsafe	• Urgent Care Centre (UCC) led by general practitioners open 24/7 • It was perceived the UCC would care for 65% of those patients who had previously visited the ED in Hemel Hempstead	2009
Newark ***a market town in the East Midlands***	125,000	• The A&E department at Newark Hospital was not sustainable in terms of staffing or in the maintenance of skills among A&E doctors	• 24/7 Minor Injury Unit (MIU) and Urgent Care Centre (UCC) • It was perceived 85% of patient who were treated in the A&E would continue to receive their care at the new MIU and UCC and there would be a reduction in the number of emergency ambulance transfers from Newark Hospital to other hospitals, as patients would receive their care in the right place first time	2011

[6] *E. Knowles et al.* Closing five Emergency Departments in England between 2009 and 2011: the closed controlled interrupted time –series analysis

Rochdale ***a market town in the north-west of England***	154,000	• To ensure that health services maintained a safe and sustainable approach to care and that care would be better situated in fewer hospital sites where resources and expertise could be concentrated • Local access to urgent care would be maintained	• Urgent Care Centre open 24/7, with services being delivered by experienced nurses, nurse practitioners and a GP • It was perceived that the UCC at Rochdale Infirmary would care for an estimated 85% of those patients who had previously used the ED in Rochdale	2011
Hartlepool ***A coastal town in the north-east of England***	155,000	• Local NHS managers and doctors supported the closure of the A&E at Hartlepool because of safety concerns, citing (1) insufficient numbers of medical staff to cover two rotas in North Tees Hospital and Hartlepool Hospital and (2) limited overnight supervision of junior medical staff at Hartlepool Hospital	• Urgent Care Centre (UCC), not based on the existing hospital site and located approximately 2 miles away from where the A&E was. • The centre provides a 24-hour Minor Injury Unit, a walk-in centre that is open for 12 hours each day (08.00 to 20.00) and out-of-hours GP medical services.	2011

As can be seen from this table, 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.

In addition, 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:

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

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

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."

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. Which 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.

Conclusions

- 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.
- 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.
- 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.

Appendix 1

The Lincolnshire health system estimated the catchment size for Grantham and District Hospital A&E department by identifying any Lower Super Output Area (LSOA) where 50% or more of the activity (not arriving by ambulance) arriving at and A&E occurs in Grantham.

Any ambulance arrivals were excluded from the activity defining the catchment since the site is unlikely to have been the choice of the patient.

All activity available in the data set was used irrespective of commissioner.

The catchment was defined using the last 12 months prior to Covid-19 (March 2019 – February 2020).

A summary of the estimated catchment size for Grantham and District Hospital A&E based on this methodology is set out below.

District Authority	Population	%
E07000133: Melton	9,401	9%
E07000139: North Kesteven	17,412	18%
E07000141: South Kesteven	68,520	69%
E07000175: Newark and Sherwood	1,569	2%
E07000176: Rushcliffe	2,312	2%
Grand Total	**99,214**	**100%**

Local campaign groups have previously identified the catchment population of Grantham and District Hospital as 120,000. However the basis for this is unknown.

In light of the above, a catchment population of c.100,000 – 120,000 for Grantham and District Hospital A&E department has been used in the consideration of the public feedback.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 0.4: 08 April 2022

Change proposal	**Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre* **Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Ambulance Conveyance
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care Yvonne Owen - Senior Partner Minster Medical Practice LCHS David Baker - GP Neil Scott - EMAS
Date feedback working group signed off response	Version 0.4: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022 and 28 April 2022

Urgent & Emergency Care and Acute Medicine proposal consultation feedback –

Ambulance conveyance

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, two of which related to the provision of services from Grantham and District Hospital:

- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre; and
- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to the Grantham and District Hospital A&E department, concerns about ambulance conveyance were feedback by those both in support and opposition to the proposal:

- Concerns of risk to life as a result of increased travel times in life-threatening emergencies – concerns about ambulance conveyance times to more distant Accident and Emergency Departments at Lincoln County Hospital and other locations
- The rural geography of much of Lincolnshire led to concerns about acute and emergency health service provision becoming more 'spread out' at a time when the population of is growing, particularly around Grantham
- NHS 111 needs to be informed that this is being proposed so that patients if needing treatment here are transferred there rather than being taken to the 2 x A&E departments at Pilgrim / Lincoln County

For the proposals relating to the establishment of integrated community/acute medical beds, concerns were raised in relation to additional impact put onto East Midlands Ambulance Service (EMAS) to transfer people to the nearest hospital with an acute bed.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback relating to ambulance conveyance in the context of the change proposal relating to establishing a 24/7 walk-in Urgent Treatment Centre (UTC). This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Existing exclusion criteria and ambulance travel times

The Grantham and District Hospital A&E department 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 & District Hospital has for some time only dealt with a limited range of presenting conditions.

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.

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.

To support these transfers United Hospitals Lincolnshire 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.

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).

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.

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.

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

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.

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)

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 ULHTs written transfer protocols.

Additional ambulance activity under the service change proposal

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. This would mean more patients going to the right place for care first time and minimising subsequent patient transfers.

To inform the assessment of the proposed service change a travel analysis was conducted to understand the increased journey time for those patients currently attending the A&E department at Grantham and District Hospital who would not if the service change was implemented.

When assessing the change proposal it was estimated that the number of additional patients travelling over 45 minutes for non-elective care would be around 1 a day on average. This was based on the assumption they travel to their nearest appropriate hospital by car and against a baseline of c.21,500 patients across Lincolnshire who currently travel more than 45 minutes to attend urgent and emergency care services by car.

However, in reality given the existing exclusion criteria and the acuity of patients who would no longer be seen at Grantham and District Hospital under the change proposal, it was identified most are likely to travel by ambulance to an alternative site and therefore their travel time could be less than 45 minutes. The independent analysis completed by ORH set out above supports this, with an average travel time to a hospital other than GDH from the wards closest to it being 00:41:29 (maximum average travel time from a ward 00:50:58).

Two key foundations of the proposed care model are to:

- Make sure patients get to the definitive treatment, first time whether that be Grantham 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.

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 proposed 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.

It is not anticipated that the change proposal would result in an increase in the number of ambulance transfers originating from Grantham and District Hospital compared to the average number per year (733). If anything the change proposal should reduce the need for ambulance transfers from Grantham and District Hospital to other sites with an A&E departments as more patients are seen by the right service first time.

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 2 additional weekly DCA vehicle hours would be required, which could be delivered through extending a shift length.

Conclusions and actions

- 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 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.
- Based on actual ambulance travel times, the average time to a hospital other than Grantham and District Hospital from the wards closest to GDH is 00:41:29. The highest average travel time from a ward closest to GDH is 00:50:58
- On average, around 733 patients a per year require transfer by the ambulance service to another hospital.
- 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 and therefore their travel time could be less than 45 minutes.
- Two key foundations of the proposed care model are to:
    - Make sure patients get to the definitive treatment, first time whether that be Grantham 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.
- 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.
- If the change proposal is implemented the additional ambulance hours required to maintain current performance levels will be reflected in the ambulance provider contract.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 0.3: 08 April 2022

Change proposal	**Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre*
Common theme	Workforce and Organisational Integration
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care Yvonne Owen - Senior Partner Minster Medical Practice LCHS David Baker - GP
Date feedback working group signed off response	Version 0.3: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Urgent & Emergency Care proposal consultation feedback –

Workforce and Organisational Integration

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of services from Grantham and District Hospital:

- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to the Grantham and District Hospital A&E department, concerns about workforce and organisational integration:

- Recruiting and retaining staff to the proposed UTC will not be straightforward, the issue of staff recruitment is not just specific to A&E doctors; UTCs experience staff shortages mean there are barely enough to safely staff the existing UTCs. There is concern over where the experienced ACPs will be found to fill these vacancies.
- There may be times in future whereby staff are re-allocated from the UTC to support A&E departments, thus reducing the capacity of the proposed Centre
- When we had the temporary UTC in place at Grantham, there was a disconnect between LCHS and ULHT in terms of safeguarding oversight and IT systems not working together. How will that be resolved in a permanent model?

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback relating to ambulance conveyance in the context of the change proposal relating to establishing a 24/7 walk-in Urgent Treatment Centre (UTC). This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Recruiting and retaining staff to the proposed UTC will not be straightforward, the issue of staff recruitment is not just specific to A&E doctors; UTCs experience staff shortages mean there are barely enough to safely staff the existing UTCs. There is concern over where the experienced ACPs will be found to fill these vacancies.

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, there is a modelling tool that can be used aligned to national guidance. There is recognition that 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. 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.

There may be times in future whereby staff are re-allocated from the UTC to support A&E departments, thus reducing the capacity of the proposed centre

It is not expected that staff would re-allocate between a UTC and A&E due to the difference required in skillset, as is the case with co-located UTCs with A&Es at Lincoln County and Boston, Pilgrim Hospitals? (TBC). The new provider could work closely with the current Lincolnshire UTCs to replicate the flexibility and agility of the current workforce to ensure a standardised offer within the workforce model. To ensure that the patient is seen by the right person at the right time. The new provider could replicate and be supported by the current UTCs around the needed skillset via the current competency and skills framework.

When we had the temporary UTC in place at Grantham, there was a disconnect between LCHS and ULHT in terms of safeguarding oversight and IT systems not working together. How will that be resolved in a permanent model?

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. The provider organisation would be expected to have strict policies in place to ensure the management of safeguarding issues and any staff transferring would be expected to adhere to these policies and would be provided full support and training to allow this to occur.

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. The new provider would provide any training and support required to transfer to a system.

Conclusions and actions

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

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 0.2: 14 April 2022

Change proposal(s)	**Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre*
Common theme	Similar UTC provided at Stamford Run a pilot to see if a 24 hour service should be provided at Spalding UTC
Feedback working group	Tracy Pilcher – System SRO for Urgent and Emergency Care Pete Burnett – System Strategy and Planning Director
Date feedback working group signed off response	Version 0.2: 14 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Similar UTC provided at Stamford and pilot of 24 hour service provision at Spalding UTC

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, three of which related to the provision of services from Grantham and District Hospital:

- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to Grantham and District Hospital suggestions of similar Urgent Treatment Centres elsewhere in Lincolnshire were put forward:

- A similar urgent treatment service to be provided at Stamford to cover areas south of Grantham
- Why have we not run a pilot to see if the same level (24hour) should be provided at Spalding UTC?

The purpose of this paper is to provide a concise evidence-based summary of the feedback received about establishing a similar urgent treatment service at Stamford to cover areas south of Grantham and running a pilot to see if 24 hour provision should be provided at Spalding UTC, in the context of the change proposal relating to establishing a 24/7 walk-in Urgent Treatment Centre at Grantham and District Hospital. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

National Urgent Care Strategy

Nationally, the NHS is in transition. The most recent strategy for the NHS, the Long Term Plan, was published in January 2019 and built on the Five Year Forward View plans of 2014 and 2016, which detailed the need for transformational change in service provision to sustainably support current and future generations.

This included the requirement that:

- In 2019 England will be covered by a 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online.

- All hospitals with a major A&E department will:

    - Provide SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20
    - Provide an acute frailty service for at least 70 hours a week. They will work towards achieving clinical frailty assessment within 30 minutes of arrival;
    - Aim to record 100% of patient activity in A&E, UTCs and SDEC via ECDS by March 2020
    - Test and begin implementing the new emergency and urgent care standards arising from the Clinical Standards Review, by October 2019
    - Further reduce DTOC, in partnership with local authorities.
- By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.

Lincolnshire Urgent Care Strategy

Demand for urgent and emergency care services has increased rapidly in the past decade, a picture which is replicated across systems nationally. Service transformations have already been delivered in facilitating same-day care and reducing the proportions of patients requiring an inpatient stay. However, rising demand on primary care services and the complexity of urgent care systems (and actual services deliverable) has often resulted in the inappropriate use of Accident & Emergency departments.

Urgent Treatment Centres (UTCs) were detailed in the Next Steps on the NHS Five Year Forward View (March 2017) and were born from an ideology for a simpler and more transparent structure to urgent/on-the-day care delivery. UTCs should support populations nationally in accessing appropriate services to manage minor illness and injuries, enabling 999 and Accident & Emergency services to focus on those with highest acuity and greatest need. NHS England published its Principles and Standards document for UTCs in July 2017, detailing a set of core standards to "establish as much commonality as possible". There are 27 standards identified for UTCs, with a set of eight core standards which must be delivered:

- Naming and timing of delivery
- Minimum 12 hours, 7 days
- GP-led with an MDT delivery
- Direct booking from NHS 111
- Access to a summary / local care record
- Electronic prescribing
- Access to simple diagnostics
- X-ray access (protocols available if off-site)

Delivering better integrated and more seamless care, lessening the over-reliance on hospital and statutory services and reducing health inequalities is an aspiration and key priority shared by the NHS, Public Health, Local Authorities and Local Resilience Forum in Lincolnshire.

Our local aspirations focus on:

- Ensuring the right care is provided in the right place at the right time. Patients will experience safe, timely and effective care and UEC services will be accessible 365 days a year; 24 hours a day
- Patients accessing health care directly through 999 or NHS 111 will be triaged through established processes and appropriately transported or booked into the correct assessment or treatment pathway.
- When patients are deemed to require specialist Urgent and Emergency Care, they will be navigated by primary, community and paramedic staff into specialist care and directed back into primary and community care when the criteria are met
- Primary and community services will refer into ambulatory services to see, assess and manage patients with specialist health care needs such as neurology, cardiology, abdominal pain and COPD, and pull them back into primary and community services as soon as appropriate
- Patients presenting directly at our acute hospital sites will be triaged and appropriately streamed into the urgent treatment centre, SDEC or direct to specialities

A similar urgent treatment service to be provided at Stamford to cover areas south of Grantham

Why have we not run a pilot to see if the same level (24hour) should be provided at Spalding UTC?

The Lincolnshire Urgent Care Strategy covers the whole of the county, including provision at Stamford and Spalding.

At the heart of this strategy there are key determining factors that inform and influence the optimum delivery of urgent care services across the county, including:

- The required scale of provision for these services to ensure staff working in them maintain and continue to develop their skills and be attractive to work in;
- The required staffing levels for urgent care services that enable the ongoing provision of safe care; and
- The availability of doctors and nursing to staff these services in a sustainable manner

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

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

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

Conclusions and actions

- The national Urgent Care Strategy set out the need for transformational change in service provision to sustainably support current and future generations.
- A local Lincolnshire Urgent Care Strategy has been developed in line with the national strategy and is already delivering system transformation.
- 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.
- The Lincolnshire Urgent Care Strategy is under constant review and development to ensure urgent care services best meet the needs of all Lincolnshire residents.
- 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.
- Services provided at Stamford and Spalding were not part of the public consultation.
- At present, there are no additional plans to replicate or pilot this model in other locations across the county.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 0.2

Change proposal(s)	**Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre*
Common theme	New Specialist Hospital
Feedback working group	Lincolnshire Strategic Infrastructure and Investment Group (LSIIG)
Date feedback working group signed off response	4th April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Urgent and Emergency Care proposal consultation feedback – New Specialist Hospital

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, three of which related to the provision of services from Grantham and District Hospital:

- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to Grantham and District Hospital a suggestion of a more radical approach was put forward:

- A new specialist hospital be built near Sleaford to deal with all emergency care, leaving other hospitals in Lincolnshire to deal with routine and planned care

The purpose of this paper is to provide a concise evidence-based summary of the feedback received about establishing a new specialist hospital near Sleaford, in the context of the change proposal relating to establishing a 24/7 walk-in Urgent Treatment Centre at Grantham and District Hospital. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

A new build scenario

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. 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.

Following widespread agreement by senior clinicians of the need for change in the prioritised services, potential solutions for improving care provision were considered.

This exercise identified a list of options for change at a service level which were put together in different combinations to develop a 'long list' of nine overarching scenario-based options.

This long list of options presented a view of significant change possibilities, thereby providing a sense of what could be achieved.

One of the nine overarching scenario-based options was not to build a new specialist hospital near Sleaford to deal with all emergency care, leaving other hospitals in Lincolnshire to deal with routine and planned care.

However, as part of the process for considering and assessing a number of options for addressing the challenges faced by the Lincolnshire health system, the ASR programme modelled a new build

scenario and analysed the consequences of closing Lincoln County Hospital, Pilgrim Hospital Boston and Grantham & District Hospitals and a new hospital site established in the centre of Lincolnshire.

This hypothetical hospital site is unknown and identified as the postcode NG34 which is in Sleaford. The ASR activity driven finance model was used to demonstrate the impact of the NG34 scenario, based on a set of input assumptions on shifting activity.

The Lincolnshire Estates and Capital Planners then considered the size of the required new building (based on the modelled activity) and concluded that an additional cost of a further £25m per year revenue cost could be added to the identified deficit. Plus, advised that 8 years is the average time for these large scale developments to go from feasibility studies, through OBC, FBC, Treasury agreement and construction.

In light of the immediate quality, financial and workforce challenges, the System Executive Team concluded not to progress further work on this single site new build scenario and to revisit this decision in three years. This future review was incorporated into the Lincolnshire's Estates and Capital Strategy submitted to NHSE in July 2018.

This new build scenario is different to the suggestion put forward through the public consultation in terms of scope, however similar issues would exist in terms of the cost and time to implement given the immediate quality, financial and workforce challenges.

Lincolnshire health system strategic estates plan

In light of the conclusion described above in terms of the new build scenario, more recently consideration has been given to the future of the Lincolnshire health system's estate strategy through a system strategic estates plan.

The Lincolnshire Health Infrastructure Plan is currently in development. This focuses on the capital infrastructure that will be needed in the next 15 years to ensure we have:

- Facilities in the right place to deliver the right capacity at the right time – reducing duplication
- Facilities that are safe and provide the best possible therapeutic environment for staff, patients, service users etc.
- Increased integration of services to proactively support patients based on population health needs. Integration including local authority and voluntary sector partners
- Improved recruitment and retention of staff including the links to the University Medical School and other training opportunities
- Facilities that are sustainable and contribute to a reduction in our carbon footprint
- Facilities that support us in our drive to be anchor partners across all of the Districts – linking in with the work we are doing with the Towns Funds, Levelling Up Funds etc.

- Impacts on economy – there will be increased opportunities for local employment during the construction phase and when in operation will support local recruitment and the local economy.

Work was carried out in 2019/20 to look at the acute hospital sites and configurations. This internal document desk top theoretical exercise considered several options:

Options	Hot	Urban Urgent Care	Local Urgent Care	Specialist Elective Care	Urban Planned Care	Local Planned Care	Step Down Beds
Option 0: do minimum: ASR with growth, no shifts	2	3	As required	3	3	As required	3 + comm-unity
Option 1: Two Hot Sites & 1 Satellite	2	3	As required	3	3	As required	3 + comm-unity
Option 2: One Hot Site & 2 Satellites	1	3	As required	2	3	As required	3 + comm-unity
Option 3: 1 Central Site plus 3 Satellites	1	3	As required	1	3	As required	3 + comm-unity
Option 4: New Central Site & 3 New Satellites	1	3	As required	1	3	As required	3 + comm-unity

The indicative costs at that time were as follows:

Option	Out-tun cost £
Option 0 – do minimum; ASR with growth, no shifts	**1,464,090,623**
Option 1a - Two Hot sites and one satellite site (utilising existing)	**1,083,739,394**
Option 1b - Two Hot sites and one satellite site (new build)	**1,403,079,388**
Option 2a - One Hot site and two satellite sites (utilising existing)	**1,125,361,851**
Option 2b - One Hot site and two satellite sites (new build)	**1,406,429,211**
Option 3 - New Central site and three Satellite sites (utilising existing)	**1,271,655,778**
Option 4 - New Central site and three New Satellite sites	**1,528,076,402**

Following internal discussions, it was agreed that 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.

Conclusion

The Infrastructure plan development has focused on the existing sites. This has supported the three expressions of interest that were submitted in September to the New Hospitals Programme.

As part of the Build Back Better the government manifesto was to build 40 new hospitals by 2030 – backed by £3.7bn. 8 build schemes already in progress were badged against this. In Oct 2020 – a further 32 schemes on the radar were then badged against it- these were where plans were quite mature/a business case existed. In July 2021 there was then a call for a further 8 schemes - so that's 48 in total now. It was open to all NHS Trusts to bid.

The three Provider Trusts to develop three Expressions of Interest for the New Hospitals Programme. These which were submitted on 9th September. The proposals from the three provider trusts totaled £790m. These were as follows:

- United Lincolnshire Hospitals NHS Trust - £560m for Phase 1 at Lincoln County Hospital, Phase 1 at Pilgrim Hospital Boston, and Grantham Hospital
- Lincolnshire Community Health Services NHS Trust - £160m for County Hospital Louth, Skegness Hospital, and John Coupland Hospital Gainsborough
- Lincolnshire Partnership NHS Foundation Trust - £70m for Norton Lea, Boston, and St Georges, Lincoln

We are awaiting national decisions – 126 EOIs were submitted for 8 potential schemes

The Lincolnshire Infrastructure Plan is in draft and is being reviewed by system partners. It takes account of digital and care closer to home initiatives as well as demographics and health inequalities/deprivation information. The Greener NHS plans and the need to look at the carbon footprint of existing buildings and new builds are also considerations.

Through the work that has taken place to date, it was agreed that a new site at Sleaford is not a viable option and the focus will be 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.

Appendix F3

Consideration of public feedback by subject matter expert working groups

ACUTE MEDICINE

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Change proposal(s)	**Acute Medical Beds** *Develop integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Quality and Workforce
Feedback working group	Carl Ratcliff - Managing Director Medicine ULHT Kate Scheele - Consultant Respiratory Medicine ULHT Yvonne Owen - LCHS David Baker - GP
Date feedback working group signed off response	Version 3.4 dated 86/04/2022 Friday 8th April
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Acute medicine beds proposal consultation feedback – Quality and Workforce

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to:

- Developing integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to acute medical beds at Grantham and District Hospital there was feedback in relation to quality and workforce in support of the proposal:

- The proposal would provide benefits such as more efficient care, with patients being discharged more quickly while continuing to receive treatment and care in their communities
- The proposal for integrated community/acute medical beds at Grantham and District Hospital is likely to improve the recruitment and retention of consultants and middle-grade doctors

Supportive feedback was also received from the Chartered Society of Physiotherapy, however they identified that adequate staffing and resources must be provided:

- The society would support the integration of acute/community medical beds at Grantham and District Hospital. This is with the proviso that the required workforce across the whole pathway can be attained, with any required training needs met prior to the service commencing
- Adequate staffing and resources must be provided for a comprehensive seven-day service with all professions having the full resources they require to enable a high level of quality of care that facilitates better outcomes for the population of Lincolnshire

However, feedback was received from a local group who expressed concerns that:

- The proposals will place elderly patients with complex needs out of a secure hospital environment supported by specialist consultants and either move them to alternative hospital sites requiring considerable journeys with associated risks, or, place them into community care which is known to be fragmented and where monitoring patient progress and outcomes will become much more challenging. They will not receive the level of medical care they would get in hospital until they make a recovery and will be at greater risk of non-recovery.
- There is no reference to Grantham & District Hospital as a training hospital in the new plans and dissatisfied staff and consultants will make the future of hospital services across the county less sustainable.

In addition there was also a common set of feedback in relation to quality and workforce that was shared both in support and in opposition of the proposal:

- Would provide benefits such as more efficient care, with patient being discharged more quickly while continuing to receive treatment and care in their communities
- Concerns expressed that other services need to be involved to facilitate the change e.g. adult social care and primary care, and these services are already overwhelmed
- Concerns about cost of implementing the changes and increased workload required
- Community staff are in short supply as well as hospital staff

Finally, some feedback was received that offered mitigations to perceived issues:

- Difficulty accessing GPs means minor illnesses are not treated, leading some to increase in severity resulting in hospitalisation – NHS could reduce the demand for hospital beds by ensuring residents can more easily organise appointments with their GP
- A huge recruitment drive is needed for clinicians, care-workers and therapists

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback received through the public consultation for the proposed acute medicine beds at Grantham and District Hospital changes in relation to quality and workforce. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Quality and outcomes benefits of the proposed medical beds change

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.

The table below provides an overview of the care, quality and outcomes benefits of the proposed services changes for acute medicine against the current model of care (i.e. that provided before the COVID-19 pandemic and subsequent temporary service changes).

Overview of acute medicine change proposal (as set out in PCBC)

Acute Medicine	
Current model **Provided from 3 sites, exclusion criteria at Grantham Hospital**	**Proposed model** **Grantham Hospital medical beds to become integrated acute/community beds (community/acute provider partnership)**
• ULHT Acute Medicine services experience significant workforce challenges in their ability to deliver a safe, quality service. • It is widely recognised the ULHT Acute Medicine service is clinically and operationally unstable in its current form. • Across ULHT Acute Medicine service there is significant recruitment and agency spend challenges. • 40% vacancy rate for respiratory consultants across ULHT. • Key specific issue relating to Grantham is sustainability of the acute medicine service as it has a selected take (exclusion criteria in place since 2007/08) • Clinical audit of patients in acute medicine beds in Grantham Hospital identified 80% of patients could be supported in the beds by a community provider. Only c.10% were seen as requiring specialist acute hospital support. Remainder of the admissions could have been avoided if appropriate alternative community service were available at time of admission. • Long lengths of stay on acute medicine wards at Grantham Hospital.	• Delivers a balance between access and sustainable long term outcomes for acute medicine services – as articulated by the East Midland Clinical Senate. • Majority of patients currently receiving Acute Medicine care at Grantham Hospital would do so in future, only c.10% of high complexity patients would be cared for at another hospital with immediate access to Specialist and/or Critical Care. • Enables Grantham Hospital to offer services which may not be offered elsewhere and build a centre of excellence for integrated multi-disciplinary care, particularly for frail patients. • 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 – improved accessibility to specialist advice for primary care and community-based teams • Supports improved community-based management of LTCs 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.

The East Midlands Clinical Senate panel described the proposal as innovative and achieved an excellent balance between access and sustainable long term outcome. Elderly, frail patients will generally be appropriate for management within the proposed model of care and are therefore unlikely to be impacted by the change.

The proposals will place elderly patients with complex needs out of a secure hospital environment and either move them to alternative hospital sites requiring considerable journeys with associated risks or place them into community care which is known to be fragmented

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.

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.

The change proposal 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. 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.

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.

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.

The conclusion of the East Midlands Clinical Senate panel following a review of the change proposal was that it is an innovative model which achieves an excellent balance between access and sustainable long term outcomes.

If the service change is agreed and implemented, changes would be completed through a sequence of changes to clinical practice and the workforce. As a natural progression each planned change either allows for the flow of patients or working practices of staff (or both) to alter to facilitate the creation of the next change. Throughout this process there would be ongoing monitoring of the clinical outcomes of patients.

The above was set out in the public consultation document and in more detail in the Pre Consultation Business Case.

Concerns about adequate staffing, cost of implementing the changes and increased workload required

For the Pre Consultation Business Case the cost of implementing the proposed service change proposal for acute medical beds at Grantham and District Hospital was calculated as c. £250k. This financial impact is based on:

- A dedicated medical establishment for Grantham and District Hospital based on the proposed 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

An overview of the acute medical beds existing service model vs proposed service model is set out in the table below.

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**

As can be seen from the table above, the proposed service model is based on an increase of c.29 whole time equivalent staff.

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.

Where it may be necessary, all staff will be consulted and have the opportunity to work on other sites within ULHT and any gaps that may exist will be recruited to. Agency & Bank work will play a part in workforce as required, to meet the service need, as they do in all trusts in Lincolnshire currently.

Existing workforce structures will be in place to support and on-board additional staff, ensuring that their own CPD is taken into account and they have agreed professional and personal goals to ensure their competencies are current and maintained to ensure the service delivery. Within Lincolnshire, we have access to multiple learning providers both via HEE and University funded programmes, and can work with individuals using our clinical educators within organisations to support competence development.

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

Concerns about Grantham and District Hospital not being referenced as a training hospital in the plans and dissatisfied staff making services less sustainable across the county

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). The information in the PCBC is reflected below. 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.

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

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

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.

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).
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.

Community staff are in short supply as well as hospital staff
A huge recruitment drive is needed for clinicians, care-workers and therapists

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

In Lincolnshire recruitment and retention, initiatives continue throughout all community service lines, to ensure we attract and retain talent within the organisation. We continue to offer various roles and pathways that suit an individual needs and supports their professional and personal lifestyle. Lincolnshire will look to offer rotational roles to allow individuals to expand their knowledge and experience in varying roles to support patients and the local population.

Concerns expressed that other services need to be involved to facilitate the change e.g. adult social care and primary care, and these services are already overwhelmed

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.

During 2021 Lincolnshire has been actively leading system improvement programmes which includes the care closer to home programme. This actively looks to support individuals in their own home and ensure that management of care stops onward admission, this programme constitutes a makeup of pathway improvements including Palliative and End of Life, Patient Flow and a new Urgent Community Response which will allow an MDT of clinicians actively manage a patient in their own home.

Difficulty accessing GPs means minor illnesses are not treated, leading some to increase in severity resulting in hospitalisation – NHS could reduce the demand for hospital beds by ensuring residents can more easily organise appointments with their GP

Lincolnshire currently offers GPs easier pathways to access minor illness and injury pathways, this may be through various routes including same day appointments at UTCs, access to the Clinical Assessment Service or using any other admission avoidance pathway to ensure patients are managed in their home.

New models of access to general practice have developed during the pandemic, with increased availability of online, video and telephone appointments where appropriate, to complement face to face appointments for patients.

From October 2022, there will be new enhanced access arrangements for primary medical services, which will reduce variability across the county. The new offer will see Primary Care Networks provide enhanced access at evenings and weekends, utilising the full multi-disciplinary team and offering a range of services in line with patient preference and need.

There are also a range of programmes to support workforce expansion to improve access to care, including significant expansion of additional roles, such as paramedics, mental health practitioners and advanced practitioners, to complement the existing clinical workforce and ensure patients access the most appropriate care in the first instance.

Conclusions and actions

- 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.

- 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.

- 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.

- 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.

- Staff will be fully supported in terms of recruitment where required, use of temporary staff to bridge gaps, full training and support.

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

- An increase in financial cost of the service has been modelled and this includes an increase in staff numbers

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 1.0: 08 April 2022

Change proposal	**Orthopaedics** *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* **Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre* **Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Conditions that would be treated at 24/7 Grantham and District Hospital UTC
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care Yvonne Owen - Senior Partner Minster Medical Practice LCHS David Baker - GP Neil Scott - EMAS
Date feedback working group signed off response	Version 1.0: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022 and 28 April 2022

Orthopaedics, Urgent & Emergency Care and Acute Medicine proposal consultation feedback – Conditions that would be treated at 24/7 Grantham and District Hospital UTC

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, three of which related to the provision of services from Grantham and District Hospital:

- 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;
- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre; and
- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to Grantham and District Hospital there was feedback in support of the proposals relating to:

- Acknowledgement that evening and overnight visitors to the A&E departments at Lincoln County Hospital or Peterborough City Hospital could be treated at a more local UTC
- 24-hour access to walk-in UTC might relieve pressure on Lincoln County Hospital's A&E, as well as benefiting those living in and near to Grantham if the majority of them would not need to travel to Lincoln to receive out of hours urgent care
- Recognition of issues such as Grantham's growing and aging population and travel to Lincoln County Hospital, for respondents and residents that supported the proposals they represent a reasonable 'real world' compromise to these issues that could be mitigated against, not least by ensuring that local residents are made fully aware of what services a UTC would be able to provide

Some concerns expressed about the proposal, in terms of the conditions that would be treated at the 24/7 UTC, 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:

- Reassurances that a 24-hour Urgent Treatment Centre would be appropriate for the vast majority of patients requiring out-of-hours assessment and treatment and might therefore lead to shorter waiting times and less pressure on A&E services in other locations in Lincolnshire, were accepted by many of those who agreed with the proposals.

- There was also recognition that most people who would require full A&E services, such as trauma patients, would in any case be transported by ambulance to the nearest appropriate site.

In addition, public feedback identified that it is vital that a UTC at Grantham and District Hospital should always operate as a walk-in service, rather than requiring people to contact NHS 111 first to ensure that people use of the service and do not travel elsewhere unnecessarily.

Other feedback identified that NHS 111 needs to be fully informed of who they can send to Grantham instead of an A&E department further afield, and that ambulances are 'allowed' to transport patients to Grantham directly. Some people were also worried that opening times would drop later to 12 hour opening from 24/7.

Feedback in opposition to the proposal linked the proposal for orthopaedic surgery to changes in urgent and emergency care provision.

Concerns about quality of care provided at A&E departments at Lincoln County Hospital and Pilgrim Hospital in Boston, as well as the long wait times some respondents had experienced (which might become worse without A&E services at Grantham and District Hospital) were expressed by those in support and opposition of the proposal.

In addition to this feedback from the consultation, a member of the public submitted information that they felt showed statements in the public consultation that Grantham and District Hospital did not have a Level 1 A&E from 2007/08 as inaccurate, as every level of severity across a wide range of critical conditions were treated and stabilised at the hospital. A question was posed around 'how does this compare to the level of service that would be provided from the proposed Urgent Treatment Centre?'.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the conditions that are currently treated at Grantham and District Hospital and those that would not be if the proposed changes were implemented. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

It is due to these clinical interdependencies that the feedback set out above relating to Urgent and Emergency Care and Acute Medical beds has been brought together and considered as one.

Orthopaedics

Current situation

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 Hospitals Lincolnshire NHS Trust (ULHT) has been part of a national orthopaedic pilot to look at how service quality and patient outcomes could be improved.

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.

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.

The Pre Consultation Business Case (PCBC) that was made publicly available at the start of the public consultation described this situation in more detail.

Proposed changes

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.

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.

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 (See Appendix 1 of this document).

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

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)

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 proposed 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.

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.

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 Hospitals Lincolnshire NHST Trust and Lincolnshire Community Health Services NHS Trust.

Urgent and Emergency Care and Acute Medicine

Current situation

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.

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.

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.

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.

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 (see Appendix 2). 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.

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.

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).

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.

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.

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.

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.

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.

<u>Proposed changes</u>

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.

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.

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)

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.

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.

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 Hospital site.

Within the PCBC the Grantham and District Hospital Acuity Model to underpin the proposed changes was outlined as follows:

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.

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 the Appendix of the PCBC (see Appendix 1 of this document).

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 proposed 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.

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.

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 Hospitals Lincolnshire NHST Trust and Lincolnshire Community Health Services NHS Trust.

Reassurances that a 24-hour Urgent Treatment Centre would be appropriate for the vast majority of patients requiring out-of-hours assessment and treatment and might therefore lead to shorter waiting times and less pressure on A&E services in other locations in Lincolnshire

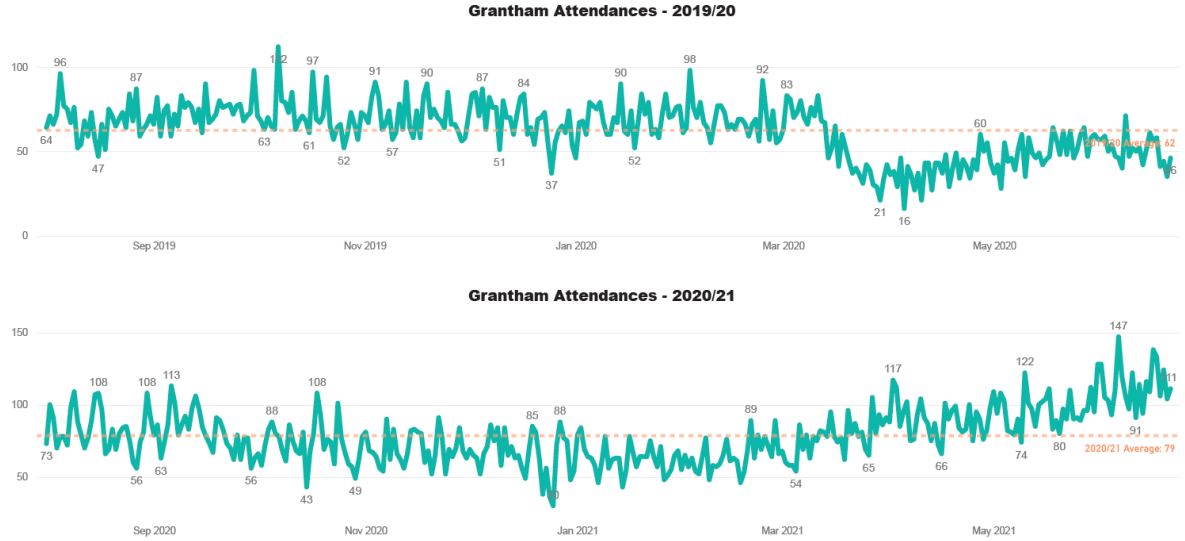
Activity modelling completed to assess the change proposal estimated that with the proposed change and refinement of the exclusions criteria, around 3% of those patients currently attending the Grantham and District Hospital A&E. This is equivalent to 2 patients a day, on average. These are patients 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.

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.

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 Hospital in response to the pandemic, the temporary changes do provide useful insights.

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.

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.



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.

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

Conclusions and actions

- 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 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.
- However, it is important to note that having the skills and experience to manage patients who initially attend with this level of acuity, as well as those who attend with a lower acuity but deteriorate to this level whilst on site, before transferring does not define the Grantham and District Hospital A&E department as 'Level 1'. This has been confirmed by independent external reviews.
- Under the proposed service change for a 24/7 Urgent Treatment Centre (UTC) at Grantham & District Hospital in place of the current A&E department, the UTC would be 24/7, walk-in and 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.
- Activity modelling completed to assess the change proposal 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. This is equivalent to 2 patients a day, on average. These are patients who require onward transfer for immediate specialist care. If the proposed change is implemented the activity modelling will be kept under ongoing review.
- Those additional patients who would be seen at a different site under the proposal 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. The refined exclusion criteria that would underpin the proposed 24/7 UTC at Grantham and District Hospital if it went ahead was included in the PCBC.
- 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. If the proposed change is implemented this analysis will be kept under ongoing review.
- 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. This will include 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.
- The communication plan will be rolled out using NHS Lincolnshire CCG's well established communication channels as well as those of all local health and care providers, including ULHT and LCHS.
- In addition, 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 proposed 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.

Appendix 1

United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust

Grantham and District Hospital
Urgent Treatment Centre, Ambulatory Care Unit and Emergency Assessment Unit exclusion criteria

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital Urgent Treatment Centre, Ambulatory Care Unit & Emergency Assessment Unit

- News ≥ 7 WITH frailty score of < 5
- A patient requiring immediate airway management and/ or resuscitation
- Status epilepticus
- Fast Positive Stroke / high risk TIA
- STEMI
- Acute coronary syndrome- Ongoing ischaemic chest pain with 1mm ST depression in more than one limb lead or in two or more consecutive chest leads
- CONFIRMED NSTEMI- Once diagnosis made In UTC or Ambulatory Care- transfer to LCH
- Post cardiac arrest
- Significant bradycardia < 40bpm, 2nd or 3rd degree AV block, Ventricular tachycardia
- Suspected acute heart failure WITH frailty score < 5
- Reduced conscious level (not alert) – Glasgow Coma Score <13- or PU on AVPU WITH frailty score < 5
- Acute respiratory distress with an oxygen saturation < 91% on room air WITH frailty score < 5 "unless" the patient has known significant chronic lung disease
- Gastro-intestinal haemorrhage (fresh blood or melaena).
- Severe abdominal pain and acute abdomen (refer patient directly to Lincoln County.)
- A female of childbearing age with lower abdominal pain
- A male with testicular pain
- A patient with suspected AAA or ischaemic limb needs admission to the on-call vascular unit (Pilgrim Hospital)
- All Obstetric and Gynaecological patients
- Neutropenic sepsis
- Patients requiring dialysis
- Patients with renal transplants
- Ophthalmological emergencies e.g. acute glaucoma, trauma
- All Major trauma is excluded from this site in line with the East Midlands Trauma Network Triage Tool, including all suspected femoral fractures.
- Fractures/ dislocations with evidence of distal neurovascular compromise. See over page for trauma that can be treated on the Grantham Hospital site
- Open lower limb fractures of femur, tibia/fibula, ankle or forefoot

Note: Patients who are house bound OR from a nursing/care home OR where RESPECT form has limitations of care in place that would make escalation of care inappropriate should normally continue to be brought to Grantham for assessment for medical conditions

Paediatric Exclusions

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital Urgent Treatment Centre

- Children with a POPS score of 5 or more
- Children requiring immediate airway management and/ or resuscitation
- Children requiring Paediatric assessment / Review
- Children with biphasic stridor
- Children with DKA
- Children with Status epilepsy
- Children who have self-harmed
- Children requiring Mental health assessment

Trauma that can be treated in 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 subsequent transfer after assessment)
- Children's suspected fractures- if confined to one area and child is haemodynamically stable(may require subsequent transfer after assessment)

Appendix 2

Count of PASID		Years	DateofObservation
		2017	Grand Total
LocationDesc	newsscore	Nov	
A&E	5	35	35
	6	34	34
	7	22	22
	8	23	23
	9	9	9
	11	4	4
	14	1	1
A&E Total		128	128
Grand Total		128	128



United Lincolnshire Hospitals NHS Trust

2014/15 - Total and Diagnosis description of patients admitted to Grantham Hospital wards as 'Emergency'

FIN_YEAR	HOSPITAL_AT_START	WARD_CODE_AT_START	ADMISSION_METHOD	DIAG_PRIMARY_NAME
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Lobar pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Viral infection, unspecified
2014/15	Grantham Hospital	GK-HDU	Emergency - GP	Lobar pneumonia, unspecified
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Infection following a procedure, not elsewhere classified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Other giant cell arteritis
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Left ventricular failure
2014/15	Grantham Hospital	GK-2	Emergency - GP	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Effusion of joint Lower leg
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Unspecified acute lower respiratory infection
2014/15	Grantham Hospital	GK-1	Accident and Emergency	Other and unspecified abnormalities of gait and mobility
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Type 2 diabetes mellitus Without complications
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Cellulitis of other parts of limb
2014/15	Grantham Hospital	GK-HDU	Accident and Emergency	Congestive heart failure
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Dyspnoea
2014/15	Grantham Hospital	GK-GAEC	Accident and Emergency	Chest pain, unspecified
2014/15	Grantham Hospital	GK-GKSU	Accident and Emergency	Cerebral infarction, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Mental and behavioural disorders due to use of alcohol Acute intoxication
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Chronic obstructive pulmonary disease with acute lower respiratory infection
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Acute transmural myocardial infarction of anterior wall
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Sepsis, unspecified
2014/15	Grantham Hospital	GK-CARD	Accident and Emergency	Acute myocardial infarction, unspecified
2014/15	Grantham Hospital	GK-2	Emergency - GP	Urinary tract infection, site not specified
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Pleural effusion, not elsewhere classified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Congestive heart failure
2014/15	Grantham Hospital	GK-GAEC	Accident and Emergency	Hypotension due to drugs
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Gastro-oesophageal reflux disease without oesophagitis
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Other specified soft tissue disorders Lower leg
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Pneumonia, unspecified
2014/15	Grantham Hospital	GK-CARD	Accident and Emergency	Other ill-defined heart diseases
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Open wound of other parts of head
2014/15	Grantham Hospital	GK-6	Accident and Emergency	Poisoning: 4-Aminophenol derivatives
2014/15	Grantham Hospital	GK-2	Accident and Emergency	Multiple fractures of ribs closed
2014/15	Grantham Hospital	GK-1	Accident and Emergency	Urinary tract infection, site not specified
2014/15	Grantham Hospital	GK-1	Emergency - GP	Sepsis, unspecified
2014/15	Grantham Hospital	GK-6	Emergency - GP	Cellulitis of other parts of limb
2014/15	Grantham Hospital	GK-EAU	Emergency - GP	Other and unspecified abdominal pain
2014/15	Grantham Hospital	GK-EAU	Accident and Emergency	Chronic obstructive pulmonary disease with acute lower respiratory infection
2014/15	Grantham Hospital	GK-1	Emergency - GP	Acute myocardial infarction, unspecified

Note: This is the first page of 142

Public consultation on four NHS services

Addressing common themes, alternative options and additional information

Version 1.1: 08 April 2022

Change proposal (s)	**Orthopaedics** *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* **Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre* **Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme *Note: the two themes arising across different change proposals have been considered together given the interdependencies*	Full A&E and hospital service provision at Grantham and District Hospital
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care David Baker - GP Yvonne Owen - Senior Partner Minster Medical Practice LCHS Neil Scott - EMAS
Date feedback working group signed off response	Version 1.1: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022 and 28 April 2022

Orthopaedics, Urgent & Emergency Care and Acute Medicine proposal consultation feedback –

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

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, three of which related to the provision of services from Grantham and District Hospital:

- 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;
- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre; and
- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For many respondents, a 24-hour UTC was viewed as preferable to the current limited services A&E department operating from 8.00am-6.30pm

The vast majority of those who rejected the proposals for a 24-hour UTC at Grantham and District Hospital did so, not on the basis that they favour the status quo of current service provision, but rather because they want a full, 24/7 A&E department in place of the current 8:00am to 6:30pm service. Feedback included:

- Grantham and District Hospital should have a full 24/7 A&E Department - Any changes to acute services at the hospital in Grantham were viewed as unacceptable and, in many cases, seen as a continuation of under-investment and a process of service reduction at Grantham and District Hospital over a period of a number of years
- Services at Grantham and District Hospital need to be protected and expanded/more services delivered with reference made to emergency orthopaedic surgery and stroke services in particular
- Lack of trust in the case for change and strong concern the proposal is another step in a deliberate 'downgrading' of Grantham and District Hospital
- Proximity of the A1, major railway links and airports increases the risk of major incident that might overwhelm remaining A&E services without Grantham and District Hospital being able to provide support
- The strength of feeling from some members of the public was further evidenced by the submission of two petitions with a combined total of 1,818 signatures or online indications of support calling for a 24-hour A&E department at Grantham and District Hospitals.

- Proposals do not take into account or properly address the growing and ageing population in Grantham – The variety of patient ailments, growth of Grantham and large rural catchment are patients deserve a better quality of service than the UTC offers
- Grantham and District Hospital should be a fully services hospital with acute medical beds
- Concerns about negative impacts on the quality of care being provided, and the potential for increased pressure on other hospital sites

In the contest of the above alternative options were put forward in the consultation feedback:

- Current part-time limited A&E department at Grantham and District Hospital to be replaced by (or 'restored to') a full Type 1 Accident and Emergency Department
- A&E services should continue to be offered at Grantham and District Hospital during the day, with a UTC in operation only overnight
- Lincoln and Pilgrim A&E departments are often stretched and prolonged ambulance handover delays. ULHT should build the A&E capabilities at Grantham to cut transfer times, reduce risk for patients, make it attractive to staff.
- Maintain A&E services at Grantham and provide dedicated, separate walk in services, run by nurse specialists, in addition to A&E services for emergency / ambulance admissions in Lincoln and Boston.

A mitigation was also put forward which was to train additional Advanced Care Practitioners (ACPs) to compensate for the shortage of consultants.

The purpose of this paper is to provide a concise summary of the key evidence-based points relating to provision of A&E services at Grantham and District Hospital as well as those services with clinical interdependencies required to deliver a 'full service', to ensure conscientious consideration of the feedback received during the public consultation.

It is due to these clinical interdependencies that the feedback set out above relating to Urgent and Emergency Care and Acute Medical beds has been brought together and considered as one.

This paper reflects and builds upon the significant scrutiny that has been placed upon the A&E department at Grantham Hospital over recent years, including that by the Independent Reconfiguration Panel (IRP) and the East of England Clinical Senate.

A&E department provision in Lincolnshire

When considering the provision of Accident and Emergency (A&E) departments it is important to consider the definition of the services.

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

- Type 1 – 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.

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.

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.

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 & 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).

Major trauma cases go to Queens Medical Centre in Nottingham.

The Grantham and District Hospital A&E department 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 & District Hospital has for some time only dealt with a limited range of presenting conditions.

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.

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.

In addition to the three A&E departments provided by ULHT, six Urgent Treatment Centres (UTC) are provided by Lincolnshire Community Health Services NHS Trust (LCHS).

These are located at:

- Lincoln; co-located with the A&E department at Lincoln County Hospital
- Boston; co-located with the A&E department at Pilgrim, Boston Hospital
- Louth
- Skegness
- Gainsborough
- Spalding

The staffing challenge faced by A&E departments

Nationally

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)[1], 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[2].

In one of its reports into the challenges facing A&E departments the Kings Fund[3] highlight that the Royal College of Emergency Medicine identify that emergency medicine has a high attrition rate from doctors in training, high early retirement rates for experienced clinicians, and significant reliance on temporary locum clinical staff. The report goes on to identify that in a General Medical Council survey in 2020, nearly three-quarters of emergency medicine trainees rated the intensity of their workload as heavy or very heavy, substantially more than any other specialty.

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.

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

[1] Health Education England, NHS England, NHS Improvement and RCEM (2017) *Securing the future workforce for Emergency Departments in England*
[2] Health Education England (2017) *Facing the facts, Shaping the Future: A draft health and care workforce strategy for England to 2027*
[3] The Kings Fund *What's going on with A&E waiting times?*

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.

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.

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.

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.

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

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.

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.

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).

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.

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

Locally

In 2016, in light of the pressures being faced by ULHT's A&E departments as a whole (a national shortage of emergency medicine doctors, insufficient doctors in training choosing to work at ULHT, an increasing reliance on locums and difficulty in securing the number of locums required to fill gaps in rotas consistently), the ULHT Board agreed to implement a temporary overnight service closure at Grantham & District Hospital to support the staffing at Lincoln County and Boston, Pilgrim A&E departments, as releasing middle-grade doctors to work at these two sites would provide safer services for the Lincolnshire population as a whole.

At the time there were four substantive consultants in post out of 15 funded whole time equivalent (wte) posts, with vacancies being filled by locums. Furthermore, there were 11.6 wte middle-grade doctors against the 28 funded posts. The reduced emergency staffing levels, combined with a reduction in skill mix of substantive staff, compromised the on-going provision of safe 24 hours, seven days per week A&E care across three sites. Although efforts were continuing to recruit additional staff, and various steps had been taken to mitigate staff shortages it was felt further action was required.

In August 2016 an initial three-month overnight closure of the Grantham and District Hospital A&E Department was introduced by ULHT taking it from a 24/7 service to 09.00-18.30 seven days a week. The closure of the A&E was initially between 18.30 and 09.00. The exclusion criteria did not change with the changes in opening times.

The Lincolnshire Health Scrutiny Committee concluded that the closure of A&E services between 18.30 and 09.00 at Grantham and District Hospital represented a substantial variation in the provision of health services in the area. The Committee decided that the matter should be referred to the Secretary of State, who passed the matter onto the Independent Review Panel (IRP).

Since the review by the East Midlands Clinical Senate, ULHT has continued to work hard to improve medical staffing levels in its A&E departments and had significant success with a wide range of initiatives (including securing significant external clinical support to coordinate its recruitment programme, refreshing its offer to new recruits, revising the approach to in-house training and rotations, reviewing relocation packages and providing a highly supportive onboarding programme), however recruitment continues to be a real challenge both locally and nationally.

The current staffing position at ULHT is described later in this paper.

Independent clinical advice on the closure of Grantham and District A&E department over night

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 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 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 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 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.

The IRP concluded that in the interests of safety the A&E service at Grantham 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 Hospital and more widely across Lincolnshire.

Following the referral to the IRP, ULHT continued its effort to recruit staff and the closure of A&E services between 18.30 and 09.00 at Grantham Hospital was reviewed. A review in February 2017 concluded that the threshold to re-open the service full time had not been met but acknowledged there had been significant improvement in staffing levels.

To inform the ULHT's Board decision on re-opening the A&E at Grantham and District Hospital, NHS Improvement commissioned a review to allow for an independent, expert, evaluation on the staffing levels across the three A&E departments and recommendations about extending the opening hours of the Grantham A&E departments.

The report produced by the East of England Clinical Senate 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 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.

In addition to the above and in summary the key recommendations coming out of the review from the Clinical Senate panel include:

Recommendation 1:

- The panel does not support the reopening of the 24/7 A&E department at Grantham Hospital on the grounds of potential adverse impact on patient safety at A&E Departments at all three United Lincolnshire NHS Trust Hospitals.
- The panel strongly recommends, on the grounds of patient safety, United Lincolnshire Hospitals NHS Trust Board reconsider its proposal to extend the current A&E service opening hours at Grantham and District Hospital.
- The Panel recommends that the Trust should continue to provide an A&E service at Grantham and District Hospital on the current opening hours of 08.00-18.30, seven days a week until a more definitive long term urgent and emergency care plan was developed and agreed.

Recommendation 2:

- The panel recommends that in order to make it clear for patients and the public the type of service available at GDH 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 GDH in any further model.

Recommendation 3:

- The panel recommended that the Trust should move to a single A&E team with a focus on standardised clinical pathways and processes across the three sites, removing any unnecessary variation and providing enhanced training opportunities.

Recommendation 4:

- The panel recommended that the Trust and CCG have clear alignment with the Lincolnshire STP, developing a system approach to urgent and emergency care, and planned care for patient and the public. The Trust and STP should move to public consultation on an agreed future model as quickly as possible.

Recommendation 5:

- The panel recommended that the United Lincolnshire Hospitals NHS Trust works with the local the CCG and STP to develop an enhanced communication and engagement strategy to ensure that all stakeholders, the public, patients and local elected representatives have an opportunity to input on the development and decision regarding the final model for urgent and emergency care across the Trust’s three sites, and not only for the Grantham site.

- The panel recommends that the communication and engagement strategy develop plans to ensure that any changes to the designation, opening times and pathways related to emergency care provision are clearly communicated with the public, patients, stakeholders and staff both within the STP footprint and with surrounding STP footprints.

Subsequent advice from NHS Improvement in a letter to the CEO of ULHT following the review by the clinical senate stated:

"The Report produced following the review was detailed and outlined 4 clear recommendations, most notably that the A&E Department at Grantham should remain closed overnight and to not extend the current opening hours. One of the key reasons for the recommendation is on the grounds of patient safety. Due to the ongoing concerns around the delivery of A&E services at Lincoln County and Pilgrim Hospital and specifically the sustainability of your staffing model, NHS Improvement strongly advises that the Trust Board follow the recommendations in the report".

Following consideration of the findings, the ULHT Trust Board agreed to accept the conclusions reached by the East of England Clinical Senate panel, and follow their recommendations, which were supported by NHS Improvement.

Within its report the East of England Clinical Senate panel advised using the Royal College of Emergency Medicine 'rule of thumb' guide for 'Medical and Practitioner Staffing in Emergency Department. Using that guide would indicate that ideally 36 middle-grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover. The number of middle-grades at the time of the review was 22 with a heavy proportion of locums amongst them which meant it was a relatively unstable position.

Current position of ULHT A&E department staffing and requirement to operate 3 'full' A&Es

As previously described 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.

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.

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

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."

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.

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"[4].

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

A&E department clinical interdependencies and scale

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.

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.

The table below provides an overview of the guidance available on the explicit and implicit scale requirements of the core specialties that need to be co-located with a Type 1 A&E, together with an estimate of the additional workforce that would be required in each area to safely and sustainably support an A&E of this type at Grantham and District Hospital. This is in addition to the additional workforce requirement described in the previous section for the A&E department itself.

[4] Goudie, R and Goddard, M. (2011) Centre for Health Economics, University of York, *Review of Evidence on What Drives Economies of Scope and Scale in the Provision of NHS Services, Focusing on A&E and Associated Hospital Services, A report for the OHE Commission on Competition in the NHS*

Guidance	Source	Estimate of additional workforce required
Critical Care / Intensive Care		
Fewer than eight level 3 beds may not be sustainable because of the need for adequate numbers of staff at all times There are no economies of scale in small units and, with limited patient exposure (that is 'case mix'), such units would not be recognised for training by the IBTICM 24/7 intensive care cover by consultants, trained medical practitioner and staff capable of managing an airway in under 3 minutes	Academy of Medical Royal Colleges, 2007	Currently major trauma into Lincoln and pilgrim is stabilised and transferred to major trauma centre. Would need full ITU, number of level 2 and 3 critical care beds and consultants and nursing workforce. ITU trained nurses on a 24/7 rota. Beds for Emergency urology, Gen surg, vascular, head and neck. If 6 beds of each, specialist nurses for each spec would be needed. Consultant cover and on-site cover all those specialties. Stand-by theatre team for each spec for emergency surgery (ODPs, recovery staff, scrub practitioner, consultant) Significant increase in infrastructure for blood provision and for theatre kit and equipment to support a 24/7 full take for anything other than major trauma 5 ITU consultants 12 ITU Nurses This would cover all emergency surgery 'takes' require for a 24/7 A&E.
Acute Medicine		
Consultant lead in acute medicine per site and larger units will require several consultants in acute medicine. All units to have SpRs (ST3) and above 24/7. Multidisciplinary team; min 2 ward rounds per day.	Academy of Medical Royal Colleges, 2007	Acute medical beds currently available at Grantham, no additional staff required
Speciality Medicine **Healthcare of older person / respiratory / gastroenterology / stroke / cardiology**		
Clearly defined contact pathways for named senior clinical opinion (speciality trainee or consultant) are on a rota for all specialties likely to require regular interaction with the AMU. These include cardiology, gastroenterology, geriatric medicine.	The Royal College of Surgeons of England, 2011	**Health care of older person / Respiratory / Gastroenterology** If an on-call team is provided from the site would mean approximately an additional 7 Gastroenterology and 5 Respiratory Consultants **Cardiology** ACU needed 1in 6 rota for consultants, 2 middle grades, 6 juniors, full nursing staffing ward **Stroke** Minimum 6 consultants, 2 middle grades and 6 juniors
600 confirmed stroke admission per year in order to sustain expert consultant-led services	British Association of Stroke Physicians (2011)	

General Surgery		
Hospitals accepting undifferentiated patients via the ED must have access to 24-hour on site surgical opinion (at ST3 level or above or a trust doctor with equivalent ability, i.e. MRCS with ATLS provider status) Staffing levels required to deliver an effective emergency general surgery service will comprise a consultant surgeon (CCT holder), middle grade (MRCS holder), core trainee and foundation Major procedures may require three surgeons. Requirement for cover arrangements during busy periods.	The Royal College of Surgeons of England, 2011	See above under critical care
Paediatrics		
Small and medium sized hospitals (Paediatric attendees =15,000, Paediatric admissions = 3,000) – rota of 8 consultants, middle grade rota of 9 and junior rota of 6	Academy of Medical Royal Colleges, 2007	For a PAU: • 8 consultants 16 senior decision-makers • 5.46 Band 6 nurses • 10.92 band 5 nurses • 5.46 HCSW
All general acute paediatric rotas are made up of at least ten WTEs, all of whom are EWTD compliant Minimum of two registered children's nurses must be in the inpatient unit at all times	Royal College of Paediatrics and Child Health, 2011	
Orthopaedics		
An Acute General Hospital taking surgical emergencies should have 24-hour, fully staffed Intensive Treatment Unit beds, provided in a ratio of 1:40,000 population as well as high dependency unit beds".	British Orthopaedic Association, 2007	See above under critical care
Obstetrics and Gynaecology		
60-hour consultant presence for units of 2,500-4,000 births per year 98 hours for 4,000-5,000 births per year	Safer Childbirth: (2007) The reconfiguration of clinical services: What	Pathways would be developed to support safe transfer of labouring mothers to Pilgrim or Lincoln, but a gynaecology acute ward would be needed: • 6 consultants • 12 senior decision-makers • 1 Band 7 nurse

168 hours for more than 5,000 births per year RCOG has argued that centralising obstetric services so that units have at least 6,000 births per years would enable the current workforce to support 24/7 consultant presence in all units. But it does not recommend centralisation in all cases Neonatal support: 24-hour availability (within 30 minutes) of consultants and 24-hour resident cover by a ST1/2 or an advanced neonatal nurse practitioner (ANNP), who is trained and assessed as competent in neonatal life support and whose only responsibility is to the neonatal and maternity service	is the evidence? Kings Fund 2014	• 1 Band 6 nurse • 15 band 5 nurses • 10 HCSW

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

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.

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."

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".[5]

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."

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.

Activity modelling by the local health system has estimated that under the service change proposal to establish a 24/7 walk in Urgent Treatment Centre (UTC) at Grantham and District Hospital (in place of the current Accident and Emergency (A&E) department) the vast majority of patients currently seen at the A&E service would continue to be seen by the proposed UTC. It is estimated that around 2 patients a day who are seen by the current service wouldn't be able to have their care needs met by the proposed 24/7 UTC and would need to have their care needs met at an alternative site with a full A&E service.

Forecast growth in Grantham and South Kesteven

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.

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.

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

[5] The Royal College of Surgeons of England. Provision of Acute General Hospital Services. London: The Royal College of Surgeons of England; July 1998 (cited in March 2006 in *Delivering High-quality Surgical Services for the Future*)

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

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.

The current catchment population of Grantham and District hospital is estimated to be c.100,000-120,000 people (see Appendix 1). 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).

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 can not be provided on site.

Catchment populations for five Accident and Emergency Departments that have been reorganised and the rationale for change

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, the table below highlights the catchment population, rationale for reorganisation, the 'new' service and year of change for the reorganisation of five Accident and Emergency departments in England[6].

Site	Catchment Population	Rationale for reorganisation	The 'new' service	Year of change
Bishop Auckland ***a market town in the north-east of England***	145,000	• A risk that safe care (including A&E, acute and critical care) could not be sustained at the hospitals in Bishop Auckland	• Urgent Care Centre (UCC) led by general practitioners open 24/7 • It was expected that many patients would use the ED services at either Darlington Memorial Hospital or the University Hospital of North Durham	2009
Hemel Hempstead ***a large town situated in southern England***	231,000	• Concerns from local clinicians that unless acute and emergency hospital services in Hertfordshire were consolidated onto fewer hospital sites, services would become substandard, unsustainable, unattractive to clinical staff and, ultimately, unsafe	• Urgent Care Centre (UCC) led by general practitioners open 24/7 • It was perceived the UCC would care for 65% of those patients who had previously visited the ED in Hemel Hempstead	2009
Newark ***a market town in the East Midlands***	125,000	• The A&E department at Newark Hospital was not sustainable in terms of staffing or in the maintenance of skills among A&E doctors	• 24/7 Minor Injury Unit (MIU) and Urgent Care Centre (UCC) • It was perceived 85% of patient who were treated in the A&E would continue to receive their care at the new MIU and UCC and there would be a reduction in the number of emergency ambulance transfers from Newark Hospital to other hospitals, as patients would receive their care in the right place first time	2011

[6] *E. Knowles et al.* Closing five Emergency Departments in England between 2009 and 2011: the closed controlled interrupted time –series analysis

Rochdale ***a market town in the north-west of England***	154,000	• To ensure that health services maintained a safe and sustainable approach to care and that care would be better situated in fewer hospital sites where resources and expertise could be concentrated • Local access to urgent care would be maintained	• Urgent Care Centre open 24/7, with services being delivered by experienced nurses, nurse practitioners and a GP • It was perceived that the UCC at Rochdale Infirmary would care for an estimated 85% of those patients who had previously used the ED in Rochdale	2011
Hartlepool ***A coastal town in the north-east of England***	155,000	• Local NHS managers and doctors supported the closure of the A&E at Hartlepool because of safety concerns, citing (1) insufficient numbers of medical staff to cover two rotas in North Tees Hospital and Hartlepool Hospital and (2) limited overnight supervision of junior medical staff at Hartlepool Hospital	• Urgent Care Centre (UCC), not based on the existing hospital site and located approximately 2 miles away from where the A&E was. • The centre provides a 24-hour Minor Injury Unit, a walk-in centre that is open for 12 hours each day (08.00 to 20.00) and out-of-hours GP medical services.	2011

As can be seen from this table, 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.

In addition, 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:

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

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

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."

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. Which 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.

Conclusions

- 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.
- 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.
- 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.

Appendix 1

The Lincolnshire health system estimated the catchment size for Grantham and District Hospital A&E department by identifying any Lower Super Output Area (LSOA) where 50% or more of the activity (not arriving by ambulance) arriving at and A&E occurs in Grantham.

Any ambulance arrivals were excluded from the activity defining the catchment since the site is unlikely to have been the choice of the patient.

All activity available in the data set was used irrespective of commissioner.

The catchment was defined using the last 12 months prior to Covid-19 (March 2019 – February 2020).

A summary of the estimated catchment size for Grantham and District Hospital A&E based on this methodology is set out below.

District Authority	Population	%
E07000133: Melton	9,401	9%
E07000139: North Kesteven	17,412	18%
E07000141: South Kesteven	68,520	69%
E07000175: Newark and Sherwood	1,569	2%
E07000176: Rushcliffe	2,312	2%
Grand Total	**99,214**	**100%**

Local campaign groups have previously identified the catchment population of Grantham and District Hospital as 120,000. However the basis for this is unknown.

In light of the above, a catchment population of c.100,000 – 120,000 for Grantham and District Hospital A&E department has been used in the consideration of the public feedback.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Change proposal(s)	**Acute Medical Beds** *Develop integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Acute Care Unit (ACU)
Feedback working group	Carl Ratcliff - Managing Director Medicine ULHT Kate Scheele - Consultant Respiratory Medicine ULHT Yvonne Owen - LCHS David Baker - GP
Date feedback working group signed off response	Version 3.5 dated 08/04/2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Acute medical beds proposal consultation feedback – Acute Care Unit (ACU)

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- Developing integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to acute medical beds at Grantham and District Hospital there was feedback in relation to the Acute Care Unit (ACU):

- Clarification is required in relation to the situation with the Acute Care Unit beds at Grantham and District Hospital and why they had been closed.
- Lincolnshire CCG propose not to replace the Acute Service Unit which provided vital medical expertise to critically ill patients and included beds commissioned by the East Midlands Critical Care network. The CCG propose to leave a minimum number of 'integrated community/acute medical beds' shared with other non-medical departments. This will result in fewer patients being admitted into Grantham Hospital.
- Specific concerns about lack of provision of Level 2 Respiratory beds at Grantham and District Hospital and suggested that respiratory ACPs could manage respiratory beds with support from anaesthetists and additional funding for recruitment and training.

As well as the above feedback a video was shared by a member of the public, in which it was stated the Acute Care Unit had been closed.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the Acute Care Unit beds at Grantham and District Hospital. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

In summary, none of the issues raised alters the proposed model, in either requiring modification or de-selection.

Acute Care Unit (ACU) beds at Grantham and District Hospital

The Acute Medicine change proposals relate to the way care is delivered on the Acute Medicine wards at Grantham and District Hospital.

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

- Emergency Assessment Unit - 28 beds
- Ward 1 - 28 beds
- Ward 6 - 23 beds
- L1 Beds are provided at GDH with 4 beds for medicine on EAU and 8 for surgery on their wards. This is the same number of L1 beds provided on the old ACU, except for these have been split between the two specialities.

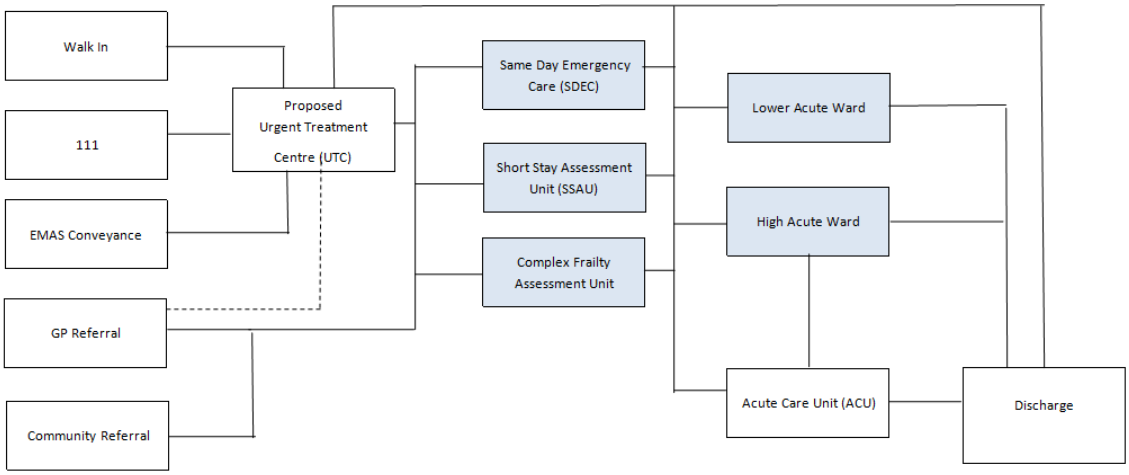
In addition to the bed elements, two further components of the proposed care model are:

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

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. 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.

This was set out in the Pre Consultation Business Case (PCBC) including the diagram and table below.

Proposed Grantham and District Hospital acute medicine service



At Grantham the ACU (12 beds) is not in one location as on the above chart. It has now been split into 8 surgical and4 Medical beds on the specialist wards to provide better care for the patients.

This was implemented when the site moved to a green model to support IPC requirements but has been kept in place, as the medical and surgical patients are better cared for by being in the relevant specialities. The L1 beds will remain in place as currently provided, regardless of the outcome of the ASR.

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

The Acute Cure Unit (ACU) or better described a L1 bed function is identified in the PCBC as potentially being part of some care pathways.

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'*.

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.

The splitting of the ACU beds into the two medical and surgical groups was done to provide better care for both sets of patients. This was not done in any way to pre-empt the ASR plan and has no impact on the deliverable care for the patients.

The L1 beds will be kept in place at Grantham regardless of the outcome of the ASR.

Level 2 Respiratory Beds.

There are not and have not been critically care trained consultants at Grantham. There have not been nor are there any anaesthetists based at GDH on the critical care specialist register. The anaesthetists at GDH 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 5 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.

Conclusions and actions

Acute care beds were provided when services were restored at Grantham. They were split to medical & surgical – There are 8 surgical L1 and 4 Medical L1 beds on site with appropriate L1 care for these patients.

The L1 beds will be maintained on the Grantham site regardless of the ASR outcome.

L2 beds cannot be provided at Grantham due to the lack of critical care trained staff AND National guidance criteria.

The configuration of the ACU beds does not alter the proposed bed model for Grantham.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 0.4: 08 April 2022

Change proposal	**Urgent and Emergency Care** *Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre* **Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Ambulance Conveyance
Feedback working group	Carl Ratcliff – Managing Director Medicine Cheryl Thomson – General Manager Urgent & Emergency Care Dr David Flynn – Consultant A&E Maxine Skinner – Matron Urgent & Emergency Care Yvonne Owen - Senior Partner Minster Medical Practice LCHS David Baker - GP Neil Scott - EMAS
Date feedback working group signed off response	Version 0.4: 08 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022 and 28 April 2022

Urgent & Emergency Care and Acute Medicine proposal consultation feedback –

Ambulance conveyance

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, two of which related to the provision of services from Grantham and District Hospital:

- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre; and
- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to the Grantham and District Hospital A&E department, concerns about ambulance conveyance were feedback by those both in support and opposition to the proposal:

- Concerns of risk to life as a result of increased travel times in life-threatening emergencies – concerns about ambulance conveyance times to more distant Accident and Emergency Departments at Lincoln County Hospital and other locations
- The rural geography of much of Lincolnshire led to concerns about acute and emergency health service provision becoming more 'spread out' at a time when the population of is growing, particularly around Grantham
- NHS 111 needs to be informed that this is being proposed so that patients if needing treatment here are transferred there rather than being taken to the 2 x A&E departments at Pilgrim / Lincoln County

For the proposals relating to the establishment of integrated community/acute medical beds, concerns were raised in relation to additional impact put onto East Midlands Ambulance Service (EMAS) to transfer people to the nearest hospital with an acute bed.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback relating to ambulance conveyance in the context of the change proposal relating to establishing a 24/7 walk-in Urgent Treatment Centre (UTC). This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Existing exclusion criteria and ambulance travel times

The Grantham and District Hospital A&E department 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 & District Hospital has for some time only dealt with a limited range of presenting conditions.

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.

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.

To support these transfers United Hospitals Lincolnshire 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.

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).

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.

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.

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

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.

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)

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 ULHTs written transfer protocols.

Additional ambulance activity under the service change proposal

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. This would mean more patients going to the right place for care first time and minimising subsequent patient transfers.

To inform the assessment of the proposed service change a travel analysis was conducted to understand the increased journey time for those patients currently attending the A&E department at Grantham and District Hospital who would not if the service change was implemented.

When assessing the change proposal it was estimated that the number of additional patients travelling over 45 minutes for non-elective care would be around 1 a day on average. This was based on the assumption they travel to their nearest appropriate hospital by car and against a baseline of c.21,500 patients across Lincolnshire who currently travel more than 45 minutes to attend urgent and emergency care services by car.

However, in reality given the existing exclusion criteria and the acuity of patients who would no longer be seen at Grantham and District Hospital under the change proposal, it was identified most are likely to travel by ambulance to an alternative site and therefore their travel time could be less than 45 minutes. The independent analysis completed by ORH set out above supports this, with an average travel time to a hospital other than GDH from the wards closest to it being 00:41:29 (maximum average travel time from a ward 00:50:58).

Two key foundations of the proposed care model are to:

- Make sure patients get to the definitive treatment, first time whether that be Grantham 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.

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 proposed 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.

It is not anticipated that the change proposal would result in an increase in the number of ambulance transfers originating from Grantham and District Hospital compared to the average number per year (733). If anything the change proposal should reduce the need for ambulance transfers from Grantham and District Hospital to other sites with an A&E departments as more patients are seen by the right service first time.

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 2 additional weekly DCA vehicle hours would be required, which could be delivered through extending a shift length.

Conclusions and actions

- 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 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.
- Based on actual ambulance travel times, the average time to a hospital other than Grantham and District Hospital from the wards closest to GDH is 00:41:29. The highest average travel time from a ward closest to GDH is 00:50:58
- On average, around 733 patients a per year require transfer by the ambulance service to another hospital.
- 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 and therefore their travel time could be less than 45 minutes.
- Two key foundations of the proposed care model are to:
    - Make sure patients get to the definitive treatment, first time whether that be Grantham 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.
- 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.
- If the change proposal is implemented the additional ambulance hours required to maintain current performance levels will be reflected in the ambulance provider contract.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Change proposal(s)	**Acute Medical Beds** *Develop integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Facilities
Feedback working group	Carl Ratcliff - Managing Director Medicine ULHT Kate Scheele - Consultant Respiratory Medicine ULHT David Baker - GP
Date feedback working group signed off response	Version 3.5 dated 08/04/2022 Friday 8th April
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Acute medical beds proposal consultation feedback – Facilities

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of acute medical beds:

- Developing integrated community/acute medical beds at Grantham and District Hospital

During the public consultation, feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

An issue raised from the consultation feedback in relation to the acute medical beds proposal was:

- Further clarity sought on impact of the proposals on overall bed space at Grantham and District Hospital

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the Acute Care Unit beds at Grantham and District Hospital. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Impact of proposals on overall bed space at Grantham and District Hospital

There is no reduction or change

Bed demand and capacity modelling formed a key part of the underpinning analysis to assess the proposed service change. An overview of this is provided below with more detail set out in the Pre Consultation Business Case (PCBC). The activity analysis in the PCBC was based on a 2019/20 baseline and forecast to 2023/24, in line with the local system strategic plan.

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

- Emergency Assessment Unit - 28 beds (19/20 non-elective av. length of stay = 2.8)
- Ward 1 - 28 beds (19/20 non-elective av. length of stay = 7.1)
- Ward 6 - 23 beds (19/20 non-elective av. length of stay = 5.6)
- L1 beds – 12 split across medicine and surgery (old ACU unit)

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

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

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

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

This modelled base case scenario for the required acute medicine bed capacity at the Grantham Hospital site is believed to be a prudent one.

Two sensitivity tests have been applied both of which result in a reduced medical bed requirement at Grantham Hospital:

- Within the current care model it is generally accepted that there is an opportunity for admission avoidance and length of stay improvements across the non-elective acute medicine admissions. This is supported by the findings of the clinical audit that identified 10% of patients audited could have had their admission avoided. This opportunity should be easier to realise given the integrated acute/community model and is a key focus of the Integrated Community Care (ICC) clinical model 'left shift'; and
- If Scenario 2 from the bed audit is modelled, i.e. 50% of patients with a NEWS ≥5 transferred to specialist site (equals c.20% reduction), then fewer beds are required on the Grantham Hospital Site.

The modelled bed requirement of 69 beds by 2023/24 is comfortably within the current acute medicine bed capacity at Grantham Hospital (79 beds).

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.

GDH has been able to run within its current bed base, without the need for escalation. GDH has also been able to take patients from other sites to free beds across the County helping with the increased pressure that the sites were under. 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 with support the wider system with the required lower acuity beds. Certainty of the ASR model could help support refreshed recruitment plans for the site.

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

Estimated future acute medicine bed requirement analysis

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

Conclusions and actions

- Bed demand and capacity modelling formed a key part of the underpinning analysis to assess the proposed service change.
- The modelled bed requirement by 2023/24 is comfortably within the current acute medicine bed capacity at Grantham Hospital, however there are no intentions to reduce the number of acute medicine beds at Grantham and District Hospital.
- It is to be noted that only one acute ward is being used currently due to the inability to safely staff this ward from both a nursing and medical perspective. This is reflective of recruitment challenges for all acute sites but worse at Grantham.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Change proposal(s)	**Acute Medical Beds** *Develop integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Alternative Suggestions
Feedback working group	Carl Ratcliff - Managing Director Medicine ULHT Kate Scheele - Consultant Respiratory Medicine ULHT Yvonne Owen - LCHS David Baker - GP
Date feedback working group signed off response	Version 3.6 dated 08/04/2022 Friday 8th April
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Acute medicine beds proposal consultation feedback – Alternative suggestions

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- Developing integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to acute medical beds at Grantham and District Hospital there were a number of alternative suggestions put forward:

- If acute and community beds are available at Grantham, blood tests should be available there too
- Establish acute and rehab pathways:
    - Acute pathway (for acutely/medically unstable patients) that would be EAU (assessment unit) and one more medical ward to allow patient flow with MDT discharge facilitation
    - Rehabilitation pathway: step down from acute beds and step up from community. The Rehab Ward should include stroke rehab beds and general rehab beds for patients with any other conditions including frail elderly and post-Covid patients.
    - Establishing a rehabilitation ward in Grantham and District Hospital would allow service provision for patients closer to their home and access for visitors.
- Provide 'half way house' care wards for those who are medically well but unable to cope with going home at present, offering convalescence and low dependency beds. Occupational therapy could be an added service.
- Hospital and ongoing social care should be staffed by fully integrated multidisciplinary teams to facilitate seamless transfer of patients into the community. This would involve integrated social services and hospital financial structures to end delayed discharge.
- Acute medical beds should not be provided at Grantham, given the limited support and other services there. Grantham should be an elective surgery and community hospital providing high quality care outside an acute setting.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback received through the public consultation for the proposed acute medicine beds at Grantham and District Hospital changes in relation to the alternative suggestions put forward. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

If acute and community beds are available at Grantham, blood tests should be available there too:

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.

The pathology service that provides blood test analysis is provided by NLAG and this provision remains unchanged.

Establish acute and rehab pathways:

- ***Acute pathway (for acutely/medically unstable patients) that would be EAU (assessment unit) and one more medical ward to allow patient flow with MDT discharge facilitation***
- ***Rehabilitation pathway: step down from acute beds and step up from community. The Rehab Ward should include stroke rehab beds and general rehab beds for patients with any other conditions including frail elderly and post-Covid patients.***
- ***Establishing a rehabilitation ward in Grantham and District Hospital would allow service provision for patients closer to their home and access for visitors.***
- **Provide 'half way house' care wards for those who are medically well but unable to cope with going home at present, offering convalescence and low dependency beds.**

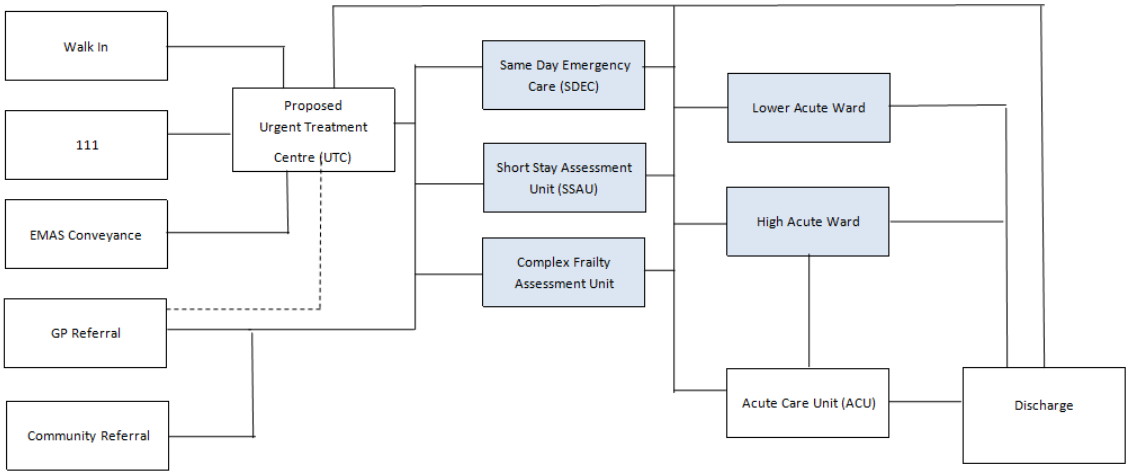
The feedback received through the public consultation that described the establishment of acute and rehab pathways and wards for those who are medially well but unable to cope with gong home is very much in line with the proposed model.

The model will also support both the concept of step up beds that GP's will be to have patients admitted to rather than sending 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.

The proposed Grantham and District Hospital integrated acute/community beds service model was set out in detail in the acute medicine chapter of the Pre Consultation Business Case (PCBC).

The diagram and table below provide an overview of the key components of the proposed model.

Proposed Grantham and District Hospital acute medicine service



Note old ACU provision is split now in medical and surgical L1 BEDS.

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

In summary, the feedback received aligns and supports the model proposed in the ASR.

Hospital and ongoing social care should be staffed by fully integrated multidisciplinary teams to facilitate seamless transfer of patients into the community.

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.

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

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

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

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.

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.

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.

During 2021 Lincolnshire has been actively leading system improvement programmes which includes the care closer to home programme. This actively looks to support individuals in their own home and ensure that management of care stops onward admission, this programme constitutes a makeup of

pathway improvements including Palliative and End of Life, Patient Flow and a new Urgent Community Response which will allow an MDT of clinicians actively manage a patient in their own home.

Acute medical beds should not be provided at Grantham, given the limited support and other services there

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

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.

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.

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?*'.

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

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

Stakeholder evaluation of acute medicine

	Criteria	No acute medical beds at Grantham *Satisfies the criteria significantly / somewhat better*	No preference	Integrated community/acute beds at Grantham *Satisfies the criteria significantly / somewhat better*
Acute medicine	Quality	8%	14%	78%
	Access	6%	7%	86%
	Affordability	8%	3%	88%
	Deliverability	10%	3%	87%
	Total	**9%**	**7%**	**85%**

Conclusions and actions

- The proposed changes are very much in line with the feedback suggesting they should establish acute and rehab pathways
- The change proposals will be fully supported by integrated multidisciplinary teams, with a number of plans and initiatives identified to support this
- As part of the options appraisal, the option of Grantham and District Hospital not providing medical beds was considered. Following an evaluation by a clinically led stakeholder group this was not identified as a preferred way forward.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Change proposal(s)	**Acute Medical Beds** *Integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Additional considerations
Feedback working group	Carl Ratcliff - Managing Director Medicine ULHT Kate Scheele - Consultant Respiratory Medicine ULHT Yvonne Owen - LCHS David Baker - GP
Date feedback working group signed off response	Version 3.5 dated 08/04/2022 Friday 8th April
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Acute medicine beds proposal consultation feedback – Additional considerations

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related:

- Integrated community/acute medical beds at Grantham and District Hospital

During the public consultation, feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to integrated community/acute medical beds at Grantham and District Hospital a number of additional considerations were put forward:

- Staff and PPG representatives would like to see this kind of model replicated across the trust
- Mental health beds should be treated as a priority in future planning
- Develop research and development linked to university and attracted graduates by asking them what they need
- Patients with chronic health conditions and co-morbidities e.g. obesity, should be centralised in one location in the county to allow staff to develop specialisms

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the additional considerations for integrated community/acute medical beds at Grantham and District Hospital feedback through the public consultation. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

In summary, none of the issues raised alters the proposed model, in either requiring modification or de-selection.

Replicating this kind of model across the trust

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.

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.

Mental health beds should be treated as a priority for future planning

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.

Develop research and development linked to university and attracted graduates by asking them what they need

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.

Patients with chronic health conditions and co-morbidities e.g. obesity should be centralised in one location across the county to allow staff to develop specialisms

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.

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

Conclusions and actions

Community beds aim to bridge the gap that sits within the existing offer for patients in Lincolnshire. This would allow other areas and trusts to focus on other specialties.

In summary, none of the issues raised alters the proposed model, in either requiring modification or de-selection.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 0.4: 02 April 2022

Change proposal(s)	**Acute Medical Beds** *Develop integrated community/acute medical beds at Grantham and District Hospital*
Common theme	Criticism of lack of detail
Feedback working group	Pete Burnett, System Strategy and Planning Director Charley Blyth, Director of Communications and Engagement Steph King, Strategic Communications and Engagement Lead Manager Tom Diamond Associate Director of Strategy
Date feedback working group signed off response	Version 0.4: 02 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	21 April 2022

Acute medical beds proposal consultation feedback – Criticism of lack of detail

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of acute medical services:

- Developing integrated community/acute medical beds at Grantham and District Hospital

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

Something specific that was raised in the consultation feedback in relation to the acute medical beds proposal was:

- Criticism over lack of detailed information on the integrated model in the consultation document

The independent consultation report suggested 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. The report identifies 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.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback criticising a lack of detailed information on the integrated model for the acute medical bed proposals. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Criticism over lack of detailed information on the integrated model in the consultation document

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.

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.

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.

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

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.

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*

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.

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. See appendix 1.

Conclusions and actions

- 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
- 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.
- Recognising some people may want more information 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.
- Additional material was made available during the consultation period to provide responses to some of the common requests for clarity received.

Appendix 1

Don't miss your chance to have your say on the future of four Lincolnshire NHS services



A 12-week public consultation on the future of four Lincolnshire NHS services ends on **Thursday 23 December**. The consultation, which launched on 30 September, is giving people from across the county the chance to share their views on the future delivery of the following services:

- **Urgent and emergency care at Grantham & District Hospital**
- **Acute medical beds at Grantham & District Hospital**
- **Orthopaedic surgery across Lincolnshire**
- **Stroke services across Lincolnshire**

We are aware that the level of detail included in the review work to date can be complicated to understand for anyone unfamiliar with the services. Some of the common requests for clarity we have received from the people of Grantham include:

Do your proposals mean that acute medical beds will be reduced or closed in Grantham & District Hospital?
No. The acute medical beds change proposal focuses on retaining this service, retaining acute specialists and strengthening it through greater integration with community and primary care providers. There is no planned reduction to the number of acute medicine beds under the proposal.
There is some confusion with this proposal and the SDEC (same day emergency care) and the ACU (acute care unit) services, which are different, but have also not closed. During the COVID pandemic the 6 bedded ACU was temporarily closed to ensure the separation of medical and surgical patients for safety reasons. These beds were immediately re-provided on the surgical and medical wards, where they remain. Since this time the overall number of beds has increased to 8.

Do the proposals suggest cuts to acute and emergency services in Grantham?
No. We believe the proposals provide much needed stability to the acute and urgent & emergency care services in Grantham. We are committed to securing services in Grantham for the future and the proposals, which include a centre of excellence for planned orthopaedic care, are part of our dedicated drive towards towards sustainability and ensuring Grantham & District Hospital as an employer of choice for health professionals wishing to build their career.

What do the proposals for stroke services mean for the people of Grantham?
Grantham has not provided acute or hyper-acute stroke services at the hospital since 2008 and this would not change under the proposal. In the event that a patient presented at Grantham having experienced an emergency such as a stroke, the team would have the clinical expertise and equipment to resuscitate, intubate and stabilise a patient until transfer, if required, to an alternative site where the correct, specialist care can be provided to best support the patient. This happens now and would continue to do so under the proposals.

Can I go to Grantham with a fracture?
Yes. Simple fractures would be treated at the proposed UTC at Grantham & District Hospital. Any patient who was found to need specialist treatment for a more complicated fracture would be transferred to ensure they had access to the care that they need. This happens now and would continue to do so under the proposals.

Join us at the Grantham event this Sunday

We are holding another event in Grantham on **Sunday 12 December**. At this event, clinicians will explain the service proposals in more detail, and those attending will have the opportunity to ask questions and share their views. Attendees must register before the event.

For more information about this event and to register please visit **www.lincolnshire.nhs.uk**, call **01522 421860** or email **lccg.asr-enquiries@nhs.net**

This is our largest public consultation to date, and we are encouraging as many people as possible to get involved. Don't miss your chance to have your say and help us shape the future of these four services.

To **complete the questionnaire**, and for more information on how we have reviewed these four services, the challenges they face and how they might change in the future, visit our website at **www.lincolnshire.nhs.uk** or contact us on **01522 421860**.

www.lincolnshire.nhs.uk

NHS Lincolnshire

Appendix F4

Consideration of public feedback by subject matter expert working groups

STROKE

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 5.2a 09th May 2022

Change proposal(s)	**Stroke Services** *Develop a 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs*
Common theme	Outcomes and Quality
Feedback working group	Carl Ratcliff – Managing Director Medicine Abdul Elmarimi – Consultant Stroke Medicine Rebecca Johnson – Business Manager Cardiovascular Anita Parmar – Deputy General Manager Cardiovascular Lesley Bradley – Trust Lead Physiotherapist Anita Cooper – Divisional Lead Clinician Angela Shimada - LCHS Deputy Director Allied Health Professionals Amy Evans - LCHS Specialist Occupational Therapist
Date feedback working group signed off response	21st April 2022 (Version 5.1)
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group as part of reviewing service change proposals	28th April 2022 (Version 5.1) *Following these discussions additional information has been included in this document to create this version (5.2)* *The additional information added is identified in the document*

Stroke proposal consultation feedback – Outcomes and Quality

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- A 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs.

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to stroke services there was feedback in support of the proposal relating to outcomes and quality in terms of:

- Agreement with the principle of a specialist centre for hyper-acute and acute stroke services
- The proposals would likely tackle many of the challenges that NHS Lincolnshire services currently face
- Increased expertise and quality of care
- Could lead to future investment into NHS Lincolnshire as a result

In addition, in its organisational response the Local Medical Council (LMC) identified that examples such as the Heart Centre at Lincoln illustrate that having specialist services concentrated leads to better outcomes. Whilst acknowledging the health system does need to be mindful though that transport times to other neighbouring specialist centres may be less than to Lincoln so this needs to be built into any plans.

Feedback in opposition to the proposal relating to outcomes and quality identified concerns:

- Until 18 months ago Pilgrim ran a safe and high quality stroke service, achieving higher targets than Lincoln. Lincoln is not a centre of excellence. This will lead to a loss in experienced nurses and therapists, and put the people of Lincolnshire at further risk.
- Removal of life-saving local services - changes are being made to the detriment of Boston, with many feeling Boston was being placed at a disadvantage as a result and that there would be a threat to other services at Pilgrim Hospital.
- Basing figures on the last two years will provide false data as prior to COVID Pilgrim saw a spike in admissions over the summer months with increased holiday makers at the coast. Therefore, having only one unit will lead to patients being on wards without specialist nurses or therapists.
- If the population of Boston is to increase at its current trajectory, stroke services would be required
- This proposal will lead to worsened rehabilitation outcomes as patients requiring longer periods of inpatient specialist rehab will not receive it due to the lack of specialist therapists and nursing staff in existing community beds.

As well as feedback in support or opposition of the proposals in terms of outcomes and quality a number of other considerations and mitigations were also put forward:

- Clarification is required on the pre-hospital treatment of stroke
- Integrated pathways should start from day one of the condition
- Social care provision needs to be strengthened in order to reduce length of stay.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback received through the public consultation for the proposed stroke service changes in relation to outcomes and quality. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Please note: the consideration of the impact of the stroke change proposal on ambulance conveyance times is in a separate document focused specifically on this point.

Quality and outcomes benefits of the proposed stroke service change

The table below provides an overview of the quality and outcomes benefits of the proposed services changes for Stroke services against the current model of care (i.e. that provided before the COVID-19 pandemic and subsequent temporary service changes).

Overview of Stroke Service change proposal

Stroke Services	
Current model **Hyper-acute and acute stroke services provided from Lincoln and Pilgrim Hospital** • Sentinel Stroke National Audit Programme (SNAP) shows ULHT need to continue to improve performance at Lincoln County Hospital and Boston Pilgrim Hospital. • In addition, ULHT is not achieving required performance in 1 of 4 priority standards for 7-day services, for hyper-acute stroke: Clinical Standard 2 – *All emergency admissions seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital* • Recommended hyper-acute stroke units see no less than 600 strokes per year, as activity below this is not sufficient to ensure staff have enough clinical and institutional experience to maintain skills; Lincoln sees just over this, Pilgrim does not and is unlikely to over next 5-10 years • Currently significant gaps exist in workforce – both Lincoln and Pilgrim should have six substantive consultant posts however each only has one. Has not been possible to recruit substantively. • Current nursing vacancy at Pilgrim is 50% which has led to a reduction in open beds • Average length of stay is c.13.5 days against a best standard target of 7-10 days	**Proposed model** **Consolidate hyper-acute and acute stroke at Lincoln Hospital supported by enhanced community service** • Evidence shows centralising hyper-acute stroke treatment on a smaller number of sites has considerable benefits including reduced mortality, faster recovery, shorter length of stay and improved workforce sustainability • 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. • This also helps to address the significant workforce shortages and challenges in stroke by concentrating specialist stroke skills and expertise under one roof. • Supports improved performance against Sentinel Stroke National Audit Programme domains and priority standards for 7-day services • Enables a critical mass for stroke units well above recommended levels, which will support the delivery of improvements in quality and outcomes • Supports reduction in length of stay in acute hospital • Enables a concentration of multi-disciplinary teams on one hospital site to support performance and quality improvement • Supports reduction in heavy reliance on locums - increases chances of recruiting to substantive roles and having to spread limited staff across two sites

The temporary consolidation of hyper-acute and acute stroke services on the Lincoln County Hospital site (at the start of April 2020) due to the additional sustainability pressures placed on United Lincolnshire Hospital Trust's stroke services due to Covid-19 provides some additional insights into the delivery of improved quality and outcome benefits through the proposed changes.

However, it is important to note the purpose of the change and 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 Lincolns 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).

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 2 substantive stroke consultants were working in the service.

A key tool to assessing and monitoring the quality of stroke services is the Sentinel Stroke National Audit Programme (SNAP). The SNAP is comprised of 44 key indicators (KI) that are grouped into 10 domains, which highlight the pre-existing and upcoming national measures. Each domain has a performance level (A to E, with A being best performance) and a total key indicator score is calculated based on the average of the 10 domains. The combined total key indicator score is adjusted for case attainment and audit compliance to provide an overall SSNAP level.

An overview of the SSNAP outputs for the Lincoln County Hospital site from October 2019 – September 2021 are set out below.

ULHT: Lincoln County Hospital SSNAP October 2019 to September 2021

SSNAP Level/Score	Oct-Dec19	Jan-Mar20	Apr-Jun20	Jul-Sep20	Oct-Dec20	Jan-Mar 21	Apr-Jun 21	Jul-Sep 21
Lincoln County Hospital								
SSNAP Level	C	B	A	B	C	C	B	D
SSNAP Score	68.0	80.0	86.0	80.0	67.5	67.0	78.0	58.9

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.

The evidence of the temporary consolidation of hyper acute stroke services demonstrated that on average patient's diagnosis and treatment times were improved and 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. A key element of delivering this thrombolysis performance is the on-call ACP workforce at Lincoln Hospital being on-site working alongside the consultant on-call team.

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 and 100% of eligible patients receiving thrombolysis; this compared to 10hrs 04mins and 85.8% nationally.

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

ULHT: Lincoln County Hospital median time between clock start and being assessed by stroke consultant (hours:mins) July 2021 to September 2021

Lincoln County Hospital	Oct-Dec20	Jan-Mar 21	Apr-Jun 21	Jul-Sep 21
Median time between clock start and being assessed by stroke consultant (hours:mins)	6:52	10:33	7.40	6.11
			National:	10:04

ULHT: Lincoln County Hospital % of eligible patients given thrombolysis July 2021 to September 2021

Lincoln County Hospital	Oct-Dec20	Jan-Mar 21	Apr-Jun 21	Jul-Sep 21
Percentage of eligible patients given thrombolysis	100	93.8	100	100
			National:	85.8

It is also worth noting that in the SSNAP 2021 Acute Organisation Audit (results based on services as of 1 October 2021), when comparing national performance at site level, out of a total of 157 sites the Lincoln County Hospital was one of only 6 sites that achieved 8 Key Indicators. Only 1 site achieved 9 Key Indicators and no site achieved 10. All the remaining sites achieved less than 8 Key Indicators.

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.

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.

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.

Consolidation of the hyper acute stroke service at Lincoln has also brought closer alignment with other co-specialities such as Cardiology, which also has its acute service provided at Lincoln.

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 on 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 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.

With practice, the Lincoln Hospital site has reduced its average door to angiogram time from 67 minutes in 2019 to 34 minutes in 2021.

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

Since the service started in 2018 and up to April 2020, Lincoln Hospital had referred 19 patients for the procedure in Nottingham, compared to a single patient from the Boston Hospital site within the same timeframe. This helps to emphasise the importance of team work in improving stroke care.

In 2021, 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.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

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 Boston Hospital catchment area before and after the change.

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.

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

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.

Comparison of access to stroke care for patients from the Boston Hospital catchment area before and after the temporary change to consolidate services on the Lincoln Hospital site

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***

Please note: consideration of consultation feedback relating to ambulance conveyance is covered in the stroke consultation feedback 'ambulance conveyance' document.

Additional information added ends here

Until 18 months ago Pilgrim ran a safe and high quality stroke service, achieving higher targets than Lincoln. Lincoln is not a centre of excellence. This will lead to a loss in experienced nurses and therapists and put the people of Lincolnshire at further risk.

The NHS Stroke Services: Configuration Decision Support Guide recommends that when assessing the case for change for stroke services the Sentinel Stroke National Audit Programme (SSNAP) analysis should provide the starting point.

The SNAP is comprised of 44 key indicators (KI) that are grouped into 10 domains, which highlight the pre-existing and upcoming national measures. Each domain has a performance level (A to E, with A being best performance) and a total key indicator score is calculated based on the average of the 10 domains. The combined total key indicator score is adjusted for case attainment and audit compliance to provide an overall SSNAP level.

ULHT continually strives to improve the SSNAP performance at Lincoln County Hospital and Boston Pilgrim Hospital, however this is challenging for the reasons set out in this case for change. ULHT's performance by site prior to the temporary change due to Covid-19 pressures is set out below.

ULHT SSNAP October 2019 to March 2020

SSNAP Level/Score	Oct-Dec19	Jan-Mar20
Lincoln County Hospital		
Team-Centred Total KI Level	C	B
Team-Centred Total KI Score	68.0	78.0
SSNAP Level	C	B
SSNAP Score	68.0	80.0
Boston Pilgrim Hospital		
Team-Centred Total KI Level	C	C
Team-Centred Total KI Score	60.0	66.0
SSNAP Level	D	C
SSNAP Score	57.9	66.0

The above information is set out in the stroke chapter of the pre-consultation business case, and highlights the 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.

Please note: consideration of consultation feedback relating to workforce is covered in the stroke consultation feedback 'Workforce' document.

Removal of life-saving local services – changes are being made to the detriment of Boston, with a feeling Boston was being placed at a disadvantage as a result

The NHS Stroke Services: Configuration Decision Support Guide also recommends that hyper-acute stroke units should see no less than 600 strokes per year, as activity below this is not sufficient to ensure staff have enough clinical and institutional learning experience to maintain their skills. The minimum of 600 strokes per year was also a threshold endorsed by the Midlands and East stroke review.

Stroke activity at ULHT in the 2019/20 year (i.e. the last 'normal' year prior to the Covid-19 pandemic' was:

- Lincoln County Hospital: 670 strokes per annum
- Boston Pilgrim Hospital: 497 strokes per annum

The option to consolidate hyper-acute and acute stroke services at Lincoln 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. A number of influential factors for why the Lincoln Hospital site was identified to centralise acute stroke services as opposed to Pilgrim Hospital were identified.

Co-location of specialised services is very important. There is an established and highly successful heart centre on the Lincolnshire Hospital site. The cardiology team support the stroke team to deliver an optimal front door service as co-location with cardiology enables access to more important time critical interventions like bubble echocardiograms and implantable loop recorders. At Lincoln Hospital there is an established Advanced Care Practioner (ACP) service and pathway that was noted as a regional example of excellence by a Getting It Right First Time (GIRFT) review.

Co-location with the heart unit also has the benefit of using the Cath lab facilities to directly access acute imaging thus bypassing A&E and further reducing door to needle time. Moving these cardiac services from the Lincoln site to another hospital would require significant financial investment and is risky in terms of being able to transfer all staff for this service.

Mechanical thrombectomy is a relatively new treatment for strokes that is currently only carried out in tertiary stroke centres, the closest of which for Lincolnshire residents is Nottingham University Hospitals NHS Trust (NUH). Lincoln Hospital offers a shorter travel time to NUH than Pilgrim Hospital by c.30 minutes. Consolidation of stroke services at Lincoln hospital also provides an increased opportunity for the Lincoln site to provide mechanical thrombectomy in the future as there has been discussion at a national level that Cardiologists may be considered as being appropriate to deliver mechanical thrombectomy based on their experience with PPCI.

Vascular Surgery is currently provided from Pilgrim Hospital, and will be going forward. Co-location with Vascular Surgery is helpful, however the timeline for surgery is within 2 weeks and reserved for those with no disability or minor disability patients who are fit for surgery.

ULHT's stroke service faced a number of ongoing recruitment challenges. Experience has shown it is easier to recruit to the Lincoln 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.

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 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 Hospital (this reduces to c.65 patients if a 15-minute travel time preference for Pilgrim hospital is applied). Lincoln Hospital is therefore a better solution for more of Lincolnshire's population on that basis.

When the model for consolidating hyper-acute and acute stroke services at Lincoln 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.

National evidence supports the consolidation of hyper-acute and acute stroke services in terms of reduced mortality, faster recovery, shorter length of stay and improved workforce sustainability. 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, and shown the Lincoln Hospital site to be performing better than the majority of other sites nationally in terms of delivering the SSNAP Key Indicators.

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.

Such an improvement in outcomes for patients by consolidating services is also seen in other services such as for heart attack patients. Lincolnshire residents have already experienced this through the establishment of the Lincolnshire Heart Centre at Lincoln Hospital.

In 2013 the Lincolnshire Heart Centre opened, underpinned by a £4.3m investment in a new facility. Since it opened 1000 lives have been saved by patients being treated at the specialist centre. The latest statistics from the National Institute for Cardiovascular Outcomes Research (NICOR) show the centre outperforming all of the national targets.

Anyone suffering a heart attack caused by blockage of an artery is treated by using a balloon catheter called an angioplasty. The national target is 150 minutes for all patients to receive this treatment 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.

On average it takes the specialist team just 32 minutes from the moment a patient arrives in the ambulance at hospital to open the artery – national average is 40 minutes. Patients spend on average 2 days at Lincoln County Hospital, whereas nationally it is 3 days.

30-day mortality for patients who have suffered a heart attack (STEMI/nSTEMI combined) has fallen from 13.8% to 5.4%.

The Heart centre continues to deliver above National averages of from first 999 call to when the balloon is inflated in the coronary artery, and is currently achieving best practice tariff for Arrival to balloon time this is similar to the BPT for thrombolysis.

This was set out in the stroke chapter of the Pre Consultation Business Case.

Changes are a threat to other services at Pilgrim Hospital.

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.

There is absolute commitment from the NHS across Lincolnshire to the hospital, its staff and the population it serves. This is demonstrated by much investment and transformation in recent years.

Since 2018, the following projects have benefitted Pilgrim Hospital, Boston:

- £9.8million investment in fire infrastructure, focusing on:
    - Fire compartmentation
    - Fire containments
    - Replacement of all fire dampers to stop spread of fire
    - Refurbishment of wards totalling £1.2m
- £5.2million spent on new medical equipment, including:
    - Replacement Radiology equipment
    - CT Scanners
    - Cardiac monitoring
    - Emergency Department Enhancements
    - Endoscopy equipment
    - Digital X-Ray equipment

- Image Intensifiers

- £1.8million has been spent on the reconfiguration of the hospital and refurbishment of its wards. This meant transformation of the following to improve the care our patients receive:
  - A 24 bed Integrated Assessment Centre opened (one of only 4 units in the country)
  - 52 acute medical short stay
  - 52 bed surgical short stay ward
  - 29 bed Trauma & Orthopaedic ward
- £900,000 spent on Pilgrim Hospital's education facilities, to completely refurbish them and enable us to continue to attract clinicians, nurses, therapists and allied health professionals into the Boston area to train, live and work.
- Aligned to the investment in the education facilities at Pilgrim Hospital and the 'grow our own' approach to tackling the staffing and recruitment challenges faced, two new training courses will use these facilities for selected cohorts. This will aid accessibility and widen opportunities and participation for students from the east of Lincolnshire whilst also enhancing the education profile of the Pilgrim Hospital and the health and social care community that it serves.
  - The courses are:
    - FdSci Nursing Associate (NA)
    - CertHE Ambulance Clinical Technician Practice
  - Both courses provide a 'stepping-stone' access to the BSc(Hons) Nursing and BSc(Hons) Paramedic Practice with registerable status, whilst at the same time meeting recognised intermediate qualifications.
  - The Pilgrim Hospital works are in their final stages, and whilst the East Coast Programmes have commenced from Lincoln, they will be transferring across to Pilgrim for their delivery in the coming few months.
  - Nursing Associate
    - Total of 43 learners have been enrolled onto the Oct 21 programme, the majority of whom are from the East Coast region, highlighting the impact of the targeted campaign.
  - Clinical Ambulance Technician
    - 22 students enrolling, many of whom are drawn from the East Coast / Boston area.
- £7.3m on estates enhancements to the A&E department and co-located Urgent Treatment Centre, including:
  - Additional 2 Resus Bays
  - New x-ray room
  - New waiting room for 20 patients
  - New Paediatrics area – children waiting area/separate entrance meeting CQC requirements

- 3 Triage rooms
- New ambulance entrance
- New family room
- Fit to Sit Area

- Of huge significance is the commitment of £36m to completely overhaul and expand the A&E Department, and to ensure that it is modernised and fit for purpose for the long term. This is a combination of funding of £20m from the Treasury, and a further £16m funding commitment from the NHS in the county. This represents the biggest single investment ULHT has made into a single service on one of its sites. ULHT is currently in the process of seeking Planning Permission which will then enable building works to commence.

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. It is anticipated that the outcome of this bid will be known in Spring 2022.

The vision for the long term future of Pilgrim Hospital, Boston remains ambitious and committed.

The NHS in Lincolnshire has a collective and integrated ambition for health and care services in the east of the county, with Pilgrim Hospital playing a full, relevant and dynamic role in the provision of care for the local population and wider local economy. Key components of this are:

- Delivering clinical excellence and high quality care to patients;
- Maximising the delivery of integrated, proactive, local community based care;
- The provision of 'anchor institutions' that integrate their main function, play a significant and recognised role in their local area by making a strategic contribution to the local economy.

From a ULHT 'site strategy' perspective the vision for Pilgrim Hospital is to be a modern general hospital with a focus on emergency care and more complex surgical services.

For example, it is envisaged that the Lincolnshire Vascular Service which is currently provided from Pilgrim Hospital, shall remain there for the long term. Pilgrim Hospital manages all of the emergency vascular surgery and the more complex elective operations.

Basing figures on the last two years will provide false data as prior to COVID Pilgrim saw a spike in admissions over the summer months with increased holiday makers at the coast. Therefore, having only one unit will lead to patients being on wards without specialist nurses or therapists.

If the population of Boston is to increase at its current trajectory, stroke services would be required

The activity baseline data used in the Pre Consultation Business Case that set out the analysis and recommendations for the proposed service changes used was 2019/20. This was forecast to 2023/24 in line with the local five-year strategic plan.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

Therefore the activity baseline used to inform the planning of the change proposal was prior to Covid.

To inform the number of stroke beds required at Lincoln Hospital under the proposed service change to consolidate acute stroke services on that site an analysis, including sensitivities, was conducted based on three key factors:

- Activity growth rate;
- Preference for hospital site; and
- Average length of stay

The factor that had the biggest impact on the required bed capacity for a consolidated acute stroke unit at Lincoln Hospital is average length of stay. The ambition is to move to an average length of stay of 7 days supported through an enhanced discharge service. However, based on the evidence from other health system's that have implemented the enhanced community model a 7-day length of stay in the acute setting may not be achieved straight away. Therefore, the bed capacity for the proposed future model was based on an average length of stay of 10 days.

The factor that had the second largest impact on the required bed capacity for the proposed model of care is hospital site preference. To strike the optimum balance between ensuring sufficient capacity at Lincoln County Hospital and the impact on out of county hospitals a 15-minute site preference for Lincoln Hospital scenario was used as the basis for service planning.

The factor that has the least impact on the required bed capacity is the activity growth rate. For this element three sensitivities were modelled (2019/20 to 2023/24):

- Office of National Statistics (ONS) all age growth
- ONS 65+ growth rate
- Average annual growth rate

The scenario that was used as the basis for the service planning was the average annual growth rate as it was felt this was most likely to reflect future demand.

This scenario identified that when factoring in demand growth Pilgrim Boston Hospital (19/20: 497 stroke admissions per annum) it is unlikely to achieve the recommended critical mass (600 admissions per annum) over the next 5 years.

If the all-age growth rate or 65+ growth rate scenarios for Boston are applied rather than the average annual growth rate for stroke admissions, Pilgrim Boston Hospital is still unlikely to achieve the recommended critical mass for stroke admissions over the next 5 years.

Further review of the ONS population suggestions suggest Pilgrim Boston Hospital is also unlikely to achieve the recommended number of stroke admissions by 2030 on a consistent basis.

ONS population projections (2018-based subnational population projections)

	2020 -2030 growth rate	No. of strokes
ONS all ages	8.6%	540
ONS 65+	18.4%	588

However it should also be noted 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.

Additional information added ends here

Proposal will lead to worsened rehabilitation outcomes as patients requiring longer periods of inpatient specialist rehab will not receive it due to the lack of specialist therapists and nursing staff in existing community beds.

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.

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.

Simultaneously Organisational Development (OD) work commenced to bring the separate teams together and agree how an integrated service would be established. The aim throughout has been 'To establish an integrated, seamless pathway and a community based stroke rehabilitation service that is able to support ALL stroke survivors, operating 7 days a week'.

Between October 2019 and January 2020 three teams worked together across the pathway with the following change achieved:

- Supported a reduction in length of stay (LoS) on the Stroke Unit in Lincoln County
- Launched the Lincolnshire Stroke YouTube Channel
- Launched a Patient Handbook that travels with the patient from acute to community and beyond
- Initiated a dedicated Stroke Orthoptic clinic
- Started acute/community staff rotational work experience
- Begun the SAM2 trial linked to timely discharge
- Enabled (hospital) WebV access for Social Care colleagues
- Initiated a trial for single assessment and single transfer form
- Piloted 'Living Well After Stroke' Groups

This enhanced community service will:

- Support all stroke survivors across Lincolnshire to receive their rehabilitation within their local community wherever possible;

- Work with the hyper-acute/acute stroke service to deliver an average length of stay of 7 days;
- Ensure a clear route back into specialist care for patients once discharged from the service;
- Offer a 6-month review to all stroke survivors;
- Support new professions to the Lincolnshire Stroke pathway in a community setting e.g. dietetics and psychology;
- Embed the Stroke Association team into the new Lincolnshire Stroke Service; and
- Improve efficiencies in the system through improved outcomes e.g. reduced hospital utilization, reduced social care costs over the medium to long term.

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.

The service will support community hospitals, which will be health & 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.

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.

The increase in the community stroke service team to deliver this service is set out in the table below.

Proposed staffing increase to community stroke team

Staff group	Current service	Proposed increase
		.
Occupational Therapy	8.63	1.78
Physiotherapy	15.72	2.26
Speech and Language Therapy	3.90	2.25
Rehabilitation Assistants	17.70	6.00
Dietician	0	1.0
Clinical Psychologist (specialising in Stroke)	0	1.0
Assistant Psychologist	0	1.0
Total	*45.95*	*15.29*

Recruitment for the enhanced community stroke rehabilitation team is underway as part of COVID response to ensure all stroke patients in Lincolnshire can be seen. In addition, there continues to be further development of roles within community services such as rotational therapist posts to support retention of staff. A new national community stroke specification via NHS England sets out the need for further work and integration with the Multi-disciplinary team ensuring the involvement of medical, nursing and social care roles.

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

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.

Clarification is required on the pre-hospital treatment of stroke

Integrated pathways should start from day one of the condition

Social care provision needs to be strengthened in order to reduce length of stay.

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 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.

The stroke service works with social care once the patient is admitted from day 1 to resolve and support care packages for the patient when they are discharged. Diagnostic and therapeutic pathways that patients are on in the acute setting are actively managed through the time they are in hospital.

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.

Conclusions and actions

- ULHT has continually strived to improve the 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.
- 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
- 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.
- When the model for consolidating hyper-acute and acute stroke services at Lincoln 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.
- Feedback from the Lincolnshire Local Medical Committee was ‘Examples such as the Heart Centre at Lincoln illustrate that having specialist services concentrated leads to better outcomes’.

- 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:
    - 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 the Lincoln County Hospital was one of only 6 sites that achieved 8 Key Indicators. Only 1 site achieved 9 Key Indicators and no site achieved 10. All the remaining sites achieved less than 8 Key Indicators.
    - The consolidation of stroke services at Lincoln will continue to support the closer working with many specialities such as Cardiology
- 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.
- 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.
- 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.
- The consolidation of hyper acute stroke services at Lincoln Hospital has also brought closer alignment with other co-specialities such as Cardiology, which is also based on the site:
    - 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 on the same hospital.
    - 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 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.
        - With practice, the Lincoln Hospital site has reduced its average door to angiogram time from 67 minutes in 2019 to 34 minutes in 2021.

- The stroke team at Lincoln Hospital has also developed an excellent working relationship with the Queens Medical Centre (QMC) Nottingham thrombectomy team, and became one of the best referring sites in the region.
    - Since the service started in 2018 and up to April 2020, Lincoln Hospital had referred 19 patients for the procedure in Nottingham, compared to a single patient from the Boston Hospital site within the same timeframe.
    - In 2021, 14 patients from the Pilgrim Hospital catchment were sent to QMC for thrombectomy, again demonstrating the net benefit to all patients going to a single, better staffed site.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

- 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 Boston Hospital catchment area before and after the change. This analysis shows that following the introduction of the temporary change, patients from the Boston Hospital catchment area get seen and scanned quicker, have more access to thrombectomy and were, on average, discharged sooner.
    - Arrival to stroke review (hr:min)
        - Pre temporary change: 01:27 (average)
        - Post temporary change: 00:36 (average)
    - Arrival to CT (hr:min)
        - Pre temporary change: 00:46 (average)
        - Post temporary change: 00:39 (average)
    - No. patients for Mechanical Thrombectomy
        - Pre temporary change: 1
        - Post temporary change: 6
    - Average LoS
        - Pre temporary change: 12 (average)
        - Post temporary change: 9 (average)

Additional information added ends here

- 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 increase geographical distance. Lincolnshire has experience of this through the consolidation of heart services on the Lincoln County Hospital site.

- The NHS in Lincolnshire has a collective and integrated ambition for health and care services in the east of the county, with Pilgrim Hospital 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.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

- The activity baseline data used in the Pre Consultation Business Case that set out the analysis and recommendations for the proposed service changes used was 2019/20 (i.e. pre temporary Covid changes).
- A sensitivity analysis was conducted in the service planning that used three growth scenarios (2019/2020 – 2023/24):
    - Office of National Statistics (ONS) all age growth
    - ONS 65+ growth rate
    - Average annual growth rate
- The scenario that was used as the basis for the service planning was the average annual growth rate as it was felt this was most likely to reflect future demand. This scenario identified that when factoring in demand growth Pilgrim Boston Hospital it is unlikely to achieve the recommended critical mass (600 admissions per annum) over the next 5 years.
- If the all-age growth rate or 65+ growth rate for Boston applied rather than the average annual growth rate for stroke admissions, Pilgrim Boston Hospital is still unlikely to achieve the recommended critical mass for stroke admissions over the next 5 years.
- Further review of the ONS population suggestions suggest Pilgrim Boston Hospital is also unlikely to achieve the recommended number of stroke admissions by 2030 on a consistent basis.
- This was forecast to 2023/24 in line with the local five-year strategic plan. Based on ONS population projections Boston Pilgrim, hospital is unlikely to achieve 600 stroke admissions per annum by 2030.

Additional information added ends here

- This 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.
- Standard operating procedures have been put in place so any patient that is having a suspected stroke, the ambulance service will call ahead to Lincoln hospital to discuss so that the team are ready to receive the patient on their arrival.

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

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 5 20th April 2022

Change proposal(s)	**Stroke Services** *Develop a 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs*
Common theme	Workforce
Feedback working group	Carl Ratcliff – Managing Director Medicine Abdul Elmarimi – Consultant Stroke Medicine Rebecca Johnson – Business Manager Cardiovascular Anita Parmar – Deputy General Manager Cardiovascular Lesley Bradley – Trust Lead Physiotherapist Anita Cooper – Divisional Lead Clinician Angela Shimada - LCHS Deputy Director Allied Health Professionals Amy Evans - LCHS Specialist Occupational Therapist
Date feedback working group signed off response	20th April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	28 April 2022

Stroke proposal consultation feedback – Workforce

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- A 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs.

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to stroke services there was also feedback from the Stroke Therapy Team at Pilgrim, Boston Hospital, which identified the following concerns:

- An increase in the number of patients at Lincoln
- The lack of additional specialist staffing proposed for the Lincoln site
- An increase in stroke patients out-lied to non-specialist wards who do not receive timely and effective specialised rehabilitation
- The management of more complex patients who require more intensive input
- The availability (or lack thereof) of community beds and specialist stroke management within community hospitals.

There was also feedback in relation to workforce that the presumption that specialist stroke staff will be able to move from Pilgrim to Lincoln is unrealistic owing to personal circumstances and a lack of transport.

The Health Scrutiny Committee for Lincolnshire feedback that it was not convinced that the proposals will lead to improvements in the recruitment and retention of staff.

In addition a number of mitigations were identified in the feedback relating to workforce:

- Improve recruitment with higher wages/benefits. Are low staff wages and a feeling they are not valued impacting on recruitment and retention?
- Increase staff numbers and ensure there are enough staff, with thrombolysis training. Increase bed numbers and resources
- Introduce a telemedicine system that matches some models used in Europe or other remote areas whereby other staff members could be upskilled to initiate investigations and treatment plans with the help of consultants to keep patient care local
- Additional therapy staffing in the community stroke team would help support more timely discharges if it enabled urgent therapy follow-up. However, the stroke unit would also require sufficient qualified therapy staffing to allow for timely assessment and discharge planning. At present the stroke community team are struggling to hire therapists at some locations. Has the impact of this been considered regarding the proposal?

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback received through the public consultation for the proposed stroke service changes in

relation to workforce. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

An increase in the number of patients at Lincoln

The lack of additional specialist staffing proposed for the Lincoln site

An increase in stroke patients out-lied to non-specialist wards who do not receive timely and effective specialised rehabilitation

The management of more complex patients who require more intensive input

Proposals won't improve the recruitment and retention of staff

There are currently 28 stroke beds in the Lincoln County Hospital stroke unit.

To inform the number of stroke beds required at Lincoln Hospital under the preferred model to consolidate acute stroke services on that site an analysis has been conducted based on three key factors:

- Activity growth rate;
- Preference for hospital site; and
- Average length of stay

In addition to these 3 factors a provision was made in the activity and capacity for stroke mimic admission.

This analysis identified a need to increase the bed capacity at Lincoln County Hospital by 7 beds under the proposed stroke service change. Following an initial appraisal the preferred estates solution to support this change, if it is agreed is to design and build an extension to the existing unit to provide a consolidated service at Lincoln County Hospital.

The detail of this is set out in the Pre Consultation Business Case.

The Pre Consultation Business Case also set out a workforce model for the proposed changes to stroke services, which was developed for the hospital setting.

The table below sets out the hospital based stroke service workforce model (19/20 baseline figures) together with the workforce model under the proposed service change for stroke services.

Stroke services workforce model (funded establishment)

Stroke services workforce model (funded establishment) Staff Group	Current configuration		Proposed model	
	Lincoln Hospital	Pilgrim Hospital	Lincoln Hospital	Pilgrim Hospital
Medical				.
• Consultants	3.0	3.0	6.0	-
• Associate Spec.	1.0	1.0	2.0	-
• F2 (Trust)	-	1.0	1.0	-
• F2 (Deanery)	1.0	-	1.0	
• F1 (Trust)	-	1.0	1.0	
• F1 (Deanery)	1.0	1.0	2.0	
• GPVTS (Deanery)	1.0	-	1.0	
• Core Trainee (Deanery)	-	1.0	1.0	
• Administration	2.0	2.66	4.66	
ACP				
• Nurse ACPs			5.80	-
Nursing				
• Registered	26.90	23.24	51.08	-
• Nursing Associate	2.00	4.0	-	-
• Non Registered	15.32	11.26	21.04	
• Ward Clerk	1.0	2.0	1.4	
AHP				
• Physio/OT/SALT	39.36 (covering both sites)		33.67 (Lincoln Only)	

The proposed service change to consolidate hyper-acute and acute stroke services at Lincoln County Hospital supported by the above workforce model would ensure the unit is staffed according to agreed national guidelines for medical, nursing and allied health professional staff.

The proposed staffing model shows an increase of staffing for the single site model in comparison to the staff currently on the Lincoln site. This would allow the acute stroke service, if the change proposal is agreed, to manage the complexities of patients needing the specific stroke care within an acute setting.

The proposed staffing model is reflective of the expected increased stroke admissions and bed numbers on the Lincoln hospital site under the proposed change. This in turn would support a reduction in the number of outliers from the stroke unit and have a positive impact on patient outcomes, the health and wellbeing of staff, and on staff recruitment and retention.

A new national community stroke specification via NHS England sets out the need for further work and integration with the multi-disciplinary team ensuring the involvement of medical, nursing and social care roles which shall allow management of patients closer to their homes in a community setting.

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

- 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

Under the proposed model, if the service consolidated onto one site there would be a reduction of 12.0 wte in total over the whole workforce within the hospital setting. However, more specialist stroke staff would provide hospital based stroke services from the Lincoln County Hospital site, and it should also be noted that under the proposed service change there would be an overall increase in specialist stroke staff across both the acute and community setting compared to the baseline.

Providing hospital based stroke services on one site would give a greater chance to achieve critical mass and improve recruitment and retention going forward. By creating a centre of excellence and a specialist centre for stroke provision, it would improve and increase opportunities for training and education on the site. This shall not only have a positive impact on recruitment and retention, but also ensure that the patients receiving care in this service shall receive a better standard of care.

Over the past few years, and in line with the above proposed workforce model, the hospital based stroke service has recruited 5.8wte Advanced Care Practioners (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.

ACPs are not a replacement for consultants, and stroke rotas are still required to have 6wte consultants on them. However, they do bring substantial knowledge and expertise to the management of stroke patients. Increasing the number of ACPs further would bring additional mitigation to not being able to fully recruit to stroke consultant rotas.

The availability (or lack thereof) of community beds and specialist stroke management within community hospitals.

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.

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.

Simultaneously Organisational Development (OD) work commenced to bring the separate teams together and agree how an integrated service would be established. The aim throughout has been 'To establish an integrated, seamless pathway and a community based stroke rehabilitation service that is able to support ALL stroke survivors, operating 7 days a week'.

Between October 2019 and January 2020 three teams worked together across the pathway with the following change achieved:

- Supported a reduction in length of stay (LoS) on the Stroke Unit in Lincoln County
- Launched the Lincolnshire Stroke YouTube Channel
- Launched a Patient Handbook that travels with the patient from acute to community and beyond
- Initiated a dedicated Stroke Orthoptic clinic
- Started acute/community staff rotational work experience
- Begun the SAM2 trial linked to timely discharge
- Enabled (hospital) WebV access for Social Care colleagues
- Initiated a trial for single assessment and single transfer form
- Piloted 'Living Well After Stroke' Groups

This enhanced community service will:

- Support all stroke survivors across Lincolnshire to receive their rehabilitation within their local community wherever possible;
- Work with the hyper-acute/acute stroke service to deliver an average length of stay of 7 days;
- Ensure a clear route back into specialist care for patients once discharged from the service;
- Offer a 6-month review to all stroke survivors;
- Support new professions to the Lincolnshire Stroke pathway in a community setting e.g. dietetics and psychology;
- Embed the Stroke Association team into the new Lincolnshire Stroke Service; and
- Improve efficiencies in the system through improved outcomes e.g. reduced hospital utilization, reduced social care costs over the medium to long term.

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.

The service will support community hospitals, which will be health & 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.

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.

The increase in the community stroke service team to deliver this service is set out in the table below (current service is based on the 2019/20 baseline 'pre-covid').

Proposed staffing increase to community stroke team (funded establishment)

Staff group	Current service	Proposed increase
		.
Occupational Therapy	8.63	1.78
Physiotherapy	15.72	2.26
Speech and Language Therapy	3.90	2.25
Rehabilitation Assistants	17.70	6.00
Dietician	0	1.0
Clinical Psychologist (specialising in Stroke)	0	1.0
Assistant Psychologist	0	1.0
Total	*45.95*	*15.29*

Staffing recruitment for the enhanced community stroke team is underway as part of COVID response to ensure all stroke patients in Lincolnshire could be seen. There continues to be further development of roles within community services such as rotational therapist posts to support retention of staff. A new national community stroke specification via NHS England sets out the need for further work and integration with the Multi-disciplinary team ensuring the involvement of medical, nursing and social care roles.

The presumption that specialist stroke staff will be able to move from Pilgrim to Lincoln is unrealistic owing to personal circumstances and a lack of transport

United Lincolnshire Hospital NHS Trust's (ULHTs) stroke service clinical and managerial leadership teams have been on the stroke unit for informal, group and individual sessions including nursing and therapies. They have engaged with the Pilgrim Boston Hospital nursing and therapist team on a regular basis ensuring that all queries have been answered as the public consultation progressed. These conversations are continuing and ongoing at the request of the staff members.

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.

ULHT are aware that this is a very challenging time for staff and have been on hand regularly to ensure full support has been given and will be provided going forward. Where it may be necessary, if the change proposal is agreed, all ULHT affected staff would be formally consulted and have the opportunity to work on other sites within the hospital trust and any gaps that may exist will be recruited to. 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.

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.

Improve recruitment with higher wages/benefits. Are low staff wages and a feeling they are not valued impacting on recruitment and retention?

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.

Reviewing the staff survey for our trust the feelings portrayed by the stroke unit are not an outlier. There has been an increased focus on wellbeing and communication from the Executive Team which is expected to improve feeling of value over time.

Increase staff numbers and ensure there are enough staff, with thrombolysis training.

There is support for the correct number of staff being training to deliver the stroke services. The primary issues is the basic ability to attract and retain staff to train. The model does aim to deliver a more stable workforce that can be built upon, whilst still delivering care to meet the National standard.

Introduce a telemedicine system whereby other staff members could be upskilled to initiate investigations and treatment plans with the help of consultants to keep patient care local

ULHT is working within a regional Integrated Stroke Delivery Network group exploring and moving forward on plans to provide a telemedicine service within Lincolnshire. Hospital Trusts within the East Midlands are working together to ensure they share knowledge and best practice to move this forward.

A benefit from a joint virtual pathway, allowing individuals to receive consultant advice when supporting individuals in a community setting or their own home.

Conclusions and actions

- 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 7 beds is planned.
- 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 Hospital, and ensure the unit is staffed according to agreed national guidelines for medical, nursing and allied health professional staff.
- The proposed future model of acute stroke services supports a more sustainable and resilient workforce, particularly in the medical consultant and nursing groups.
- Over the past few years, and in line with the proposed workforce model, the hospital based stroke service has recruited 5.8wte Advanced Care Practioners (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.
- The recruitment of more ACPs provide further mitigation to the stroke consultant recruitment challenges in the short and medium term.

- 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.
- 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.
- 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.
- 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.
- Increase staff numbers and ensure there are enough staff, with thrombolysis training. The model supports the consolidated number of nursing and medical staff that will then be appropriately trained
- ULHT is working within a regional Integrated Stroke Delivery Network group exploring and moving forward on plans to provide a telemedicine service within Lincolnshire.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 5.2 04th May 2022

Change proposal(s)	**Stroke Services** *Develop a 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs*
Common theme	Travel time and ambulance conveyance
Feedback working group	Carl Ratcliff – Managing Director Medicine Abdul Elmarimi – Consultant Stroke Medicine Rebecca Johnson – Business Manager Cardiovascular Anita Parmar – Deputy General Manager Cardiovascular Lesley Bradley – Trust Lead Physiotherapist Anita Cooper – Divisional Lead Clinician Angela Shimada - LCHS Deputy Director Allied Health Professionals Amy Evans - LCHS Specialist Occupational Therapist
Date feedback working group signed off response	21st April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group as part of reviewing service change proposals	28th April 2022 (Version 5.1) *Following these discussions additional information has been included in this document to create this version (5.2)* *The additional information added is identified in the document*

Stroke proposal consultation feedback – Travel time and ambulance conveyance

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- A 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs.

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to stroke services there was feedback recognising that the proposals would support improved outcomes and quality:

- Supporters of the proposals agree with the principles of a specialist centre for hyper-acute and acute stroke services
- Proposals would likely tackle many of the challenges that the NHS Lincolnshire services currently face
- Increased expertise and quality of care
- Could lead to future investment into Lincolnshire as a result.

However, for the stroke service proposals there was feedback from people both in support and opposition of the stroke proposal relating to travel time and ambulance conveyance:

- Increased travel times that Boston residents would have to travel to Lincoln in the event of a stroke
- Travel times, including by ambulance to reach Lincoln are too long – 'Time is of the essence' and people living in places outside the 'Golden Hour' of travel time to Lincoln, will be disadvantaged by these proposals
- Concerns about centralised model is a risk in England's second largest county where there are infrastructure issues, particularly when treatment time is so critical for stroke patients
- Less availability of ambulance in Boston if they are having to make the journey between sites

In addition, a couple of mitigations were put forward during the public consultation in terms of alleviating concerns. The first being the availability of an air ambulance to cover the east of the county would be supported and the second a mobile stroke unit.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback received through the public consultation for the proposed stroke service changes in relation to travel time and ambulance conveyance. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Increased travel times that Boston residents would have to travel to Lincoln in the event of a stroke

Travel times, including by ambulance to reach Lincoln are too long – 'Time is of the essence' and people living in places outside the 'Golden Hour' of travel time to Lincoln, will be disadvantaged by these proposals

Concerns about centralised model is a risk in England's second largest county where there are infrastructure issues, particularly when treatment time is so critical for stroke patients

Stroke travel analysis completed to inform the Pre Consultation Business Case

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.

In 2019/20 Pilgrim, Boston Hospital 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.

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

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

Independent analysis and modelling conducted by Operational Research in Health Ltd. (ORH) on potential changes to stroke services at Pilgrim, Boston Hospital in 2018, identified approximately 50% of the Pilgrim Hospital 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.

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.

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 will increase from 23m58s to 44m28s (increase of 20m30s on average). This is based on the assumption patients attend their nearest unit.

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).

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 Hospital no patients would travel over 60-minutes. Assuming patients travel to their nearest acute stroke unit.

A sensitivity analysis was also conducted on the number of patients travelling over 60-minutes if stroke services were consolidated at Lincoln 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 patients would attend Lincoln Hospital under this scenario.

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.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

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.

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.

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

Additional information added ends here

A number of stroke patients currently transferred to Boston Hospital 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.

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 stroke services being consolidated at Lincoln 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).

The ORH modelling identified that under the scenario where Boston Hospital 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.

The analysis and modelling completed by ORH on potential changes to stroke services at Pilgrim Boston Hospital 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.

Boston, Pilgrim 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

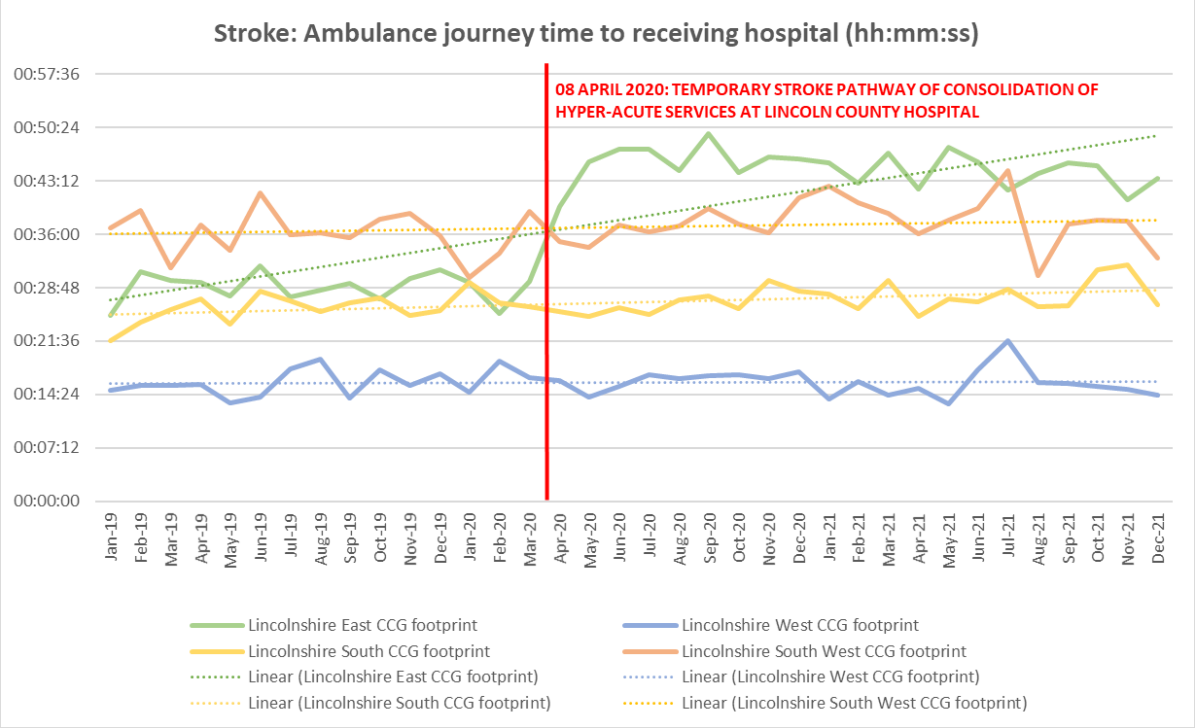
Stroke travel analysis completed to inform the Decision Making Business Case

The temporary consolidation of hyper-acute and acute stroke services on the Lincoln County Hospital site (at the start of April 2020) due to the additional sustainability pressures placed on United Lincolnshire Hospital Trust's stroke services due to Covid-19 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.

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. The Lincolnshire East CCG footprint was used as a proxy for those patients who would have gone to

Boston Pilgrim Hospital prior to the temporary change made by ULHT to consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site. The analysis is set out in the chart below.

Stroke: Ambulance journey time to receiving hospital by old Lincolnshire CCG footprints



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.

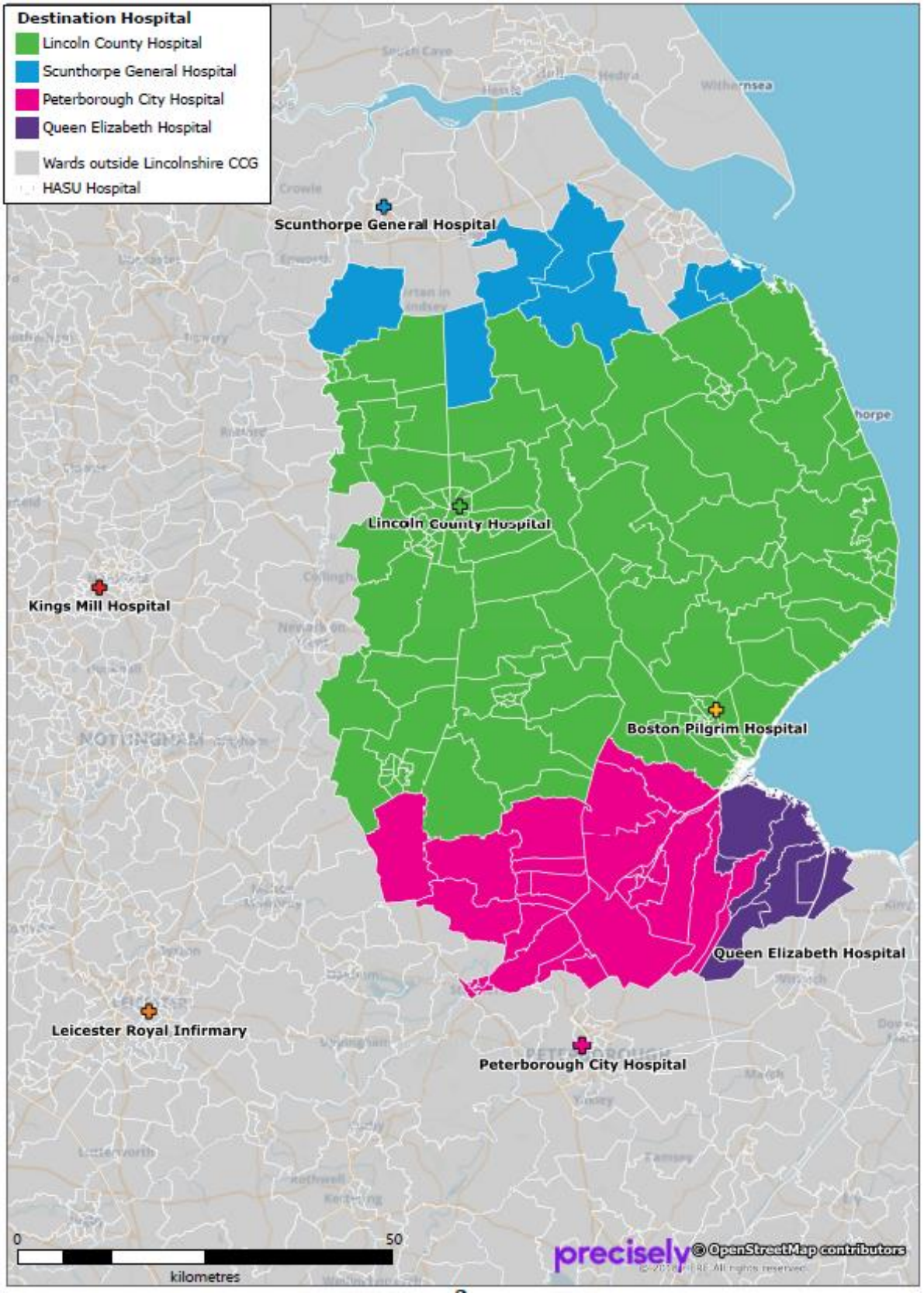
Following the temporary change the average ambulance journey time to receiving hospital for those stroke patients from the old Lincolnshire East CCG footprint was around 45 minutes, which is very much in line with the modelling completed for the PCBC.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

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.

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 Boston Pilgrim Hospital 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.

Most frequent destination hospital by Ward – May 2020 to December 2021



The analysis conducted by ORH also identified the average travel time by ambulance by wards within the Boston Hospital catchment area for patients going to Lincoln County Hospital. This identified that out of 48 wards within the Boston Hospital 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.

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.

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

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*

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

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. This is described further later in this document.

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).

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 Hospital to review previous medical history and decision for treatment commences as soon as patients arrives at hospital

Consolidation of cardiology services on the Lincoln Hospital site to concentrate capacity, skills and expertise, in a similar way proposed for stroke, has demonstrated improvements in outcomes for all Lincolnshire residents.

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.

The table below shows a comparison between the modelled destination hospital in the PCBC (based on 15-minute preference for Lincoln 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.

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

This analysis also showed that none of the average travel times by ambulance for wards within the Boston Hospital 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.

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.

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.

If the proposed stroke changes went ahead, the impact on travel times and destination hospitals would be kept under constant review.

Additional information added ends here

The 'Golden Hour'

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.

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.

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.

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.

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.

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 Hospital site to create the Lincolnshire Heart Centre and what can be achieved:

- On average it takes the specialist team in Lincoln 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.

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.

The evidence of the temporary consolidation of hyper acute stroke services demonstrated that on average patient's diagnosis and treatment times were improved and 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. A key element of delivering this thrombolysis performance is the on-call ACP workforce at Lincoln Hospital being on-site working alongside the consultant on-call team.

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 and 100% of eligible patients receiving thrombolysis; this compared to 10hrs 04mins and 85.8% nationally.

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

ULHT: Lincoln County Hospital median time between clock start and being assessed by stroke consultant (hours:mins) July 2021 to September 2021

Lincoln County Hospital	Oct-Dec20	Jan-Mar 21	Apr-Jun 21	Jul-Sep 21
Median time between clock start and being assessed by stroke consultant (hours:mins)	6:52	10:33	7.40	6.11
			National:	10:04

ULHT: Lincoln County Hospital % of eligible patients given thrombolysis July 2021 to September 2021

Lincoln County Hospital	Oct-Dec20	Jan-Mar 21	Apr-Jun 21	Jul-Sep 21
Percentage of eligible patients given thrombolysis	100	93.8	100	100
			National:	85.8

It is also worth noting that in the SSNAP 2021 Acute Organisation Audit (results based on services as of 1 October 2021), when comparing national performance at site level, out of a total of 157 sites the Lincoln County Hospital was one of only 6 sites that achieved 8 Key Indicators. Only 1 site achieved 9 Key Indicators and no site achieved 10. All the remaining sites achieved less than 8 Key Indicators.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

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 Boston Hospital catchment area before and after the change.

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.

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

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.

Comparison of access to stroke care for patients from the Boston Hospital catchment area before and after the temporary change to consolidate services on the Lincoln Hospital site

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***

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.

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 improved outcomes outweigh the impact of increased geographical distance.

Please note: consideration of consultation feedback relating to outcomes is covered in the stroke consultation feedback 'Outcomes and Quality' document.

Additional information added ends here

Less availability of ambulances in Boston

As part of the independent analysis and modelling of ambulance travel times completed by ORH, an analysis of the impact of the proposed changes on ambulance performance and utilisation was completed.

In the base position (i.e. the current situation in 2019/20), Category 1 mean response performance in NHS Lincolnshire CCG was 9m27s, and category 2 mean hybrid performance was 37m14s. The average ambulance utilisation at Boston station was 73.5%.

The modelling by ORH 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.

The East Midlands Ambulance NHS Trust (EMAS) who provide ambulance services to Lincolnshire were involved in the work completed by ORH and supported the conclusion of the modelling and said it was deliverable.

If the proposed change went ahead the additional ambulance hours required to restore the base position performance would be reflected in the EMAS contract.

An air ambulance to cover the east of the county and a mobile stroke unit

This suggestion was considered as part of the Transport Report and will not been taken forward as the air ambulance does not respond to stroke patients.

Another exciting development in emergency stroke care is the Mobile Stroke Unit (MSU). This includes the use of a mobile CT scanner and resources for thrombolysis on the ambulance while the patient is being transferred to the most appropriate setting. This has been shown to cut the time to thrombolysis and reduce the rate of admission for TIAs and stroke mimics as well. MSU relies heavily on the availability of highly skilled staff 24/7, and given our geography in Lincolnshire, we will be exploring this option as part of further improvement to the provision of hyperacute stroke care.

Conclusions and actions

- 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).
- 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 Hospital no patients would travel over 60-minutes.
- When developing the change proposal and to inform the Pre Consultation Business Case, an analysis of historical ambulance travel data was conducted on the number of patients travelling over 60-minutes if stroke services were consolidated at Lincoln Hospital. This estimated that even with patients travelling to their nearest acute stroke unit plus a 15-miunte threshold preference for Lincoln County Hospital (which was agreed for the proposed model), no patients would travel over 60-minutes (increase in average travel time of 22m53s). It is estimates around 75% of Pilgrim Hospital patients would attend Lincoln Hospital under this scenario.
- 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.
- 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 Boston Pilgrim Hospital prior to the temporary change made by ULHT to consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site.
- 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.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

- Building on this 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.
- This analysis identified that based on all ambulance journeys between 1st May and 31st December for those patients who live in the wards closest to Boston Pilgrim Hospital 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.
- For Lincoln County Hospital as the destination, this analysis identified that out of 48 wards within the Boston Hospital 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. 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 therefor the average could be skewed by one or two incidents. The average annual patients from all of these wards was 128.
- 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
- 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. This is described further later in this document.
- 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.
- 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 model, a good joint working model has been established between ambulance paramedics and stroke ACPs at Lincoln Hospital to review previous medical history and decision for treatment commences as soon as patients arrives at hospital
- 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.
- A comparison between the modelled destination hospital in the PCBC (based on 15-minute preference for Lincoln Hospital) and the actual destination hospital during the temporary change to ULHT's stroke services showed 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.

- This analysis also showed that none of the average travel times by ambulance for wards within the Boston Hospital 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.
- 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. 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.
- If the proposed stroke changes went ahead, the impact on travel times and destination hospitals would be kept under constant review.

Additional information added ends here

- 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.
- 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. However, it is a target and has no clinical significance to outcome. There is however 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.
- 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:
    - 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 the Lincoln County Hospital was one of only 6 sites that achieved 8 Key Indicators. Only 1

site achieved 9 Key Indicators and no site achieved 10. All the remaining sites achieved less than 8 Key Indicators.

Section below added following discussion at joint meeting of ICS Clinical Directorate and CCG Clinical Policies Sub Group

- 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 Boston Hospital catchment area before and after the change. This analysis shows that following the introduction of the temporary change, patients from the Boston Hospital catchment area get seen and scanned quicker, have more access to thrombectomy and were, on average, discharged sooner.
    - Arrival to stroke review (hr:min)
        - Pre temporary change: 01:27 (average)
        - Post temporary change: 00:36 (average)
    - Arrival to CT (hr:min)
        - Pre temporary change: 00:46 (average)
        - Post temporary change: 00:39 (average)
    - No. patients for Mechanical Thrombectomy
        - Pre temporary change: 1
        - Post temporary change: 6
    - Average LoS
        - Pre temporary change: 12 (average)
        - Post temporary change: 9 (average)
- 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.

Additional information added ends here

- 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.
- 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.

- This suggestion of an air ambulance being used to cover residents in the east of the county was considered as part of the Transport Report and will not been taken forward as the air ambulance does not respond to stroke patients.
- Given our geography in Lincolnshire, the health system will be exploring the option of a mobile stroke unit option as part of further improvement to the provision of hyperacute stroke care.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 5- 20th April 2022

Change proposal(s)	**Stroke Services** *Develop a 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs*
Common theme	Facilities
Feedback working group	Carl Ratcliff – Managing Director Medicine Abdul Elmarimi – Consultant Stroke Medicine Rebecca Johnson – Business Manager Cardiovascular Anita Parmar – Deputy General Manager Cardiovascular Lesley Bradley – Trust Lead Physiotherapist Anita Cooper – Divisional Lead Clinician Angela Shimada - LCHS Deputy Director Allied Health Professionals Amy Evans - LCHS Specialist Occupational Therapist
Date feedback working group signed off response	20th April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	28 April 2022

Stroke proposal consultation feedback – Facilities

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- A 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs.

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to stroke services there was feedback in relation to the facilities at Lincoln County Hospital to support the proposed changes. This was shared in the context of both support and opposition to the proposal:

- Concern over capacity and infrastructure at Lincoln County Hospital and questioned whether the site would be able to work effectively and deal with increased demand with proposed stroke services.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the feedback received through the public consultation for the proposed stroke service changes in relation to facilities at Lincoln County Hospital. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Stroke change proposal demand and capacity modelling

Stroke activity demand and hospital bed capacity modelling formed a key part of the underpinning analysis to assess the proposed service change. An overview of this is provided below with more detail set out in the Pre Consultation Business Case.

Currently there are 28 stroke beds in the Lincoln County Hospital stroke unit. To inform the number of stroke beds required at Lincoln Hospital under the preferred model to consolidate acute stroke services on that site an analysis was been conducted based on three key factors, using the 2019/20 activity baseline (i.e. the last 'normal' year pre-Covid 19):

- Activity growth rate;
- Preference for hospital site; and
- Average length of stay

Future stroke service bed requirement at Lincoln Hospital 2023/24

	Lincoln Hospital bed requirement under preferred option			
	Current	Current av. LoS	10 day av. LoS	7 day av. LoS
Based on ONS all age growth (19/20-23/24: 2.17%)				
Nearest	*28*	*43*	28	20
Nearest + 5mins	*28*	*45*	30	21
Nearest + 10mins	*28*	*47*	32	22
Nearest + 15mins	*28*	*48*	33	23
Based on av. annual growth rate (19/20-23/24: 3.88%)				
Nearest	*28*	*44*	29	20
Nearest + 5mins	*28*	*46*	30	21
Nearest + 10mins	*28*	*48*	32	23
Nearest + 15mins	*28*	*49*	33	23
Based on ONS 65+ growth rate (19/20-23/24: 6.70%)				
Nearest	*28*	*45*	29	21
Nearest + 5mins	*28*	*47*	31	22
Nearest + 10mins	*28*	*49*	33	23
Nearest + 15mins	*28*	*51*	34	24

The factor that has the biggest impact on the required bed capacity for a consolidated acute stroke unit at Lincoln Hospital is average length of stay. The ambition is to move to an average length of stay of 7 days supported through an enhanced discharge service.

However, based on the evidence from Northampton and Peterborough that have implemented the enhanced community model a 7-day length of stay in the acute setting may not be achieved straight away. Therefore, the bed capacity for the proposed future model was been based on an average length of stay of 10 days.

Although care should be taken when comparing data between 2019/20, 2020/21 and 2021/22 given the impact Covid-19 had on peoples behaviours and the changes in patient pathways, the average length of stay at Lincoln County hospital reduced from c.15 days to c.13 days between these years, which coincided with the consolidation of hyper-acute stroke services on the Lincoln Hospital site. With the average length of stay in some months below 10 days.

The factor that has the second largest impact on the required bed capacity for the proposed model of care is hospital site preference. Given within the 15-minute site preference scenario for Lincoln Hospital it is estimated patient travel times will not exceed 60 minutes, to strike the optimum balance of ensuring sufficient capacity at Lincoln Hospital and the impact on out of county hospitals this scenario was been used as the basis for the future bed capacity requirement.

The factor that has the least impact on the required bed capacity is the activity growth rate. The future bed capacity requirement has been based on the average annual growth rate.

Drawing the chosen assumptions for these three factors together gives a future bed requirement of 33 acute stroke beds on the Lincoln Hospital site to deliver the preferred model.

When giving consideration to the future capacity requirements for a consolidated acute stroke service at Lincoln Hospital, as well as the stroke activity consideration needs to be given to mimic activity.

It is estimated that currently at Lincoln Hospital mimics use around 2 beds a year and around 2.7 beds at Pilgrim Hospital. Under the proposed model for acute stroke services it is estimated that Lincoln Hospital would need an additional 1.3 beds for mimics if patients attend their nearest hospital and an additional 2 beds if a 15-minute preference for Lincoln Hospital is applied.

Based on mimics requiring 2 beds, this gives a total bed requirement of 35 beds for the proposed model to consolidate acute stroke services on the Lincoln Hospital site.

Stroke change proposal estates plan

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 Hospital.

Using the options framework a structured analysis determined which of the options met the core requirements of the project whilst also appearing affordable and delivering the intended benefits. An overview of these options is set out below:

- **Delivering acute stroke services from two sites – Business as Usual**

  Retaining the service across two acute hospital sites (Lincoln and Boston) results in no improvement to the service quality. Whilst the option appears better in terms of affordability, it is evident that it does not deliver any of the intended objectives and subsequent benefits of improved service quality and outcomes.

- **Reconstruct the existing unit to provide a consolidated service at Lincoln County Hospital - Do Minimum**

  Reviewing the design of the existing stroke unit at Lincoln showed there is scope to reconstruct parts of the internal layout to create the additional capacity (seven inpatient beds) for the consolidation of inpatient beds. The option requires the Trust to derogate from Health Building Note (HBN) best practice guidance. As a result of this, the option has a high likelihood for resulting in an adverse impact on the quality of care received by patients and will actually deliver no benefits to some of the intended beneficiaries of the project, such as staff.

  The initial appraisal makes the option appear unviable in terms of the lack of public value that it brings though it appears feasible to physically achieve. Whilst the option is carried forward, it arguably accumulates as much, if not more, risk as the BAU option and with equally few, if not less, benefits being realised.

- **Design and build an extension to the existing unit to provide a consolidated service at Lincoln Hospital – <u>Preferred way forward at this stage</u>**

  Seven additional inpatient beds requires an additional 280 to 315 square meters of floor area. This is allowing 40 to 45 square meters per inpatient to conform to HBN space requirements for a single bedroom (23.5m2) or multi-bed room for four persons (72.5 m2) and for necessary ancillary rooms.

  An extension to the existing unit has been scoped at a high level with support from external design and architectural consultants. ULHT has an area of land adjacent to the current stroke unit that allows for a 400 square meter build to be achieved. At this stage, this is the preferred

way forward in terms of feasibility and delivering the intended outcomes and benefits. It suggests that the current unit could continue to operate with little to no disturbance making the option also more affordable at this stage as a result of not having to consider decant costs.

- **Reconstruct and grow the footprint of the entire existing unit to provide a consolidate service at Lincoln County Hospital**

  Amalgamating the option to reconstruct the layout of the existing unit as well build in additional floor area does create a slightly more expensive option to reconstruct the entire unit and build the necessary additional floor area to allow for thirty-five inpatient beds to be accommodated.

  The complexity associated with achieving this option makes it more expensive than the 'do minimum' and current preferred way forward. The existing unit accommodates twenty-eight inpatient beds within a 700m2 area: 25m2 per patient. In order to achieve compliance with HBN, planners indicate that the unit would need to be sized between 1,400 and 1,575 square meters: 40 to 45 meters square per patient in order to accommodate thirty-five inpatient beds and provide the necessary ancillary rooms.

  It is difficult to determine the feasibility of this option at this stage but the output is beyond the core scope of the project, being a desirable solution to the intended service change. There is a high likelihood that that the option will be unaffordable because of the location and existing structural design of the stroke unit, causing the complexity associated with this option.

- **Build a new stroke unit in a new location to provide a consolidated service at Lincoln County Hospital**

  The immediate challenge when appraising this option is where a new stroke unit could be provided onsite whilst maintaining the efficiencies that the existing unit has by being suitability located near other key departments such as Accident and Emergency. The option to build a new stroke unit could comparatively be more affordable than the previous option that explored reconstructing the existing unit and building in additional floor area to achieve HBN standards but it is still likely to be significantly more expensive than the current preferred way forward whilst delivering a similar amount of benefits but taking longer to achieve due to the time it would take to build a new unit.

  The option to build a unit that would accommodate an increased number of inpatient beds: beyond thirty-five, is beyond the business needs of ULHT and so discounted from being carried forward from this appraisal.

- **Build a new facility to provide a consolidated stroke service at Lincoln County Hospital, a new physiotherapy department and occupational therapy department**

  Physiotherapy is currently delivered within a building that is condition ranked as DX: "operationally unsound and is impossible to improve without replacement". Similarly, to physiotherapy, occupational therapy is delivered within a small unit within a building that is operational but will fall below 'condition B' within five years.

  Whilst consolidating the different services into one building brings the most public value in terms of benefits, the scope is beyond the core and desirable business needs of ULHT making the option unaffordable given the current financial climate concerning ULHT. There is also the challenge of appropriately locating a facility of this size that maintains the efficiencies that the

existing stroke unit, physiotherapy and occupational therapy departments have by being suitability located near other key wards and departments, making the option unfeasible.

Following this initial appraisal, recognising a more detailed and fuller analysis will be required at Outline Business Case stage and then Full Business Case stage if the service change proposal is agreed, the emerging preferred estates option for the stroke services change proposal is to design and build an extension to the existing unit to provide a consolidated service at Lincoln Hospital. The cost estimate of this estate solution was £7.5m at the time of producing the Pre Consultation Business Case.

Conclusions and actions

- Stroke activity demand and hospital bed capacity modelling formed a key part of the underpinning analysis to assess the proposed service change. An overview of this is provided
- 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 Hospital site was identified.
- 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 Hospital.
- 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).
- 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.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 5 20th April 2022

Change proposal(s)	**Stroke Services** Develop a 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs
Common theme	Alternative Suggestions - Hyper-acute and acute wards
Feedback working group	Carl Ratcliff – Managing Director Medicine Abdul Elmarimi – Consultant Stroke Medicine Rebecca Johnson – Business Manager Cardiovascular Anita Parmar – Deputy General Manager Cardiovascular Lesley Bradley – Trust Lead Physiotherapist Anita Cooper – Divisional Lead Clinician Angela Shimada - LCHS Deputy Director Allied Health Professionals Amy Evans - LCHS Specialist Occupational Therapist
Date feedback working group signed off response	20th April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	28 April 2022

Alternative suggestions for hyper-acute and acute stroke provision

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- A 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs.

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to stroke services a number of alternative suggestions were put forward for the provision of hyper-acute and acute stroke provision:

- Both Lincoln County Hospital and Pilgrim Hospital, Boston should be a centres of excellence for stroke, attracting good staff to manage them. There should be a focus on recommended speed for treatment rather than numbers of patients.
- Keep the hyperacute at site; make consultants and ACPs work pan-trust and put money into ACP training for experienced stroke nurses.
- Locating stroke services in Boston was seen by some to suit the overall needs of the population better than Lincoln.
- Train teams stepping into hyper acute care in a timely way; for example Specialist Strokes and Registrants stepping onto ACP University courses using LBR funds or Apprenticeship Levy. Also HCAs have upskilled using Stroke.org.
- If there is to be a second ward at Lincoln this should be a small hyperacute ward (close to the stroke unit) and use the current stroke unit for acute/rehab as this already has several therapy rooms. Therapy teams would work across the two wards to provide consistency of care and help maintain cover during annual leave/staff absence etc.
- It would be beneficial to have a dedicated MDT/discharge coordinator(s).
- A standard operating procedure should be in place that allows thrombolysis to be given in the emergency department if time to transfer to HASU is >45 minutes (in the same manner Major Trauma patients divert to local TUs if an MTC cannot be reached in 45 minutes). Patients should then be transferred to HASU post thrombolysis. This is supported by NICE and there are examples of this working in practice elsewhere in the country.
- Develop a centre of excellence at Peterborough, Grimsby and Nottingham and don't have anything in Lincolnshire at all

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the alternative suggestions for hyper-acute and acute stroke care feedback through the public consultation. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Both Lincoln County Hospital and Pilgrim Hospital should be centres of excellence, attracting good staff to manage them

Keep the hyperacute at both sites; make consultants and ACPs work pan-trust and put money into ACP training for experienced stroke nurses

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 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

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.

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.

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?'*.

There was a consensus to consolidate stroke services (hyper-acute and acute) at Lincoln Hospital:

- Overall 61% of participants thought this proposal satisfies the criteria significantly or somewhat better than a two site service at Lincoln and Pilgrim Hospitals.
- Overwhelming support to consolidate the hyper-acute and acute stroke service at Lincoln Hospital in relation to improved quality (90%) and deliverability (93%) of the service.
- Recognition that consolidation will potentially impact on access, and there is therefore a 'trade off' with significantly improved quality and deliverability.
- Recognition that consolidation of stroke services onto one site will require capital investment.

The outcomes of the evaluation in terms of the percentage of attendees that showed a preference for a proposal are set out below.

	Criteria	One site at Lincoln *Satisfies the criteria significantly / somewhat better*	No preference	Two sites at Lincoln and Pilgrim - one rota *Satisfies the criteria significantly / somewhat better*
Stroke	Quality	90%	5%	5%
	Access	36%	20%	44%
	Affordability	26%	17%	57%
	Deliverability	93%	3%	3%
	Total	**61%**	**12%**	**27%**

When the model for consolidating hyper-acute and acute stroke services at Lincoln 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.

The challenges of operating and staffing two hyper-acute and acute stroke units at Pilgrim Hospital, Boston and Lincoln County Hospital were highlighted and exacerbated by Covid-19, which led to the need to temporarily consolidate these services at Lincoln County Hospital.

The major drive for moving to a single site is because the hospital based stroke service does not have enough doctors, or nurses, and it is not possible to run a rota with just consultant nurses, even if there were 10 of them.

Locating stroke services in Boston would suit the overall needs of the population better than Lincoln

The option to consolidate hyper-acute and acute stroke services at Lincoln Hospital was designed through a number of clinically led workshops headed by the Stroke Consultants at United Lincolnshire Hospitals NHS Trust (ULHT) with support and contributions from Professor Rudd (the National Clinical Director for Stroke Services), and local acute, primary and community based health professionals. A number of influential factors for why the Lincoln Hospital site was identified to centralise acute stroke services as opposed to Pilgrim Hospital were identified.

Co-location of specialised services is very important. There is an established and highly successful heart centre on the Lincoln Hospital site. The cardiology team support the stroke team to deliver an optimal front door service as co-location with cardiology enables access to more important time critical interventions like bubble echocardiograms and implantable loop recorders. At Lincoln Hospital there is an established Advanced Care Practioner (ACP) service and pathway that was noted as a regional example of excellence by a Getting It Right First Time (GIRFT) review.

Co-location with the heart unit also has the benefit of using the Cath lab facilities to directly access acute imaging thus bypassing A&E and further reducing door to needle time. Moving these cardiac services from the Lincoln site to another hospital would require significant financial investment and is risky in terms of being able to transfer all staff for this service.

Mechanical thrombectomy is a relatively new treatment for strokes that is currently only carried out in tertiary stroke centres, the closest of which for Lincolnshire residents is Nottingham University Hospitals NHS Trust (NUH). Lincoln Hospital offers a shorter travel time to NUH than Pilgrim Hospital by c.30 minutes. Consolidation of stroke services at Lincoln hospital also provides an increased opportunity for the Lincoln site to provide mechanical thrombectomy in the future as there has been discussion at a national level that Cardiologists may be considered as being appropriate to deliver mechanical thrombectomy based on their experience with PPCI.

Vascular Surgery is currently provided from Pilgrim Hospital and there are no plans for that to change going forward. Co-location with Vascular Surgery is helpful, however the timeline for surgery is within 2 weeks and reserved for those with no disability or minor disability patients who are fit for surgery.

ULHT's stroke service faced a number of ongoing recruitment challenges. Experience has shown it is easier to recruit to the Lincoln 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.

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 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 Hospital (this reduces to c.65 patients if a 15-minute travel time preference for Pilgrim hospital is applied). Lincoln Hospital is therefore a better solution for more of Lincolnshire's population on that basis.

When the model for consolidating hyper-acute and acute stroke services at Lincoln 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.

Training of teams stepping into hyper acute care in a timely way, for example Specialist Strokes and Registrants stepping onto ACP University courses using LBR funds or Apprenticeship Levy. Also HCAs have upskilled using Stroke.org.

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 Practioners (ACPs) ending in them ultimately obtaining their Master's degree and qualifications.

Over the past few years, and in line with the proposed workforce model for the service change, the hospital based stroke service has recruited 5.8wte Advanced Care Practioners (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.

There is a national shortage of stroke consultants, at present 51% of substantive consultant posts are vacant. Therefore the service has been looking at different models such as consultant nurse practitioner to have more resilience in the system.

ACPs are not a replacement for consultants, and stroke rotas are still required to have 6wte consultants on them. However, they do bring substantial knowledge and expertise to the management of stroke patients. Increasing the number of ACPs further would bring additional mitigation to not being able to fully recruit to stroke consultant rotas.

One of ULHT's aims is to be a university teaching hospital offering academic as well as clinical posts which will increase the attraction to our service. Neurology trainees would then also have stroke placements.

HCA also can have enhanced skills but even if these were in place they do not support changes to the proposed model.

If there is to be a second ward at Lincoln this should be a small hyper-acute ward close to the stoke unit, and use the current stroke unit for acute/rehab

The preferred option for the future provision of acute stroke services across Lincolnshire, as identified through the ASR options appraisal process, is to consolidate acute stroke services on the Lincoln Hospital site.

Currently the acute stroke unit at Lincoln Hospital has 28 beds, and the modelling completed for the consolidated acute stroke unit on the site has identified a need for 35 beds. Therefore, requiring an increase in the overall footprint of the estate and an increase in the amount of floor area requiring day-to-day maintenance.

A broad range of options have been identified to support delivery of the preferred service solution, to consolidate hyper-acute and acute stroke services at Lincoln County Hospital. Using the options framework a structured analysis determined which of the options met the core requirements of the project whilst also appearing affordable and delivering the intended benefits. These options were as follows:

- **Delivering acute stroke services from two sites – Business as Usual**

  Retaining the service across two acute hospital sites (Lincoln and Boston) results in no improvement to the service quality. Whilst the option appears better in terms of affordability, it is evident that it does not deliver any of the intended objectives and subsequent benefits of improved service quality and outcomes.

- **Reconstruct the existing unit to provide a consolidated service at Lincoln County Hospital - Do Minimum**

  Reviewing the design of the existing stroke unit at Lincoln showed there is scope to reconstruct parts of the internal layout to create the additional capacity (seven inpatient beds) for the consolidation of inpatient beds. The option requires the Trust to derogate from Health Building Note (HBN) best practice guidance. As a result of this, the option has a high likelihood for resulting in an adverse impact on the quality of care received by patients and will actually deliver no benefits to some of the intended beneficiaries of the project, such as staff.

  The initial appraisal makes the option appear unviable in terms of the lack of public value that it brings though it appears feasible to physically achieve. Whilst the option is carried forward, it arguably accumulates as much, if not more, risk as the BAU option and with equally few, if not less, benefits being realised.

- **Design and build an extension to the existing unit to provide a consolidated service at Lincoln Hospital – <u>Preferred way forward at this stage</u>**

  Seven additional inpatient beds requires an additional 280 to 315 square meters of floor area. This is allowing 40 to 45 square meters per inpatient to conform to HBN space requirements for a single bedroom (23.5m2) or multi-bed room for four persons (72.5 m2) and for necessary ancillary rooms.

  An extension to the existing unit has been scoped at a high level with support from external design and architectural consultants. ULHT has an area of land adjacent to the current stroke unit that allows for a 400 square meter build to be achieved. At this stage, this is the preferred way forward in terms of feasibility and delivering the intended outcomes and benefits.

It suggests that the current unit could continue to operate with little to no disturbance making the option also more affordable at this stage as a result of not having to consider decant costs.

- **Reconstruct and grow the footprint of the entire existing unit to provide a consolidate service at Lincoln County Hospital**

  Amalgamating the option to reconstruct the layout of the existing unit as well build in additional floor area does create a slightly more expensive option to reconstruct the entire unit and build the necessary additional floor area to allow for thirty-five inpatient beds to be accommodated.

  The complexity associated with achieving this option makes it more expensive than the 'do minimum' and current preferred way forward. The existing unit accommodates twenty-eight inpatient beds within a 700m2 area: 25m2 per patient. In order to achieve compliance with HBN, planners indicate that the unit would need to be sized between 1,400 and 1,575 square meters: 40 to 45 meters square per patient in order to accommodate thirty-five inpatient beds and provide the necessary ancillary rooms.

  It is difficult to determine the feasibility of this option at this stage but the output is beyond the core scope of the project, being a desirable solution to the intended service change. There is a high likelihood that that the option will be unaffordable because of the location and existing structural design of the stroke unit, causing the complexity associated with this option.

- **Build a new stroke unit in a new location to provide a consolidated service at Lincoln County Hospital**

  The immediate challenge when appraising this option is where a new stroke unit could be provided onsite whilst maintaining the efficiencies that the existing unit has by being suitability located near other key departments such as Accident and Emergency. The option to build a new stroke unit could comparatively be more affordable than the previous option that explored reconstructing the existing unit and building in additional floor area to achieve HBN standards but it is still likely to be significantly more expensive than the current preferred way forward whilst delivering a similar amount of benefits but taking longer to achieve due to the time it would take to build a new unit.

  The option to build a unit that would accommodate an increased number of inpatient beds: beyond thirty-five, is beyond the business needs of ULHT and so discounted from being carried forward from this appraisal.

- **Build a new facility to provide a consolidated stroke service at Lincoln County Hospital, a new physiotherapy department and occupational therapy department**

  Physiotherapy is currently delivered within a building that is condition ranked as DX: "operationally unsound and is impossible to improve without replacement". Similarly, to physiotherapy, occupational therapy is delivered within a small unit within a building that is operational but will fall below 'condition B' within five years.

  Whilst consolidating the different services into one building brings the most public value in terms of benefits, the scope is beyond the core and desirable business needs of ULHT making the option unaffordable given the current financial climate concerning ULHT.

There is also the challenge of appropriately locating a facility of this size that maintains the efficiencies that the existing stroke unit, physiotherapy and occupational therapy departments have by being suitability located near other key wards and departments, making the option unfeasible.

Following this 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 Hospital. ULHT has an area of land adjacent to the current stroke unit that allows for a 400 square meter build to be achieved. At this stage, this is the preferred way forward in terms of feasibility and delivering the intended outcomes and benefits. It suggests that the current unit could continue to operate with little to no disturbance making the option also more affordable at this stage as a result of not having to consider decant costs.

However, 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

It would be beneficial to have a dedicated MDT/discharge coordinator(s)

This role would be beneficial to explore to lead the interface between the ward / communicate services. This role would be useful regardless of the clinical model.

A standard operating procedure should be in place that allows thrombolysis to be given in the emergency department if time to transfer to HASU is >45 minutes (in the same manner Major Trauma patients divert to local TUs if an MTC cannot be reached in 45 minutes). Patients should then be transferred to HASU post thrombolysis. This is supported by NICE and there are examples of this working in practice elsewhere in the country.

Since the introduction of the temporary change to consolidate hyper-acute and acute stroke services on the Lincoln Hospital site, the process for patients attending the emergency department at Pilgrim Hospital who require thrombolysis is for the patient to be 'blue-lighted to Lincoln Hospital by ambulance.

The process has been in place since the start of the temporary change and there have been no issues. Analysis of the Sentinel Stroke National Audit Programme (SNAP) data for the Lincoln Hospital site shows that 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. A key element of delivering this thrombolysis performance is the on-call Advanced Care Practioner workforce at Lincoln Hospital being on-site working alongside the consultant on-call team.

In the quarter July to September 2021 Lincoln County Hospital achieved 100% of eligible patients receiving thrombolysis; this compared to 10hrs 04mins and 85.8% nationally.

If the proposed service change is agreed the process of transferring patients who attend at Pilgrim Hospital emergency department and require thrombolysis to Lincoln Hospital by ambulance (as currently happens under the temporary change) would continue.

For any patients in the Boston catchment area calling an ambulance, they would be taken to their nearest HASU department.

Develop a centre of excellence at Peterborough, Grimsby and Nottingham and don't have anything in Lincolnshire at all

The proposal does not deliver the required National standards for stroke care, given the size of the county. Having a centre at Lincoln does support delivery for Lincolnshire as per the proposed model.

Conclusions and actions

- 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
- 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.
- 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 10 of them.
- Locating a single hyper-acute and acute stroke unit at Lincoln Hospital rather than Boston Pilgrim Hospital 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 Practioner (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 the Lincoln Hospital compared to Pilgrim Hospital,
    - More Lincolnshire residents would receive their care out of the county if stroke services were consolidated on the Pilgrim Hospital site rather than at Lincoln Hospital.
- 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 Practioners (ACPs) ending in them ultimately obtaining their Master's degree and qualifications.

- 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 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.
- Since the introduction of the temporary change to consolidate hyper-acute and acute stroke services on the Lincoln Hospital site, the process for patients attending the emergency department at Pilgrim Hospital who require thrombolysis is for the patient to be 'blue-lighted to Lincoln 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.
- 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.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 5 20th April 2022

Change proposal(s)	**Stroke Services** *Develop a 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs*
Common theme	Alternative Suggestions - Rehabilitation
Feedback working group	Carl Ratcliff – Managing Director Medicine Abdul Elmarimi – Consultant Stroke Medicine Rebecca Johnson – Business Manager Cardiovascular Anita Parmar – Deputy General Manager Cardiovascular Lesley Bradley – Trust Lead Physiotherapist Anita Cooper – Divisional Lead Clinician Angela Shimada - LCHS Deputy Director Allied Health Professionals Amy Evans - LCHS Specialist Occupational Therapist
Date feedback working group signed off response	20th April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	28 April 2022

Alternative suggestions for rehabilitation

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- A 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs.

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to stroke services a number of alternative suggestions were put forward for the provision of hyper-acute and acute stroke provision:

- As time is critical for stroke patients, Grantham should have the rehabilitation service but only have an acute service if there is an A&E unit there.
- Ringfence specialist beds at Boston to create a hub and spoke stroke rehabilitation service across Lincolnshire. This would provide a highly specialist stroke provision in a centre with ongoing rehabilitation and preparation for discharge to the community. High quality service provision should link the pathway for rehabilitation across acute and community sectors.
- An appropriate stroke rehab ward would ensure throughput sufficient to allow new patients to be admitted and longer term patients to receive the stroke rehabilitation they require.
- Community rehabilitation services need to be in place for stroke and other neurological conditions, especially brain injury. Also, a step up/step down inpatient/outpatient unit where all patients can go to regain lost skills: able to learn to walk again, talk, eat, swallow etc.
- Provide step down beds in Pilgrim and GDH to allow a manageable caseload for LCH and so that patients receive specialist stroke rehabilitation closer to home. ADSS/community stroke services will not be able to provide an effective service to all patients as stroke rehabilitation requires specialist facility and equipment. The recovery of patients who are more dependent and require more than two people to treat them will be compromised and their outcomes will be poorer. Pre- covid GDH had five beds for stroke rehabilitation. Those beds were always occupied and patients had the opportunity to have treatment near home.
- There is no mention regarding the link to community rehab beds within care homes or community hospitals. Is there a risk for those patients with dysphagia etc, as a result of a stroke, will be 'stuck' in Lincoln acute stroke beds.
- Why are brain and head injury rehabilitation kept separate from stroke rehabilitation – these services should align better

In relation to the suggestion to provide stroke rehabilitation beds at Pilgrim Hospital, Boston a written submission was provided by the Stroke Therapy Team at the hospital which stated the team understands the reasoning for developing a centre of excellence at Lincoln but feels that the full pathway has not been considered in terms of the wide range of complex patients' needs. A percentage of patients are unable to go home, requiring more specialist rehabilitation on their sitting ability

and/or having non-oral feeding requirements – and that there is evidence to suggest that these patients would benefit from further multi-disciplinary team (MDT) input. This group of patients also need expert input including the use of special equipment which is not available in the community.

The team feels that beds in community hospitals are rarely available and there is lack of specialist stroke management, meaning patients do not reach their full potential/outcomes. When working with the Lincolnshire Stroke Service on best discharge outcomes, the Service often advises that referring to a community bed will not provide the necessary specialist rehabilitation for these patients. This apparently results in patients being referred to a new placement despite the fact that if they had further rehabilitation, they could have returned home in certain cases.

The team recommends that funding is maintained for the number of beds at Pilgrim Hospital Boston to enable patient flow. It also believes that stroke-specific inpatient rehabilitation beds are key to the success of the proposal should it be taken forward.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the alternative suggestions for hyper-acute and acute stroke care feedback through the public consultation. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Grantham should have a rehabilitation service

Ringfence specialist beds at Boston to create a hub and spoke rehabilitation service across Lincolnshire. An appropriate stroke rehab ward would ensure throughput sufficient to allow new patients to be admitted and longer term patients to receive the stroke rehabilitation they require

Provide step down beds at Pilgrim and Grantham and District Hospital to allow manageable caseload for Lincoln County Hospital and so that patients receive specialist stroke rehabilitation closer to home

There is no mention regarding the link to community rehab beds within care homes or community hospitals. Is there a risk for those patients with dysphagia etc, as a result of a stroke, will be 'stuck' in Lincoln acute stroke bed?

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

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.

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.

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.

Simultaneously Organisational Development (OD) work commenced to bring the separate teams together and agree how an integrated service would be established. The aim throughout has been

‘To establish an integrated, seamless pathway and a community based stroke rehabilitation service that is able to support ALL stroke survivors, operating 7 days a week’.

Between October 2019 and January 2020 three teams worked together across the pathway with the following change achieved:

- Supported a reduction in length of stay (LoS) on the Stroke Unit in Lincoln County
- Launched the Lincolnshire Stroke YouTube Channel
- Launched a Patient Handbook that travels with the patient from acute to community and beyond
- Initiated a dedicated Stroke Orthoptic clinic
- Started acute/community staff rotational work experience
- Begun the SAM2 trial linked to timely discharge
- Enabled (hospital) WebV access for Social Care colleagues
- Initiated a trial for single assessment and single transfer form
- Piloted ‘Living Well After Stroke’ Groups

This enhanced community service will:

- Support all stroke survivors across Lincolnshire to receive their rehabilitation within their local community wherever possible;
- Work with the hyper-acute/acute stroke service to deliver an average length of stay of 7 days;
- Ensure a clear route back into specialist care for patients once discharged from the service;
- Offer a 6-month review to all stroke survivors;
- Support new professions to the Lincolnshire Stroke pathway in a community setting e.g. dietetics and psychology;
- Embed the Stroke Association team into the new Lincolnshire Stroke Service; and
- Improve efficiencies in the system through improved outcomes e.g. reduced hospital utilization, reduced social care costs over the medium to long term.

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.

The service will support community hospitals, which will be health & 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.

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.

The appropriate training needs 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.

The increase in the community stroke service team to deliver this service is set out in the table below (current service is based on the 2019/20 baseline 'pre-covid').

Proposed staffing increase to community stroke team (funded establishment)

Staff group	Current service	Proposed increase
		.
Occupational Therapy	8.63	1.78
Physiotherapy	15.72	2.26
Speech and Language Therapy	3.90	2.25
Rehabilitation Assistants	17.70	6.00
Dietician	0	1.0
Clinical Psychologist (specialising in Stroke)	0	1.0
Assistant Psychologist	0	1.0
Total	*45.95*	*15.29*

Staffing recruitment for the enhanced community stroke team is underway as part of COVID response to ensure all stroke patients in Lincolnshire could be seen. There continues to be further development of roles within community services such as rotational therapist posts to support retention of staff. A new national community stroke specification via NHS England sets out the need for further work and integration with the Multi-disciplinary team ensuring the involvement of medical, nursing and social care roles.

Community rehabilitation services need to be in place for stroke and other neurological conditions, especially brain injury. Also, a step up/down inpatient/outpatient unit

Enhancement of the current community stroke rehabilitation service is a key part of the service change proposal, as set out above.

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

The Acute Brain Injury and MS neuro pathway is well defined from Ashby ward to the outreach therapy team in the community.. There is also some scoping of the Parkinsons pathway at present to look at gaps in service and workforce

Why are brain and head injury rehabilitation kept separate from stroke rehabilitation – these services should align better

At present these functions are separate. 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.

Conclusions and actions

- 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.
- 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.
- 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.
- 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.
- 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.
- The service will support community hospitals, which will be health & 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.
- 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.
- The appropriate training needs 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.
- Neurological conditions and a step up/down inpatient/outpatient unit were not part of the change proposals consulted on.
- 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.

Public consultation on four NHS services

Addressing public consultation feedback comments, messages and concerns

Version 1 7th April 2022

Change proposal(s)	**Stroke Services** *Develop a 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs*
Common theme	Additional Considerations
Feedback working group	Sandra Williamson – NHS Lincolnshire CCG Chief Operating Officer Andy Fox – Consultant in Public Health
Date feedback working group signed off response	7 April 2022
Date working group response considered by ICS Clinical Directorate and CCG Clinical Policies Sub-Group	28 April 2022

Additional considerations

Introduction

Between the 30 September and 23 December 2021 the Lincolnshire CCG held a public consultation on four of Lincolnshire's NHS services, one of which related to the provision of stroke services:

- A 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital, which will be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs.

During the public consultation feedback has been received on all proposals through a variety of routes, including a consultation questionnaire and public meetings.

For the proposals relating to stroke services an additional consideration was put forward, which was:

- Although this consultation is on treatment services there is a need to consider prevention. Smoking, high blood pressure, diabetes, heavy drinking, high salt and high fat diets and lack of exercise increase the risk of stroke. These are health concerns in Boston, South Holland and East Lindsey and we would welcome further discussion on addressing these challenges holistically across the system.

The purpose of this paper is to provide a concise evidence-based summary of the situation in relation to the alternative suggestions for hyper-acute and acute stroke care feedback through the public consultation. This is to ensure conscientious consideration of the feedback received during the public consultation in relation to this.

Lincolnshire update – Prevention

One You Lincolnshire (OYL) was commissioned in 2019 as the Integrated Lifestyle Service (ILS) for the county. The four key pillars of support the One You service offers are as follows:

- Go Smoke Free – quit smoking tobacco.
- Move More – increase moderate physical activity minutes to more than 150 per week.
- Eat Well and Lose Weight – reduce bodyweight by 5% for those with a BMI over 27.5.
- Drink Less – reduce weekly alcohol intake to below 14 units (or by 50% if drinking more than 28 units).

This is a county wide offer and in 2021, additional weight management funding was secured to support more specialist populations. Investment was placed in male obesity, obesity prevention, post pregnancy weight management and weight management in mental health.

We have developed a referral flow diagram to support GPs with referring to the correct weight management service (NHSE Diabetes Prevention Programme, One You Lincolnshire, NHS Digital Weight Management Programme). Referrals and outcomes have increased throughout 2021/22 with record levels of outcome achieved in quarter two as the service returns to face-to-face delivery.

Our partnership work with Active Lincolnshire, as members of a multi-agency project to embed physical activity within health care pathways will also contribute to reducing obesity and weight management.

The main ILS service is funded by both the CCG and Local Authority and agreement has been reached to extend the contract for the service until June 2024. In 2022/23 the service will target over 1800 adults for weight management outcomes and over 3000 4-week quits.

In terms of specific focus on delivery in the East Coast please see below:

Referral generation and partnerships

OYL have a high-level partnership with the Office for Health Improvement and Disparities (OHID) 'Healthy Weight' Lead for the Midlands - as such recently developed a webinar for primary care around weight management referral routes for patients with hypertension/diabetes/pre-diabetes. To this end - all GP surgeries have a printed/digital infographic ensuring they make appropriate referrals. We are pleased to update that c50 Health care professionals attended our webinar on this in February, a further meeting is planned in May to review the impact on adult weight management referrals following this.

There is an ongoing relationship with the public health leads working on hypertension and OYL. This relationship directly relates to Better Lives and the aspiration to correctly diagnose/case find more people with Hypertension and treat. A collaborative social media campaign is planned for 'Know your numbers' week in September. The campaign will feature public facing assets that surgeries can use, alongside our own social media. Preceding this - a webinar for healthcare professionals is being scoped out for August 2022. Furthermore, OYL have contributed ideas and suggestions to help patients understand their hypertension diagnosis.

No Smoking Day promotion was recently completed following collaboration with Lincolnshire County Council (LCC) and OYL. Messaging was around CVD risks. Further campaigns will happen during Stoptober.

OYL are looking to work with the public health team around the possibility of developing a patient centred Q-risk score resource. This would be for patients to take away after their health check.

Adult Weight Management

Salt and fat recommendations are discussed (including takeaways, eating out and restaurants) within the adult weight management programme. Example initiatives include -

- MAN v FAT Football League takes place on a Friday evening in Boston. Currently around 57 players engaged. Nutrition support is provided to the players on a 1:1 during their weekly check in where conversations around high fat/high salt takeaway foods/eating out often take place.
- Also, alcohol support was provided to players on February 25th 2021 from Drink Less Lead who attended in person.
- Slimming World delivery locations across the east coast have supported 29% of the full cohort of clients that have been supported across the county.

Smoking

The stop smoking support delivered by the OYL core team continues to be telephone based so therefore provides equitable support across the county. Regarding face-to-face support there are several active groups within these parts of the county, as listed below by PCN.

Boston PCN	**Market Deeping & Spalding**	**South Lincs & Rural**	**East Lindsey/Coastal**
Liquorpond	West Elloe Pharmacy	Gosberton	Boots Mablethorpe
Co-op Kirton	Munro	Moulton	Woodhall Spa New Surgery
Co-op Swineshead	Beechfield	Holbeach	Co-op Horncastle
Parkside Medical		Galletly	
Co-op Parkside		Littlebury	
		Boots Long Sutton	
		Boots Bourne	

In addition to the above, OYL carry out targeted work around smoking – example shared below:

- Visit to Maple Lodge in Boston to present at one of their Skill for Life group sessions and discuss the benefits of quitting smoking, what to expect when quitting smoking and the support you will receive. This was engaged with very well, and the session included quizzes and open discussion between patients and the practitioners.

- Attending a Health and Safety week at Elsoms Seeds in Spalding to discuss quitting smoking and how to access support.
- Working alongside Trading Standards and the Fire Service as part of Operation June and will be supporting with a stall in Boston Town Centre on 20th April.

Physical Activity - Exercise on Prescription

OYL's Exercise on Prescription programme is operational at the following leisure centres across Boston, South Holland and East Lindsey Area:

- Castle Leisure Centre Spalding
- Meridian Leisure Centre
- Horncastle Leisure Centre
- Station Sports Centre – Mablethorpe
- Geoff Moulder Leisure Centre – Boston

Our Move More Lead recently spoke to Jessica Horn, Communities Officer at SHDC, and mentioned about whether they might be able to help support facilitate and promote group sessions across the Boston, EL, and SH areas. SHDS are interested to support this and will be looking to increase access to green spaces/parks that are managed by the district's councils. This could be an opportunity to offer more group provision over the summer months and we can use the learning for other District Council areas.

Let's Move Lincolnshire

Active Lincolnshire is a strategic organisation rather than delivery, and through actively promoting and supporting other people's activities through Let's Move Lincolnshire – using the Activity Finder - where any local organisation, service or sports facility can promote their opportunities, and secondly through the advice provided linked to long-term health conditions.

Examples:

- Joint working with One You Lincolnshire to align both our areas of work and maximise impact.
- Joining the steering group of the Wolds Outdoor Festival and are supporting that, as well as supporting the new mountain bike event taking place in the Wolds.
- Through our Tackling Inequalities funded programme they have supported several projects in all 3 areas that have provided grant funding to community groups to enable them to deliver / sustain groups that incorporate activity – including supporting a COPD group in Spalding, a self defence for women in Boston and more.

In addition, Active Lincolnshire are refreshing their Let's Move Lincolnshire strategy and will include stakeholders and partners in the priority work for the next 3 years which includes a 'Connected with Health & Wellbeing' strand which meets for the first time on Thursday 7th April 2022.

Public Health: Key Areas of Focus

Know your numbers is a key priority area and will take several approaches:

- *Hypertension Case Finding*

Early detection of hypertension is vital and there are many opportunities, through existing services to detect and subsequently provide hypertension treatment. There are a wide range of services available for people to support them manage their blood pressure. Through this work, we will promote these services to both the public and organisations.

The Blood Pressure UK *Know your Numbers* campaign raises the awareness of high blood pressure and encourages adults to get a blood pressure check. *The Know Your Numbers* week will be used as an opportunity to promote some system wide communication across Lincolnshire, to improve the public's awareness of high blood pressure and the importance of *Knowing Your Numbers.*

In addition, as part of the roll out of the National blood pressure monitoring @home project, we are pleased that 85 practices across Lincolnshire have received blood pressure units, with over 3,000 units being circulated across general practice to date in 2021/22. This will be a core aspect of the Health Inequalities - CVD programme of work for 2022/23.

- *Making Every Contact Count (MECC)*

MECC is an approach to behaviour change that uses the interactions that organisations and individuals have with people to support them in making positive changes. It enables the opportunistic delivery of consistent and concise healthy lifestyle information. There are many opportunities to promote the awareness of Know Your Numbers via MECC opportunities, which this project will aim to do.

- Substance Misuse Treatment service

There are no specific discussions taking place between district councils and substance misuse treatment services however they are active members of the community alcohol partnerships across the area including Boston and Spalding. This may be an opportunity for future joint working.

There is also regular contact between housing staff and treatment services for referral and signposting activity.

- Pilot Child and family weight management service

The Local Authority have secured funding over two years to develop a pilot child and family weight management service, which is expected to be launched in 2022. This service will target support of 400 children and families in year 1, who will be offered fun, engaging physical activity interventions whilst parents & carers receive direct nutritional & lifestyle

support and advice. This will be targeted at areas of highest need to ensure a positive impact on underlying inequalities in nutrition and physical activity.

Immunisation and screening

Significant work has been undertaken to date to increase vaccination uptake in rural and high deprivation areas. This has included specific activities including language translation (culturally competent) and pop-up vaccination sites. We will continue our focus on reducing inequalities in access to and outcomes from NHS public health screening and immunisation services and continue to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower than overall average uptake as of March 2022

Our Covid19 vaccination work has included tailored approaches working with all partners to support uptake of specific health inclusion groups e.g. Homeless, Travellers Community and population groups where analysis shows uptake is lower than average (ethnicity/deprivation). Through this approach we have developed a Health Inclusion Strategy for Covid vaccinations, which targets low uptake in areas of greatest deprivation and ethnic groups with lower uptake than the whole population (Significantly lower vaccination uptake by 'White Other' ethnicity, particularly Eastern European communities) and uses our learning to date as well as data dashboards to monitor progress and tailor responses to increase uptake.

We will use the learning from our Covid vaccination work to develop our 2022/23 plans for Flu to ensure inclusive uptake, including a specific focus on increase uptake of Covid, Flu and Pneumonia vaccines (Core 20+5) for people with Chronic Respiratory Disease (COPD).

- What discussions have happened to date with Boston Borough Council, ELC, SHDC in relation to these issues
- What future discussions are planned with the Boston Borough Council, ELC, SHDC in relation to these issues

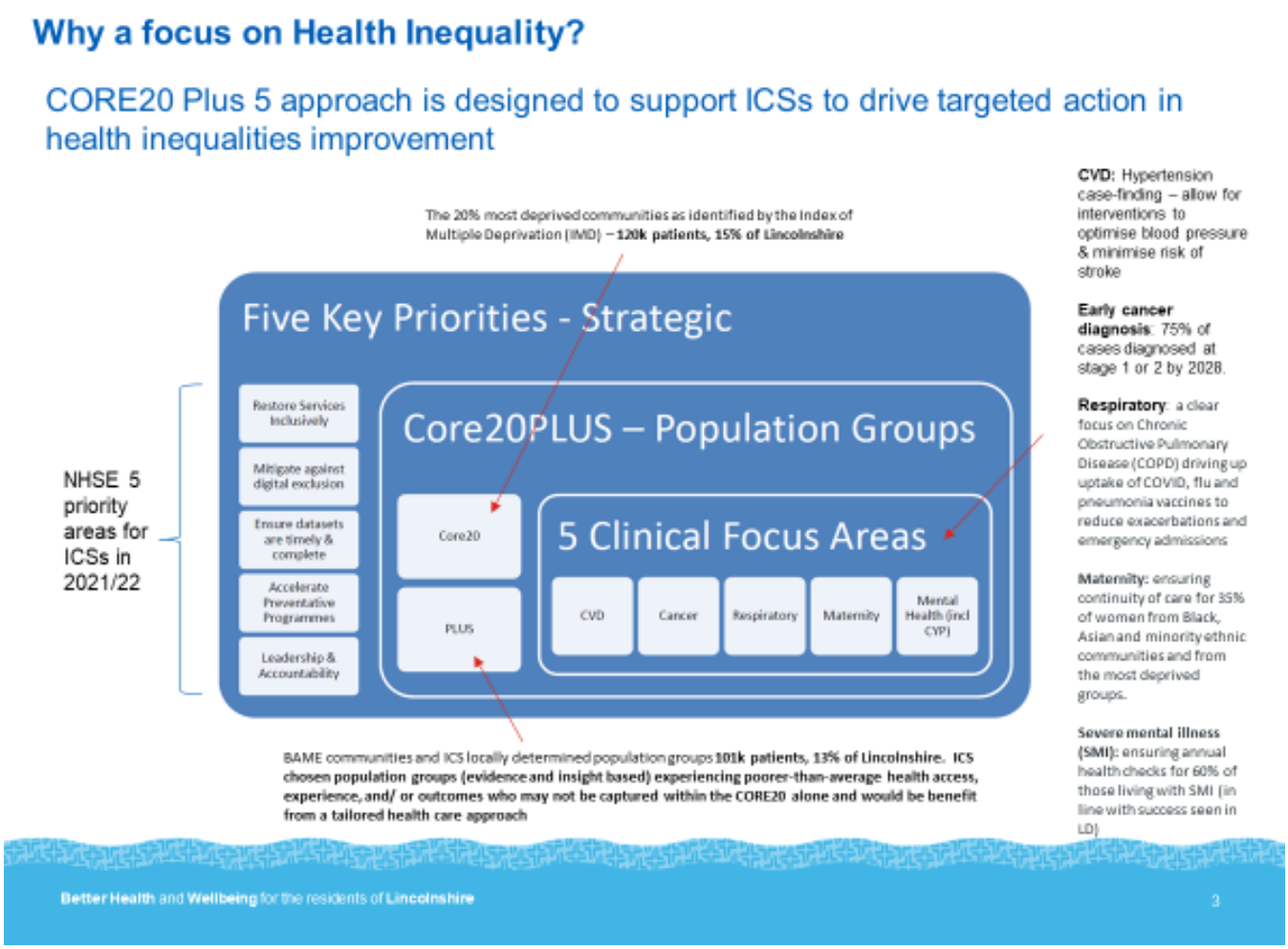
LincoInshire Health Inequalities Programme

Health inequalities and prevention continues to be one of our key system priorities. We will continue to focus our efforts on preventing ill health and tacking health Inequalities in 2022/23.This will be led and delivered by our Health Inequalities SRO and Health Inequalities Programme Team, working collaboratively with Public Health colleagues, system programme leads, PCNs, Trusts and partners across our ICS.

The programme board meets regularly and includes representation from District Councils, which includes representation from Boston Borough Council, East Lindsey District Council and South Holland District Council.

2022/23 will see a continued focus on the Five Strategic Priorities and Core20Plus5 and we will use this framework to:

- Ensure everyone has opportunity to improve health and wellbeing
- Level-up health and care provision to ensure our communities in highest deprivation and need get the resources needed to minimise inequalities
- Focus time and resources according to population need with appropriately more capacity in areas of high need including ability to develop local bespoke solutions to start to surface unmet need
- Facilitate organisations to join on PCN footprints as a key partner in the community and offer joined up/ co-ordinated care where people receive most of their health and care services in the community and recognise the key role locally for the voluntary sector in supporting particularly excluded groups
- Ensure reducing health inequalities and improving health equity is a “golden thread” through all our work and at all levels. All plans, service and quality improvements and policies put forward will take account of Health Equity assessment through adoption of the ‘Health Equity Assessment tool (HEAT)
- Embed greater focus on prevention within the NHS, working with local partners, to help prevent or lessen impact of illness. This will be important in improving health equity.
- Embed a population health management approach in using data, insight and best evidence to take action to reduce health inequalities and evaluate impact
- Embed personalisation within our approach - giving everyone the choice, control and accessible information; making a positive power shift in relationships between people and professionals; embedding co-production and co-design with people with lived experience within service redesign



Prevention is a core component of the Long Term Plan (LTP) and the Health Inequalities Programme. The LTP has outlined a clear requirement to provide all people admitted to hospital who smoke with an NHS-funded tobacco treatment service by March 2024.

The expectation is that;

- every patient admitted to hospital and pregnant women are screened for their smoking status;
- they are referred for an opt-out discussion with a Tobacco Dependency Adviser (TDA);
- they have access to appropriate pharmacotherapy;
- They are able to agree a personalised plan to support them to quit smoking tobacco, whilst both in contact with NHS services and beyond.

The model will be adapted for pregnant women and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.

Opt-out services will be delivered in conjunction with, and in addition to, OYL Stop Smoking Services (SSS). They will also support delivery of the government's Tobacco Control Plan and the ambition to go smoke-free in England by 2030.

Smoking is a fundamental contributor to health inequalities, accounting for half the difference in life expectancy between richest and poorest. Tackling these issues clearly presents a major opportunity to make services across the entire Lincolnshire health and care system more sustainable, and it is for that reason why this a key priority for Lincolnshire ICS.

We have established Tobacco Dependency Steering group to oversee this key priority working alongside Lincolnshire County Council and other partners, to continue to develop our approach to population health management and prevention so that people can play a more proactive role in promoting good health.

Work undertaken to-date is in partnership with public health colleagues and local authority commissioners to support integration and connectivity with current smoking cessation services provided by One You Lincolnshire as described earlier. It is also aligned with the other Tobacco Control activities in Lincolnshire.

Due to the impact across the life course and in providing children with the best start in life and the prevalence in pregnancy seen across Lincolnshire, Maternity is seen as the area of highest need and therefore identified as the first area to initiate services. The remaining areas have then been prioritised in order of need, current available capacity and processes already in place.

- Maternity
- Mental Health
- Acute
- Community

The first area to initiate services (Maternity) will implement over three phases. Phase one during 2022/23 (services provided to 40% of maternal smokers) will be in areas with high levels of deprivation, English as an additional language and where prevalence of smoking at time of booking is high. This will not only help to reduce health inequalities but also provide

opportunities to understand the needs of the population further. Key lessons / learnings will be realised from this, which will ensure a solid foundation to proceed with future implementations of phase 2 (70%) and 3 (100%) within maternity; along with the other development areas (Mental Health, Acute and Community) as they begin to initiate their services.

- What future discussions are planned with the Boston Borough Council, ELC, SHDC in relation to these issues

Early conversations have taken place with Boston, East Lindsey and South Holland district councils on projects to support Health and Wellbeing action plan for 2022/23 – focusing on the role of prevention in improving the health of the population and tackling health inequalities across the sub region – South East Lincolnshire Council Partnership (SELCP).

It is envisaged that the joint action plan will focus on identifying the priority actions that need to take place, using 3 parameters:

1. Elements that fall within the HWB strategy
2. Key health inequalities issues that impact on the SELCP area
3. Key priorities within the Lincolnshire Health Inequalities programme

The purpose of the plan is to enable real change to be enacted in service delivery and partnerships, including:

- Resource allocation to ensure appropriate resources are focused on proactive and prevention activity
- Transformation of services (including communications) to focus on achieving prevention (e.g. focusing leisure services in tackling childhood obesity rather than replicating a commercial operator)
- Development and identification of key partners and new ways of working to deliver change (e.g. the Council/health operating as an enabler within communities rather than just the deliverer of services)

Conclusions and actions

- One You Lincolnshire (OYL) was commissioned in 2019 as the Integrated Lifestyle Service (ILS) for the county. This is a county wide offer.
- 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
- One You Lincolnshire have a high-level partnership with the Office for Health Improvement and Disparities 'Healthy Weight' Lead for Midlands
- 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

Appendix G

Quality Impact Assessments (QIAs)

Version: 04-May-22

QIA: Orthopaedics

	AS PART OF PRE CONSULTATION BUSINESS CASE (PCBC) DEVELOPMENT	FOLLOWING PUBLIC CONSULTATION AS PART OF DECISION MAKING BUSINESS CASE (PCBC) DEVELOPMENT
Date of Initial Review by Medical Director/ Director of Nursing & Midwifery	2018 ULHT Head of Nursing Services for Surgical Services	
Date of last review	14 April 2022 Lisa Pim ULHT Divisional Lead Nurse - Surgery	22 April 2022 Mr Kulandaivel Sakthivel, Clinical Lead / Consultant Orthopaedic Surgeon ULHT Lisa PIM, Divisional Lead Nurse - Surgery ULHT Vanessa Wort, Associate Director of Nursing & Quality NHS Lincolnshire CCG
Approved	26th February 2021 NHS Lincolnshire CCG Clinical Policies Subgroup	
Accepted	5th May 2021 NHS Lincolnshire CCG Quality & Patient Experience Committee	

#	Area of Impact		Consequence	Likelihood	Total	Potential Impact	Impact (Positive or Negative)	Action	Owner	What is the measurement?	New or existing metric	Frequency of measurement	Baseline measurement
1	Quality	Duty of Quality	3	1	3	How does it impact adversely the rights and pledges of the NHS Constitution?	No impact	NA	NA	NA	NA	NA	NA
2						How does the impact affect the organisations commitment to being an employer of choice?	Positively - it will ensure lists are cancelled less frequently, and 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 Trustwide working. An Equality Impact Assessment (EIA) has been undertaken - see EIA document.	NA	NA	NA	NA	NA	NA
3						What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individuals access to services and experience of the service?	Patient groups less able to travel may be impacted by the changes, as all elective patients will likely be asked to travel to a different hospital for elective care. The majority of patient care, diagnostics and appointments will be undertaken at the patients local hospital and the travel would only be for the elctive surgery, We do not feel all elective patients need to be travelling to a new site as some of these patient already live in the Grantham area. Travlleing is supported with the use of transport providers arranged through their GP. There will also be a positive impact in that there is less likelihood of cancellation of the procedure. An Equality Impact Assessmnet has been undertaken - See EIA document.	Commissioners are responsible for ensuring patient transport is provided for all patients. The project team have communicated the change and increased requirements. Patients will be assessed for transport under criteria that already exists.	CCGs	Number of patients cancelled due to no transport	New	Monthly	NA
5		Patient Safety	3	2	6	How will this impact on the organisation's duty to protect children, young people and adults?	Positively - the changes will allow both planned and unplanned T&O patients to be given treatment quicker.	NA	NA	NA	NA	NA	NA
6						How will it impact on patient safety? • infection rates • medication errors •significant untoward incidents and serious adverse events •Mortality & Morbidity •Failure to recognise a deteriorating patient •Safe staffing levels	Positively - the changes will decrease the risk of post-op infections by splitting up post-op care for orthopaedic patients and general surgery patients. Patients will also have improved access to elective and non-elective care, improving health outcomes	NA	NA	NA	NA	NA	NA
7						How will it impact on preventable harm? (eg slips, trips, falls)	No impact	NA	NA	NA	NA	NA	NA
8						How will it impact upon the reliability of safety systems? (eg WHO checklist)	No Impact	NA	NA	NA	NA	NA	NA
9						How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	Positively - the segregation of orthopaedic patients will drastically reduce the risk of post-op infection to joints	NA	NA	NA	NA	NA	NA
10						How will this impact on workforce capability, care and/or skills?	**To deliver the change the theatres at Grantham will need to increase headcount and skill mix for T&O. The nursing establishemnt is likely to be increased to accommodate the increase in activity and a Busisness case is currently being written. All current theatre nursing teams are undergoing training for competency to be able to undertake the Orthopaedic scrub role.	Recruit to WTE vacancies	ULHT Directors	Lists cancelled due to no staff	New	Monthly	NA
11	Experience	Patient Experience	2	3	6	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	Patients will be asked to travel further for elective care. However, this will be offset by a reduction in the current cancellation rate (34% for elective orthopaedic patients.) Also patients will be getting treatment in a centre of excellence.	A script has been developed for booking staff and medics to explain the reason for travel. A communication plan has not yet been developed however if/when a decision is made a comprehensive Communication Plan will be developed at this stage	ULHT Directors	Number of patient complaints for having to travel for elective care	New	Monthly	NA
12						How will it impact on choice?	Significant impact. Patients will be offered a reduced choice to be operated on at their local hospital.	NA - the reconfiguration of Orthopaedic services is essential for the ASR. The patients will have the majority of their care undertaken locally with the elective inpatient and day case care being undertaken at Grantham.There will be a reduction in cancellations of operations and an improvement in patient experience, quality and length of stay.	ULHT Directors	Number of patient complaints for having to travel for elective care	New	Monthly	NA
13						Will there be an impact on waiting times?	Positively - significant reduction in the 18-week backlog and much shorter admission-to-operating timescales	NA	NA	NA	NA	NA	NA
14						How will it impact upon the compassionate and personalised care agenda?	Positively - ward staff at all sites will be specialised and able to focus on the management of Orthopaedic patients more directly	NA	NA	NA	NA	NA	NA

		Staff Experience	**2**	**2**	**4**	How will it impact on recruitment of staff	Positively - the changes should make roles more attractive by reducing cancellations	NA	NA	NA	NA	NA	NA
						What will the impact be on staff turnover and absentee rates	**Positively - the new model should make remaining in post more attractive, with more opportunities for development in the care of orthopaedic work.	NA	NA	NA	NA	NA	NA
						How will it impact on staff satisfaction surveys	Positively - will reduce cancellations and overruns	NA	NA	NA	NA	NA	NA
15	**Effectiveness**	**Clinical Effectiveness and Outcomes**	**2**	**2**	**4**	How does it impact on implementation of evidence based practice?	Positively - the changes are in accordance with GIRFT principals	NA	NA	NA	NA	NA	NA
16						How will it impact on patient's length of stay?	Positively - reduced chance of post-op infection, extended use of enhanced recovery	NA	NA	NA	NA	NA	NA
17						Will it reduce/impact on variations in care? (eg readmission rates)	Yes	NA	NA	NA	NA	NA	NA
18						What will the impact be upon clinical and cost effective care delivery?	Positive - the trial will deliver at least a six-figure saving, reduce downtime for clinicians. The pilot has demonstrated a number of improvements including; reduced Length of Stay, reduced cancellation rates and increased operating list efficiency. This clearly shows the improvement this reconfigoration has had.	NA	NA	NA	NA	NA	NA
						How does it impact upon care pathway(s)? Eg mortality	Positive - reduces cancellations, reduces the risk of post-op infection	NA	NA	NA	NA	NA	NA
19						How will it impact on target performance?	Positive - major improvement to cancellation rate and RTT	NA	NA	NA	NA	NA	NA
20	**Other**	**Please use this section to detail any other impacts to clinical and quality that are not listed in the questions above.**			**0**								
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Version: 05-May-22

QIA: Urgent and Emergency Care

	AS PART OF PRE CONSULTATION BUSINESS CASE (PCBC) DEVELOPMENT	FOLLOWING PUBLIC CONSULTATION AS PART OF DECISION MAKING BUSINESS CASE (PCBC) DEVELOPMENT
Date of Initial Review by CCG Clinical Lead	12th October 2018 Dr Dave Baker, Clinical Chair SW Lincolnshire CCG	
Date of last review	18 February 2021 Dr Yvonne Owen, Medical Director Lincolnshire Community Health Services	March 2022 Dr Dave Baker, SW Locality Clinical Lead NHS Lincolnshire CCG Dr Yvonne Owen, Medical Director Lincolnshire Community Health Services Dr Ciro Rinaldi, Divisional Clinical Director CSS & Medicine United Lincolnshire Hospital NHS Trust Vanessa Wort, Associate Director of Nursing & Quality NHS Lincolnshire CCG
Approved	26th February 2021 NHS Lincolnshire CCG Clinical Policies Subgroup	
Accepted	5th May 2021 NHS Lincolnshire CCG Quality & Patient Experience Committee	

#	Area of Impact		Consequence	Likelihood	Total	Potential Impact	Impact (Positive or Negative)	Action	Owner	What is the measurement?	New or existing metric	Frequency of measurement	Baseline measurement
1	Quality	Duty of Quality	2	2	4	How does it impact adversely the rights and pledges of the NHS Constitution?	No impact	NA	NA	NA	NA	NA	NA
2						How does the impact affect the organisations commitment to being an employer of choice?	No impact	NA	Service Provider Directors	NA	NA	NA	NA
3						What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individuals access to services and experience of the service?	2.5% (c.600 patients per annum) of patients currently seen at Grantham A&E will be impacted by the change. These patients would be taken to an A&E department by EMAS because the presenting symptom would indicate that care at a full A&E department would be required. Population who would access the UTC need to understand what symptoms are appropriate for presentation to the UTC, and which symptoms they should take to an A&E department e.g. life changing or life threatening symptoms EIA completed (see this document)	Commissioner will need to ensure adequate communication is made to the public about the change, and that for life threatening or life changing symptoms, they should present to an A&E Dept rather than the UTC, or call the ambulance service for life changing, life threatening scenarios EIA completed (see this document)	Service Commissioner	Number of patients transferred from Grantham UTC to an A&E Dept	New	Monthly	Baseline of A&E / UTC Transfers previously held
4		Patient Safety	2	2	4	How will this impact on the organisation's duty to protect children, young people and adults?	No impact	NA	NA	NA	NA	NA	NA
5						How will it impact on patient safety? • infection rates • medication errors •significant untoward incidents and serious adverse events •Mortality & Morbidity •Failure to recognise a deteriorating patient •Safe staffing levels	Positive / Negative Impact - This service change may improve patient safety as it will ensure those patients with the highest acuity go to the right hospital first time. However patients could percieve as adverse due to understanding of a A&E to UTC.	During the pandemic there was a year period when the A&E was operating as a UTC led by the community trust. Majority of attendances to A&E at Grantham could attend a UTC and qualifying with the need to be more explicit on presenting conditions that are appropriate for UTC. Should patients be inappropriately referred to Grantham, immediate resuscitation/support will be provided whilst awaiting emergency transfer to an acute site.	Service Provider Directors	Number of incidents / complaints	New	Monthly	Baseline of current incidents from A&E
6						How will it impact on preventable harm? (e.g. slips, trips, falls)	No impact	NA	NA	NA	NA	NA	NA
7						How will it impact upon the reliability of safety systems? (e.g. WHO checklist)	No Impact	NA	NA	NA	NA	NA	NA
8						How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	No impact	NA	NA	NA	NA	NA	NA
9						How will this impact on workforce capability, care and/or skills?	Positive / Negative Impact - This will impact on staff working in the existing A&E Department as staff may need to transfer employment to a new provider and/or may be asked to undertake sessions in other UTC departments to sustain rotas and competencies. This will however support driving the change by developing the workforce to work to a see and treat model.	Support will be offered to the staff to facilitate the change.	Service Provider Directors	WTE and Vacancy Fill	Exisiting	Monthly	Current WTE and Vacancy Fill
10	Experience	Patient Experience	2	3	6	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	Minimal impact. The quality of service will remain high, and access will change for only 2.5% of the current services users of Grantham A&E. Positive impact related to greater accessibility (opening hours) and a direct link with Primary Care and Community services via a joint S1 record 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	Clear communication to the public will be required to ensure that they understand the service remains consistent to the current provision for 97.5% of current service users, and why it needs to be different for the remaining 2.5% There are multiple actions within the communication to reiterate the awareness of what clinical conditions can be managed at Grantham as previous during the consultation and being explicit regarding red flags and ensuring the DOS profile aligns so that patients are appropriately seen by the right service.	Service Commissioner	Results of national/local surveys, complaints, Family & Friends surveys	Existing	Monthly	NA
11						How will it impact on choice?	Minimal impact. Access will only impact on 2.5% of the current service users, who will not have a choice to use the UTC as their symptoms may be considered life threatening or life changing.	Clear communication to the public will be required to ensure that they understand the service remains consistent to the current provision for 97.5% of current service users, and why it needs to be different for the remaining 2.5%	Service Provider Directors	Number of patients presenting to the UTC for care	Existing	Monthly	NA
12						Will there be an impact on waiting times?	No impact	NA	NA	NA	NA	NA	NA
13						How will it impact upon the compassionate and personalised care agenda?	No impact	NA	NA	NA	NA	NA	NA
14	Experience	Staff Experience	1	1	1	How will it impact on recruitment of staff	Positive - the changes should make roles more attractive to some staff groups	NA	Service Provider Directors	WTE and Vacancy Fill	Exisiting	Monthly	Current WTE and Vacancy Fill
15						What will the impact be on staff turnover and absentee rates	Positively - stability and a confirmed long term service model should reduce anxiety among staff. There may be some negative impact to staff turnover due to the changes of service.	NA	Service Provider Directors	WTE and Vacancy Fill	Exisiting	Monthly	Current WTE and Vacancy Fill
16						How will it impact on staff satisfaction surveys	Positively - stability and a confirmed long term service model should reduce anxiety among staff	NA	Service Provider Directors	Staff Survey Results	Existing	Quarterly	Current Staff Survey Results
17	Effectiveness	Clinical Effectiveness and Outcomes	1	2	2	How does it impact on implementation of evidence based practice?	No impact	NA	NA	NA	NA	NA	NA
18						How will it impact on patient's length of stay?	No impact	NA	NA	NA	NA	NA	NA
19						Will it reduce/impact on variations in care? (e.g. readmission rates)	Minimal Impact - Ambulance Conveyance times to acute sites.	This is a current risk to all UTCs and involves working closely with local ambulance trusts to support actions and mitigations.	NA	NA	NA	NA	NA
20						What will the impact be upon clinical and cost effective care delivery?	Positive, the new model of care will reduce cost of service provision without compromising the standard of quality care	NA	NA	NA	NA	NA	NA
21						How does it impact upon care pathway(s)? E.g. mortality	No impact	NA	NA	NA	NA	NA	NA
22						How will it impact on target performance?	No impact as the Grantham A&E Department already achieves expected performance against the 4 hour A&E standard	NA	NA	NA	NA	NA	NA
23	Other	Please use this section to detail any other impacts to clinical and quality that are not listed in the questions above.			0								
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Version: 05-May-22

QIA: Acute Medicine

	AS PART OF PRE CONSULTATION BUSINESS CASE (PCBC) DEVELOPMENT	FOLLOWING PUBLIC CONSULTATION AS PART OF DECISION MAKING BUSINESS CASE (PCBC) DEVELOPMENT
Date of Initial Review by Medical Director/ Director of Nursing & Midwifery	24th September 2018 Dr Dave Baker, Clinical Chair SW Lincolnshire CCG	
Date of last review	18th February 2021 Dr Yvonne Owen, Medical Director Lincolnshire Community Health Services	March 2022 Dr Dave Baker, SW Locality Clinical Lead NHS Lincolnshire CCG Dr Yvonne Owen, Medical Director Lincolnshire Community Health Services Dr Ciro Rinaldi, Divisional Clinical Director CSS & Medicine United Lincolnshire Hospital NHS Trust Vanessa Wort, Associate Director of Nursing & Quality NHS Lincolnshire CCG
Approved	26th February 2021 NHS Lincolnshire CCG Clinical Policies Subgroup	
Accepted	5th May 2021 NHS Lincolnshire CCG Quality & Patient Experience Committee	

#	Area of Impact		Consequence	Likelihood	Total	Potential Impact	Impact (Positive or Negative)	Action	Owner	What is the measurement?	New or existing metric	Frequency of measurement	Baseline measurement
1	Quality	Duty of Quality	3	1	3	How does it impact adversely the rights and pledges of the NHS Constitution?	This programme will not effect the rights and pledges of the NHS Constitution.	No action required	N/A	N/A	N/A	N/A	N/A
2						How does the impact affect the organisations commitment to being an employer of choice?	This programme will not effect the organisation's commitment to being 'an employer of choice'.	No action required	N/A	N/A	N/A	N/A	N/A
3						What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individuals access to services and experience of the service?	EIA completed (see this document)	EIA completed (see this document)	N/A	N/A	N/A	N/A	N/A
4		Patient Safety	2	3	6	How will this impact on the organisation's duty to protect children, young people and adults?	This programme will not impact upon the organisation's safeguarding responsibility.	No action required	N/A	N/A	N/A	N/A	N/A
5						How will it impact on patient safety? • infection rates • medication errors •significant untoward incidents and serious adverse events •Mortality & Morbidity •Failure to recognise a deteriorating patient •Safe staffing levels	This proposed changes should improve patient safety: - Patients will be cared for in the most appropriate setting for their needs - Integrated community/acute provision that safely meets patient's clinical needs and maintains access locally - Ambulatory and bed based care that meets the patient's acuity - A 'shared' integrated response on the site to deteriorating patients - Frailty expertise is fully developed within the local teams	The implementation needs to be completed through a sequences of changes to clinical practice and the workforce. As a natural progression each planned change either allows for the flow of patients or working practices of staff (or both) to alter to facilitate the creation of the next change. The Exclusion Criteria for the site is reviewed and implemented to ensure those people with high acuity and life threatening illness and injuries go to a more specialist site, first time to receive treatment.	Service Provider Directors	Current recorded incidents and patient quality indicators	Existing	Monthly	Provider patient quality reporting metrics
6						How will it impact on preventable harm? (e.g. slips, trips, falls)	Neutral impact	No action required	N/A	N/A	N/A	N/A	N/A
7						How will it impact upon the reliability of safety systems? (e.g. WHO checklist)	This programme should not impact upon safety reliability systems.	No Action required	N/A	N/A	N/A	N/A	N/A
8						How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	This programme will have not adverse affects.	No action required	N/A	N/A	N/A	N/A	N/A
9						How will this impact on workforce capability, care and/or skills?	Currently ULHT acute medicine experience significant workforce challenges impacting on the ability to deliver a safe, quality service. Significant gaps exist in the consultant workforces especially respiratory and cardiology at Pilgrim. Sub-optimal cardiology services at Pilgrim; unable to develop CT and pacing due to workforce challenges. It has been agreed the ULHT wide service is operationally unsustainable in its current form. The development of an integrated community/acute provision that safely meets patient's clinical needs and maintains access locally should address the workforce challenges.	Further work on the workforce model, including working with NHS England, as the incremental implementation plan for 'the how' is refined and mobilised: - How to attract and retain increased use of advanced clinical practioners - Ascertain impact(s) on associated specialty doctors/trainees and identify how new opportunities to attract trainee staff in a different way can be created - How posts can rotate between lower acuity (e.g. community hospitals) and higher acuity sites (e.g. acute hospitals) to offer a broad and rounded experience to staff maintaining and employ to Physician Associates posts - Implement and employ to Physician Associates posts - Provide training placements for Medical Students - Attract and retain clinical pharmacists that support patients both in their own home and 'track' the patient when admitted into a lower acuity bedded service	Service Provider Directors	Current WTE and Vacancy Gap	Existing	Monthly	Understanding of current issues with WTE/Vacancy
10	Experience	Patient Experience	2	2	4	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	Positive - 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. For the small cohort of patients who will receive care further way from home, this care will be provided in a facility most appropriate to their needs	Monitor Patient feedback Assess impact on increased demand for patient transport services to return patients home	Service Commissioner	Results of national/local surveys, complaints, Family & Friends surveys	NA	NA	NA
11						How will it impact on choice?	This programme will not have adverse affects on choice as the focus of care provided under this model is non-elective. A small cohort of patients will receive their care at a facility further away from their home which will align to their clinical need as part of current practice.	Action - Provide patients and the public with higher levels of communication, making them aware of all services in Lincolnshire.	Service Provider Directors	NA	NA	NA	NA
12						Will there be an impact on waiting times?	This proposal 'uncouples' ULHT from direct provision of non-elective care on the Grantham site so 'protecting' elective services from a non elective admissions at times of surge. Impact on waiting times should therefore be improved.	Monitor Performance	Service Provider Directors	Referral to Treatment Times	Existing	Monthly	As part of current reportable RTT.
13						How will it impact upon the compassionate and personalised care agenda?	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. Working at s single team within their communities the Integrated Care Team will 'in reach' to support people when they require bed-based care	Plan with Integrated Care Team	Service Provider Directors	NA	NA	NA	NA

14		**Staff Experience**	**3**	**3**	**9**	How will it impact on recruitment of staff	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. Under the new model there will be a greater role for advanced clinical practioners and physician posts	Work with Health Education England on recruitment/new roles	Service Provider Directors	WTE and Vacancy Gap	Existing	Monthly	Workforce Metrics current
15						What will the impact be on staff turnover and absentee rates	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. Under the new model there will be a greater role for advanced clinical practioners and physician posts	Monitor staff turnover	Service Provider Directors	WTE and Vacancy Gap	Existing	Monthly	Workforce Metrics current
16						How will it impact on staff satisfaction surveys	The impact would be variable dependent on role and employment status of staff.	Full Consultations would be required. Appropriate Notification of Terms and conditions would be required. Ongoing monitoring of staff surveys would be required	Service Provider Directors	Staff Survey Results	Existing	Monthly	Workforce Metrics current
17	**Effectiveness**	**Clinical Effectiveness and Outcomes**	**2**	**2**	**4**	How does it impact on implementation of evidence based practice?	The integrated community/acute provision is seen a viable based on the clinical model described, associated workforce and finances. The model was developed with reference to: - Nice Clinical Guidance 50 - D05. Adult Critical Care - BMJ, 2013: Outpatient parenteral antimicrobial therapy - Flatten, H. et al. Sept 2017. Impact on Frailty on ICU & mortality in very elderly patients (>80 years). - Knowles, E. et al Closing five Emergency Departments in England between 2009 and 2011: the closed controlled interrupted time-series analysis published in Health Services and Delivery Research Volume:6, Issue: 27, August 2018 - NHS Improvement, NHS England, the Ambulatory Emergency Care Network and the Acute Frailty Network. June 201. Ambulatory emergency care guide. Same day acute frailty services - Clark et al. (2014) Imminence of death among hospital inpatients: Prevalent cohort study, published online Lin et al. (2016) Frailty and post-operative outcomes in older surgical - Lothian et al. The challenges of population ageing: accelerating demand for emergency ambulance services by older patients, 1995-2015 - Dr Jay Banerjee presentation, Royal College of Emergency Medicine, Building a frailty-friendly emergency department - Romero-Ortuno et al. Clinical frailty adds to acute illness severity in predicting mortality in hospitalized older adults: An observational study - Internal Consortium for health outcome measurement (2016) Older Person Reference Guide Version 1.1	Monitor clinical outcomes	Service Provider Directors	Patient Quality Indicators	Existing	Monthly	Baseline of past previous 12 months of Patient Quality Indicators.
18						How will it impact on patient's length of stay?	Greater integration with the Integrated Neighbourhood Team should support earlier discharge from the integrated community/acute beds		Service Provider Directors	Length of Stay	Existing	Monthly	Current baseline of LOS.
19						Will it reduce/impact on variations in care? (e.g. readmission rates)	By 'uncoupling' ULHT from direct provision of non-elective care on the Grantham site it elective services will be 'protected' from non elective admissions at times of surge	No Actions required	NA	NA	NA	NA	NA
20						What will the impact be upon clinical and cost effective care delivery?	Current model has a selected medical 'take' with low volumes compared to other sites, which creates sustainability challenges. Significant gaps existing in the medical consultant workforce. New model is seen as being more viable as able to meet patients' clinical needs and maintain access locally. It will relieve pressure on consultant workforce, to which locums are currently a solution.	No action required	NA	NA	NA	NA	NA
21						How does it impact upon care pathway(s)? E.g. mortality	New care pathways will be developed for the care of patients in the integrated community/acute beds that are integrated with the community neighbourhood teams	Plan with Integrated Care Team and agree metrics to monitor performance within pathway development.	Service Provider Directors	NA	NA	NA	NA
22						How will it impact on target performance?	This program should improve overall performance against constitutional standards.	No Actions required	Service Provider Directors	NA	NA	NA	NA
23	**Other**	**to detail any other impacts to clinical and quality that are not listed in the questions above.** **Please enter any additional potential positive or negative impacts.**			**0**		Positive Impact - 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.	Service Commissioner	NA	NA	NA	NA
24							Conditions treated at 24/7 UTC and clarity to health and care system e.g. 111	Hyper-acute treatment for conditions such as MI and stroke are best done in central units and patients with conditions with high likelihood of need for critical care need to be treated at an acute site with immediate access to ICU. Similarly, frail patients will have better outcomes managed locally at Grantham rather than having an inappropriate episode of acute, invasive intervention	Service Provider Directors	NA	NA	NA	NA
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26													
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Version: **22-Apr-22**

AS PART OF PRE CONSULTATION BUSINESS CASE (PCBC) DEVELOPMENT

FOLLOWING PUBLIC CONSULTATION AS PART OF DECISION MAKING BUSINESS CASE (PCBC) DEVELOPMENT

QIA: Hyper-acute / acute stroke services

Date of Initial Review by Medical Director/ Director of Nursing & Midwifery	30 August 2018 ULHT Head of Nursing Services for Medicine	
Date of last review	14 April 2022 ULHT Managing Director of Medicine Division	22 April 2022 Dr Abdul Elamrimi - Stroke Clinical Lead United Lincolnshire Hospital NHS Trust Angela Shimada - Deputy Director of AHP and Integrated Community Care Dr Ciro Rinaldi - Divisional Clinical Director CSS & Medicine United Lincolnshire Hospital NHS Trust Vanessa Wort - Associate Director of Nursing & Quality NHS Lincolnshire CCG
Approved	26th February 2021 NHS Lincolnshire CCG Clinical Policies Subgroup	
Accepted	5th May 2021 NHS Lincolnshire CCG Quality & Patient Experience Committee	

#	Area of Impact		Consequence	Likelihood	Total	Potential Impact	Impact (Positive or Negative)	Action	Owner	What is the measurement?	New or existing metric	Frequency of measurement	Baseline measurement
1	**Quality**	**Duty of Quality**	**2**	**2**	**4**	How does it impact adversely the rights and pledges of the NHS Constitution?	This programme will not effect the rights and pledges of the NHS Constitution. A reduction in local access may be perceived as less convenient for east coast residents.	No action required	ULHT Directors	Adverse media or increased complaints	N/A	N/A	Current level of complaints
2						How does the impact affect the organisations commitment to being an employer of choice?	It will have a dual impact: By creating a specialist centre of excellence for Stroke Services, this should attract candidates from further afield into the Trust Boston staff unable to relocate may seek alternative employment. Vacancy rates at Boston are high; some staff unable to move may move into other vacancies, thereby reducing the Boston vacancy rates.	Staff Consultation Assess potential impact on future staffing numbers	ULHT Directors	Vacancy rate	Existing	Monthly	Current vacancy level
3						What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individuals access to services and experience of the service?	EIA completed (see this document)	EIA completed (see this document)	N/A	N/A	N/A	N/A	N/A
5		**Patient Safety**	**2**	**2**	**4**	How will this impact on the organisation's duty to protect children, young people and adults?	No anticipated impact	No action required	N/A	N/A	N/A	N/A	N/A
6						How will it impact on patient safety? • infection rates • medication errors •significant untoward incidents and serious adverse events •Mortality & Morbidity •Failure to recognise a deteriorating patient •Safe staffing levels	This proposed changes will improve patient safety: - Specialist Centre that safely meets patient's clinical needs and maintains access locally - A specialist Centre of excellence will aid retention and Recruitment of specialist staffing levels which will create workforce stability and continiuity of care therefore reducing the likehood of Medication errors, untoward incidents and adverse events Potential risk in respect of increase in transfer times for east coast patients and impact on meeting throbolysis window. An Independent analysis and modelling was conducted by Operational Research in Health Ltd (ORH) as part of the consultation, which included a travel time analysis and a sensitivity analysis. Their assessment identified that the estimated average travel time by ambulance to an acute stroke unit for stroke patients who would have gone to Pilgrim Hospital will increase from 23m58s to 44m28s (increase of 20m30s on average). This is based on the assumption patients attend their nearest unit. The travel time analysis conducted estimated that under the proposal where stroke services are consolidated at Lincoln Hospital no patients would travel over 60-minutes. Across the full duration of the on the temporary ocnsolidation of the hyperactute service on the lincoln site, no patients have been identified that have missed their thrombolysis window.	Formal Staff Consultation Assess potential impact on future staffing numbers Clearly defined recruitment and retention strategy Consideration of supervised training time built into future rotas to rapidly upskill staff and ensuring shared learning is taking place. Ongoing monitoring in partnership with EMAs on transfer times /thrombolysis Review and updating of Clinical intervention pathway if required for patients in transit from east coast to Lincoln	ULHT Directors	Stroke Trained Nurses in Post Stroke Consultants in Post	Existing	Monthly	Current % Stroke trained nurses in post Current % Stroke Consultants in post Mortality data Nunmber and nature of adverse incidents for east coast stroke patients
7						How will it impact on preventable harm? (eg slips, trips, falls)	No anticipated impact	No action required	N/A	N/A	N/A	N/A	N/A
8						How will it impact upon the reliability of safety systems? (eg WHO checklist)	No anticipated impact	No action required	N/A	N/A	N/A	N/A	N/A
9						How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	No anticipated impact	No action required	N/A	N/A	N/A	N/A	N/A
10						How will this impact on workforce capability, care and/or skills?	Only impact anticipated is on staffing levels. Risk is the potential loss of Stroke trained nurses or Stroke Consultants based at Boston who do not wish to relocate to Lincoln. This will create a risk to service delivery	Staff Consultation Assess potential impact on future staffing numbers Clearly defined recruitment and retention strategy Consideration of supervised training time built into future rotas to rapidly upskill staff	ULHT Directors	Stroke Trained Nurses in Post Stroke Consultants in Post	Existing	Monthly	Current % Stroke trained nurses in post Current % Stroke Consultants in post

11	**Experience**	**Patient Experience**	**2**	**5**	**10**	What impact is it likely to have on self reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/incidents)	Increased travel distances for relatives based on the east coast may be reflected negatively in patient satisfaction surveys. Lack of local in-patient service may cause dissatisfaction with residents local to Pilgrim Hospital. Quality of care is not anticipated to be impacted at all.	Monitor Patient feedback Assess impact on increased demand for patient transport services to return patients home	ULHT Directors	Adverse media/ increased complaints/negative survey results	Existing	Monthly	Current level of complaints, FFT and patient survey responses
12						How will it impact on choice?	It will limit choice of in-patient care to a single site within ULHT with the potential for patients to wish to receive treatment in surrounding trusts	Communicate the benefits of providing single site delivery of care utilising a centre of excellence model	ULHT Directors	Consultation feedback	New	Single Event	None
13						Will there be an impact on waiting times?	None anticipated	N/A	N/A	N/A	N/A	N/A	N/A
14						How will it impact upon the compassionate and personalised care agenda?	None anticipated	N/A	N/A	N/A	N/A	N/A	N/A
		Staff Experience	**3**	**3**	**9**	How will it impact on recruitment of staff	Potentially positive impact being able to recruit to a specialist centre may make posts more attractive	Strong recruitment campaign to market the Trust and benefits of working in a specialist centre	Divisional Management Team HR	Vacancy Rates	Existing	Monthly	Current vacancy rates
						What will the impact be on staff turnover and absentee rates	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.	Communicate the benefits of providing single site delivery of care utilising a centre of excellence model	ULHT Directors	Turnover Rates Sickness Rates	Existing	Monthly	Current Turnover rates Current sickness rates
						How will it impact on staff satisfaction surveys	Could be both positive and negative impact. Pilgrim Staff will potentially respond negatively and Lincoln Staff will potentially respond positively	Communicate the benefits of providing single site delivery of care utilising a specialist centre model	ULHT Directors	Staff Survey	Existing	Annual	Current staff survey results
15	**Effectiveness**	**Clinical Effectiveness and Outcomes**	**3**	**3**	**9**	How does it impact on implementation of evidence based practice?	The service has been developed in line with the National Clinical guidelines for Stroke which is based on evidence based practice. The necessary improvements required to secure optimal provision are identified within the GIRFT recommendations.	To review compliance with the guidelines and GIRFT recommendations, create and implement an improvement plan as required	ULHT Directors	Consultation feedback; SSNAP data Incident management	Existing	Monthly	SSNAP Incident management Improvement plan implementation
16						How will it impact on patient's length of stay?	STP Model of a community slow stream rehab service would be in place which will support a reduction in LOS in the acute sector by imcreasing the availability of acute beds for patients with complex needs.	Ensure robust bed modelling takes place to ensure capacity to manage patient numbers at optimum levels and to model shift of patients at 7-10 days to the community	ULHT & LCHS Directors	LOS	Existing	Monthly	Current LOS
17						Will it reduce/impact on variations in care? (eg readmission rates)	No anticipated impact	N/A	N/A	N/A	N/A	N/A	N/A
18						What will the impact be upon clinical and cost effective care delivery?	Services will be more cost effective with a consolidated in-patient service model. Recruitment is anticipated to be easier, thus reducing reliance on agency locum cover at Boston Site.	Development of robust recruitment plans. Development of clear service/staff integration plans.	Divisional Management Team	Agency Reduction Reduction in vacancies	Existing	Monthly	Current agency expenditure Current vacancy rates
						How does it impact upon care pathway(s)? Eg mortality	No anticipated negative impacts	N/A	N/A	N/A	N/A	N/A	N/A
19						How will it impact on target performance?	These proposed changes will improve patient safety which will be evidenced through the SSNAP data collation / incident monitoring/ staff turnover rates: - Specialist Centre that safely meets patient's clinical needs and maintains access locally - A specialist Centre that aids retention and Recruitment of specialist staffing levels , creating service stability, continuity of care for patients and reducing the likehood of Medication errors, untoward incidents and adverse events	N/A	Divisional Management Team	Reduction inturnover rates Reduction in untworad incidents/ meds errors SSNAP data	Existing	Monthly	SSNAP data collation / incident monitoring/ staff turnover rates:
20	**Other**	**Please use this section to detail any other impacts to clinical and quality that are not listed in the questions above.**			**0**								
21													
22													
23													
24													

Appendix H

Equality Impact Assessments (EIAs)

Maktub Consulting Ltd

LINCOLNSHIRE CCG

EQUALITY IMPACT ASSESSMENT ON PROPOSED CHANGES TO FOUR SERVICES

LEGISLATION	Equality Act 2010 Health & Social Care Act 2012
CONSULTATION	Public Consultation 30th September 2021 – 23rd December 2021

RECOMMENDED: that the Governing Body;

Considers the Equality Impact Assessments (EIAs) undertaken and exercises its Statutory and Common Law duties with "due regard" under section 149 EA 2010. The duty requires due regard to be had "in substance with rigour and an open mind" when taking decisions.

PURPOSE

This report provides an overview of the equality impact assessments undertaken to understand the potential impact and potential mitigations when considering making changes to the four services listed below

- Orthopaedic surgery across Lincolnshire
- Urgent and emergency care at Grantham and District Hospital
- Acute medical beds at Grantham and District Hospital
- Stroke services across Lincolnshire

Equality impact assessments for each of the four services are provided as appendices and should be considered in conjunction with this document:-

Appendix 1	Legal Considerations
Appendix 2	Orthopaedic Surgery
Appendix 3	Urgent & Emergency Care
Appendix 4	Acute Medical Beds
Appendix 5	Stroke Services

RELATED DOCUMENTS

- Lincolnshire NHS public consultation on proposed changes to four services feedback report full draft 4.1
- Consultation feedback themes V0.9
- Equality Impact Assessments provided in the 2021 Pre-Consultation Business Case
- Independent Review of the 2018 Equality Impact Assessments September 2021

OVERVIEW

Following a period of options development and appraisal that involved senior clinicians, key stakeholders and members of the public, proposals for changes to the following four NHS services were put forward for public consultation over a 12-week period from 30th September 2021 until 23rd December 2021:

Proposals for orthopaedic surgery

- Consolidate planned orthopaedic surgery in a 'centre for excellence' at Grantham and District Hospital; and
- Create a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery.

Proposals for urgent and emergency care at Grantham and District Hospital

- Grantham and District Hospital A&E department to become an 24/7 Urgent Treatment Centre.

Proposals for acute medical beds at Grantham and District Hospital

- Integrated community/acute medical beds at Grantham and District Hospital.

Proposals for stroke services

- Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.

Public sector organisations are under a statutory duty, commonly known as the Public Sector Equality Duty (PSED) as both service providers and exercisers of public function for purposes of the Equality Act 2010. This means there is a responsibility to ensure that engagement and consultation is inclusive and accessible.

A mechanism for applying 'due regard' is Equality Impact Analysis (EIA). The benefits of undertaking an EIA to support stakeholder consultation and engagement processes are to:

- Ensure a wide range of stakeholders are involved and their voices are considered within service change proposals
- Record and describe the positive and reasonable adjustment that will be made to reach groups of people with protected characteristics or through ensuring equality of access to services
- Understand the barriers and opportunities that may be encountered when delivering services and when involving them in decision making and
- Inform decision makers about any potential impact on people from the protected groups as defined in the Act. An overview of the legal considerations when undertaking public consultation are outlined in Appendix 1.

Most importantly due regard leads to:

- Better informed decision makers
- Better understanding of needs
- Better health services
- Reduced discrimination and reduction of health inequalities

Lincolnshire CCG has publicly demonstrated that it takes the duties very seriously as is borne out in its Commitment to Equality, Inclusion and Human Rights which states that:-

"Through communication and engagement exercises, ensure that up to date information is distributed widely as possible and is accessible in different languages and formats as required – assessing the demographics of the areas being targeted prior to conducting exercise, helps to ascertain communication and engagement methods."

HEADLINE DEMOGRAPHICS

Lincolnshire is the 4th largest county in England with an area of 5,921 sq. km.
It has 761,224 residents (2019) and 783,080 GP registered patients (2019) dispersed across city, market towns, rural and coastal areas.

Lincolnshire is predominately rural, being the 4th most sparsely populated county, with no motorways, little dual carriageway and 80km of North Sea coastline, which provides fundamental difficulties in service provision.

The population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to almost double over the next 25 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.

The combination of an ageing population, a rural geography and areas of high socioeconomic deprivation defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire.

Age	In relation to age the statistics show that, out of the total population of 751,171, the age range 0-15 makes up 17.1% of the population, whilst the other sections of the population aged 16-24, 25-64, 65 -84 and 85 years and over make up 10.1%, 49.6% 20.3%, and 2.9% respectively. Lincolnshire's population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is estimated to double over the next 20 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
Disability	The 2011 Census shows that 27.1% of households in Lincolnshire have one person or more with a long-term disability. With regard to learning disabilities, statistics show that over 15,000 people have learning disability in Lincolnshire.
Ethnicity	The diversity of the population has increased in recent years as a result of new and emerging communities. As of the 2011 Census, around 93% of residents identify themselves as White British with a significant 4% identifying as White Other. This 4% is primarily made of Eastern European communities, which represents much in the agricultural, hospitality and tourist industries. Recent issues relating to Brexit have influenced the migration of EU foreign nationals back to their countries of birth. This in the future will no doubt have impact on the statistics of the white European population and detrimental impact on the Lincolnshire's agricultural industries. The non-white population makes up 2.4% of the total population in 2011 compared to 1.4% in 2001 and although slight increases are

	becoming apparent since 2011, the proportions are still very small in comparison to the national non-white population of 14%.
Gender*	According to the 2011 census, statistics for Lincolnshire's show the population as 713,653 (2017 estimates 751,200). In total there are more females 366,498 (51.3%) than males 348,270 (48.7%), with slight variations amongst different age groups. The estimated difference in 2017 slightly narrows that gap between male and female population at 385,800 (51%) female and 370,000 (49%) male.
Religion & belief	In relation to Religion/belief, Christians make up the largest group 68.50%, followed by those who do not have religion at 23.10%. Other smaller religious groups include Muslim 0.40%, followed by Hindu's and Buddhist at 0.20% the smallest religious groups include the Jewish and Sikh both at 0.10%
Sexual Orientation & *transgender	There is no accurate data on the numbers of men and women who are lesbian, gay, bisexual or transgender (LGBT) in Lincolnshire, reflecting a national problem with accurate statistical analysis. Both Stonewall and HM Treasury concur that between 5 – 7% of the population of the UK are lesbian, gay, bisexual or transgender, but acknowledge the difficulty in accurate analysis. In Lincolnshire this represents over 50,000 people.

HEALTH INEQUALITIES

In Lincolnshire, health inequalities exist between levels of income deprivation and gender.

Between the most and least income deprived deciles, the gap in male life expectancy is 6.5 years, and for healthy life expectancy is 11.8 years.

For women, the gap in life expectancy is smaller at 4.8 years and for healthy life expectancy is 10.8 years.

Life expectancy, premature cancer mortality, mental health-related, smokingrelated, alcohol-specific and drug-related hospital admissions all show a moderate association with BAME.

Both life expectancy and healthy life expectancy are strongly associated with income deprivation.

Moderate levels of variation in mental healthrelated, alcohol-specific and drug-related hospital admissions can be explained by income deprivation in older people.

In the most income deprived decile of Lincolnshire, life expectancy is 5.1 years less and healthy life expectancy is 11.2 years less compared to the least income deprived decile.

Preventable mortality rates in the most income deprived decile are 1.7 times higher than in the least deprived decile

The greatest causes of ill health and mortality are cardiovascular disease, cancers, musculoskeletal conditions and mental ill-health. Musculoskeletal conditions and mental ill-health are the biggest contributors to the number of Years Lived with Disability in Lincolnshire's population.

ENSURING THE FORMAL CONSULTATION REACHED THE SELDOM HEARD

Based on stakeholder mapping and population profiling, a Consultation Strategy and Plan was developed to make sure that reasonable attempt has been made to allow people with a protected characteristic to participate in the process, should they wish to do so.

Many and varied methods of encouraging and supporting people to respond were deployed such as paper, translated, Easy Read, telephone and digital surveys. Accessible venues, provisions for people with hearing loss and bespoke activity undertaken in partnership with the voluntary sector to reach protected groups.

An independent review of the Equality Impact Assessment of the Consultation Strategy and Plan itself has been undertaken and a mid-point review of respondents enabled the program to target under-represented areas and communities in the second part of the consultation.

Independent Quality Assurance of the consultation process was undertaken by The Consultation Institute who include Equality Impact as part of their assessment criteria.

EQUALITIES AND HEALTH INEQUALITIES IMPACTS FEEDBACK SUMMARY

Analysis of the questionnaire and survey responses from the consultation did not indicate that there were many strong differences in views on the proposals, or specific additional concerns being expressed by respondents from groups with protected characteristics under the Equalities Act 2010 (e.g., age, ethnicity, gender) or other demographic groups. 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.

The exception to this was that there was some evidence that residents with the most life-limiting disabilities and long -term conditions were more negative than other residents about the proposals around acute medical beds and urgent and emergency care at Grantham and District Hospital, and to a lesser extent the proposal for stroke services, (although on all proposals there was still majority agreement from this group). The feedback suggested, however, that it was again concerns about travel and transport and local provision of services that were behind these more negative views.

Where concerns were raised in feedback about particular groups, the focus was predominantly on travel and transport, particularly for those with limited access to private transport. Specific groups and communities were mentioned in this regard, including:

- People with physical disabilities, and long-term conditions and co-morbidities;
- People with learning disabilities, and neurodiverse people such as those ASD;
- Older people;
- People living in areas of deprivation or with low incomes;
- Residents in rural and isolated communities; and
- Those without access to private vehicles or who routinely rely on public transport.

Where concerns were raised that did not relate directly to travel, they tended to focus on issues around lack of familiarity with ‘new’ or different locations. For example, there were concerns that older people from Grantham might be taken by ambulance to Lincoln, Boston or Peterborough to be treated in an emergency. The unfamiliar setting, it was felt, could cause additional distress. Furthermore, there was a concern that increased travel times for care would have a negative impact on the mental health of the older population in particular.

The needs of people with sensory disabilities who might be used to accessing certain hospitals and were therefore confident that they would receive any additional support they might require at those locations, were also raised as an issue for consideration.

Healthwatch Lincolnshire raised wider concerns around the impact of service changes on what it saw as the 'most affected' groups, namely: people living in rural and isolated communities; people living with disabilities and co-morbidities; public transport users; and people who are geographically impacted because of changes to current provision. Healthwatch strongly urged the CCG to fully consider all negative and positive impacts on people and communities when reviewing the results of the public consultation and its Equality Impact Assessments.

The Health Scrutiny Committee urges the NHS in Lincolnshire to take full account of equalities assessments prior to making decisions on service changes.

Source ORS Public Consultation feedback report V4.1

REVISED EIAs FOLLOWING CONSULTATION

Initial part one and two EIAs were undertaken in 2018 and informed the PCBC 2021.

Following the public consultation relating to the four services undertaken from 30 September 2021 – 23 December 2021, the responses were analysed by Opinion Research Services.

Thematic analysis of the consultation responses by protected characteristic group is presented in this report in order to inform decision makers about any required mitigations. The table below summarises the demographic information of those who responded to the consultation questionnaire. Lincolnshire CCG population data is used as a comparator, to give some general indication of how well the response profile of the questionnaire matches the wider population. An asterisk has been used to denote percentages greater than zero, but less than half of one per cent.

Characteristic		Questionnaire Responses		Population aged 16+
		Number of Respondents	%	
BY AGE	Under 25	18	1%	12%
	25 to 34	134	5%	13%
	35 to 44	247	10%	13%
	45 to 54	423	17%	16%
	55 to 64	580	24%	17%
	65 to 74	762	31%	16%
	75 or over	280	11%	13%
	Total valid responses	**2,444**	**100%**	**100%**
	Not known	*584*	-	-
BY GENDER	Male	774	33%	49%
	Female	1,560	67%	51%
	Other[1]	11	*	-

	Total valid responses	**2,345**	**100%**	**100%**
	Not known	*683*	-	-
BY DISABILITY	Has a disability	569	24%	23%
	No disability	1,821	76%	77%
	Total valid responses	**2,390**	**100%**	**100%**
	Not known	*638*	-	-
BY ETHNIC GROUP	White	2,264	97%	98%
	Mixed/multiple ethnic groups	16	1%	1%
	Asian/Asian British	25	1%	1%
	Black/Black British	8	*	*
	Other	10	*	*
	Total valid responses	**2,323**	**100%**	**100%**
	Not known	*705*	-	-

Characteristic		Questionnaire Responses	
		Number of Responses	%
BY RELIGION	Buddhist	10	*
	Christian	1,449	63%
	Hindu	8	*
	Jewish	9	*
	Muslim	5	*
	Sikh	1	*
	Other religion	35	2%
	No religion	771	34%
	Total valid responses	**2,288**	**100%**
	Not known	*740*	
BY PREGNANCY/ HAVING GIVEN BIRTH IN THE LAST 12 MONTHS	Yes	26	1%
	No	2,422	99%
	Total valid responses	**2,448**	**100%**
	Not known	*580*	-
BY WHETHER RESPONDENT HAS ANY DEPENDENT CHILDREN	Yes	481	20%
	No	1,971	80%
	Total valid responses	**2,452**	**100%**
	Not known	*576*	-
BY WHETHER RESPONDENT PROVIDES HELP / SUPPORT TO OTHERS[2]	Yes	920	38%
	No	1,488	62%
	Total valid responses	**2,408**	**100%**
	Not known	*620*	-
	Yes	2,345	99%

[2] Defined as being any help or support provided to family members, friends, neighbours or others because of long-term physical or mental ill-health/disability or problems relating to old age

BY WHETHER GENDER IS THE SAME AS ASSIGNED AT BIRTH	No	16	1%
	Total valid responses	**2,361**	**100%**
	Not known	*667*	-
BY SEXUAL ORIENTATION	Bisexual	17	1%
	Gay or lesbian	34	2%
	Heterosexual or straight	2,194	97%
	Other	14	1%
	Total valid responses	**2,259**	**100%**
	Not known	*769*	-

In summary, the profile of respondents does not present cause for concern.

The under 34 age group were not identified as being disproportionately disadvantaged in the original EIA presented in the PCBC.

The high response from carers (37%) was validated by ORS and found to be accurate. ORS said “it is a good thing to have a strong response from carers, as they are often affected by changes in practical terms as much as, if not more than, service users. The second is that there are various factors that mean that we often receive a higher response from carers to consultation questionnaires than might be expected from the relevant population data”.

The most significant of these factors are likely to be that:

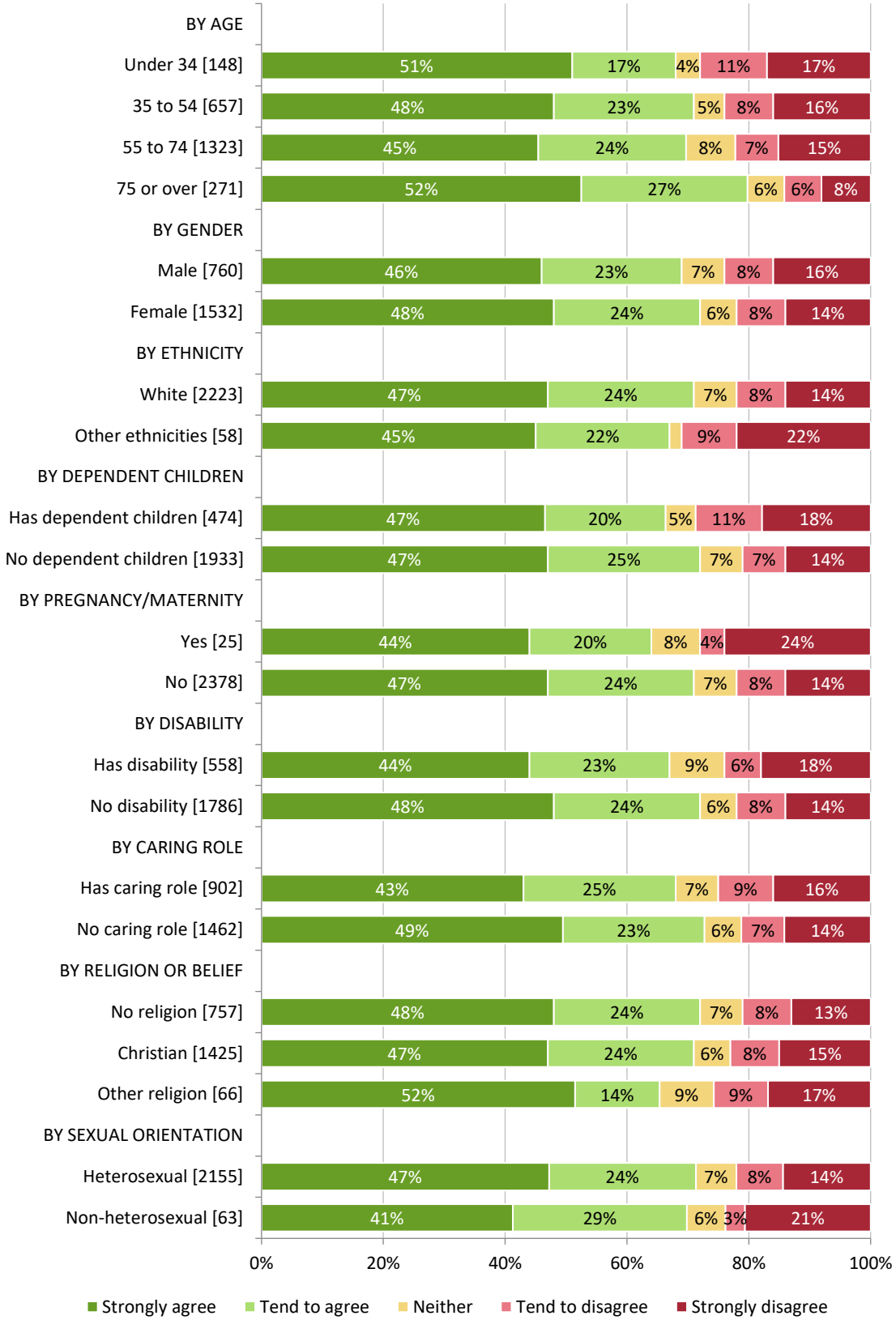
- The 2011 census question from which the 12.5% figure may be drawn specifically clarifies not to include paid work as a carer, whereas the Lincs ASR consultation questionnaire does, so it is likely we capture more than say yes to the census. Understanding whether people involved in caring roles (paid or unpaid) feel differently to other people about the proposals is arguably more important than achieving a representative sample.

- The 12% figure for the population may cover all ages and genders, whereas the questionnaire response (as is almost always the case) is strongest from women in the age bracket of 45–74, who are significantly more likely to play a caring role for children, parents or spouses. By contrast, we tend to see a lower response rate from younger people (aged 34 and under), the same group that is less likely to have a caring role at this stage in their lives.

- Populations are geographically heterogenous, with urban populations often skewing younger and rural populations older, which may come into play here given the substantial response from South Kesteven compared to some other areas.

- ‘Open’ questionnaires of this type are not typically representative of the general public, and the strongest response tends to come from individuals who have a personal connection to the services in question, as well as from particular demographics In this case, with both orthopaedic and stroke services being part of the proposed changes, we might expect carers to be particularly motivated to respond.

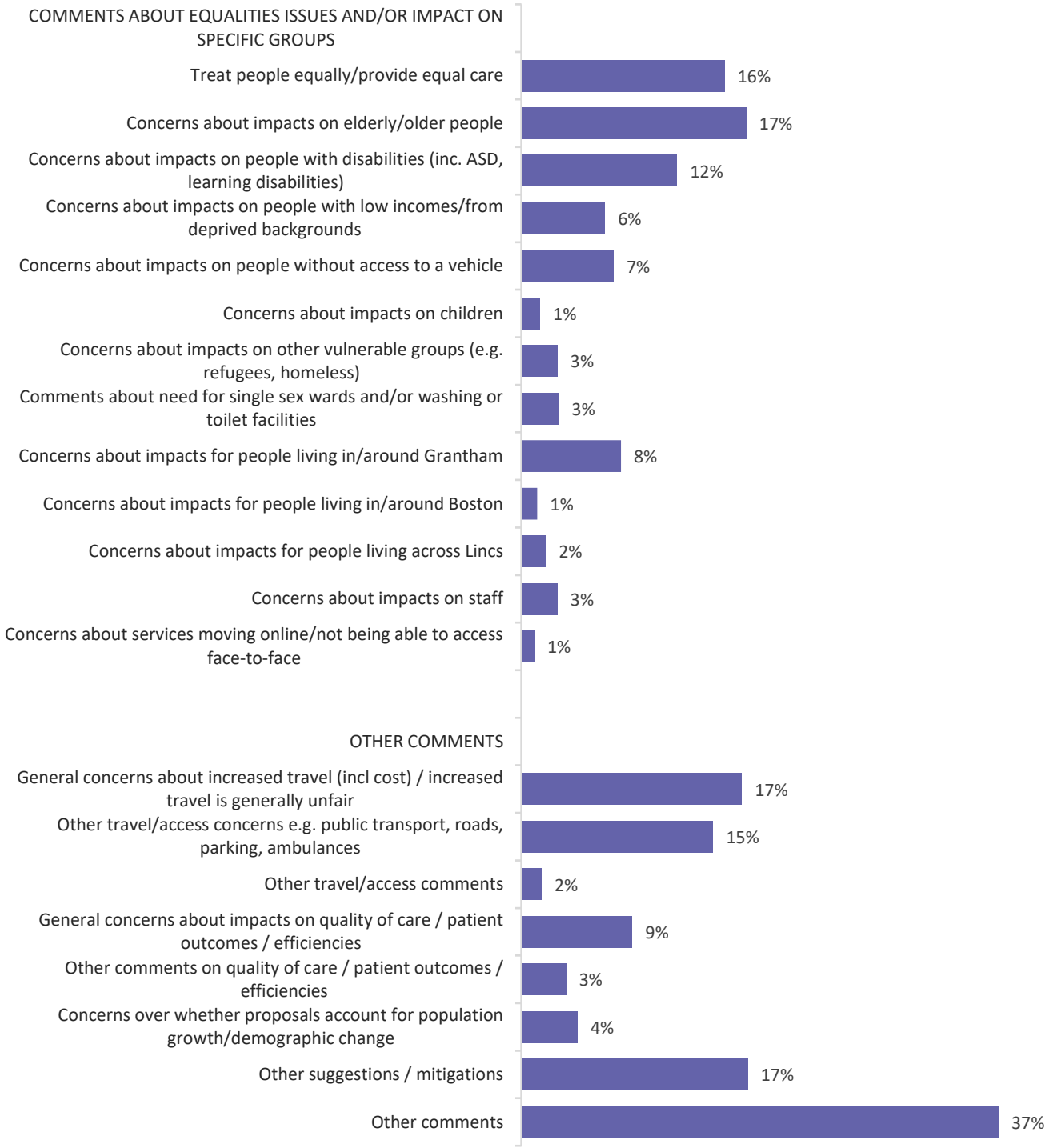
The following table presents questionnaire respondents’ views on the need for change, broken down by key demographics, including protected characteristics such as age, gender, ethnicity etc.); there are some slight variations but there is majority agreement across all groups.


BY AGE
Under 34 [148]
51%
17%
4%
11%
17%
35 to 54 [657]
48%
23%
5%
8%
16%
55 to 74 [1323]
45%
24%
8%
7%
15%
75 or over [271]
52%
27%
6%
6%
8%
BY GENDER
Male [760]
46%
23%
7%
8%
16%
Female [1532]
48%
24%
6%
8%
14%
BY ETHNICITY
White [2223]
47%
24%
7%
8%
14%
Other ethnicities [58]
45%
22%
9%
22%
BY DEPENDENT CHILDREN
Has dependent children [474]
47%
20%
5%
11%
18%
No dependent children [1933]
47%
25%
7%
7%
14%
BY PREGNANCY/MATERNITY
Yes [25]
44%
20%
8%
4%
24%
No [2378]
47%
24%
7%
8%
14%
BY DISABILITY
Has disability [558]
44%
23%
9%
6%
18%
No disability [1786]
48%
24%
6%
8%
14%
BY CARING ROLE
Has caring role [902]
43%
25%
7%
9%
16%
No caring role [1462]
49%
23%
6%
7%
14%
BY RELIGION OR BELIEF
No religion [757]
48%
24%
7%
8%
13%
Christian [1425]
47%
24%
6%
8%
15%
Other religion [66]
52%
14%
9%
9%
17%
BY SEXUAL ORIENTATION
Heterosexual [2155]
47%
24%
7%
8%
14%
Non-heterosexual [63]
41%
29%
6%
3%
21%
0%
20%
40%
60%
80%
100%
Strongly agree
Tend to agree
Neither
Tend to disagree
Strongly disagree

Views on potential equalities impacts across the four service proposals

A further question encouraged respondents to identify any potential positive or negative impacts in relation to specific equalities groups, and to suggest possible mitigations for any negative impacts. Most of the comments related to concerns or negative impacts rather than positive ones.

High-level summary of the further comments made in response to the text question about equalities impacts



Base: All individual respondents who provided comments (899)

Nearly a fifth of individuals who commented mentioned potential impacts on older people, and over a tenth mentioned potential impacts for those with disabilities. Other potentially affected groups included people with low incomes and/or from deprived backgrounds, people with a range of other vulnerabilities (e.g., due to homelessness etc) and people without access to personal vehicles.

Where issues were raised in relation to specific groups, these tended to be a mixture of points relating to travel and access issues (e.g., suggestions that the increased travel would disproportionately affect a particular group in terms of greater difficulty accessing services, facing increased costs, etc) and concerns around quality of care and/or the risk of more adverse outcomes for certain groups as a result of them having to travel further to access care. Some respondents spoke about a general need to ensure a particular group is treated fairly.

Although not directly relating to the main proposals, another area of concern identified by small numbers of respondents was around services potentially moving online and/or face-to-face appointments becoming more difficult to access in the future, with potential impacts for those not having internet access or being unable to use IT. A small proportion also made comments about a need to provide single sex wards and toilet and/or washing facilities. Some of the comments identified negative impacts on residents living in particular areas (as opposed to specific demographic groups etc) – most frequently in relation to Grantham and surrounding areas. There were also some concerns about staff and their treatment and wellbeing.

There were also some suggestions that the issues might be exacerbated by population growth or other demographic changes (e.g., an increasingly older population).
Most of the suggested mitigations involved investing in and/or maintaining current services across the various hospitals. A small proportion (around 3% of those who commented) suggested that staff should undergo training in relation to equalities issues. There were a few comments advocating the provision of free transport (e.g., a shuttle bus) between sites in order to mitigate travel impacts.

Comments about equalities and health inequalities considerations from organisations responding to the consultation questionnaire

The organisations representing the views of Gypsies and Travellers in Lincolnshire made some general comments around the discrimination and exclusion they continue to face.

> *The society we live in today there should be no discrimination under any circumstances, however I have witnessed first-hand that gypsies/traveller do be discriminated against. So, it would probably be a good idea to get to know a race before you have an opinion and tell staff to talk quietly when having a chat.*
>
> ***Lincolnshire Traveller Initiative Health Champion***
>
> *Some Travellers/Gyps[ies] feel left behind with things. Working forward, being online and are unable to access this and some can't read letters, they say it all seems so un personal.*
>
> ***Lincolnshire Traveller Initiative, Well Woman Group***

Ensuring other groups are considered in decision-making

Other organisations commented on the importance of supporting and involving different communities across Lincolnshire. The elderly, disabled residents and the economically

disadvantaged were considered a priority, as were those whose first language is not English, those who rely on public transport, and residents of particular geographical areas (in the east of the county for example).

The most vulnerable people in Lincolnshire (elderly, disabled or anyone with additional needs) are likely to be negatively impacted by services being further away from their home.

Skegness Town Council

The consultation document highlights the consideration given to equalities impacts of the proposals. There is limited information about what mitigations can or will be put in place – or how addressing these concerns will be taken forward. Consideration and support to access services by older residents, lower income or economically disadvantaged residents, patients or families whose first language is not English, disabled residents and public transport challenges need to be clear. Support from partners across the system can assist with this.

Boston Borough Council, East Lindsey District Council, and South Holland District Council

The current climate is making the elderly feel extremely vulnerable. They do tend to think they are being neglected over the younger population.

Homecare

Lincolnshire East patients will be further away from the orthopaedic and stroke units, so transport and rehabilitation need to be adjusted to ensure these patients are not disadvantaged.

Lincolnshire Local Medical Committee

From the data and responses received from the consultation, there are very few mentions of real equalities impacts; most of the differences in views are linked to geographical areas.

The responses provided with respect to equality and health inequality included:-

Proposals for orthopaedic surgery

- Consolidate planned orthopaedic surgery in a 'centre for excellence' at Grantham and District Hospital; and
- Create a dedicated day-case centre at County Hospital Louth for planned orthopaedic surgery.

Theme	Comment / Message / Concern
Equalities & Health Inequalities	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/more expensive journeys to hospitals Patients with comorbidities were also mentioned, including those who might require access to kidney dialysis while in hospital.
	Review of eligibility criteria for patient transport services to address any potential barriers to access – particularly for most deprived communities in rural and inner-city areas or frail or older people who might find travel stressful/difficult
	Challenge of ensuring equitable access in large, rural county, especially for localities where health service provision and public transport services were described already as being poor (e.g. East Coast)

	People with disabilities who are used to attending particular hospitals where additional support is available if needed, might find that the same support not available elsewhere
	ability of carers being able to travel to Grantham to support vulnerable patient, specifically if an overnight stay is needed
	The continuing, planned run down of Grantham and Louth Hospitals is endangering the care and safety of populations living at a distant from Pilgrim and Lincoln hospitals.
	Some Travellers/Gypsies feel left behind with things working forward, being on line and are unable to access this and some cannot read letters, they say it all seems so unpersonal.
	The cost to the NHS in transport for patients without own means of transport could outweigh the benefits of the proposal.
	Concern by a disabled, deaf person over potential loss of appointments and operations at valued local Pilgrim Hospital and belief that this support would be unavailable elsewhere - is there any specific extra service for hard of hearing here?

Proposals for urgent and emergency care at Grantham and District Hospital

Grantham and District Hospital A&E department to become an 24/7 Urgent Treatment Centre.

Theme	Comment / Message / Concern
Equalities & Health Inequalities	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.

Proposals for acute medical beds at Grantham and District Hospital

Integrated community/acute medical beds at Grantham and District Hospital.

Theme	Comment / Message / Concern
Equalities & Health Inequalities	Patients would be seen to quicker, resulting in more efficient care; patients will benefit by being discharged back into their community more quickly. Elderly or frail patients were highlighted as particularly benefiting from this
	Reducing pressure on acute hospital sites at Lincoln and Boston – specifically in relation to 'frail' population is sensible and the integrated multi-disciplinary care team for frail patients is positive. Where else in the County will this specialism for frailty be available?

Proposals for stroke services Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.	
Theme	**Comment / Message / Concern**
Equalities & Health Inequalities	Proposal could widen health inequalities and patient access could be taken away from a deprived area
	A number of patients have elderly spouses/family who will be unable to visit due to increased travel distance. The impact of this on patients' mental health and recovery may have been overlooked in this proposal.
	The stroke figures for the whole of the area served by Pilgrim Hospital are higher owing to an ageing population. It makes more sense, therefore, to have a centre of excellence in Boston. This would reduce travel times for the majority
	Where concerns were raised that did not relate directly to travel, they tended to focus on issues around lack of familiarity with 'new' or different locations. For example, there were concerns that older people from Grantham might be taken by ambulance to Lincoln, Boston or Peterborough to be treated in an emergency. The unfamiliar setting, it was felt, could cause additional distress. Furthermore, there was a concern that increased travel times for care would have a negative impact on the mental health of the older population in particular.
	Similarly, the needs of people with sensory disabilities who might be used to accessing certain hospitals and were therefore confident that they would receive any additional support they might require at those locations, were also raised as an issue for consideration.
	With current waiting times for ambulance services, the people in Grantham and Boston will be severely disadvantaged because of a substandard access to emergency care.

CONCLUSION

Lincolnshire CCG has made reasonable adjustments throughout the consultation process to allow participation in the process by people with protected characteristics should they chose to do so. Each method used, whether it be the survey, focus groups, public meetings or bespoke events asked people for their views on any potential equality impacts.

The analysis of the consultation responses undertaken by ORS clearly describes the level of support for each of the proposals and suggested mitigations by protected group. Furthermore, each proposal sought views about any potential equality impacts.

There was no further information gathered about service usage by protected characteristic group following the PCBC and the latest Census data has not yet been published to inform the analysis.

Health inequalities, accessibility of services and the wider determinants of health were also considered.

In conclusion, the four accompanying equality impact assessments and associated documents provide the necessary information to inform decision makers in their deliberations.

Maktub Consulting Ltd

Anna Collins FCIM, Director of Maktub Consulting Ltd: Director of Maktub Consulting Ltd has over 20 years' experience in the public sector working in senior leadership roles in communication, engagement and corporate services. She is experienced in creating accessible narrative and dialogue to help clients to find their corporate voice, tackle tricky reputational issues and involve stakeholders in their decision making.

Underpinning the advice and hands-on delivery is an approach to good governance with the aim of minimising the risk of legal challenge and making sure that decision makers are empowered to adopt good practice methodology to inform their thinking.

Anna is a Fellow of the Chartered Institute of Marketing and an Associate of The Consultation Institute with 20 years' experience in the public sector and was Marketing Manager for Europe for ICL computers for 11 years prior to that.

Anna has operated at executive level as Director of Communication & Corporate Affairs in the NHS at a Foundation Trust where her portfolio included communication, governance, legal services, information governance and the hospital charity.

She has also worked as Associate Director of Communication & Engagement for the six Staffordshire Clinical Commissioning Groups and the Sustainability & Transformation Partnership. Whilst there, she delivered several contentious transformational change consultation programmes including the prescribing of gluten free foods, proposals to merge the six CCGs and the reconfiguration of community hospitals and community hub services without legal challenge.

She led on communication and involvement on behalf of the CCGs for the system wide change programme 'Together We're Better' managing several supplier relationships to deliver against both statutory duties and best practice. She has successfully delivered to regulatory assurance frameworks and has a proven track record in building positive relationships with campaigners, scrutineers and elected members at local and national level.

Anna's passion lies in giving service users, particularly the seldom heard, and stakeholders a voice to inform decision making using innovative and best practice methodology and has experience of managing the tactical delivery of a citizen's jury, large and focussed deliberative events and digital engagement. She has a personal interest in health literacy and the 'It's OK to Ask' campaign was shortlisted for an HSJ award.

Anna also has 14 years public sector communication and engagement leadership experience with two Cheshire Police & Crime Commissioners and Cheshire Police Authority where she managed public consultation about the police budget, priorities and the recommissioning of victim support services as well as proposals for police station closures and police force mergers.

Anna was the Equality & Diversity lead under Sir Peter Fahy when the 'Secret Policeman' documentary highlighted the need for better awareness of culture and racial issues and led on the development of the Equality Strategy and Equality and Community Impact Assessments. She was the lead for Hate Crime and undertook some intense engagement activity with ethnic communities, LGBT victims of hate crime, young people's experiences of Stop & Search as well as working with survivors of sexual assault and domestic abuse. She supported the National ACPO lead for Disability. She led on equality and diversity and managed the Constabulary's Independent Advisory Group.

Appendix 1

LEGAL CONSIDERATIONS

EQUALITY

Section 149(3) of the Equality Act 2010 states that advancing equality of opportunity involves having due regard to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The protected characteristics outlined in the Equality Act 2010 are:

- age
- sex
- race
- religion or belief
- disability
- sexual orientation
- gender reassignment
- pregnancy and maternity
- marriage and civil partnership (relating to workforce only)

In practice, every 'reasonable' attempt must be taken to provide evidence that people with protected characteristics have been considered and involved in the decision-making process.

"A decision maker, having taken reasonable steps to inquire into the issues must understand the impact or likely impact of the decision of those of the listed equality needs …a process of consideration, a thought process…at a time when decisions which could have an impact are being taken.." Bracking Principles 2018.

This has been tried and tested in court, the most important cases are that of;

R(ex parte Judy Brown) v Secretary of State for Work & Pensions (2008); As part of a nationwide programme of post office closures it was challenged that the Secretary of State had failed to undertake a Disability Equality Impact Assessment (pre-dates Equality Act 2010). This resulted in the formulation of six general principles.

R(ex parte Bracking & others) v Secretary of State for Work & Pensions. (2013); At the High Court, Blake J considered a claim that consultees had inadequate information and therefore could not make an effective response, to paraphrase it was concluded that

"in the absence of evidence of a structured attempt to focus upon the details of equality issues a decision maker is likely to be in difficulties if his or her subsequent decision is challenged."

To demonstrate a good quality EIA, it is important to adhere to the Bracking principles (which superseded but incorporated the Brown principals) in both decision-making papers and the EIA, which in summary are:

1. The equality duty is an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation.

2. An important evidential element in the discharge of the duty is the recording of the steps taken by the decision maker in seeking to meet the statutory requirements.

3. The duty is upon the decision maker personally. What matters is what he or she considered and what he or she knew.

4. A decision maker must assess the risk and extent of any adverse impact and the ways in which such a risk may be eliminated before the adoption of a proposed policy/decision. It is not a rear-guard action following a concluded decision.

5. The duty to have due regard must be fulfilled before and at the time when a decision is being considered and it is a continuing one. The duty must be exercised in substance, with rigour and with an open mind.

6. Public bodies should place considerations of equality, where they arise, at the centre of formulation of policy, side by side with all other pressing circumstances of whatever magnitude. They must be properly informed before taking the decision. If the relevant material is not available, there is a duty to acquire it – even if this means more consultation

7. A public body must have available enough evidence to demonstrate that it has discharged the duty.

HEALTH INEQUALITY

Health Service Act 2006 (amended by Health and Social Care Act 2012) introduced the first legal duties on health inequalities, with specific duties on NHS England and CCGs, as well as duties on the Secretary of State for Health. These duties took effect from 1 April 2013.

Each Clinical Commissioning Group must, in the exercise of its functions, have regard to the need to:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
- Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved (s.14Z1)
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities (s. 14Z11)
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities (s. 14Z15).

Health inequalities are unjust differences in health and wellbeing between different groups of people (communities) which are systematic and avoidable. Health inequalities in England exist across a range of dimensions or characteristics, including the nine protected characteristics of the Equality Act 2010, socio-economic status, geographic deprivation, or being part of a vulnerable health group.

Health inequalities may be driven by:

- Different experiences and distribution of the wider determinants of health or structural factors. For example, the environment, community life, income or housing. In other words, the social economic and environmental conditions in which people live, work and play.

- Different exposure to social, economic and environmental stressors and adversities. These affect states of mind from an early age and throughout life. Stress and psychological wellbeing directly affect resilience, health conditions and health behaviours.
- Differences in health behaviours or other risk factors between groups, for example smoking, diet, and physical activity levels have different social distributions. Health behaviours may be influenced by wider determinants of health, like income.

- Unequal access to or experience of health and other services between social groups.

People who share protected characteristics, as defined in the Equality Act 2010, may experience poorer health outcomes as a direct result of discrimination or due to different experiences of the factors described above.

There are a number of different dimensions to consider including:

1. Socio-economic differences by individual socio-economic position. For example, National Statistics Socio-economic Classification, employment status, income, area deprivation.

2. Area variations by deprivation level (Index of Multiple Deprivation), service provision, urban/rural or in general.

3. Vulnerable and Inclusion Health groups, for example people experiencing homelessness, people in prison, or young people leaving care.

Arden&GEM

NHS
Arden and
Greater East Midlands
Commissioning Support Unit

Appendix 2
Equality Impact Analysis
Proposals for orthopaedic surgery

Project Details

Project Name:	Proposals for orthopaedic surgery
EA Author:	Anna Collins
Team:	Maktub Consulting Ltd
Date completed:	April 2022
Version:	1.1

What is the aim of the project/proposal?

Following a period of options development and appraisal that involved senior clinicians, key stakeholders and members of the public, proposals for changes to four NHS services were put forward for public consultation over a 12-week period from 30th September 2021 until 23rd December 2021:

Proposals for orthopaedic surgery

- Consolidate planned orthopaedic surgery in a 'centre for excellence' at Grantham and District Hospital; and
- Create a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

- Staff
- Patients
- Carers

Stage 1, Scoping point

Is a full Equality Impact Analysis required for this project?

You should consider whether a full EIA is required, referring to the relevant guidance for information and guidance on making this decision.

It is important this decision is made with an open mind and correctly, advice should be sought from the EIHR team if you are unsure.

Yes	☑	Proceed to the full Equality Impact Analysis form	**No**	☐	Explain why further analysis is not required.

If no, explain below why further Equality Impact Analysis is not required. E.g. 'This report is for information only' or 'The decision has not been made by the CCG' or 'The decision will not have any impact on patients or staff'. (Very few decisions affect all groups equally and this is not a rationale for not completing an EIA.)

Equality Impact Analysis Form

If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EIA. An Equality Impact Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

1. Evidence used

To demonstrate that the decision made has been informed you should include examples of the information used to determine the impact and complete the EIA.

Examples are likely to include:

- ***Population Data -*** *e.g. demographic profile (Census),*
- ***Service Activity Data e.****g. profile of patients using a service*
- ***Consultation and Involvement findings -*** *e.g. any engagement with service users, local community, specific groups.*
- ***Research -*** *e.g. good practice guidelines, service evaluations, literature reviews, reports*
- ***Participant knowledge -*** *e.g. experiences of working with different or population groups, experiences of service users in other service areas / localities*

- Lincolnshire NHS public consultation on proposed changes to four services feedback report Full draft 4.1
- Consultation feedback themes V0.9
- Equality Impact Assessments of orthopaedic services February 2021 Public documents relating to the four services and approach to consultation
- Pre Consultation Business Case

POPULATION DATA

Headline Demographics

Lincolnshire is the 4th largest county in England with an area of 5,921 sq. km.

It has 761,224 residents (2019) and 783,080 GP registered patients (2019) dispersed across city, market towns, rural and coastal areas.

Lincolnshire is predominately rural, being the 4th most sparsely populated county, with no motorways, little dual carriageway and 80km of North Sea coastline, which provides fundamental difficulties in service provision.

The population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to almost double over the next 25 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.

The combination of an ageing population, a rural geography and areas of high socioeconomic deprivation defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire.

Age	In relation to age the statistics show that, out of the total population of 751,171, the age range 0-15 makes up 17.1% of the population, whilst the other sections of the population aged 16-24, 25-64, 65 -84 and 85 years and over make up 10.1%, 49.6% 20.3%, and 2.9% respectively. Lincolnshire's population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is estimated to double over the next 20 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
Disability	The 2011 Census shows that 27.1% of households in Lincolnshire have one person or more with a long-term disability. With regard to learning disabilities, statistics show that over 15,000 people have learning disability in Lincolnshire.
Ethnicity	The diversity of the population has increased in recent years as a result of new and emerging communities. As of the 2011 Census, around 93% of residents identify themselves as White British with a significant 4% identifying as White Other. This 4% is primarily made of Eastern European communities, which represents much in the agricultural, hospitality and tourist industries. Recent issues relating to Brexit have influenced the migration of EU foreign nationals back to their countries of birth. This in the future will no doubt have impact on the statistics of the white European population and detrimental impact on the Lincolnshire's agricultural industries. The non-white population makes up 2.4% of the total population in 2011 compared to 1.4% in 2001 and although slight increases are becoming apparent since 2011, the proportions are still very small in comparison to the national non-white population of 14%.
Gender*	According to the 2011 census, statistics for Lincolnshire's show the population as 713,653 (2017 estimates 751,200). In total there are more females 366,498 (51.3%) than males 348,270 (48.7%), with slight variations amongst different age groups. The estimated difference in 2017 slightly narrows that gap between male and female population at 385,800 (51%) female and 370,000 (49%) male.
Religion & belief	In relation to Religion/belief, Christians make up the largest group 68.50%, followed by those who do not have religion at 23.10%. Other smaller religious groups include Muslim 0.40%, followed by Hindu's and Buddhist at 0.20% the smallest religious groups include the Jewish and Sikh both at 0.10%
Sexual Orientation & *transgender	There is no accurate data on the numbers of men and women who are lesbian, gay, bisexual or transgender (LGBT) in Lincolnshire, reflecting a national problem with accurate statistical analysis. Both Stonewall and HM Treasury concur that between 5 – 7% of the population of the UK are lesbian, gay, bisexual or transgender, but acknowledge the difficulty in accurate analysis. In Lincolnshire this represents over 50,000 people.

Health Inequalities

In Lincolnshire, health inequalities exist between levels of income deprivation and gender.

Between the most and least income deprived deciles, the gap in male life expectancy is 6.5 years, and for healthy life expectancy is 11.8 years.

For women, the gap in life expectancy is smaller at 4.8 years and for healthy life expectancy is 10.8 years.

Life expectancy, premature cancer mortality, mental health-related, smoking related, alcohol-specific and drug-related hospital admissions all show a moderate association with BAME.

Both life expectancy and healthy life expectancy are strongly associated with income deprivation.

Moderate levels of variation in mental health related, alcohol-specific and drug-related hospital admissions can be explained by income deprivation in older people.

In the most income deprived decile of Lincolnshire, life expectancy is 5.1 years less and healthy life expectancy is 11.2 years less compared to the least income deprived decile.

Preventable mortality rates in the most income deprived decile are 1.7 times higher than in the least deprived decile

The greatest causes of ill health and mortality are cardiovascular disease, cancers, musculoskeletal conditions and mental ill-health. Musculoskeletal conditions and mental ill-health are the biggest contributors to the number of Years Lived with Disability in Lincolnshire's population.

SERVICE ACTIVITY DATA

Overview of activity impact

The orthopaedic pilot at Grantham Hospital started on Monday 20 August 2018. An estimate of the volume of displaced activity and associated travel time that has occurred through the pilot has been made by comparing activity seen at each site in 2017/18 the last full year before the pilot started and 2019/20 the first full year it has run.

It is estimated that since the Orthopaedic Pilot started c.1,710 (c.825 Elective, c.475 Day Case, c.410 Non Elective) patients per year have been displaced. This figure does include a small proportion of patients being repatriated from providers out of the county (it should be noted that in 2020/21 and 2021/22 all orthopaedic activity across ULHT will have dropped due to Covid).

This analysis has estimated that under the current pilot arrangements an additional c.365 patients per annum travel more than 75 minutes by car for elective orthopaedic surgery and procedures within Lincolnshire.

An additional factor that has occurred during the period of the pilot is a change to the Referral Facilitation Service (RFS) that covers what were 3 of the 4 Lincolnshire CCGs, with full effect occurring in 19/20.

Between 2017/18 and 2019/20 there has been a reduction in inpatient and daycase activity at out of county (OoC) and independent sector (IS) providers, some of which seems to have been redirected to ULHT under the RFS and some of which has been converted into 'left shift'.

It is estimated that between 2017/18 and 2019/20 there has been a ‘left shift’ of c.9.3% of day case activity.

The main constraint to delivering the full extent of the planned activity shift to Grantham Hospital under the preferred option is bed and theatre capacity. The pilot has utilised the existing capacity on the Grantham Hospital site and to consolidate any more activity would require an increase in capacity.

Age and sex profile of patients impacted

Based on the age and sex profile of patients using ULHT’s orthopaedic services it is estimated that of the displaced patients:

- For Elective and Day Case patients:
    - 58% would be female and 42% male
    - 56% would be 65 or over
- For Non Elective patients:
    - 52% would be female and 48% male
    - 52% would be 65 or over

Ethnicity profile of patients impacted

Based on the ethnicity profile of patients using ULHT’s orthopaedic services it is estimated that of the displaced patients:

- For Elective and Day Case patients:
    - 91% would be White British
    - 2% would be Other White
    - 2% would be Other Ethnic Group
    - With the remainder not having their ethnicity recorded or Not Stated
- For Non Elective patients:
    - 91% would be White British
    - 3% would be Other White
    - 0% would be Other Ethnic Group
    - With the remainder not having their ethnicity recorded or Not Stated

Deprivation profile of patients impacted

Based on the ethnicity profile of patients using ULHT’s orthopaedic services it is estimated that of the displaced patients:

- For Elective and Day Case patients:
    - 30% would be from the 3 most deprived deciles in Lincolnshire
    - 51% would be from the 5 most deprived deciles in Lincolnshire
- For Non Elective patients:
    - 13% would be from the 3 most deprived deciles in Lincolnshire
    - 41% would be from the 5 most deprived deciles in Lincolnshire

CONSULTATION AND INVOLVEMENT FINDINGS

Overview of public consultation findings

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 (**Error! Reference source not found.**).

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.

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

Equalities and health inequalities impacts of proposals for orthopaedic services in Lincolnshire

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.

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.

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.

Individuals' comments on equalities impacts of the orthopaedics proposal

Nearly a fifth of respondents foresaw access issues for particular groups of people, specifically: the elderly, people with disabilities, people from low income or deprived backgrounds, children, and other vulnerable groups (e.g., refugees or those experiencing homelessness).

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. In regard to potential impacts on vulnerable groups, one respondent requested assurance that there will be a review of the eligibility criteria for patient transport services to address any potential barriers to access, particularly

for the most deprived communities in rural and inner city areas, and that additional support and transport will be provided to address need.

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.

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.

It was said that any access and travel difficulties resulting from the proposals would impact certain groups more than others, especially in the absence of easily accessible patient transport. Elderly people, people on low incomes, people without cars, and people with disabilities were all mentioned in this context.

Suggested mitigations, alternative suggestions and additional considerations put forward by the public during the consultation

The Chartered Society of Physiotherapy (CSP), in their response to the consultation, raised concerns that lack of funding for weekend rehabilitation services is resulting in increasing patient length of stay, and sought confirmation that high quality care and best practice rehabilitation for orthopaedic discharged patients would be put in place under the proposed changes.

Measures which might mitigate against challenges that some service users might face around travelling to more distant or unfamiliar hospitals sites were suggested, such as increased provision of patient transport services, working with local authorities to explore improvements to public transport links and more follow-up appointments being provided in the community.

Beyond the view from some respondents that emergency orthopaedic surgery should be retained at Grantham and District Hospital, alongside a new Centre of Excellence, few suggestions of alternative approaches to delivery of planned orthopaedic services were forthcoming.

There were, however, additional points for consideration raised in feedback about the proposals:

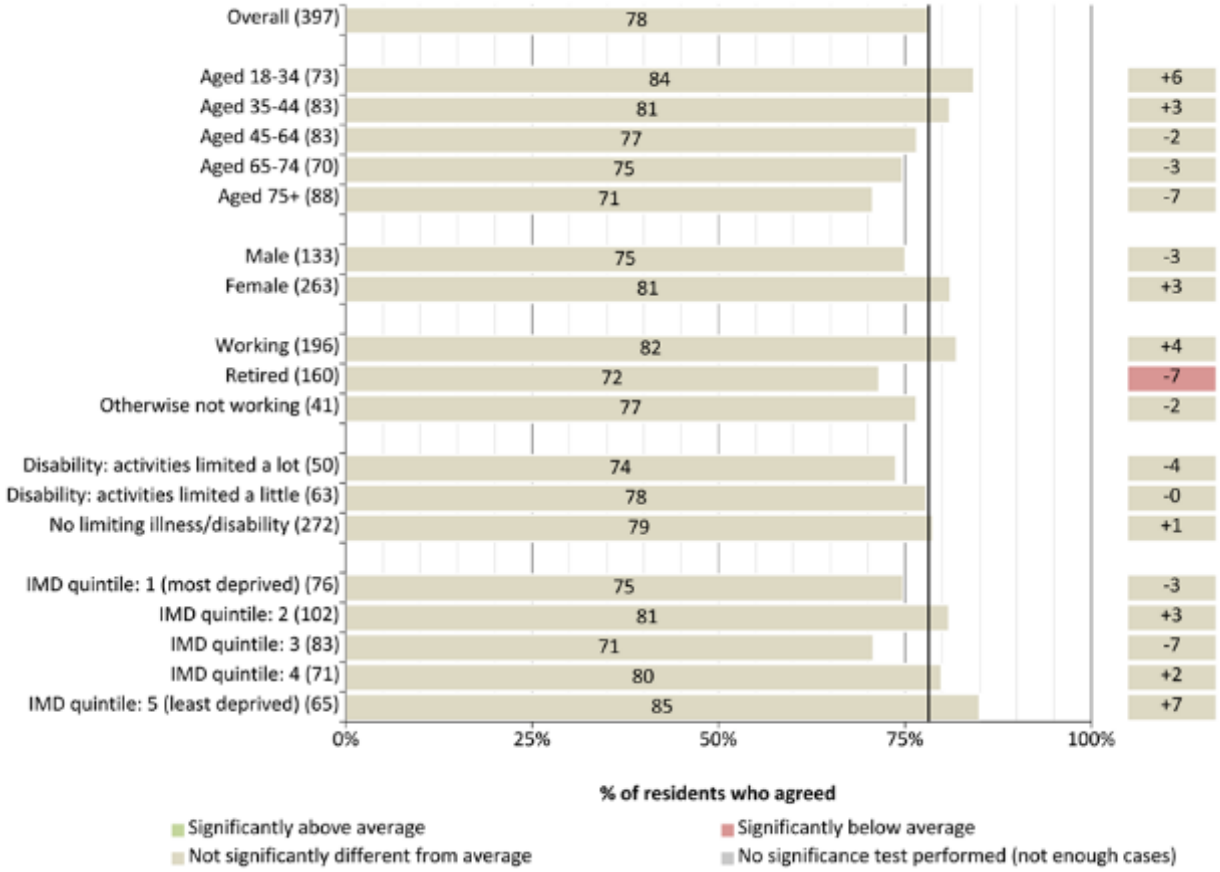
- Communication between care facilities, including hospital departments and GPs, needs to be addressed urgently to ensure the timely flow of information on patient care and treatment;
- The NHS Lincolnshire should work with and learn from private hospitals to improve patient care and assist with the crisis; and
- That Grantham and District Hospital is poor state of maintenance, and that it would be more cost effective in the long run to build a brand new centre for orthopaedic services.

Please note the purpose of this document is not to consider or provide a view on these mitigations, alternative options and additional considerations. All mitigations, alternative options and additional considerations have been themed and considered by the relevant clinical and professional working group.

Residents' views on the proposal for orthopaedic surgery in Lincolnshire by demographic sub-groups

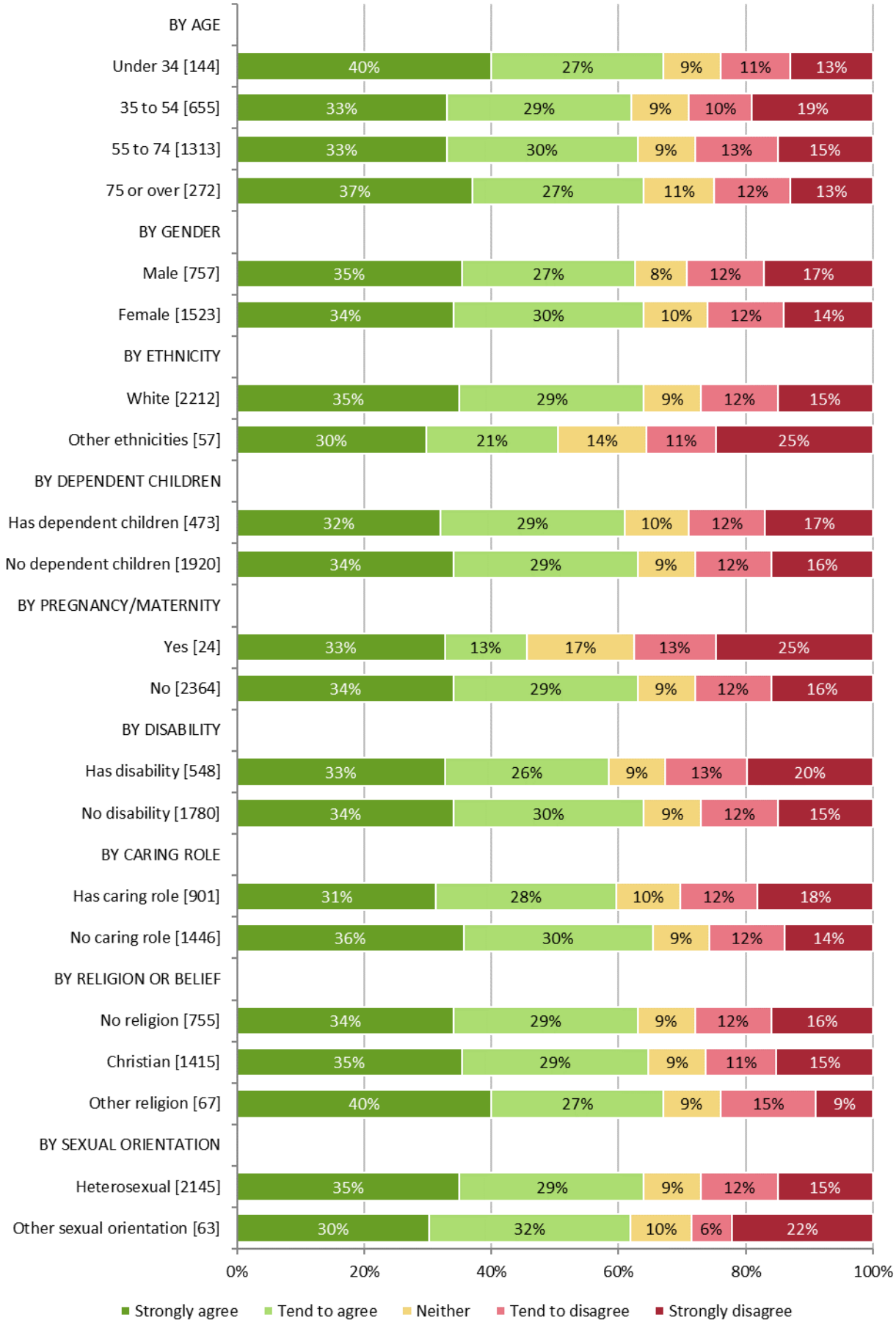
Against a background of strong support, retired residents were statistically significantly less likely (than the overall result) to agree with the proposal for orthopaedic services (Figure 13), although more than seven in ten (72%) agreed with the proposal.

Level of agreement with the proposal for orthopaedic surgery, BY POPULATION CHARACTERISTICS



Base: All Respondents (number of respondents shown in brackets)

Views on the proposal for orthopaedic surgery BY KEY DEMOGRAPHICS (individuals only)



Proposal development and clinical reviews

Proposed benefits

A pilot of the change proposal to i) Consolidate planned orthopaedic surgery in a 'centre for excellence' at Grantham and District Hospital and ii) Create a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery, has demonstrated:

- Reductions in the number of patients who have their planned orthopaedic surgery cancelled due to a lack of beds
- Care provided in line with national best practice and care standards
- A reduction in the amount of time patients wait for their planned orthopaedic surgery
- A reduction in the amount of time patients spend in hospital after their planned surgery
- An improvement in patient satisfaction and experience
- A reduction in the number of patients receiving their care in the private sector, funded by the NHS

Clinical reviews

Prior to commencing the public consultation 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.

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.

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.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*
As part of these considerations you should consider how the CCG will be meeting the requirements of the Public Sector Equality Duty • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low. **Before** completing this section you should ensure you can suitably answer the following: What is the equality profile of the population i.e. service users/patients and/or workforce that is intended to benefit from the activity/project? (By collecting and analysing demographic data of protected characteristics relating to patients/service users and/or workforce, within the geographical area concerned, the CCG will be able to identify the groups that may be adversely affected at a greater proportion to others).

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.1 Age *Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of age considerations, including: • Improved service quality • Reduced waiting times • More coordinated care Comments received about the possible negative impacts of this proposed change on the **older** population included: • Longer travel requirements which is impractical especially when some will not be able to drive for much longer • Negative impact on health • Their concerns of greater reliance on family and friends for increased travel needs	Retired residents were significantly less likely (than the overall result) to agree with the proposal for orthopaedic services. Several specific groups such as older people were mentioned as being particularly vulnerable to impacts as a result of longer/more expensive journeys to hospitals. Review of eligibility criteria for patient transport services to address any potential barriers to access – particularly for frail or older people who might find travel stressful/difficult. Based on the age and sex profile of patients using ULHT's orthopaedic services it is estimated that of the displaced patients:	For some patients there may be longer travel times and a greater reliance on family and friends for transport. However this is balanced against reduced waiting times, reduced cancelations, improved service quality, reduced lengths of stay in hospital and improved outcomes. (TR) Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS. (TR) Comments received from the consultation feedback indicated concerns about the impact on the ambulance service of the additional

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
• Reliance on public transport, which is perceived to be limited in accessibility • Impractical to travel the longer distance from some areas Possible negative impacts of this proposed change on the **younger** population included: • Negative impact on health • Reliance on hospital transport • Longer travel requirements which is impractical • Reliance on public transport, which is perceived to be limited in accessibility. 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. This figure does include a small proportion of patients being repatriated from providers out of the county. • 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.	• For Elective and Day Case patients:56% would be 65 or over • For Non Elective patients: 52% would be 65 or over	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 so that the impact of the proposed service changes on ambulance capacity is negligible. (TR) Non-emergency patient transport (NEPTS) is provided for patients who meet the nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for patients who are going to hospital for outpatient appointments, diagnostics or treatment or for admission, and for patients who are eligible for transport from hospital following outpatient or diagnostic appointments or daycase or inpatient care and treatment. (TR) It is therefore 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

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
• 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.		further away from their home and for the discharge from these hospitals. (TR) The current patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers and this is also a requirement in the new contract. (TR) Other Transport – includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors attending hospitals. 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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services. (TR) The CCG could commission bespoke service for patients, carers and visitors impacted by the proposals however key issue of 'fairness' and

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		‘equity’ for all patients, carers and visitors. It is not therefore seen to be a viable option. (TR) Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council ‘County Views’ exercise; key is to strengthen current arrangements. (TR) 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.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.2 Disability *Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of disability considerations. Potential positive impacts are the same as above in section '2.1 Age'	Several specific groups such as people with disabilities were mentioned as being particularly vulnerable to impact as a result of longer/more expensive journeys to hospitals. People with disabilities who are used to attending particular hospitals where additional support is available if needed, might find that the same support not available elsewhere 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.	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of disability considerations Potential impacts and mitigations are the same as above in section '2.1 Age', plus: • 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

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Possible negative impacts of this proposed change on the disabled (physically and mentally) population included: • Longer travel requirements which is impractical • Additional cost related to travel to services further away • Inability to drive especially if sight impaired and wheelchair user • Greater reliance on family and carers for increased travel needs • Negative impact on health and anxiety levels Activity impacts are the same as above in section '2.1 Age'		need from health and care services. The provision of additional support for deaf service users is the same at all of ULHT's hospitals
2.3 Gender reassignment (including transgender) *Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
None identified	None identified	N/A
2.4 Marriage and civil partnership *Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A
2.5 Pregnancy and maternity *Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.?*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.6 Race *Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	Some Travellers/Gypsys feel left behind with things working forward, being online and are unable to access this and some cannot read letters, they say it all seems so unpersonal Based on the ethnicity profile of patients using ULHT's orthopaedic services it is estimated that of the displaced patients: • For Elective and Day Case patients: • 91% would be White British • 2% would be Other White • 2% would be Other Ethnic Group • With the remainder not having their ethnicity recorded or Not Stated	To be considered as part of accessible services provision

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		

	• For Non Elective patients:
	  • 91% would be White British
	  • 3% would be Other White
	  • 0% would be Other Ethnic Group
	  • With the remainder not having their ethnicity recorded or Not Stated	

2.7 Religion or belief *Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A
2.8 Sex *Describe any impact and evidence in relation to men and women. This could include access to services and employment.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
None identified	Based on the age and sex profile of patients using ULHT's orthopaedic services it is estimated that of the displaced patients: • For Elective and Day Case patients: 58% would be female and 42% male • For Non Elective patients: 52% would be female and 48% male	N/A
2.9 Sexual orientation *Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A
2.10 Carers *Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities.* *(Not a legal requirement but a CCG priority and best practice)*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
	Additional analysis completed in light of responses received during consultation in 2021	
Carers of those in the 'Age', 'Disability' and 'Economically Disadvantaged' groups potentially have a 'knock-on' negative impact i.e. longer travel times and greater reliance on public transport. However, some positive impacts identified with services provided locally at Grantham Hospital.	Ability of carers being able to travel to Grantham to support vulnerable patient, specifically if an overnight stay is needed.	For some carers there may be longer travel times, but this is balanced against reduced waiting times and improved service quality and outcomes for patients. (TR) Other Transport – includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors attending hospitals. 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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services. (TR) The CCG could commission bespoke service for patients, carers and visitors impacted by the proposals

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is not therefore seen to be a viable option. (TR) Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements. (TR) 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.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.11 Other disadvantaged groups *Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.*		
Economically Disadvantaged		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of economically disadvantaged considerations. Potential positive impacts are the same as above in section '2.1 Age' No specific feedback was received in relation to this group during the pre consultation engagement in relation to the Orthopaedic change proposal	Several specific groups such as people on low incomes and those without access to private vehicles were mentioned as being particularly vulnerable to impacts as a result of longer/more expensive journeys to hospitals. Nearly a fifth of respondents foresaw access issues for particular groups of people, specifically: the elderly, people with disabilities, people from low income or deprived backgrounds, children, and other vulnerable groups (e.g., refugees or those experiencing homelessness).	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of economically disadvantaged considerations Potential impacts and mitigations are the same as above in section '2.1 Age'

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
	Review of eligibility criteria for patient transport services to address any potential barriers to access – particularly for most deprived communities in rural and inner city areas who might find travel stressful/difficult Challenge of ensuring equitable access in large, rural county, especially for localities where health service provision and public transport services were described already as being poor (e.g. East Coast)	

3. Human rights *The principles are Fairness, Respect, Equality, Dignity and Autonomy.*				
Will the proposal impact on human rights?	Yes	☒	No	☑
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☑
If so what actions are needed? *Please explain below.*				
N/A				

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

1. **What evidence have you considered to determine what health inequalities exist in relation to your work?**

   This can include local and national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them.

   (this may be different or similar to that which has informed the EIA)

Lincolnshire Research Observatory - Joint Strategic Needs Assessment (research-lincs.org.uk)
Wider determinants of health inequalities in Lincolnshire
Lincolnshire Joint Health & Wellbeing Strategy
Lincolnshire Research Observatory - Area Profiles (research-lincs.org.uk)
Health & Wellbeing in Lincolnshire 2019
Area Disease Prevalence Analysis

2. **What is the potential impact of your work on health inequalities?** Can you demonstrate through evidenced based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?

   If you feel that the project will not impact / be relevant to Health Inequalities please give a rationale.

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

In the public consultation feedback several specific groups including people on low incomes were mentioned as being particularly vulnerable to impacts as a result of longer or more expensive journeys to hospitals.

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

The challenge of ensuring equitable access in a large, rural county was also raised, especially for localities (e.g., on the east coast) where health service and public transport provision were described as already being poor.

It is 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. This figure does include a small proportion of patients being repatriated from providers out of the county.

Based on the ethnicity profile of patients using ULHT's orthopaedic services it is estimated that of the displaced patients:

- For Elective and Day Case patients:
    - 30% would be from the 3 most deprived deciles in Lincolnshire
    - 51% would be from the 5 most deprived deciles in Lincolnshire
- For Non Elective patients:
    - 13% would be from the 3 most deprived deciles in Lincolnshire
    - 41% would be from the 5 most deprived deciles in Lincolnshire

A pilot of the change proposal to i) Consolidate planned orthopaedic surgery in a 'centre for excellence' at Grantham and District Hospital and ii) Create a dedicated day case centre at County Hospital Louth for planned orthopaedic surgery, has demonstrated:

- Reductions in the number of patients who have their planned orthopaedic surgery cancelled due to a lack of beds
- Care provided in line with national best practice and care standards
- A reduction in the amount of time patients wait for their planned orthopaedic surgery
- A reduction in the amount of time patients spend in hospital after their planned surgery
- An improvement in patient satisfaction and experience

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

- A reduction in the number of patients receiving their care in the private sector, funded by the NHS

3. How can you make sure that your work has the best chance of reducing health inequalities?

The quality and long-term sustainability of services within ULHT is critical to Lincolnshire's community. To support ULHT to address the national challenges and improve services we need to change the way they are currently delivered. This programme is focused on improving this quality of care, and retention and recruitment of staff, rather than on financial savings. If we improve these four NHS services, we believe there will be:

- Shorter waiting times for planned orthopaedic procedures in Lincolnshire
- Fewer cancellations of planned orthopaedic procedures in Lincolnshire
- Better urgent and emergency care for patients across Lincolnshire
- Clinically optimum hospital stays for recovering stroke patients
- Better hospital care for recovering stroke patients
- More integrated community and hospital medical services
- Quicker access to specialist staff across these four NHS services
- Reduced risk that Lincolnshire would lose these services if they become unsustainable
- Increased ability for the NHS in Lincolnshire to attract new staff to work in the county
- Better retention of staff already in the county, as they would be working for more sustainable and progressive services

5. Engagement/consultation
What engagement is planned or has already been done to support this project?

It is expected that the CCG will have carried out a level of engagement with those affected whether formal or informal. This should be focussed to the groups most affected.

Engagement activity	**With whom?** *e.g. protected characteristic/group/community*	**Date**
Formal Consultation	Detailed in the Consultation Strategy & Plan	2021

5. Engagement/consultation
What engagement is planned or has already been done to support this project?

It is expected that the CCG will have carried out a level of engagement with those affected whether formal or informal. This should be focussed to the groups most affected.

Engagement activity	**With whom?** *e.g. protected characteristic/group/community*	**Date**
Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)		
• Lincolnshire NHS public consultation on proposed changes to four services feedback report Full draft 4.1 • EIA of the Consultation Strategy & Plan		

6. Mitigations and changes
If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.

Are these vital to the project continuing?

New service configuration proposals to be detailed in Decision Making Business Case.

7. Is further work required to complete this EIA?
Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)

Work needed	**Section**	**When**	**Date completed**
If change proposal is agreed there would be ongoing analysis and assessment of the impact on travel and transport for patients as a whole, as well as those with protected characteristics	*Ongoing engagement*	*If service change is agreed – from implementation*	*Can only be confirmed if change proposal is agreed*

8. Development of the Equality Impact Analysis *If the EIA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data*		
Version	**Change and Rationale**	**Version Date**
PCBC EIA	Equality Impact Assessments of orthopaedic services revised following consultation in 2021	February 2021

9. Final Sign off Completed EIA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. Service lines should maintain an up to date log of all EIAs.		
Version approved:	1.1	
	Name	**Date**
Signature of responsible officer	 Pete Burnett System Director of Strategy and Planning	21 April 2022
Which committee will be considering the findings and sign off the EIA?	Joint meeting of ICS Clinical Directorate CCG Clinical Policies Sub-Group (to make recommendations to QPEC) CCG Quality and Patient Experience Committee (to make recommendation to the CCG Board)	28th April 2022 12th May 2022
Minute number *(to be inserted following presentation to committee)*		

Arden&GEM

NHS
Arden and
Greater East Midlands
Commissioning Support Unit

Appendix 3

Equality Impact Analysis

Proposals for urgent and emergency care

Project Details

Project Name:	Proposals for urgent and emergency care
EA Author:	Anna Collins
Team:	Maktub Consulting Ltd
Date completed:	April 2022
Version:	1.1

What is the aim of the project/proposal?

Following a period of options development and appraisal that involved senior clinicians, key stakeholders and members of the public, proposals for changes to four NHS services were put forward for public consultation over a 12-week period from 30th September 2021 until 23rd December 2021:

Proposals for urgent and emergency care at Grantham and District Hospital

- Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

- Staff
- Patients
- Carers

Stage 1, Scoping point

Is a full Equality Impact Analysis required for this project?

You should consider whether a full EIA is required, referring to the relevant guidance for information and guidance on making this decision.

It is important this decision is made with an open mind and correctly, advice should be sought from the EIHR team if you are unsure.

Yes	☑	Proceed to the full Equality Impact Analysis form	**No**	☐	Explain why further analysis is not required.

If no, explain below why further Equality Impact Analysis is not required. E.g. 'This report is for information only' or 'The decision has not been made by the CCG' or 'The decision will not have any impact on patients or staff'. (Very few decisions affect all groups equally and this is not a rationale for not completing an EIA.)

Equality Impact Analysis Form

If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EIA. An Equality Impact Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

1. Evidence used

To demonstrate that the decision made has been informed you should include examples of the information used to determine the impact and complete the EIA.

Examples are likely to include:

- ***Population Data -*** *e.g. demographic profile (Census),*
- ***Service Activity Data e.****g. profile of patients using a service*
- ***Consultation and Involvement findings -*** *e.g. any engagement with service users, local community, specific groups.*
- ***Research -*** *e.g. good practice guidelines, service evaluations, literature reviews, reports*
- ***Participant knowledge -*** *e.g. experiences of working with different or population groups, experiences of service users in other service areas / localities*

- Lincolnshire NHS public consultation on proposed changes to four services feedback report Full draft 4.1
- Consultation feedback themes V0.9
- Equality Impact Assessments of urgent & emergency care February 2021
- Public documents relating to the four services and approach to consultation
- Pre Consultation Business Case

POPULATION DATA

Headline Demographics

Lincolnshire is the 4th largest county in England with an area of 5,921 sq. km.

It has 761,224 residents (2019) and 783,080 GP registered patients (2019) dispersed across city, market towns, rural and coastal areas.

Lincolnshire is predominately rural, being the 4th most sparsely populated county, with no motorways, little dual carriageway and 80km of North Sea coastline, which provides fundamental difficulties in service provision.

The population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to almost double over the next 25 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.

The combination of an ageing population, a rural geography and areas of high socioeconomic deprivation defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire.

Age	In relation to age the statistics show that, out of the total population of 751,171, the age range 0-15 makes up 17.1% of the population, whilst the other sections of the population aged 16-24, 25-64, 65 -84 and 85 years and over make up 10.1%, 49.6% 20.3%, and 2.9% respectively. Lincolnshire's population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is estimated to double over the next 20 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
Disability	The 2011 Census shows that 27.1% of households in Lincolnshire have one person or more with a long-term disability. With regard to learning disabilities, statistics show that over 15,000 people have learning disability in Lincolnshire.
Ethnicity	The diversity of the population has increased in recent years as a result of new and emerging communities. As of the 2011 Census, around 93% of residents identify themselves as White British with a significant 4% identifying as White Other. This 4% is primarily made of Eastern European communities, which represents much in the agricultural, hospitality and tourist industries. Recent issues relating to Brexit have influenced the migration of EU foreign nationals back to their countries of birth. This in the future will no doubt have impact on the statistics of the white European population and detrimental impact on the Lincolnshire's agricultural industries. The non-white population makes up 2.4% of the total population in 2011 compared to 1.4% in 2001 and although slight increases are becoming apparent since 2011, the proportions are still very small in comparison to the national non-white population of 14%.
Gender*	According to the 2011 census, statistics for Lincolnshire's show the population as 713,653 (2017 estimates 751,200). In total there are more females 366,498 (51.3%) than males 348,270 (48.7%), with slight variations amongst different age groups. The estimated difference in 2017 slightly narrows that gap between male and female population at 385,800 (51%) female and 370,000 (49%) male.
Religion & belief	In relation to Religion/belief, Christians make up the largest group 68.50%, followed by those who do not have religion at 23.10%. Other smaller religious groups include Muslim 0.40%, followed by Hindu's and Buddhist at 0.20% the smallest religious groups include the Jewish and Sikh both at 0.10%
Sexual Orientation & *transgender	There is no accurate data on the numbers of men and women who are lesbian, gay, bisexual or transgender (LGBT) in Lincolnshire, reflecting a national problem with accurate statistical analysis. Both Stonewall and HM Treasury concur that between 5 – 7% of the population of the UK are lesbian, gay, bisexual or transgender, but acknowledge the difficulty in accurate analysis. In Lincolnshire this represents over 50,000 people.

Health Inequalities

In Lincolnshire, health inequalities exist between levels of income deprivation and gender.

Between the most and least income deprived deciles, the gap in male life expectancy is 6.5 years, and for healthy life expectancy is 11.8 years.

For women, the gap in life expectancy is smaller at 4.8 years and for healthy life expectancy is 10.8 years.

Life expectancy, premature cancer mortality, mental health-related, smoking related, alcohol-specific and drug-related hospital admissions all show a moderate association with BAME.

Both life expectancy and healthy life expectancy are strongly associated with income deprivation.

Moderate levels of variation in mental health related, alcohol-specific and drug-related hospital admissions can be explained by income deprivation in older people.

In the most income deprived decile of Lincolnshire, life expectancy is 5.1 years less and healthy life expectancy is 11.2 years less compared to the least income deprived decile.

Preventable mortality rates in the most income deprived decile are 1.7 times higher than in the least deprived decile

The greatest causes of ill health and mortality are cardiovascular disease, cancers, musculoskeletal conditions and mental ill-health. Musculoskeletal conditions and mental ill-health are the biggest contributors to the number of Years Lived with Disability in Lincolnshire's population.

SERVICE ACTIVITY DATA

Overview of activity impact

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.

It is estimated that with the refinement of the exclusions criteria, once fully implemented the preferred option to establish an UTC at Grantham Hospital will displace c.600 patients per year who are currently seen at Grantham Hospital A&E (based on 2019/20 activity; 694 based on 2023/24 forecast). This is equivalent to c.2.5-3.0% 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 proposal it is estimated that the number of additional patients travelling over 45 minutes for non-elective care, the travel time threshold set by the local health system for activity of this type, is c. 375 (based on 2019/20 activity, c.435 forecast to 2023/24). This is based on the assumption they travel to their nearest appropriate hospital by car and against a baseline of c.21,500 patients across Lincolnshire who currently travel more than 45 minutes to attend urgent and emergency care services by car, given their geographical proximity to services.

However, in reality given the existing exclusion criteria and the acuity of patients who would no longer be seen at Grantham Hospital many are likely to travel by

ambulance to an alternative site and therefore their travel time could be less than 45 minutes. 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.

Where data has been available, additional analysis has been completed in light of responses received during the public consultation on the proposed service change to better understand the impact.

Age and sex profile of patients impacted

Based on the age and sex profile of patients currently using the A&E service at Grantham and District Hospital it is estimated that of the displaced patients:

- 52% would be female and 48% male
- 26% would be 65 or over (note this is likely to be an under estimation given the focus of the exclusion criteria refinement)

Ethnicity profile of patients impacted

Based on the ethnicity profile of patients currently using the A&E service at Grantham and District Hospital it is estimated that of the displaced patients:

- 86% would be White British
- 6% would be Other White
- 3% would be Other Ethnic Groups
- With the remainder not having their ethnicity recorded or Not Stated

Deprivation profile of patients impacted

Based on the deprivation profile of patients currently using the A&E service at Grantham and District Hospital it is estimated that of the displaced patients:

- 18% would be from the 3 most deprived deciles in Lincolnshire
- 41% would be from the 5 most deprived deciles in Lincolnshire

CONSULTATION AND INVOLVEMENT FINDINGS

Overview of public consultation findings

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.

Support for the proposal for urgent and emergency care among the Lincolnshire population (identified through a residents telephone survey) 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.

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.

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

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.

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.

Equalities and health inequalities impacts of proposals for urgent and emergency care in Grantham

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.

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.

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 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 was again focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.

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.

Travel and accessibility were concerns for multiple organisations, even some who agreed with the proposals. For example, the Older People's Forum acknowledged the benefits of the proposed changes, while noting potential difficulties for those without their own transport. Moreover, access to public transport was again a concern for local councils.

Suggested mitigations, alternative suggestions and additional considerations put forward by the public during the consultation

In light of the concerns about travel and access, the main mitigation measure suggested was that more patient transport options be offered between hospital sites, and to help patients to return home following discharge if they were transferred from the UTC to an A&E at a different hospital.

In feedback, it was also seen as vital that a UTC at Grantham and District Hospital should always operate as a walk-in service, rather than requiring people to contact NHS 111 first, to ensure that people make use of the service and do not travel elsewhere unnecessarily.

By far the most common alternative that was proposed was for the current part-time, limited A&E department at Grantham and District Hospital to be replaced by (or 'restored to') a full Type 1 Accident and Emergency Department.

There were several other alternative suggestions forthcoming, including:

If the proposals for a 24/7 UTC goes ahead, ULHT should provide their own emergency and non-emergency transfer service to local A&E departments, so that East Midlands Ambulance Services are not affected;

A&E services should continue to be offered at Grantham and District Hospital during the day, with a UTC in operation only overnight;

That additional Nurse ACPs[1] be trained to compensate for the shortage of consultants; and

A similar urgent treatment service be provided at Stamford to cover areas south of Grantham.

Finally, there was also a suggestion for a more radical approach - that a new specialist hospital be built near Sleaford to deal with all emergency care, leaving other hospitals in Lincolnshire to deal with routine and planned care.

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.

Please note the purpose of this document is not to consider or provide a view on these mitigations, alternative options and additional considerations. All mitigations, alternative options and additional considerations have been themed and considered by the relevant clinical and professional working group.

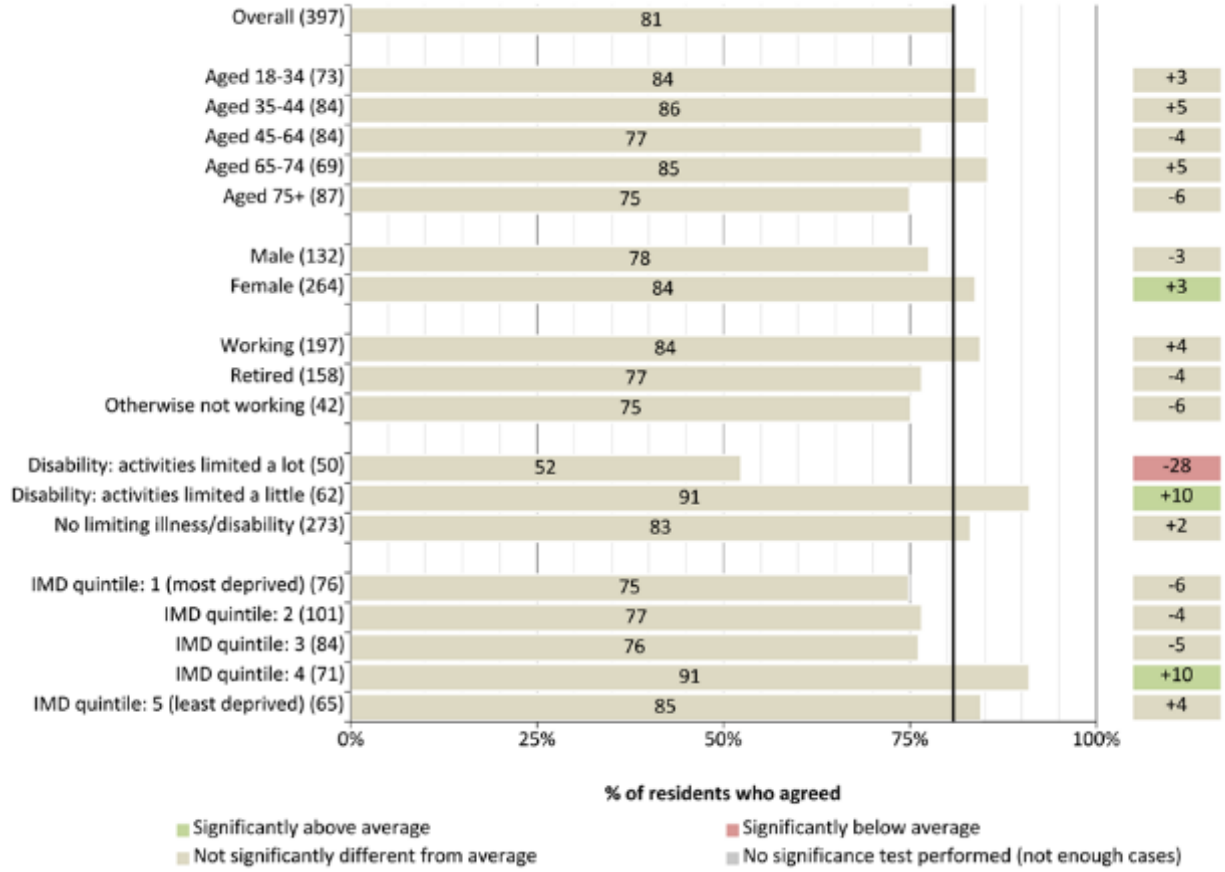
Residents' views on the proposal for urgent and emergency care at Grantham and District Hospital by demographic sub-groups

In relation to the proposal for urgent and emergency care residents with a substantially limiting disability or illness were significantly less likely than other residents to agree (52% compared to 81% overall) and were also more likely to disagree (34% compared to 12% overall).

There were also some statistically significant differences in terms of gender and deprivation. Feedback comments indicated that concern about the proposal was focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.

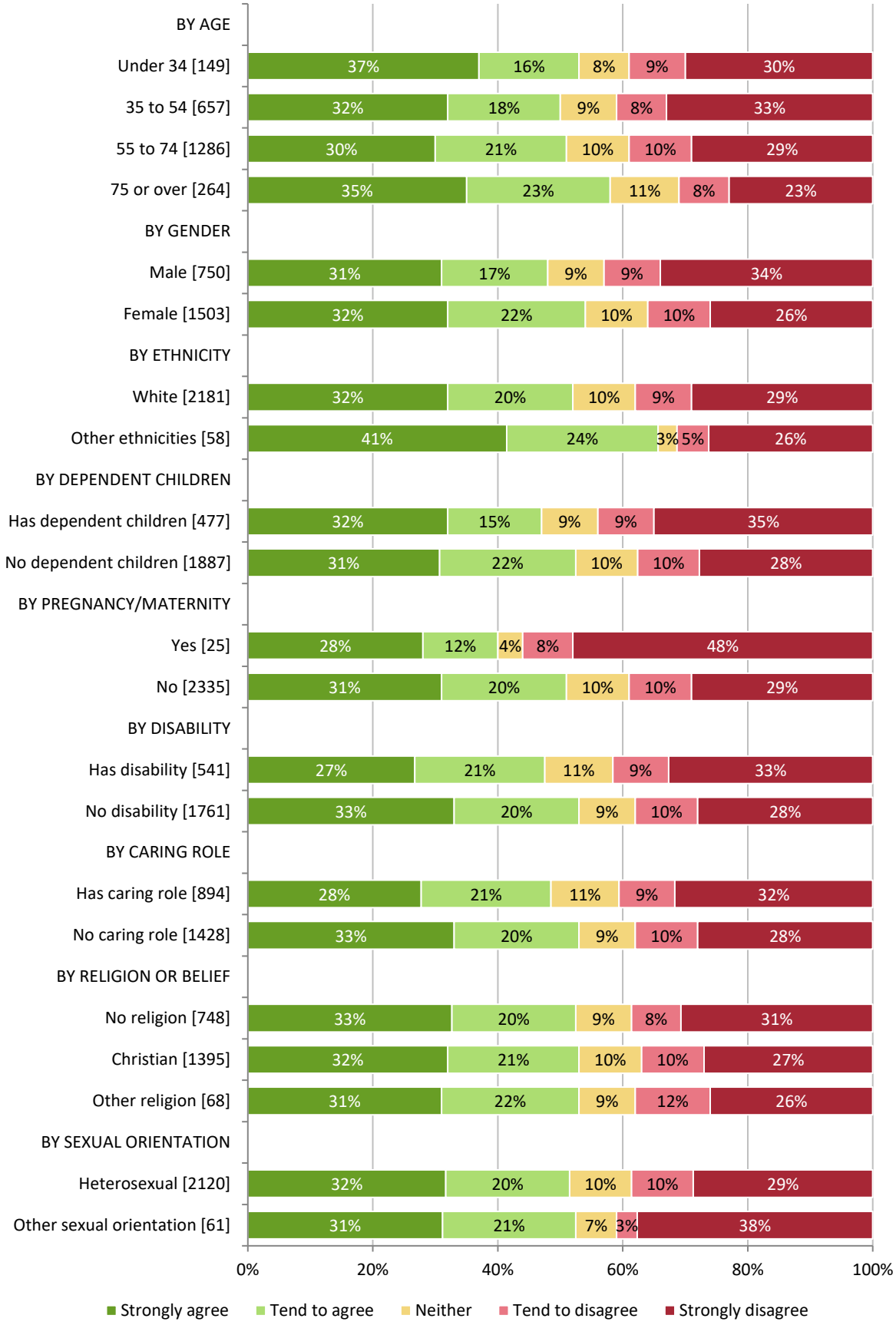
[1] Advanced Clinical Practitioners

Level of agreement with the proposal for urgent and emergency care at Grantham Hospital, BY POPULATION CHARACTERISTICS



Base: All Respondents (number of respondents shown in brackets)

Views on the proposal for urgent and emergency care BY KEY DEMOGRAPHICS (individuals only)



Proposal development and clinical reviews

Proposed benefits

Through the clinically led development of the proposal for a 24/7 Urgent Treatment Centre at Grantham and District Hospital a number of benefits were identified:

- 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)
- 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.
- 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.

Clinical reviews

Prior to commencing the public consultation 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.

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 Hospital and Pilgrim Hospital, 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 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 Hospital.
    - Concluded that in the interests of safety the A&E service at Grantham 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 supporting the reopening of the 24/7 A&E department at Grantham 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 GDH 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 GDH in any further model.

The presentation of the preferred option for urgent and emergency care services to the East Midlands Clinical Senate was led by local lead clinicians.

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’.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*
As part of these considerations you should consider how the CCG will be meeting the requirements of the Public Sector Equality Duty • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low. **Before** completing this section you should ensure you can suitably answer the following: What is the equality profile of the population i.e. service users/patients and/or workforce that is intended to benefit from the activity/project? (By collecting and analysing demographic data of protected characteristics relating to patients/service users and/or workforce, within the geographical area concerned, the CCG will be able to identify the groups that may be adversely affected at a greater proportion to others).

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.1 Age *Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of age considerations, including: • The vast majority of patients currently seen at the Grantham A&E will continue to be seen at the Grantham UTC • Patients will benefit from the creation of an integrated acute, community, primary care and wider social care/voluntary sector staff and multi-disciplinary team model. • Only a small number of patients will be seen at an alternative site and the basis for this is to ensure people get to the right hospital with the right facilities first time to ensure the best outcomes • A reduction in the number of intra hospital transfers.	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. Based on the age profile of patients currently using the A&E service at Grantham and District Hospital it is estimated that of the displaced patients (c.600) 26% would be 65 or over (this is likely to be an underestimate given the proposed refinement to the exclusion criteria)	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of age considerations 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) The proposal for change would deliver a more comprehensive local service provision at Grantham hospital,

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Possible negative impacts of this proposed change on the older population included: • Longer travel requirements • Their concerns of greater reliance on family and friends for increased travel needs • Negative impact on health • Reliance on public transport, which is perceived to be limited in accessibility Possible negative impacts of this proposed change on the younger population included: • Negative impact on health • Longer travel requirements which is impractical • Their concerns of greater reliance on family and friends for travel needs • Reliance on public transport, which is perceived to be limited in accessibility 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		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. (TR) Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS. (TR) Comments received from the consultation feedback indicated concerns about the impact on the ambulance service of the additional journey times associated with the

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
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 Hospital many are likely to travel by ambulance to an alternative site and therefore travel time could be less than 45 min.		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 so that the impact of the proposed service changes on ambulance capacity is negligible. If a patient goes to the proposed UTC and needs to be moved to an alternative hospital site travel arrangements will be made to transfer the patient, meaning no increased demand upon family and friends. (TR) Non-emergency patient transport (NEPTS) is provided for patients who meet the nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for patients who are going to hospital for outpatient appointments, diagnostics or treatment or for admission, and for patients who are eligible for transport from hospital following outpatient or diagnostic appointments or daycase or inpatient care and treatment. (TR) It is therefore fully expected that non-emergency patient transport

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		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. (TR) The current patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers and this is also a requirement in the new contract. (TR) Other Transport – includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors attending hospitals. 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. Considerations include the shape and scope of any additional services commissioned by the CCG to

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		supplement existing public and community transport services. (TR) The CCG could commission bespoke service for patients, carers and visitors impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is not therefore seen to be a viable option. (TR) Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements. (TR) The transport impact overall as well on those groups with protected characteristics would continue to be monitored during the implementation

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		and 'go live' period of any agreed change.
2.2 Disability *Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of disability considerations. Potential positive impacts are the same as above in section '2.1 Age'	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 relation to the proposal for urgent and emergency care residents with a substantially limiting disability or illness were significantly less likely than other residents to agree (52% cf. 81% overall) and were also more likely to disagree (34% cf.12% overall).	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of disability considerations Potential impacts and mitigations are the same as above in section '2.1 Age', plus: • 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

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Possible negative impacts of this proposed change on the disabled (physically and mentally) population include: • Longer travel requirements • Additional cost related to travel to services further away • Inability to drive and limited public transport • Greater reliance on family and carers for increased travel needs • Negative impact on health and stress levels Activity impacts are the same as above in section '2.1 Age'		and understand, and any communication support they need from health and care services.
2.3 Gender reassignment (including transgender) *Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.4 Marriage and civil partnership *Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.5 Pregnancy and maternity *Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.?*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.6 Race *Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and	Considerations of potential impact

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
	Additional analysis completed in light of responses received during consultation in 2021	(TR) = mitigation is reflected in the DMBC Travel Report
None identified	Some Travellers/Gypsys feel left behind with things working forward, being online and are unable to access this and some cannot read letters, they say it all seems so unpersonal Based on the ethnicity profile of patients currently using the A&E service at Grantham and District Hospital it is estimated that of the displaced patients: • 86% would be White British • 6% would be Other White • 3% would be Other Ethnic Groups • With the remainder not having their ethnicity recorded or Not Stated	To be considered as part of accessible services provision

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.7 Religion or belief *Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.8 Sex *Describe any impact and evidence in relation to men and women. This could include access to services and employment.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation is reflected in the DMBC Travel Report
None identified	There were also some statistically significant differences in terms of gender. Feedback indicated that concern about the proposal was focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of sex considerations Potential impacts and mitigations are the same as above in section '2.1 Age'

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
	Based on the gender profile of patients currently using the A&E service at Grantham and District Hospital it is estimated that of the displaced patients (c.600) 52% would be female and 48% male.	
2.9 Sexual orientation *Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.10 Carers *Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities.* *(Not a legal requirement but a CCG priority and best practice)*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation is reflected in the DMBC Travel Report

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Carers of those in the 'Age', 'Disability' and 'Economically Disadvantaged' groups potentially have a 'knock-on' negative impact i.e. longer travel times and greater reliance on public transport. However, some positive impacts identified with services provided locally at Grantham Hospital.	The consultation feedback included a number of comments and concerns related to patients and visitors being able to get to and from hospital services that may be further away from their current hospital and which therefore take longer to travel to.	(TR) Other Transport – includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors attending hospitals. 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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services. (TR) The CCG could commission bespoke service for patients, carers and visitors impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is not therefore seen to be a viable option. (TR) Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements. (TR) 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.
2.11 Other disadvantaged groups *Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.*		
Economically Disadvantaged		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation is reflected in the DMBC Travel Report

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of economically disadvantaged considerations. Potential positive impacts are the same as above in section '2.1 Age' Possible negative impacts of this proposed change on the disabled (physically and mentally) population include: • Longer travel requirements • Negative impact on health and stress levels Activity impacts are the same as above in section '2.1 Age'	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. Based on the deprivation profile of patients currently using the A&E service at Grantham and District Hospital it is estimated that of the displaced patients: • 18% would be from the 3 most deprived deciles in Lincolnshire • 41% would be from the 5 most deprived deciles in Lincolnshire	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of economically disadvantaged considerations Potential impacts and mitigations are the same as above in section '2.1 Age'

3. Human rights *The principles are Fairness, Respect, Equality, Dignity and Autonomy.*				
Will the proposal impact on human rights?	Yes	■	No	☑
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☑
If so what actions are needed? *Please explain below.*				
N/A				

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

1. What evidence have you considered to determine what health inequalities exist in relation to your work?

This can include local and national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them.

(this may be different or similar to that which has informed the EIA)

Lincolnshire Research Observatory - Joint Strategic Needs Assessment (research-lincs.org.uk)
Wider determinants of health inequalities in Lincolnshire
Lincolnshire Joint Health & Wellbeing Strategy
Lincolnshire Research Observatory - Area Profiles (research-lincs.org.uk)
Health & Wellbeing in Lincolnshire 2019
Area Disease Prevalence Analysis

2. What is the potential impact of your work on health inequalities?

Can you demonstrate through evidenced based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?

If you feel that the project will not impact / be relevant to Health Inequalities please give a rationale.

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

There were some statistically significant differences in terms of responses from areas of deprivation. Feedback indicated that concern about the proposal was focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.

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.

It is estimated that with the refinement of the exclusions criteria, once fully implemented the preferred option to establish an UTC at Grantham Hospital will displace c.600 patients per year who are currently seen at Grantham Hospital A&E (based on 2019/20 activity; 694 based on 2023/24 forecast). This is equivalent to c.2.5-3.0% 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.

Given the serious nature of the conditions these patients are expected to have, most are 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.

Based on the deprivation profile of patients currently using the A&E service at Grantham and District Hospital it is estimated that of the displaced patients:

- 18% would be from the 3 most deprived deciles in Lincolnshire
- 41% would be from the 5 most deprived deciles in Lincolnshire

Through the clinically led development of the proposal for a 24/7 Urgent Treatment Centre at Grantham and District Hospital a number of benefits were identified:

- 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)
- 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

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

and primary care staff (eg. 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.
- 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.

3. How can you make sure that your work has the best chance of reducing health inequalities?

The quality and long-term sustainability of services within ULHT is critical to Lincolnshire's community. To support ULHT to address the national challenges and improve services we need to change the way they are currently delivered. This programme is focused on improving this quality of care, and retention and recruitment of staff, rather than on financial savings. If we improve these four NHS services, we believe there will be:

- Shorter waiting times for planned orthopaedic procedures in Lincolnshire
- Fewer cancellations of planned orthopaedic procedures in Lincolnshire
- Better urgent and emergency care for patients across Lincolnshire
- Clinically optimum hospital stays for recovering stroke patients
- Better hospital care for recovering stroke patients
- More integrated community and hospital medical services
- Quicker access to specialist staff across these four NHS services
- Reduced risk that Lincolnshire would lose these services if they become unsustainable
- Increased ability for the NHS in Lincolnshire to attract new staff to work in the county
- Better retention of staff already in the county, as they would be working for more sustainable and progressive services

5. Engagement/consultation
What engagement is planned or has already been done to support this project?

It is expected that the CCG will have carried out a level of engagement with those affected whether formal or informal. This should be focussed to the groups most affected.

Engagement activity	**With whom?** *e.g. protected characteristic/group/community*	**Date**
Formal Consultation	Detailed in the Consultation Strategy & Plan	2021

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)

- Lincolnshire NHS public consultation on proposed changes to four services feedback report Full draft 4.1
- EIA of the Consultation Strategy & Plan

6. Mitigations and changes
If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.

Are these vital to the project continuing?

New service configuration proposals to be detailed in Decision Making Business Case.

7. Is further work required to complete this EIA?
Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)

Work needed	**Section**	**When**	**Date completed**
If change proposal is agreed there would be ongoing analysis and assessment of the impact on travel and transport for patients across all patients as a whole, as well as those with protected characteristics	*Ongoing engagement*	*If service change is agreed – from implementation*	*Can only be confirmed if change proposal is agreed*

8. Development of the Equality Impact Analysis *If the EIA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data*		
Version	**Change and Rationale**	**Version Date**
PCBC EIA	Equality Impact Assessments of urgent and emergency care have been revised following consultation in 2021	February 2021

9. Final Sign off Completed EIA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. Service lines should maintain an up to date log of all EIAs.		
Version approved:	1.1	
	Name	**Date**
Signature of responsible officer	 Pete Burnett System Director of Strategy and Planning	14th April 2022
Which committee will be considering the findings and sign off the EIA?	Joint meeting of ICS Clinical Directorate CCG Clinical Policies Sub-Group (to make recommendations to QPEC) CCG Quality and Patient Experience Committee (to make recommendation to the CCG Board)	21st April 2022 12th May 2022
Minute number *(to be inserted following presentation to committee)*		

Appendix 4

Equality Impact Analysis

Proposals for acute medical beds

Project Details

Project Name:	Proposals for acute medical beds at Grantham and District Hospital
EA Author:	Anna Collins
Team:	Maktub Consulting Ltd
Date completed:	April 2022
Version:	1.1

What is the aim of the project/proposal?

Following a period of options development and appraisal that involved senior clinicians, key stakeholders and members of the public, proposals for changes to four NHS services were put forward for public consultation over a 12-week period from 30th September 2021 until 23rd December 2021:

Proposals for acute medical beds at Grantham and District Hospital

- Integrated community/acute medical beds at Grantham and District Hospital.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

- Staff
- Patients
- Carers

Stage 1, Scoping point

Is a full Equality Impact Analysis required for this project?

You should consider whether a full EIA is required, referring to the relevant guidance for information and guidance on making this decision.

It is important this decision is made with an open mind and correctly, advice should be sought from the EIHR team if you are unsure.

Yes	☑	Proceed to the full Equality Impact Analysis form	**No**	☐	Explain why further analysis is not required.

If no, explain below why further Equality Impact Analysis is not required. E.g. 'This report is for information only' or 'The decision has not been made by the CCG' or 'The decision will not have any impact on patients or staff'. (Very few decisions affect all groups equally and this is not a rationale for not completing an EIA.)

Equality Impact Analysis Form

If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EIA. An Equality Impact Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

1. Evidence used

To demonstrate that the decision made has been informed you should include examples of the information used to determine the impact and complete the EIA.

Examples are likely to include:

- ***Population Data -*** *e.g. demographic profile (Census),*
- ***Service Activity Data e.****g. profile of patients using a service*
- ***Consultation and Involvement findings -*** *e.g. any engagement with service users, local community, specific groups.*
- ***Research -*** *e.g. good practice guidelines, service evaluations, literature reviews, reports*
- ***Participant knowledge -*** *e.g. experiences of working with different or population groups, experiences of service users in other service areas / localities*

- Lincolnshire NHS public consultation on proposed changes to four services feedback report Full draft 4.1
- Consultation feedback themes V0.9
- Equality Impact Assessments of acute medical beds February 2021
- Public documents relating to the four services and approach to consultation
- Pre-Consultation Business Case

POPULATION DATA

Headline Demographics

Lincolnshire is the 4th largest county in England with an area of 5,921 sq. km.

It has 761,224 residents (2019) and 783,080 GP registered patients (2019) dispersed across city, market towns, rural and coastal areas.

Lincolnshire is predominately rural, being the 4th most sparsely populated county, with no motorways, little dual carriageway and 80km of North Sea coastline, which provides fundamental difficulties in service provision.

The population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to almost double over the next 25 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.

The combination of an ageing population, a rural geography and areas of high socioeconomic deprivation defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire.

Age	In relation to age the statistics show that, out of the total population of 751,171, the age range 0-15 makes up 17.1% of the population, whilst the other sections of the population aged 16-24, 25-64, 65 -84 and 85 years and over make up 10.1%, 49.6% 20.3%, and 2.9% respectively. Lincolnshire's population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is estimated to double over the next 20 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
Disability	The 2011 Census shows that 27.1% of households in Lincolnshire have one person or more with a long-term disability. With regard to learning disabilities, statistics show that over 15,000 people have learning disability in Lincolnshire.
Ethnicity	The diversity of the population has increased in recent years as a result of new and emerging communities. As of the 2011 Census, around 93% of residents identify themselves as White British with a significant 4% identifying as White Other. This 4% is primarily made of Eastern European communities, which represents much in the agricultural, hospitality and tourist industries. Recent issues relating to Brexit have influenced the migration of EU foreign nationals back to their countries of birth. This in the future will no doubt have impact on the statistics of the white European population and detrimental impact on the Lincolnshire's agricultural industries. The non-white population makes up 2.4% of the total population in 2011 compared to 1.4% in 2001 and although slight increases are becoming apparent since 2011, the proportions are still very small in comparison to the national non-white population of 14%.
Gender*	According to the 2011 census, statistics for Lincolnshire's show the population as 713,653 (2017 estimates 751,200). In total there are more females 366,498 (51.3%) than males 348,270 (48.7%), with slight variations amongst different age groups. The estimated difference in 2017 slightly narrows that gap between male and female population at 385,800 (51%) female and 370,000 (49%) male.
Religion & belief	In relation to Religion/belief, Christians make up the largest group 68.50%, followed by those who do not have religion at 23.10%. Other smaller religious groups include Muslim 0.40%, followed by Hindu's and Buddhist at 0.20% the smallest religious groups include the Jewish and Sikh both at 0.10%
Sexual Orientation & *transgender	There is no accurate data on the numbers of men and women who are lesbian, gay, bisexual or transgender (LGBT) in Lincolnshire, reflecting a national problem with accurate statistical analysis. Both Stonewall and HM Treasury concur that between 5 – 7% of the population of the UK are lesbian, gay, bisexual or transgender, but acknowledge the difficulty in accurate analysis. In Lincolnshire this represents over 50,000 people.

Health Inequalities

In Lincolnshire, health inequalities exist between levels of income deprivation and gender.

Between the most and least income deprived deciles, the gap in male life expectancy is 6.5 years, and for healthy life expectancy is 11.8 years.

For women, the gap in life expectancy is smaller at 4.8 years and for healthy life expectancy is 10.8 years.

Life expectancy, premature cancer mortality, mental health-related, smoking related, alcohol-specific and drug-related hospital admissions all show a moderate association with BAME.

Both life expectancy and healthy life expectancy are strongly associated with income deprivation.

Moderate levels of variation in mental health related, alcohol-specific and drug-related hospital admissions can be explained by income deprivation in older people.

In the most income deprived decile of Lincolnshire, life expectancy is 5.1 years less and healthy life expectancy is 11.2 years less compared to the least income deprived decile.

Preventable mortality rates in the most income deprived decile are 1.7 times higher than in the least deprived decile.

The greatest causes of ill health and mortality are cardiovascular disease, cancers, musculoskeletal conditions and mental ill-health. Musculoskeletal conditions and mental ill-health are the biggest contributors to the number of Years Lived with Disability in Lincolnshire's population.

SERVICE ACTIVITY DATA

Overview of activity impact

Under the proposed model to establish an integrated community/acute inpatient model for acute medicine at Grantham Hospital is fully implemented, c.385 patients per year (c.10% of current non-elective inpatient admissions) currently seen at Grantham Hospital would be displaced (based on 2019/20 activity; 396 based on 2023/24 forecast).

This is equivalent to around 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. It is envisaged the number of medical beds at Grantham and District Hospital in this new model will not be reduced.

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

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

Where data has been available, additional analysis has been completed in light of responses received during the public consultation on the proposed service change to better understand the impact.

Age and sex profile of patients impacted

Based on the age and sex profile of patients currently using acute medical services at Grantham and District Hospital it is estimated that of the displaced patients:

- 54% would be female and 46% male
- 59% would be 65 or over

Ethnicity profile of patients impacted

Based on the ethnicity profile of patients currently using acute medical services at Grantham and District Hospital it is estimated that of the displaced patients:

- 59% would be White British
- 11% would be Other White
- 10% would be Other Ethnic Groups
- With the remainder not having their ethnicity recorded or Not Stated

Deprivation profile of patients impacted

Based on the deprivation profile of patients currently using acute medical services at Grantham and District Hospital it is estimated that of the displaced patients:

- 22% would be from the 3 most deprived deciles in Lincolnshire
- 43% would be from the 5 most deprived deciles in Lincolnshire

CONSULTATION AND INVOLVEMENT FINDINGS

Overview of public consultation findings

There was majority support for the proposals to provide integrated community/acute medical beds across all stakeholder and consultation strands.

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.

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 two fifths and a quarter of respondents neither agreed nor disagreed with these proposals.

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

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.

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.

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.

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.

Equalities and health inequalities impacts of the proposal for community/acute medical beds at Grantham and District Hospital

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.

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.

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.

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.

Suggested mitigations, alternative suggestions and additional considerations put forward by the public during the consultation

In terms of mitigating against potential challenges, difficult access to primary care was said to result in minor illnesses not being treated, leading in some cases to increased severity and hospitalisation. As such, it was suggested that the NHS could reduce demand for hospital beds by ensuring that residents can more easily organise appointments with their GP.

A significant recruitment drive was also thought to be needed to achieve the requisite numbers of clinicians, care-workers and therapists – and related to this, research

and development linked to universities was suggested, as was attracting graduates by asking them what they want and need.

Some alternative suggestions or enhancements to the proposal were suggested as follows:

- If acute and community beds are available at Grantham, blood tests should be too;
- Establish acute and rehabilitation pathways:
- An acute pathway (for acutely/medically unstable patients) consisting of an Emergency Assessment Unit (EAU) and one more medical ward to allow patient flow with multi-disciplinary team (MDT) discharge facilitation;
- A rehabilitation pathway including step down from acute beds and step up from community beds, to incorporate a rehabilitation ward with stroke and general rehabilitation beds for patients with any other conditions, including frail elderly and post-Covid patients. Establishing this at Grantham and District Hospital would allow service provision for patients closer to their home and access for visitors;
- Provide 'halfway house' care wards for those who are medically well but unable to cope with going home, offering convalescence and low dependency beds, and the potential for occupational therapy;
- Acute medical beds should not be provided at Grantham, given the limited support and other services there. Grantham should be an elective surgery and community hospital, providing high quality care outside an acute setting; and
- Hospital and ongoing social care should be staffed by fully integrated MDTs to facilitate seamless transfer of patients from hospital into the community. This would involve integrated social services and hospital financial structures to end delayed discharge.

One NHS staff member raised specific concerns about lack of provision of Level 2 Respiratory beds at Grantham and District Hospital and suggested that respiratory ACPs could manage respiratory beds with support from anaesthetists and additional funding for recruitment and training.

It was also suggested that:

- mental health beds should be treated as a priority in future planning; and
- patients with chronic health conditions and co-morbidities like obesity should be centralised in one location in the county to allow staff to develop specialisms.

In relation to the proposal around acute medical beds at Grantham and District Hospital, there some was criticism based on the view that there was a lack of detailed information on the integrated model in the consultation document.

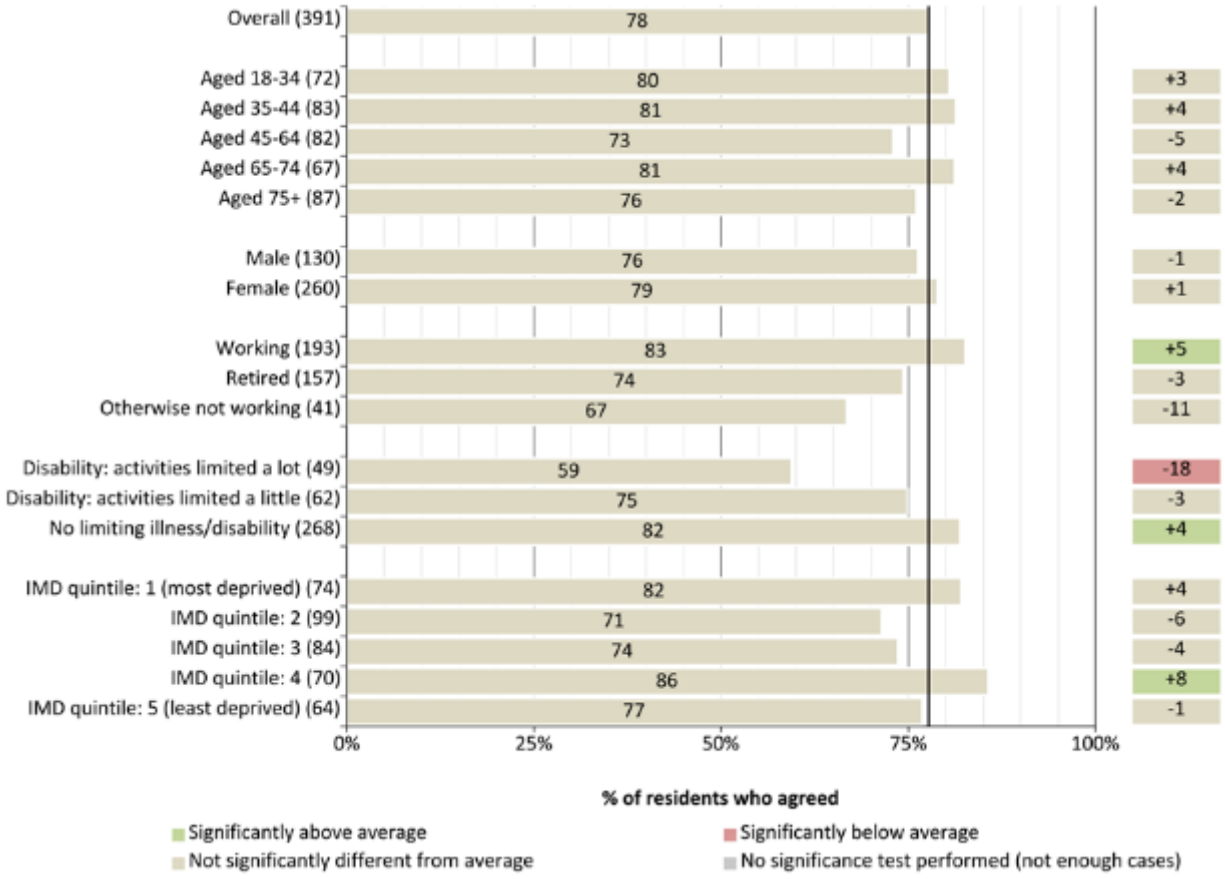
Please note the purpose of this document is not to consider or provide a view on these mitigations, alternative options and additional considerations. All mitigations, alternative options and additional considerations have been themed and considered by the relevant clinical and professional working group.

Residents' views on the proposal for acute medical beds at Grantham and District Hospital by demographic sub-groups

In relation to the proposal for integrated community/acute medical beds (Figure 16), residents with a substantially limiting disability or illness were significantly less likely than other residents to agree (59% compared to 78% overall) and were also more likely to disagree (33% compared to 11% overall), whereas those who do not have any limiting disability or illness were significantly more likely to agree.

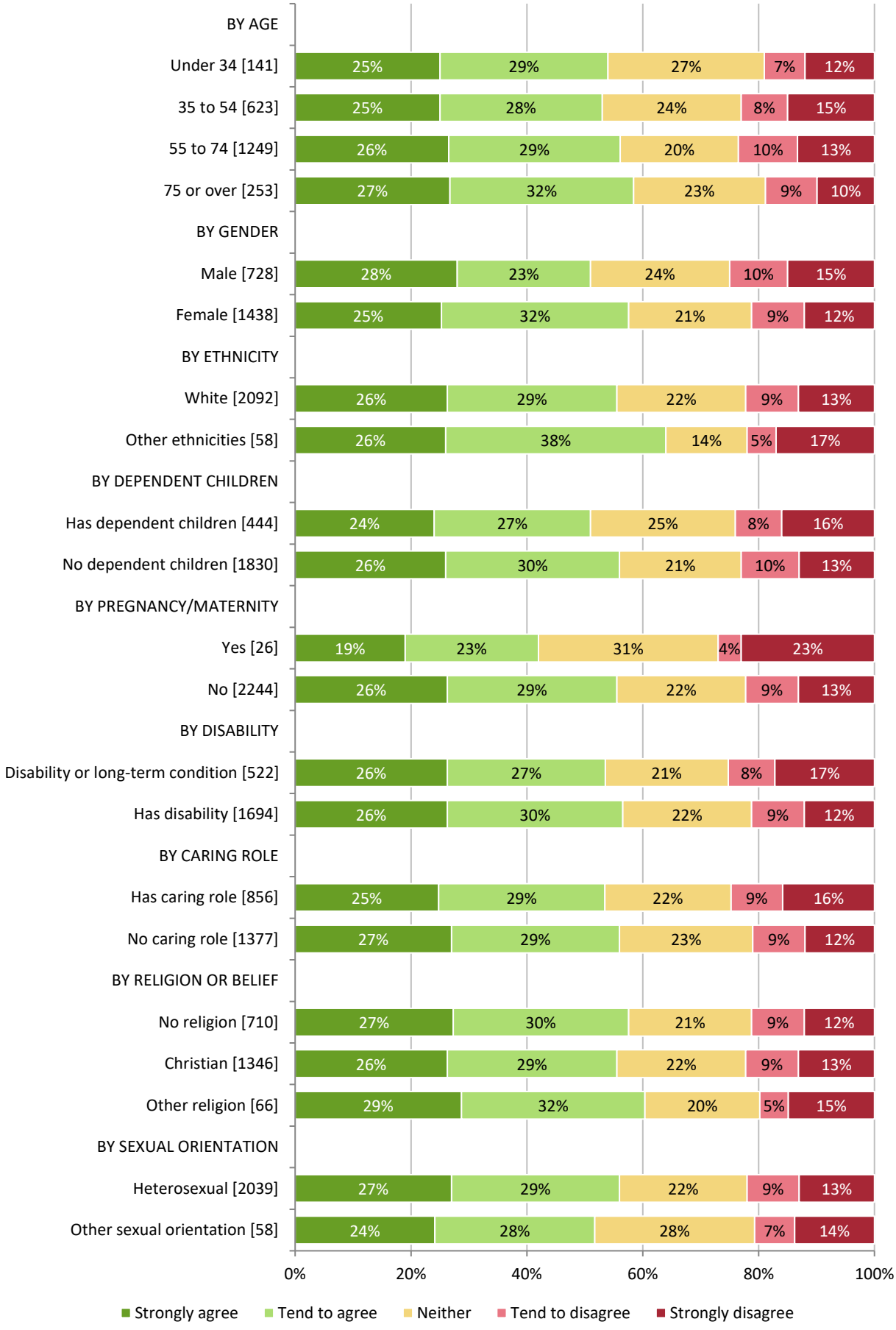
Where disagreement was expressed, feedback indicated that it was based on concerns about loss of acute services and travel and access to alternative sites. There were also differences in terms of working status and IMD (with residents who are working, and residents from the 4th IMD quintile, being more likely to agree).

Level of agreement with the proposal for acute medical beds at Grantham Hospital, BY POPULATION CHARACTERISTICS



Base: All Respondents (number of respondents shown in brackets)

Views on the proposal concerning acute medical beds BY KEY DEMOGRAPHICS (individuals only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Proposal development and clinical reviews

Proposed benefits

Through the clinically led development of the proposal for integrated community / acute medical beds at Grantham and District Hospital a number of benefits were identified:

- Acute medical beds provision would continue to be delivered at Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term – including a more sustainable medical and nursing workforce.
- 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 hospital, specifically in relation to the 'frail' population, thereby reducing pressure on acute hospital sites at Lincoln and Boston.
- The 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.

Clinical reviews

Prior to commencing the public consultation 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.

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.

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 Hospital.

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

2. Impact of decision
In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

As part of these considerations you should consider how the CCG will be meeting the requirements of the Public Sector Equality Duty

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Before completing this section you should ensure you can suitably answer the following:

What is the equality profile of the population i.e. service users/patients and/or workforce that is intended to benefit from the activity/project?
(By collecting and analysing demographic data of protected characteristics relating to patients/service users and/or workforce, within the geographical area concerned, the CCG will be able to identify the groups that may be adversely affected at a greater proportion to others).

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.1 Age *Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of age considerations, including: • Improved sustainability of acute medicine provision across ULHT. • Improved service quality and patient satisfaction • Improved continuity of care for those patients likely to be known by their neighbourhood team • Promotes ambulatory care interventions • Patients cared for by a service and in a setting most appropriate to their clinical need as close to home as possible, with the majority of patient's care still being delivered locally.	Patients would be seen to quicker, resulting in more efficient care; patients will benefit by being discharged back into their community more quickly. Elderly or frail patients were highlighted as particularly benefiting from this Reducing pressure on acute hospital sites at Lincoln and Boston – specifically in relation to 'frail' population is sensible and the integrated multi-disciplinary care team for frail patients is positive. Participants said that if patients (especially elderly patients) are seen in a timely and efficient manner, they would benefit by being discharged back into their communities more quickly.	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of age considerations 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 hospital, specifically in relation to the 'frail' population. For some patients there may be longer travel times, but this is balanced

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Possible negative impacts of this proposed change on the older population included: • Longer travel requirements which is impractical • Negative impact on health • Reliance on public transport, which is perceived to be limited in accessibility • Their concerns of greater reliance on family and friends for increased travel needs Possible negative impacts of this proposed change on the younger population included: • Additional costs • Reliance on public transport, which is perceived to be limited in accessibility • Negative impact on health 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. • 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.	Based on the age profile of patients currently using the acute medicine service at Grantham and District Hospital it is estimated that of the displaced patients (c.385): • 59% would be 65 or over	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. (TR) Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS. (TR) 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 so that the impact of the proposed

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
• 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 • However, in reality given the existing exclusion criteria and current usage of the Grantham Hospital site many of the patients who would no longer attend Grantham Hospital would actually travel by ambulance and therefore their travel time would likely to be less than 60 minutes.		service changes on ambulance capacity is negligible. (TR) Non-emergency patient transport (NEPTS) is provided for patients who meet the nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for patients who are going to hospital for outpatient appointments, diagnostics or treatment or for admission, and for patients who are eligible for transport from hospital following outpatient or diagnostic appointments or daycase or inpatient care and treatment. (TR) It is therefore 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. (TR) The current patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		transport providers and this is also a requirement in the new contract. (TR) Other Transport – includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors attending hospitals. 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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services. (TR) The CCG could commission bespoke service for patients, carers and visitors impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is not therefore seen to be a viable option. (TR) Public transport is the responsibility of the Local Authority; solutions already exist such as

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements. (TR) 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.
2.2 Disability *Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Considerations of potential impact (TR) = mitigation reflected in the DMBC Travel Report

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of disability considerations. Potential positive impacts are the same as above in section '2.1 Age' Possible negative impacts of this proposed change on the disabled (physically and mentally) population include: • Longer travel requirements • Additional cost related to travel to services further away • Inability to drive and limited public transport • Greater reliance on family and carers for increased travel needs • Negative impact on health and stress levels Activity impacts are the same as above in section '2.1 Age'	None identified	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of disability considerations Potential impacts and mitigations are the same as above in section '2.1 Age', plus: • 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.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.3 Gender reassignment (including transgender) *Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Mitigations identified (TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.4 Marriage and civil partnership *Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Mitigations identified (TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.5 Pregnancy and maternity *Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.?*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and	Mitigations identified

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
	Additional analysis completed in light of responses received during consultation in 2021	(TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.6 Race *Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Mitigations identified (TR) = mitigation is reflected in the DMBC Travel Report
None identified	Based on the ethnicity profile of patients currently using the acute medicine service at Grantham and District Hospital it is estimated that of the displaced patients: • 59% would be White British • 11% would be Other White • 10% would be Other Ethnic Groups • With the remainder not having their ethnicity recorded or Not Stated	To be considered as part of accessible service provision

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.7 Religion or belief *Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Mitigations identified (TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.8 Sex *Describe any impact and evidence in relation to men and women. This could include access to services and employment.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Mitigations identified (TR) = mitigation is reflected in the DMBC Travel Report
None identified	Based on the age and sex profile of patients currently using the acute medical service at Grantham and District Hospital it is estimated that of the displaced patients (c.385): • 54% would be female and 46% male	N/A

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.9 Sexual orientation *Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Mitigations identified (TR) = mitigation is reflected in the DMBC Travel Report
None identified	None identified	N/A
2.10 Carers *Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities.* *(Not a legal requirement but a CCG priority and best practice)*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Mitigations identified (TR) = mitigation is reflected in the DMBC Travel Report
Carers of those in the 'Age', 'Disability' and 'Economically Disadvantaged' groups potentially have a 'knock-on' negative impact i.e. longer travel times and greater reliance on public transport. However, some positive impacts identified with services provided locally at Grantham Hospital.	None identified	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

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		The proposal for change would deliver a more comprehensive local service provision at Grantham hospital, specifically in relation to the 'frail' population. (TR) Other Transport – includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors attending hospitals. 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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services. (TR) CCG could commission bespoke service for patients, carers and visitors impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is not therefore seen to be a viable option.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		(TR) Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements (TR) 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.
2.11 Other disadvantaged groups *Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.*		
Economically Disadvantaged		

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021; and Additional analysis completed in light of responses received during consultation in 2021	Mitigations identified (TR) = mitigation is reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of economically disadvantaged considerations. Potential positive impacts are the same as above in section '2.1 Age' Possible negative impacts of this proposed change on the disabled (physically and mentally) population include: • Longer travel requirements, and additional cost of this • Specific concern about the costs of return travel from hospital, especially at times of limited/no public transport Activity impacts are the same as above in section '2.1 Age'	None identified	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of economically disadvantaged considerations Mitigations are the same as above in section '2.1 Age'

3. Human rights *The principles are Fairness, Respect, Equality, Dignity and Autonomy.*				
Will the proposal impact on human rights?	Yes	☒	No	☑
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☑
If so what actions are needed? *Please explain below.*				
N/A				

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

1. **What evidence have you considered to determine what health inequalities exist in relation to your work?**

   This can include local and national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them.

   (this may be different or similar to that which has informed the EIA)

Lincolnshire Research Observatory - Joint Strategic Needs Assessment (research-lincs.org.uk)
Wider determinants of health inequalities in Lincolnshire
Lincolnshire Joint Health & Wellbeing Strategy
Lincolnshire Research Observatory - Area Profiles (research-lincs.org.uk)
Health & Wellbeing in Lincolnshire 2019
Area Disease Prevalence Analysis

2. **What is the potential impact of your work on health inequalities?** Can you demonstrate through evidenced based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?

   If you feel that the project will not impact / be relevant to Health Inequalities please give a rationale.

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

Under the proposed model to establish an integrated community/acute inpatient model for acute medicine at Grantham Hospital is fully implemented, c.385 patients per year (c.10% of current non-elective inpatient admissions) currently seen at Grantham Hospital would be displaced (based on 2019/20 activity; 396 based on 2023/24 forecast)).

This is equivalent to around 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. It is envisaged the number of medical beds at Grantham and District Hospital in this new model will not be reduced.

Under the proposal it is estimated that no more patients than currently do now will be travelling over 60 minutes for non-elective care, the travel time threshold set by the local health system for activity of this type.

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

Based on the deprivation profile of patients currently using the acute medical service at Grantham and District Hospital it is estimated that of the displaced patients:

- 22% would be from the 3 most deprived deciles in Lincolnshire
- 43% would be from the 5 most deprived deciles in Lincolnshire

Through the clinically led development of the proposal for integrated community / acute medical beds at Grantham and District Hospital a number of benefits were identified:

- Acute medical beds provision would continue to be delivered at Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term – including a more sustainable medical and nursing workforce
- 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 hospital, specifically in relation to the ‘frail’ population, thereby reducing pressure on acute hospital sites at Lincoln and Boston

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

- The 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

3. How can you make sure that your work has the best chance of reducing health inequalities?

The quality and long-term sustainability of services within ULHT is critical to Lincolnshire's community. To support ULHT to address the national challenges and improve services we need to change the way they are currently delivered. This programme is focused on improving this quality of care, and retention and recruitment of staff, rather than on financial savings. If we improve these four NHS services, we believe there will be:

- Shorter waiting times for planned orthopaedic procedures in Lincolnshire
- Fewer cancellations of planned orthopaedic procedures in Lincolnshire
- Better urgent and emergency care for patients across Lincolnshire
- Clinically optimum hospital stays for recovering stroke patients
- Better hospital care for recovering stroke patients
- More integrated community and hospital medical services
- Quicker access to specialist staff across these four NHS services
- Reduced risk that Lincolnshire would lose these services if they become unsustainable
- Increased ability for the NHS in Lincolnshire to attract new staff to work in the county
- Better retention of staff already in the county, as they would be working for more sustainable and progressive services

5. Engagement/consultation
What engagement is planned or has already been done to support this project?

It is expected that the CCG will have carried out a level of engagement with those affected whether formal or informal. This should be focussed to the groups most affected.

Engagement activity	**With whom?** *e.g. protected characteristic/group/community*	**Date**
Formal Consultation	Detailed in the Consultation Strategy & Plan	2021

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)

- Lincolnshire NHS public consultation on proposed changes to four services feedback report Full draft 4.1
- EIA of the Consultation Strategy & Plan

6. Mitigations and changes
If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.

Are these vital to the project continuing?

New service configuration proposals to be detailed in Decision Making Business Case.

7. Is further work required to complete this EIA?
Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)

Work needed	**Section**	**When**	**Date completed**
If change proposal is agreed there would be ongoing analysis and assessment of the impact on travel and transport for patients across all patients as a whole, as well as those with protected characteristics	*Ongoing engagement*	*If service change is agreed – from implementation*	*Can only be confirmed if change proposal is agreed*

8. Development of the Equality Impact Analysis *If the EIA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data*		
Version	**Change and Rationale**	**Version Date**
PCBC EIA	Equality Impact Assessments of urgent and emergency care have been revised following consultation in 2021	February 2021

9. Final Sign off Completed EIA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. Service lines should maintain an up to date log of all EIAs.		
Version approved:	1.1	
	Name	**Date**
Signature of responsible officer	 Pete Burnett System Director of Strategy and Planning	14th April 2022
Which committee will be considering the findings and sign off the EIA?	Joint meeting of ICS Clinical Directorate CCG Clinical Policies Sub-Group (to make recommendations to QPEC) CCG Quality and Patient Experience Committee (to make recommendation to the CCG Board)	21st April 2022 12th May 2022
Minute number *(to be inserted following presentation to committee)*		

Arden&GEM

NHS
Arden and Greater East Midlands
Commissioning Support Unit

Appendix 5
Equality Impact Analysis
Proposals for stroke services

Project Details

Project Name:	Proposals for stroke services
EA Author:	Anna Collins
Team:	Maktub Consulting Ltd
Date completed:	April 2022
Version:	1.1

What is the aim of the project/proposal?

Following a period of options development and appraisal that involved senior clinicians, key stakeholders and members of the public, proposals for changes to four NHS services were put forward for public consultation over a 12-week period from 30th September 2021 until 23rd December 2021:

Proposals for stroke services

- Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

- Staff
- Patients
- Carers

Stage 1, Scoping point

Is a full Equality Impact Analysis required for this project?

You should consider whether a full EIA is required, referring to the relevant guidance for information and guidance on making this decision.

It is important this decision is made with an open mind and correctly, advice should be sought from the EIHR team if you are unsure.

Yes	☑	Proceed to the full Equality Impact Analysis form	**No**	☐	Explain why further analysis is not required.

If no, explain below why further Equality Impact Analysis is not required. E.g. 'This report is for information only' or 'The decision has not been made by the CCG' or 'The decision will not have any impact on patients or staff'. (Very few decisions affect all groups equally and this is not a rationale for not completing an EIA.)

Equality Impact Analysis Form

If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EIA. An Equality Impact Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

1. Evidence used

To demonstrate that the decision made has been informed you should include examples of the information used to determine the impact and complete the EIA.

Examples are likely to include:

- ***Population Data -*** *e.g. demographic profile (Census),*
- ***Service Activity Data e.****g. profile of patients using a service*
- ***Consultation and Involvement findings -*** *e.g. any engagement with service users, local community, specific groups.*
- ***Research -*** *e.g. good practice guidelines, service evaluations, literature reviews, reports*
- ***Participant knowledge -*** *e.g. experiences of working with different or population groups, experiences of service users in other service areas / localities*

- Lincolnshire NHS public consultation on proposed changes to four services feedback report Full draft 4.1
- Consultation feedback themes V0.9
- Equality Impact Assessments of acute medical beds February 2021
- Public documents relating to the four services and approach to consultation
- Pre Consultation Business Case

POPULATION DATA

Headline Demographics

Lincolnshire is the 4th largest county in England with an area of 5,921 sq. km.

It has 761,224 residents (2019) and 783,080 GP registered patients (2019) dispersed across city, market towns, rural and coastal areas.

Lincolnshire is predominately rural, being the 4th most sparsely populated county, with no motorways, little dual carriageway and 80km of North Sea coastline, which provides fundamental difficulties in service provision.

The population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to almost double over the next 25 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.

The combination of an ageing population, a rural geography and areas of high socioeconomic deprivation defines the specific challenge of delivering high-quality and effective treatment and preventative services in Lincolnshire.

Age	In relation to age the statistics show that, out of the total population of 751,171, the age range 0-15 makes up 17.1% of the population, whilst the other sections of the population aged 16-24, 25-64, 65 -84 and 85 years and over make up 10.1%, 49.6% 20.3%, and 2.9% respectively. Lincolnshire's population is on average older than the population of England and the East Midlands. It also has a higher proportion of adults over the age of 75 and the number in this age range is estimated to double over the next 20 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.
Disability	The 2011 Census shows that 27.1% of households in Lincolnshire have one person or more with a long-term disability. With regard to learning disabilities, statistics show that over 15,000 people have learning disability in Lincolnshire.
Ethnicity	The diversity of the population has increased in recent years as a result of new and emerging communities. As of the 2011 Census, around 93% of residents identify themselves as White British with a significant 4% identifying as White Other. This 4% is primarily made of Eastern European communities, which represents much in the agricultural, hospitality and tourist industries. Recent issues relating to Brexit have influenced the migration of EU foreign nationals back to their countries of birth. This in the future will no doubt have impact on the statistics of the white European population and detrimental impact on the Lincolnshire's agricultural industries. The non-white population makes up 2.4% of the total population in 2011 compared to 1.4% in 2001 and although slight increases are becoming apparent since 2011, the proportions are still very small in comparison to the national non-white population of 14%.
Gender*	According to the 2011 census, statistics for Lincolnshire's show the population as 713,653 (2017 estimates 751,200). In total there are more females 366,498 (51.3%) than males 348,270 (48.7%), with slight variations amongst different age groups. The estimated difference in 2017 slightly narrows that gap between male and female population at 385,800 (51%) female and 370,000 (49%) male.
Religion & belief	In relation to Religion/belief, Christians make up the largest group 68.50%, followed by those who do not have religion at 23.10%. Other smaller religious groups include Muslim 0.40%, followed by Hindu's and Buddhist at 0.20% the smallest religious groups include the Jewish and Sikh both at 0.10%
Sexual Orientation & *transgender	There is no accurate data on the numbers of men and women who are lesbian, gay, bisexual or transgender (LGBT) in Lincolnshire, reflecting a national problem with accurate statistical analysis. Both Stonewall and HM Treasury concur that between 5 – 7% of the population of the UK are lesbian, gay, bisexual or transgender, but acknowledge the difficulty in accurate analysis. In Lincolnshire this represents over 50,000 people.

Health Inequalities

In Lincolnshire, health inequalities exist between levels of income deprivation and gender.

Between the most and least income deprived deciles, the gap in male life expectancy is 6.5 years, and for healthy life expectancy is 11.8 years.

For women, the gap in life expectancy is smaller at 4.8 years and for healthy life expectancy is 10.8 years.

Life expectancy, premature cancer mortality, mental health-related, smoking related, alcohol-specific and drug-related hospital admissions all show a moderate association with BAME.

Both life expectancy and healthy life expectancy are strongly associated with income deprivation.

Moderate levels of variation in mental health related, alcohol-specific and drug-related hospital admissions can be explained by income deprivation in older people.

In the most income deprived decile of Lincolnshire, life expectancy is 5.1 years less and healthy life expectancy is 11.2 years less compared to the least income deprived decile.

Preventable mortality rates in the most income deprived decile are 1.7 times higher than in the least deprived decile

The greatest causes of ill health and mortality are cardiovascular disease, cancers, musculoskeletal conditions and mental ill-health. Musculoskeletal conditions and mental ill-health are the biggest contributors to the number of Years Lived with Disability in Lincolnshire's population.

SERVICE ACTIVITY DATA

Overview of activity impact

Pilgrim Hospital currently treats 497 strokes a year (19/20), those patients transported to Pilgrim Hospital by ambulance generally originate from Boston, Mablethorpe on the east coast and Spalding to the south.

Once fully implemented the preferred option to consolidate stroke services at Lincoln Hospital will displace all 497 stroke patients currently seen at Pilgrim Hospital.

Travel analysis has modelled that under the preferred option no patients are estimated to travel over 60-minutes (the agreed threshold for this type of activity by local health system clinical leads), assuming they travel to their nearest acute stroke unit by ambulance.

The majority of patients who access acute stroke services are likely to arrive at hospital by ambulance. Upon discharge if the patient has a healthcare need or meets the ULHT transport support criteria transport support will be provided.

Age and sex profile of patients impacted

Based on the age and sex profile of patients using the Pilgrim Hospital stroke service it is estimated that of the displaced patients:

- 50% would be female and 50% male
- 82% would be 65 or over

Ethnicity profile of patients impacted

Based on the ethnicity profile of patients using the Pilgrim Hospital stroke service it is estimated that of the displaced patients:

- 92% would be White British
- <1% would be Other White
- 1% would be Other Ethnic Groups
- With the remainder not having their ethnicity recorded or Not Stated

Deprivation profile of patients impacted

Based on the deprivation profile of patients currently using the Pilgrim Hospital stroke service at Grantham and District Hospital it is estimated that of the displaced patients:

- 46% would be from the 3 most deprived deciles in Lincolnshire
- 69% would be from the 5 most deprived deciles in Lincolnshire

CONSULTATION AND INVOLVEMENT FINDINGS

Overview of public consultation findings

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, just over half of whom expressed agreement (51%) and just under two fifths (38%) disagreed.

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

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

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 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.

The residents telephone survey, by contrast, indicates that there is majority support from the overall resident population, including among living closest to Pilgrim Hospital in 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 in Boston no longer delivering specialist stroke services.

Equalities and health inequalities impacts of proposals for orthopaedic services in Lincolnshire

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.

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.

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.

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.

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.

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).

Individual respondents' views on equalities impacts of the proposal for stroke services in Lincolnshire

There were concerns expressed that the proposal could widen health inequalities and negatively impact patient access due to acute stroke services being moved from Pilgrim Hospital, with some calls for a Centre of Excellence to be established in Boston as well as, or instead of, the proposed centre at Lincoln County Hospital. As with the other proposals, feedback from and about protected characteristics groups and other key demographics tended to express some concerns about travel and transport. The potential impacts on patients' loved ones was also noted, particularly older family members and carers 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.

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. 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.

Suggested mitigations, alternative suggestions and additional considerations put forward by the public during the consultation

The following mitigations were mentioned in relation to the proposal for stroke services:

- Social care provision should be strengthened to reduce the length of hospital stays;
- An air ambulance to cover the East of the county;
- Improved recruitment with higher wages and better benefits so staff feel valued;
- More beds, staff (including staff with thrombolysis training) and other resources;
- A telemedicine system that matches some models used in Europe or other remote areas, whereby more junior staff members could be upskilled to initiate investigations and treatment plans with the help of consultants, to keep patient care local; and
- Additional therapy staffing in the stroke unit and community stroke team to support more timely assessment and discharge planning – as well as discharges themselves.
- Two more general alternative suggestions were made; firstly, that both Lincoln County Hospital and Pilgrim Hospital, Boston should be centres of excellence for stroke; and secondly, that specialist stroke services should be located in Boston to better suit the overall needs of the population.
- More specifically, the following suggestions were made in relation to the hyper-acute and acute wards:
- Train teams stepping into hyper acute care in a timely way; for example, specialist strokes and registrants stepping onto Advanced Clinical Practitioner (ACP) university courses using ‘learning beyond registration’ (LBR) funds or apprenticeship levies;
- If there is to be a second ward at Lincoln, this should be a small hyper-acute ward (close to the stroke unit), and the current stroke unit should be used for acute care and rehabilitation as it already has several therapy rooms. Therapy teams should work across the two wards to provide consistency of care and help maintain cover during annual leave/staff absence etc.;
- It would be beneficial to have a dedicated MDT/discharge co-ordinator(s);
- Keep the hyper-acute at site; make consultants and ACPs work pan-trust and put money into ACP training for experienced stroke nurses; and

- A standard operating procedure should be in place that allows thrombolysis to be given in the emergency department if the time to transfer to a hyper-acute stroke unit (HASU) is greater than 45 minutes. Patients should then be transferred to HASU post-thrombolysis. This, it was said, is supported by NICE and there are examples of it working in practice elsewhere in the country.

The following suggestions were made in relation to rehabilitation:

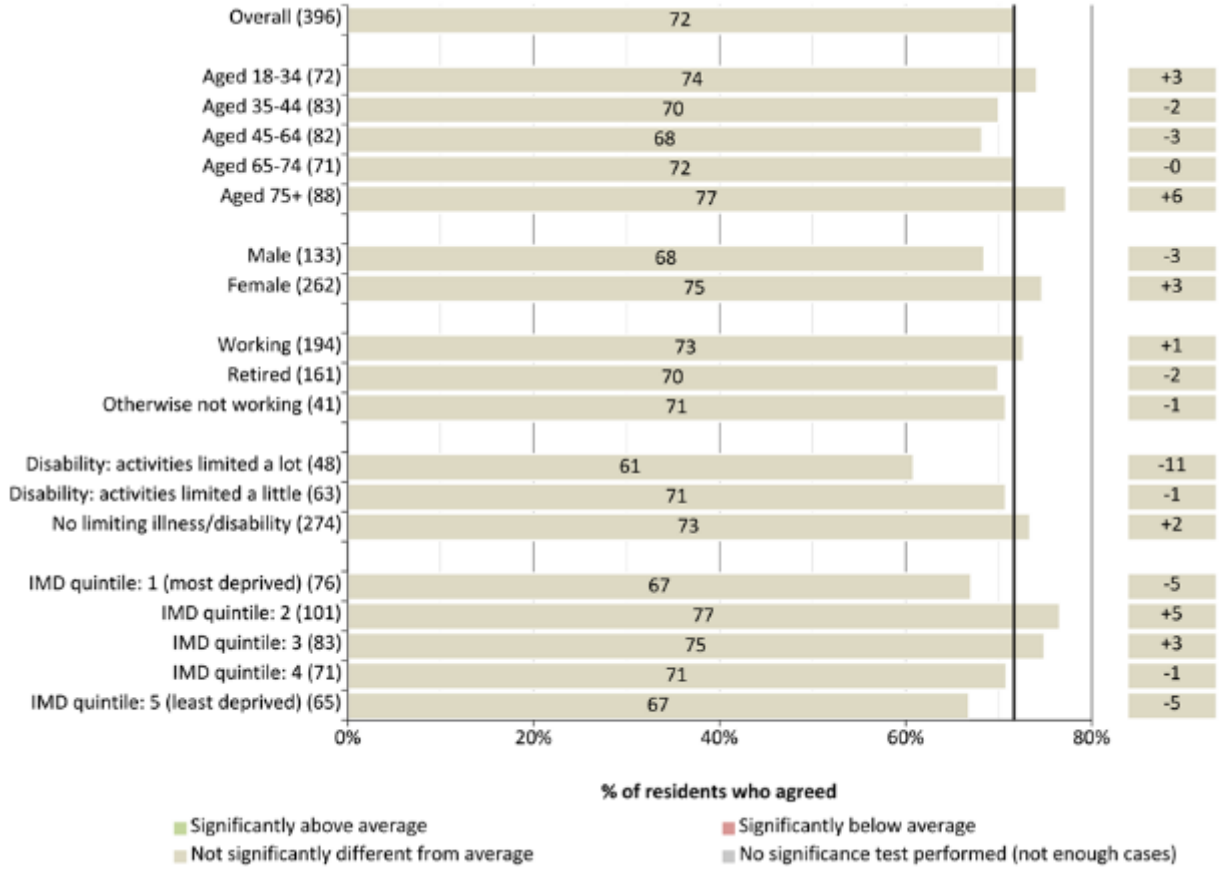
- Grantham and District Hospital should have a rehabilitation service, but not an acute service if there is no A&E unit there;
- Ringfence specialist beds at Boston to create a hub and spoke stroke rehabilitation service across Lincolnshire. This would provide highly specialised stroke service provision in a centre with ongoing rehabilitation and preparation for discharge to the community. High quality service provision should link the pathway for rehabilitation across acute and community sectors;
- An appropriate stroke rehabilitation ward would ensure throughput is sufficient to allow new patients to be admitted and longer-term patients to receive the rehabilitation they require;
- Community rehabilitation services must be in place for stroke and other neurological conditions, especially brain injury – as well as a step up and down inpatient/outpatient unit where all patients can go to regain lost skills; and
- Provide step down beds in Pilgrim and Grantham and District Hospitals to allow a manageable caseload for Lincoln County Hospital, and so that patients can receive specialist stroke rehabilitation closer to home.

Please note the purpose of this document is not to consider or provide a view on these mitigations, alternative options and additional considerations. All mitigations, alternative options and additional considerations have been themed and considered by the relevant clinical and professional working group

Residents' views on the proposal for stroke services in Lincolnshire by demographic sub-groups

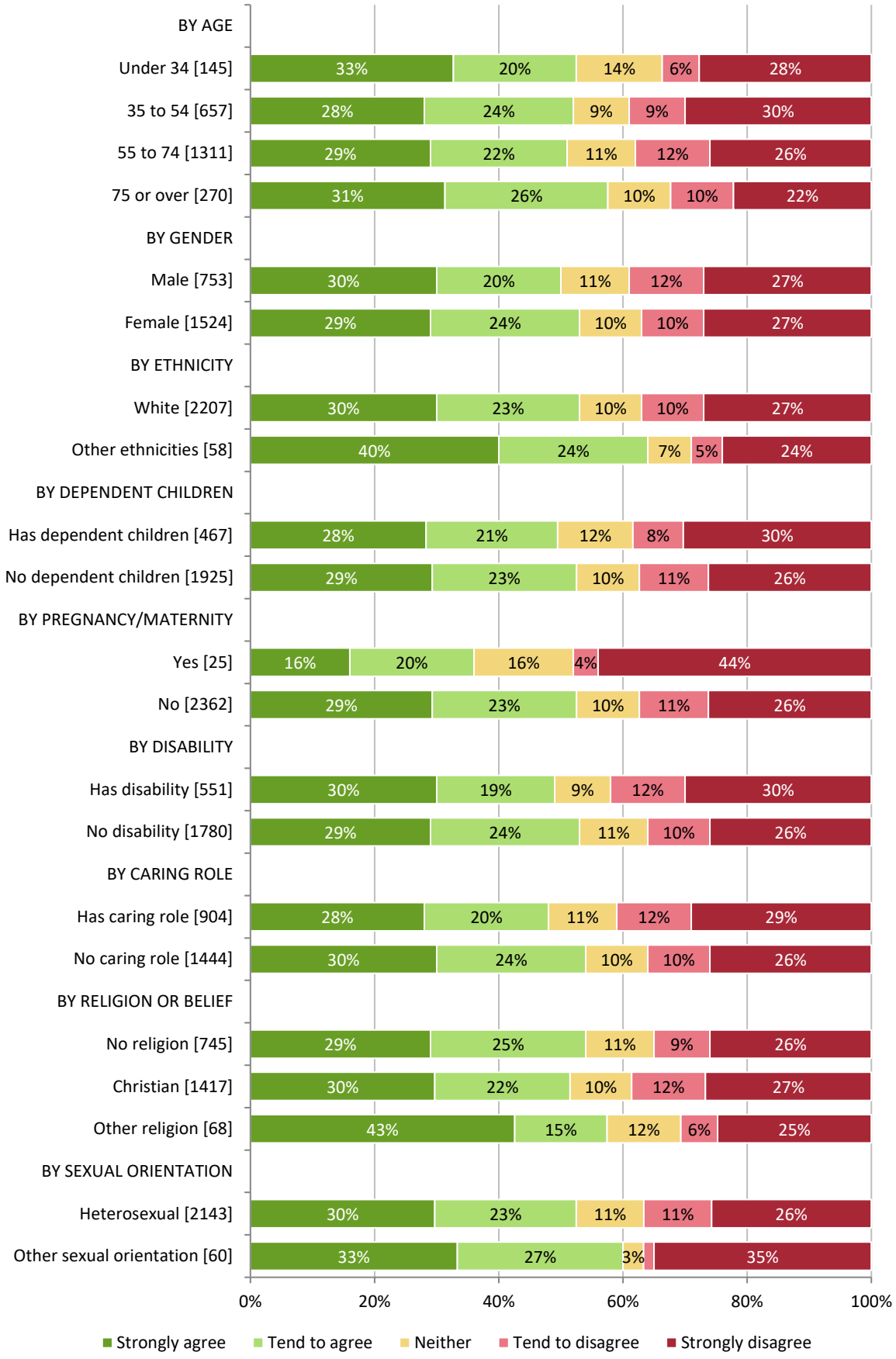
The table below provides an overview of the views of the various sub-groups in relation to the proposal for stroke services. Although not statistically significant at the 95% confidence level, there was some indication (at a 90% confidence level) that residents with disabilities that limit their activities a lot, were less likely to agree, and more likely to disagree with this proposal, compared to other residents.

Level of agreement with the proposal for stroke services, BY POPULATION CHARACTERISTICS



Base: All Respondents (number of respondents shown in brackets)

Views on the proposal for stroke services BY KEY DEMOGRAPHICS (individuals only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Proposal development and clinical reviews

Proposed benefits

Through the clinically led development of the proposal to consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service the following benefits were identified:

- 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

Clinical reviews

Prior to commencing the public consultation 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.

The proposal to consolidate hyper-acute and acute stroke services at Lincoln 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.

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.

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.

The clinical review team supported the proposal for stroke services and recommended the health system proceed with it.

2. Impact of decision

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

As part of these considerations you should consider how the CCG will be meeting the requirements of the Public Sector Equality Duty

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Before completing this section you should ensure you can suitably answer the following:

What is the equality profile of the population i.e. service users/patients and/or workforce that is intended to benefit from the activity/project?
(By collecting and analysing demographic data of protected characteristics relating to patients/service users and/or workforce, within the geographical area concerned, the CCG will be able to identify the groups that may be adversely affected at a greater proportion to others).

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.1 Age *Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of age considerations, including: • Improved patient outcomes • Services based on national clinical evidence • Improved service quality • Services in a stronger position to attract and retain staff Possible negative impacts of this proposed change on the older population include: • Their concerns of greater reliance on family and friends for increased travel needs • Longer travel requirements which is impractical • Reliance on public transport, which is perceived to be limited in accessibility	Public consultation feedback identified 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. Based on the age profile of patients using the Pilgrim Hospital stroke service it is estimated that of the displaced patients 82% would be 65 or over. Further analysis on ambulance travel times has been completed to assess the impact of the temporary change to consolidate hyper-acute and acute stroke services on the Lincoln site in light of Covid-19.	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of age considerations. 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.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Possible negative impacts of this proposed change on the younger population include: • Negative impact on health • Reliance on public transport, which is perceived to be limited in accessibility Estimated c.500 patients a year displaced - travel analysis has modelled that under the preferred option no patients are estimated to travel over 60-minutes (the agreed threshold for this type of activity), assuming they travel to their nearest acute stroke unit by ambulance. • The majority of patients who access acute stroke services are likely to arrive at hospital by ambulance. Upon discharge if the patient has a healthcare need or meets the ULHT transport support criteria transport support will be provided. • Community care (including follow up and routine appointments) will not be affected by this model, in fact they will be enhanced enabling patients to return home sooner. The view at the time of completing the Pre Consultation Business case was the increase in travel ties would be offset by improved service quality and patient outcomes.	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. If the proposed stroke changes went ahead, the impact on travel times would be kept under constant review. 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: • 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	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.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
	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 the Lincoln County Hospital was one of only 6 sites that achieved 8 Key Indicators. Only 1 site achieved 9 Key Indicators and no site achieved 10. All the remaining sites achieved less than 8 Key Indicators. The view remains the increase in travel times would be offset by improved service quality and patient outcomes.	(TR) Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS. (TR) 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 so that the impact of the proposed service changes on ambulance capacity is negligible. If a patient attends Pilgrim A&E and they need to be transferred to the stroke centre at Lincoln this will be done by ambulance. (TR) Non-emergency patient transport (NEPTS) is provided for patients who meet the nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for patients

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		who are going to hospital for outpatient appointments, diagnostics or treatment or for admission, and for patients who are eligible for transport from hospital following outpatient or diagnostic appointments or daycase or inpatient care and treatment. (TR) It is therefore 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. (TR) The current patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers and this is also a requirement in the new contract. (TR) Other Transport – includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		attending hospitals. 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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services. (TR) The CCG could commission bespoke service for patients, carers and visitors impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is not therefore seen to be a viable option. (TR) Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		of the County Council 'County Views' exercise; key is to strengthen current arrangements. (TR) 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. During the development of the stroke change proposal consideration was given to having a centre of excellence in Boston rather than Lincoln. This consideration identified that locating a single hyper-acute and acute stroke unit at Lincoln Hospital rather than Boston Pilgrim Hospital 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

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		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 the Lincoln Hospital compared to Pilgrim Hospital, • More Lincolnshire residents would receive their care out of the county if stroke services were consolidated on the Pilgrim Hospital site rather than at Lincoln Hospital.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.2 Disability		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of disability considerations. Potential positive impacts are the same as above in section '2.1 Age'. No negative impacts were identified by this group during the pre-consultation engagement. Activity impacts are the same as above in section '2.1 Age'.	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). Additional analysis on ambulance travel times and outcomes is the same as above in section '2.1 Age'.	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of disability considerations. Potential impacts and mitigations are the same as above in section '2.1 Age', plus: • 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

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		need from health and care services.
2.3 Gender reassignment (including transgender) *Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A
2.4 Marriage and civil partnership *Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A
2.5 Pregnancy and maternity *Describe any impact and evidence in relation to Pregnancy and Maternity. This can include working arrangements, part time working and caring responsibilities.?*		

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A
2.6 Race *Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
During the engagement exercise, having English as a second language was identified as a possible barrier to engagement	Based on the ethnicity profile of patients using the Pilgrim Hospital stroke service it is estimated that of the displaced patients: • 92% would be White British • <1% would be Other White • 1% would be Other Ethnic Groups • With the remainder not having their ethnicity recorded or Not Stated	To be considered as part of accessible services provision

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A
2.8 Sex *Describe any impact and evidence in relation to men and women. This could include access to services and employment.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	Based on the sex profile of patients using the Pilgrim Hospital stroke service it is estimated that of the displaced patients 50% would be female and 50% male.	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of sex considerations. Potential impacts and mitigations are the same as above in section '2.1 Age'

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
2.9 Sexual orientation *Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
None identified	None identified	N/A
2.10 Carers *Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities.* *(Not a legal requirement but a CCG priority and best practice)*		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
Carers of those in the 'Age' and 'Economically Disadvantaged' groups potentially have a 'knock-on' negative impact i.e. longer travel times and greater reliance on public transport. Through the further engagement and analysis, no adverse impacts were identified for the following groups:	None identified	(TR) Other Transport – includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors attending hospitals. This transport category presents the most complex area for consideration as it covers

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		transport and travel services that the CCG does not have a duty to provide. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services. (TR) The CCG could commission bespoke service for patients, carers and visitors impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is not therefore seen to be a viable option. (TR) Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements.

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		(TR) 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.
2.11 Other disadvantaged groups *Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.*		
Economically disadvantaged		
Pre-Consultation Business Case EIA	Additional responses received during consultation in 2021 and Additional analysis completed in light of responses received during consultation in 2021	Consideration of potential impacts (TR) = mitigation reflected in the DMBC Travel Report
There are a number of potential positive impacts for all patients of the proposed changes which will be relevant in the context of economically disadvantaged considerations. Potential positive impacts are the same as above in section '2.1 Age'.	There were concerns expressed that the proposal could widen health inequalities and negatively impact patient access due to acute stroke services being moved from Pilgrim Hospital, with some calls for a Centre of Excellence to be established in Boston as well as, or instead of, the proposed centre at Lincoln County Hospital.	The consideration of potential impacts identified are for all patients of the proposed service change, and are equally relevant in the context of economically disadvantaged considerations

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
Possible negative impacts of this proposed change on the disabled (physically and mentally) population include: • Longer travel requirements, and additional cost of this • Specific concern about the costs of return travel from hospital, especially at times of limited/no public transport Activity impacts are the same as above in section '2.1 Age'.	Based on the deprivation profile of patients currently using the Pilgrim Hospital stroke service at Grantham and District Hospital it is estimated that of the displaced patients: • 46% would be from the 3 most deprived deciles in Lincolnshire • 69% would be from the 5 most deprived deciles in Lincolnshire Additional analysis on ambulance travel times and outcomes is the same as above in section '2.1 Age'.	Potential impacts and mitigations are the same as above in section '2.1 Age' PLUS • 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 • At an evaluation workshop attended by over 60

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*		
		stakeholders from across the Lincolnshire health system, the consensus was the preferred option was to consolidate services on the Lincoln County Hospital site.

3. Human rights *The principles are Fairness, Respect, Equality, Dignity and Autonomy.*				
Will the proposal impact on human rights?	Yes	☒	No	☑
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☑
If so what actions are needed? *Please explain below.*				
N/A				

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

1. **What evidence have you considered to determine what health inequalities exist in relation to your work?**

   This can include local and national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them.

   (this may be different or similar to that which has informed the EIA)

Lincolnshire Research Observatory - Joint Strategic Needs Assessment (research-lincs.org.uk)
Wider determinants of health inequalities in Lincolnshire
Lincolnshire Joint Health & Wellbeing Strategy
Lincolnshire Research Observatory - Area Profiles (research-lincs.org.uk)
Health & Wellbeing in Lincolnshire 2019
Area Disease Prevalence Analysis

2. **What is the potential impact of your work on health inequalities?** Can you demonstrate through evidenced based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?

   If you feel that the project will not impact / be relevant to Health Inequalities please give a rationale.

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

There were concerns expressed that the proposal could widen health inequalities and negatively impact patient access due to acute stroke services being moved from Pilgrim Hospital, with some calls for a Centre of Excellence to be established in Boston as well as, or instead of, the proposed centre at Lincoln County Hospital. As with the other proposals, feedback from and about protected characteristics groups and other key demographics tended to express some concerns about travel and transport.

Based on the deprivation profile of patients currently using the Pilgrim Hospital stroke service at Grantham and District Hospital it is estimated that of the displaced patients:

- 46% would be from the 3 most deprived deciles in Lincolnshire
- 69% would be from the 5 most deprived deciles in Lincolnshire

Initial travel analysis modelled that under the preferred option no patients are estimated to travel over 60-minutes (the agreed threshold for this type of activity), assuming they travel to their nearest acute stroke unit by ambulance.

The majority of patients who access acute stroke services are likely to arrive at hospital by ambulance. Upon discharge if the patient has a healthcare need or meets the ULHT transport support criteria transport support will be provided.

Following the temporary change to consolidate hyper-acute and acute stroke services on the Lincoln Hospital site due to Covid-19 challenges to service sustainability, 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.

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

Through the clinically led development of the proposal to consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service the following benefits were identified:

- 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

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

- 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:

- 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 the Lincoln County Hospital was one of only 6 sites that achieved 8 Key Indicators. Only 1 site achieved 9 Key Indicators and no site achieved 10. All the remaining sites achieved less than 8 Key Indicators.

The view remains the increase in travel times would be offset by improved service quality and patient outcomes.

4. Health Inequalities.

The Health and Social Care Act 2012 established the first specific legal duties on CCGs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from April 1st 2013.
The duties require that CCGs properly and seriously takes into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

3. How can you make sure that your work has the best chance of reducing health inequalities?

The quality and long-term sustainability of services within ULHT is critical to Lincolnshire's community. To support ULHT to address the national challenges and improve services we need to change the way they are currently delivered. This programme is focused on improving this quality of care, and retention and recruitment of staff, rather than on financial savings. If we improve these four NHS services, we believe there will be:

- Shorter waiting times for planned orthopaedic procedures in Lincolnshire
- Fewer cancellations of planned orthopaedic procedures in Lincolnshire
- Better urgent and emergency care for patients across Lincolnshire
- Clinically optimum hospital stays for recovering stroke patients
- Better hospital care for recovering stroke patients
- More integrated community and hospital medical services
- Quicker access to specialist staff across these four NHS services
- Reduced risk that Lincolnshire would lose these services if they become unsustainable
- Increased ability for the NHS in Lincolnshire to attract new staff to work in the county
- Better retention of staff already in the county, as they would be working for more sustainable and progressive services

5. Engagement/consultation
What engagement is planned or has already been done to support this project?

It is expected that the CCG will have carried out a level of engagement with those affected whether formal or informal. This should be focussed to the groups most affected.

Engagement activity	**With whom?** *e.g. protected characteristic/group/community*	**Date**
Formal Consultation	Detailed in the Consultation Strategy & Plan	2021

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)

5. Engagement/consultation
What engagement is planned or has already been done to support this project?

It is expected that the CCG will have carried out a level of engagement with those affected whether formal or informal. This should be focussed to the groups most affected.

Engagement activity	**With whom?** *e.g. protected characteristic/group/community*	**Date**
• Lincolnshire NHS public consultation on proposed changes to four services feedback report Full draft 4.1 • EIA of the Consultation Strategy & Plan		

6. Mitigations and changes
If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.

Are these vital to the project continuing?

New service configuration proposals to be detailed in Decision Making Business Case.

7. Is further work required to complete this EIA?
Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)

Work needed	**Section**	**When**	**Date completed**
If change proposal is agreed there would be ongoing analysis and assessment of the impact on travel and transport for patients as a whole, as well as those with protected characteristics	*Ongoing engagement*	*If service change is agreed – from implementation*	*Can only be confirmed if change proposal is agreed*

8. Development of the Equality Impact Analysis
If the EIA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data

Version	**Change and Rationale**	**Version Date**
PCBC EIA	Equality Impact Assessments of stroke services has been revised following consultation in 2021	February 2021

9. Final Sign off Completed EIA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. Service lines should maintain an up to date log of all EIAs.		
Version approved:	1.1	
	Name	**Date**
Signature of responsible officer	 Pete Burnett System Director of Strategy and Planning	21 April 2022
Which committee will be considering the findings and sign off the EIA?	Joint meeting of ICS Clinical Directorate CCG Clinical Policies Sub-Group (to make recommendations to QPEC) CCG Quality and Patient Experience Committee (to make recommendation to the CCG Board)	28th April 2022 12th May 2022
Minute number *(to be inserted following presentation to committee)*		

Appendix I

Travel and Transport Report

LINCOLNSHIRE ACUTE SERVICES REVIEW

TRANSPORT CONSIDERATIONS
Version: 0.7

1. Purpose

This report sets out considerations for travel to and from hospitals accessed by Lincolnshire patients, carers, relatives, and others, related to the changes in hospital-based services proposed in the Lincolnshire Acute Service Review (ASR).

The focus of this report is the issues and potential mitigations related to the practicalities of patients, carers, relatives, and others undertaking journeys to and from hospitals that are at a more distant site than currently and therefore take longer to travel to than would be the case if the current service arrangements were continued.

This report does not focus on the more general issue of care being at a more distant hospital or consider any issues of changes to patient outcomes related to longer journey times to access care.

2. Executive Summary

The proposals for changes to four services set out in the Lincolnshire Acute Services Review (ASR) mean that patients and their families, carers and other visitors will need to travel greater distances and for longer to access care for these services. Feedback on the consultation on the ASR proposals has identified travel and transport as a significant concern for patients and stakeholders, with the key concerns being the ability to access services at more distant sites and the challenge for people without their own transport to be able to get home from hospital in the evening or overnight when public transport does not operate.

The three categories of transport service that are impacted by the changes are 999 ambulance services, non-emergency patient transport services and other transport services.

The CCG has a duty to provide services for patients requiring 999 ambulance services and patients meeting non-emergency patient transport eligibility criteria. For these services the CCG will mitigate the impact of the longer travel distances and times by commissioning additional service from its current, and in the case of patient transport, future providers.

For other transport services, for example for patients who are ineligible for patient transport or for hospital visitors, the CCG has a choice of whether and how it seeks to mitigate the longer journey times. Three options, to support patients requiring other transport services are suggested in this report for discussion by the CCG Executive. These are as follows:

- CCG commissioned additional bus transport
- CCG commissioned targeted transport support
- Cost per mile reimbursement

Estimated costs for each of the transport categories are set out in section 9 of this report.

For emergency and urgent transport and non-emergency patient transport the cost driver is the longer journey distances and times to access care. It is not expected that the number of patients accessing care will increase. For other transport the cost driver is the provision of transport for a new cohort of patient and visitors that has not previously been funded by the CCG.

Following deep discussion and consideration by the CCG Executive, there was a consensus that the group could not currently see a case to create a bespoke 'other transport' service for the small number of patients affected by the four change proposals that would be feasible, deliverable and fair. However, if a proposition was to come forward that overcame these issues around 'fairness' and 'equity' then this would certainly be considered in full.

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

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

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.

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.

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.

3. Structure of this Report

For the purpose of this report, transport issues are considered across three broad types of transport service. This is because there are common issues and factors for each type of transport for each clinical service where a change has been proposed. The types of transport that are considered and the service changes they are relevant to are as follows:

Transport Type	**Service change proposal**
Emergency and urgent transport	Orthopaedics - Non-elective Urgent and Emergency Care Acute Medicine Stroke
Non-emergency patient transport	Orthopaedics - All Urgent and Emergency Care Acute Medicine Stroke
Other transport	Orthopaedics - All Urgent and Emergency Care

	Acute Medicine Stroke

4. Background

The Lincolnshire Acute Services Review (ASR) proposes changes to four services that are currently provided at a number of hospital sites in Lincolnshire and at hospitals outside of the Lincolnshire county boundary. The proposed changes are for elective and non-elective orthopaedic services, urgent and emergency care attendances, medical admissions, and stroke services. A detailed summary of these changes set out in provided in Appendix 1.

Building on concerns identified from stakeholders during early work on the ASR, transport was identified as a key issue to be considered for the ASR, with a transport workstream formed in order to review and suggest potential ways of mitigating the effects of increased travel times for patients, carers, relatives, and others associated with the proposed changes to the four services.

A formal public consultation has been undertaken on the proposed changes. This included a survey which individuals and organisations were able to complete, public engagement events and presentations to and written submissions from key stakeholders. Comments received during the public consultation have been independently reviewed and analysed and the comments collated into themes. Transport issues have been commented on in a large number of responses to the consultation, with the number and strength of comments indicating the importance that Lincolnshire citizens place on transport issues that are related to the proposed changes. Transport related comments from the consultation are set out in Appendix 2.

Modelling undertaken to support the ASR proposals suggests that a relatively small number of patients of around 3,320 patients annually (9 per day) will be affected by the proposed changes. These patients will have longer distances and travel times to access care than they would currently and journeys that my not be able to be completed by public transport in the evening or overnight. These issues will also impact of people who may wish to visit affected patients during their hospital stay.

The number of patients affected varies by service and whilst modelling suggests there are relatively small numbers affected for some of the services, the impact on individual patients who are affected is considerable. For example, a journey to hospital that currently takes 30 minutes, after the change to services may take one of two hours.

The ordinary elective orthopaedic service change at Grantham Hospital was piloted during the peak of the COVID pandemic. For patients, patient transport was used to support patients travelling further distances to and from Grantham with additional patient transport resource being commissioned. Due to COVID restrictions, visitors were not allowed to attend the hospitals during the pilot period but since visiting has been restored there has been little adverse comment received by the CCG related to access for visitors.

5. Commissioning Objectives and Key Assumptions

It is recognised that the service changes proposed in the ASR will result in longer distances and therefore journey times for a number of patients, and for their carers relatives and friends who wish to visit patients in hospital.

The key commissioning objective of the CCG in considering travel and transport impacts of proposed changes to services set out in the ASR is to minimise the risk of patients deciding not to access assessment, diagnosis and treatment where they consider that the travel time or complexity of travel arrangements are too onerous. This risk is largely associated with elective (planned) care aspects of the proposed change and would be minimal for the proposed changes for emergency care pathways such as non-elective orthopaedics, acute medicine, and stroke.

The CCG has a duty to provide emergency and urgent transport and to provide patient transport for patients who meet national patient transport eligibility criteria. The CCG will put in place any changes notified to the national criteria including any flexibilities that may be to the benefit of Lincolnshire patients.

Whilst the CCG does not have a duty to provide transport for patients who do not meet patient transport eligibility criteria or for visitors, the CCG fully considers feedback received through the ASR consultation process and mitigations that may be put in place to address this feedback.

The number of patients affected varies by service and whilst modelling suggests there are relatively small numbers affected for some of the services, the impact on individual patients who are affected is considerable. For example, a journey to hospital that prior currently takes 30 minutes may in future take one or two hours.

The CCG has to balance what it reasonably provides to mitigate the impact of the changes on patients who do not require emergency and urgent transport and / or who are not eligible for patient transport. The considerations in this report suggest options for alternative transport solutions for those Lincolnshire citizens where the proposed changes have the greatest impact on their travel distances and times.

6. Emergency and Urgent Transport

6.1 Description

This service is for patients who need the support of an emergency ambulance for their journeys to hospitals following and accident or emergency, for example, acute medical patients or stroke patients.

6.2 Current Position

The Emergency and urgent transport service is provided by East Midlands Ambulance Service NHS Trust (EMAS). This includes providing emergency ambulances for patients who have an accident or emergency at home or in the community and need conveying to hospital, and who are assessed as needing an ambulance response to convey them safely to a hospital where the patient is able to revive more specialist care for their condition.

6.3 Future Position

Whilst demand for emergency transport is not expected to increase as a result of the ASR proposals, the journey time and distance will increase.

EMAS has been a key stakeholder in working with commissioners in the proposed changes to services set out in the ASR consultation. EMAS has been involved in the specialist working groups that support the consultation and has contributed to the design of the pathways for patients affected by the changes.

The proposed changes and their impact on emergency and urgent transport service are recognised by EMAS. EMAS will be commissioned to support the proposed changes so that patients who need urgent or emergency transport are able to be conveyed to the hospital that is able to best meet their needs. For example, this could mean taking a patient who has a stroke at their home in or around Boston to Peterborough Hospital or Lincoln County Hospital rather than to Pilgrim Hospital. The longer journey times will mean that EMAS will need to provide additional crews and vehicles and EMAS are aware of and ready to respond to this requirement on formal agreement of the changes set out in the ASR consultation.

6.4 Considerations and mitigations

Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS.

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 so that the impact of the proposed service changes on ambulance capacity is negligible.

One comment from the consultation feedback suggested that United Lincolnshire Hospitals provide their own emergency and non-emergency transfer service (from the UTC) to local A&E departments, so that East Midlands Ambulance Services are not affected. Emergency and urgent patient transport is a specialist area and although it would be possible to commission an additional service, EMAS are recognised as the specialist provider in Lincolnshire and there would be greater coordination through the EMAS control room, flexibility, resilience, and economies of scale through engaging EMAS for this service rather than having this service provided directly by the hospitals or an additional provider. From time-to-time EMAS use private emergency ambulance crews to support their service and this would continue under the control of EMAS. For these reasons this suggestion will not be implemented but will be kept under review delivery of additional journeys by EMAS.

A further comment suggested that the air ambulance service could be used to take stroke patients to hospital. Under the proposals, stroke patient who are currently taken to Pilgrim Hospital would have their initial care at Lincoln County Hospital rather than at Pilgrim. This suggestion has been considered will not been taken forward as the air ambulance does not respond to stroke patients.

7. Non-emergency Patient Transport

7.1 Description

Non-emergency patient transport (NEPTS) is provided for patients who meet the nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for patients who are going to hospital for outpatient appointments, diagnostics or treatment or for admission, and for patients who are eligible for transport from hospital following outpatient or diagnostic appointments or daycase or inpatient care and treatment.

7.2 Current Position

Non-emergency patient transport for Lincolnshire patients is provided under contract to the CCG by Thames Ambulance Service (TASL). Some additional support is provided for discharge from hospital by another ambulance provider.

During 2020/21, the CCG undertook a procurement process for a new contract for patient transport services as the current contract was nearing the end of its original term. This procurement included bringing all patient transport services for eligible Lincolnshire patients under the control single provider. The procurement required bidders to build into their response to the procurement the patient transport impact of the proposed changes to services included in the ASR consultation.

7.3 Future Position

Whilst demand for patient transport is not expected to increase as a result of the ARS proposals, the journey time and distance will increase.

It is expected that current patterns of eligibility for patient transport will continue if the proposed changes are implemented. It is assumed that patient transport will support:

- 40% of ordinary elective inpatients to travel to hospital and 50% to travel from hospital
- 30% of day cases to travel to and from hospital
- 80% of non-elective orthopaedic patient to travel from hospital
- 80% of A&E and non-elective admission, and stroke patients to travel from hospital

At the date of writing this report the CCG is not able to confirm the outcome of its recent procurement. We have confirmed with TASL that they have recognised the requirement of increased journey distances and times to support the proposed service changes. The preferred bidder for the new contract has also fully recognised the likely impact of the proposed service changes in their resourcing and costing submitted in their tender response.

It is therefore 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 current patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers and this is also a requirement in the new contract.

7.4 Considerations and mitigations

Work is planned with TASL and within the new contract to meet the additional journey times associated with the proposed service changes set out in the ASR consultation. There is therefore a high degree of confidence that services the changes proposed in the ASR consultation will be supported by current and future contracted providers for patients who are eligible for patient transport.

The consultation feedback included comments on the potential impact on patient transport capacity of increased journey distances and times. As stated above this has been fully recognised by the CCG and will be mitigated by commissioning resources from the current and future contracted provider.

8. Other Transport

8.1 Description

This includes transport arrangements for patients who are ineligible for non-emergency patient transport and transport for relatives, carers, and other visitors attending hospitals.

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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services. Potential options to mitigate concerns raised in the ASR consultation feedback are set out in section 8.4 below.

8.2 Current Position

8.2.1 Bus services to and from Hospitals Sites

There is limited coverage of public transport arrangements in Lincolnshire. Bus routes largely operate between the main centres of population. Rural areas and villages are generally not well served by bus operators and bus services outside of main centres of population often do not operate in the evening or overnight. Currently there is little scope for current or new bus operators to increase the number or frequency of bus operations.

Current bus services between hospital sites are as follows:

- There is a direct daily bus service that operates on an hourly basis daily between Lincoln County Hospital and Pilgrim Hospital, and Lincoln County Hospital and Grantham Hospital;
- There is a Monday to Saturday bus service operating at limited times every 2 hours between Lincoln County Hospital and Louth Hospital.

Direct bus services generally operate between 8.00am and 8.00pm.

However:

- There is no direct bus service between Grantham Hospital and Louth Hospital;
- There is no direct bus service between Grantham Hospital and Queens Medical Centre, Nottingham;
- There are no direct bus services between Pilgrim Hospital and Grantham Hospital, or from Pilgrim Hospital to Peterborough Hospital;
- There are no direct bus services from Grantham Hospital to Peterborough Hospital.

Indirect bus services between hospitals sites require one or more changes and changes do not always coincide with the connecting services.

8.2.2 Train services

Daily train services operate between Lincoln and Grantham and between Lincoln and Boston. Daily services also operate between Grantham and Nottingham and Grantham and Peterborough. All train journeys require an onward journey to and from the train station to the hospital site.

There are no trains to Louth.

8.2.3 Community Transport / Voluntary Car Schemes

Dial-a-ride services operate in the Lincoln area for elderly or disabled people who have registered with the service. There is a minimum journey distance requirement of 3 miles and charges are £1.50 per mile.

There are 15 voluntary car schemes operating in Lincolnshire. They all use voluntary drivers with their own cars with charges being around £0.50 per mile. Some schemes charge a membership, and some have minimum distance requirements. Individual schemes decide whether they will take patients for health or health and social needs and whether the service is restricted from or to a local area. Two schemes have recently closed.

8.3 Future Position

Expanding and changing current public bus routes is problematic with many commercial operators under considerable pressures including driver shortages, increased operating costs, and low levels of use. Low levels of use are a carry-over from the height of COVID. There is likely to be a contraction of commercial bus routes in the next few months.

Expanding the number of community transport schemes or increasing the service offer of current schemes would also present a significant challenge due to the difficulty in recruiting drivers.

Train services are likely to remain as current or reduce as government subsidies available through COVID are progressively reduced.

8.4 Considerations and mitigations

The consultation feedback included a number of comments and concerns related to patients and visitors being able to get to and from hospital services that may be further away from their current hospital and which therefore take longer to travel to.

The CCGs key commissioning objective is to minimise the risk of patients deciding not to access assessment diagnosis and treatment due to greater distances and travel times. Whilst it is not expected to mitigate the greater journey distances for all patients and visitors, the CCG has considered the options below as potential mitigations of the longer travel distances and times for this group of patients and their visitors.

8.4.1 CCG commissioned additional bus transport

This service would operate between key hospital sites and be for patients who are ineligible for patient transport and their visitors. This assumes that patients will start and finish their journeys at their local hospital.

The assumptions of the number of patients in each service who would travel to hospital by 999 ambulance or the patient transport service, or who would travel from hospital by patient transport means that there are likely to be very few patients who would need support from this service. It is estimated that the annual number of journeys would be:

- 314 between Lincoln and Louth
- 443 between Grantham and Louth
- 290 between Grantham and Lincoln
- 172 between Grantham and Peterborough
- 78 between Pilgrim and Lincoln

Due to low patient numbers affected it is not intended to consider this option for patients who might access services at Nottingham or Kings Lynn. It is assumed that patients currently accessing independent sector hospitals will have their own transport and will continue to use this to access services following implementation of any proposed changes.

Whilst ordinary elective and daycase patients may be 'grouped' to attend hospitals, the relatively small number of these journeys mean that the provision of additional bus transport is likely to have unused capacity.

It is unclear how many visitors might choose to travel, but again, given the relatively small number of patients it is unlikely that bus transport would be fully utilised through a combination of patients and visitors.

It is suggested that any additional bus services are piloted for a period of three months and with patient and visitor use evaluated in this period.

8.4.2 CCG commissioned targeted transport support

This service would provide support transport for patients having to travel to more distant hospitals. This would take the form of a taxi service that would pick up patients who are ineligible for patient transport services and take them to or from hospital.

Transport would be arranged through a central call point managed by the CCG PTS provider or another provider. The CCGs PTS provider could provide the service using sub-contract arrangements with taxi companies or, alternatively the service could be provided through the Lincolnshire County Council transport service. This option would support all patients affected by the ASR changes.

Access to the service would be restricted through the application of criteria to patients affected by the ASR options. Criteria would include the distance of the patient's home address from the hospital where the admission / attendance would have taken place (this restricts to patients/ visitors who are likely to be affected by the ASR change) and the distance from hospital where the admission / attendance will take place. For example, orthopaedic day cases would be eligible if they live with 15 miles of Grantham and more than 30 miles from Louth or an alternative independent sector hospital. These criteria would also be applied to visitors, with the number of visits also being restricted.

The service could be targeted to support transport for patients in area of high areas of deprivation for example patients travelling from the East Coast to Grantham for elective surgery.

Administration costs would need to be built into the overall cost of the service.

The annual maximum number of patient journeys that this option would cover is estimated at 1,975. The annual number of visitor journeys is uncertain but is estimated to be 4,300.

8.4.3 Cost per mile reimbursement

Under this option, patients would be encouraged to used community transport, family, or friends to convey them to or from hospital wherever possible and would be reimbursed for additional milage at a rate per mile. This could also apply to visitor journeys. Access to the service would only be for patients affected by the ASR options.

Administration costs would need to be built into the overall cost of the service.

The annual maximum number of patient journeys this would apply to is 1,975. The number of visitor journey is uncertain but is estimated to be 4,300.

8.4.4 NHS Lincolnshire CCG Executive discussion

The NHS Lincolnshire CCG Executive considered the options set out above as potential mitigations to the concerns raised through the public consultation in relation to longer travel distances and times for patients, carers and visitors.

Following deep discussion and consideration by the CCG Executive, there was a consensus that the group could not currently see a case to create a bespoke 'other transport' service for the small number of patients affected by the four change proposals that would be feasible, deliverable and fair. However, if a proposition was to come forward that overcame these issues around 'fairness' and 'equity' then this would certainly be considered in full.

It was acknowledged that:

- Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital.
- A number of solutions already exist and strengthening the current arrangements is central to addressing the concerns raised. Opportunities include:
    - Promoting the use of public transport options to try to reduce reliance on car usage
    - Promote and use existing infrastructure wherever possible
    - Making the best use of existing public transport facilities wherever possible – including engagement with transport operators to discuss how services could accommodate changing travel patterns
    - Ensure users have clear and easily accessible information about public transport options to encourage uptake
    - Tackling issues relating to expanding existing volunteer driver schemes
- The NHS in Lincolnshire is committed to working in partnership with all partners, particularly Lincolnshire County Council, to support and improve travel and transport solutions for health and care services in the widest sense, not just in relation to the four proposed services changes.
- This is being actively considered with the County Council and continuing to tackle this challenge is a priority for the Lincolnshire Health system.
- 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.

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:

- 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

9. Financial Considerations

Estimated additional transport costs associated with the ASR changes including the options for other transport set out in this report are included in the table below. These costs will need to be further confirmed and refined in discussion with providers as part of the detailed implementation of any ASR proposals.

For emergency and urgent transport and non-emergency patient transport the key cost driver is the longer journey distances and times to access care. It is not expected that the number of patients accessing care will increase.

For other transport, the cost driver is the provision of transport for a new cohort of patient and visitors that has not previously been funded by the CCG.

Transport Type	**Expected annual number of Journeys**	**Estimated Cost £(000)**	
Emergency and urgent transport (999)	1,312		349.5
Non-emergency patient transport	3,298		277.6
Other transport	1,975 patients	Option 1	390.0
		Option 2	110.8
		Option 3	72.4
	4,300 visitors	Option 1	Included in above
		Option 2	335.2
		Option 3	232.2

Note: Other transport options 2 and 3 do not include costs of administration and this will need to be added to final costs.

10. Conclusions

The proposals for changes to four services set out in the Lincolnshire Acute Services Review (ASR) mean that patients and their families, carers and other visitors will need to travel greater distances and for longer to access care for these services.

Feedback on the consultation on the ASR proposals has identified travel and transport as a significant concern for patients and stakeholders.

The three categories of transport service that are impacted by the changes are 999 ambulance services, non-emergency patient transport services and other transport services.

In light of the above assessment the following conclusions have been drawn and mitigations identified in respect of the feedback received through the public consultation in relation to travel and transport.

Emergency and Urgent Transport

- Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS.

- 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.

- The estimated additional cost for this type of transport is £349.5k

Non-emergency Patient Transport

- Non-emergency patient transport (NEPTS) is provided for patients who meet the nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for 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.

- It is therefore 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 discharge from these hospitals.

- The current patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers and this is also a requirement in the new contract.

- The estimated additional cost for this type of transport is £277.6k

Other Transport

- 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.

- Following deep discussion and consideration by the CCG Executive, there was a consensus that the group could not currently see a case to create a bespoke 'other transport' service for the small number of patients affected by the four change proposals that would be feasible, deliverable and fair. However, this is not to say that if a proposition was to come forward that overcame these issues around 'fairness' and 'equity' then this would certainly be considered in full.

- 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.

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

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

- Irrespective of whether the 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.

<u>All Transport</u>

- 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.

- 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.

Tim Fowler
Associate Director of Contracting and Performance

Tom Diamond
Associate Director of Strategy

18 May 2022

SUMMARY OF SERVICE CHANGES

Service / Patient Type	Patient Type Description	Change From	Change To	Modelled number of patients affected
Orthopaedics				
Ordinary elective patients	Patients who have a pre-arranged date for surgery and stay in hospital more than one day	Surgery at Lincoln County Hospital, Pilgrim Hospital, Louth Hospital and at a number of out of area and independent sector hospitals	Surgery at Grantham	824 ordinary elective patients per year will move to Grantham. This is 169 patients from Lincoln, 125 from Pilgrim, 199 from Louth and 331 from out of area and IS hospitals
Daycase patients	Patients who have a pre-arranged date for surgery and are admitted and discharged on the same day	Surgery at Lincoln County Hospital, Grantham District Hospital and at a number of out of area and independent sector hospitals	Surgery at Louth Hospital with a further small number of patients having their day case surgery at Pilgrim Hospital	442 daycase patients per year will move to Louth and 35 to Pilgrim from Grantham (218), Lincoln (224) and out of area and IS hospitals
Non-elective patients	Patients who do not have a pre-arranged date for surgery and where their surgery is urgent or an emergency	Surgery at Grantham Hospital	Surgery at Lincoln County Hospital and out of area hospitals Nottingham and Peterborough) with a small number of patients having their non-elective surgery at Pilgrim Hospital	137 non-elective patients will move to Lincoln, 12 to Pilgrim, 215 to Peterborough and 35 to Nottingham hospitals from Grantham
Urgent and Emergency Care				
Attendances	Patients who attend an hospital for assessment and treatment following and accident or in an emergency. This includes patients who	Attendance at Grantham Hospital	Attendance at Lincoln County Hospital and at a number of out of area hospitals: mainly Nottingham and Peterborough	228 attendances per year will move to Lincoln and 400 to Peterborough and 66 to Nottingham hospitals from Grantham

	would travel to a hospital by ambulance or who travel to the hospitals by their own means.			
Acute Medicine				
Non-elective admissions	Patients who are admitted to hospital for treatment of an unplanned urgent or emergency medical need.	Inpatient medical treatment at Grantham Hospital	Inpatient medical treatment Lincoln County Hospital and at a number of out of area hospitals: mainly Nottingham and Peterborough	153 admissions per year will move to Lincoln and 243 to Peterborough Hospital from Grantham
Stroke				
Non-elective admission	Patients who are admitted to hospital for treatment of an unplanned urgent or emergency medical need.	Inpatient treatment for stroke at Pilgrim Hospital	Inpatient treatment for stroke at Lincoln County Hospital, Peterborough Hospital and Kings Lynn Hospital	392 patients per year will move to Lincoln, 89 to Peterborough and 36 to Kings Lynn from Pilgrim Hospital

SUMMARY OF CONSULTATION FEEDBACK

Lincolnshire NHS public consultation on proposed changes to four services
Transport Detail Taken from Full Draft Report 21.3.22
Info taken from selected consultation activities which provide further, quantifiable responses with regards to travel and transport

Service	Transport Related theme
Orthopaedics	1.5 The biggest area of concern was in relation to travel and access; over two-fifths of those who commented had concerns in general, felt that services needed to remain local to reduce travel, and/or had concerns about the accessibility of different sites.
	1.6 Around a tenth raised various concerns around travel and access practicalities including costs, public transport (in the sense of lacking coverage, being too infrequent etc), issues with road infrastructure and congestion, and parking.
	1.8 Other concerns raised by small proportions related to possible environmental impacts (i.e., if people have to travel further)
	1.8 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
	1.10 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
	1.11 A small proportion were concerned about impacts on the ambulance service and on patient transport. In regard to potential impacts on vulnerable groups, one respondent requested assurance that there will be a review of the eligibility criteria for patient transport services to address any potential barriers to access, particularly for the most deprived communities in rural and inner city areas, and that additional support and transport will be provided to address need.
	1.14 Travel and access were noted as issues by five of the sixteen organisations. Public transport infrastructure was a particular concern, with Boston Borough Council, East Lindsey District Council, South Holland District Council, and Skegness Town Council all raising it as a potential issue in need of mitigation.
	1.15 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.

Service	Transport Related theme
Urgent and Emergency Care	1.19 A third had general concerns relating to travel and access themes: the accessibility of emergency services at the remaining sites, the need for some local emergency provision in Grantham, and so on. There were also a number of more specific concerns relating to issues such as roads, parking and public transport.
	1.20 A tenth commented about a potential negative impact on the ambulance service and on patient transport (e.g., in terms of greater response times and an inability to cope with demand).
	1.25 As with the orthopaedics question, 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.
	1.27 Travel and accessibility were concerns for multiple organisations, even some who agreed with the proposals. For example, the Older People's Forum acknowledged the benefits of the proposed changes, while noting potential difficulties for those without their own transport. Moreover, access to public transport was again a concern for local councils.
	1.29 Distance and travel time was also concerning from a council perspective, particularly in terms of impacting visitor support and impacting patient recovery. Digital communication options were suggested as solutions to this issue.

Service	Transport Related theme
Acute Medical Beds	1.33 As with the questions about the previous proposals, there were various concerns expressed in terms of travel and access issues: either around the general principle of travelling further for care, various practicalities concerning travel/transport, and/or the impact on particular groups (in terms of this latter point, the ability for family and friends to visit patients was felt to be particularly important).

Service	Transport Related theme
Stroke Services	1.43 As with the previous proposals, there were concerns about travel and access issues, with many of these focusing on the perceived inaccessibility of services at Lincoln specifically. Some felt there would be particular issues for service users (i.e., stroke patients), the elderly, people without access to vehicles, and patients' families and friends. Others were concerned about the impacts on ambulance response times and the ambulance service as a whole, as a result of high demand and longer journeys to hospital.
	1.47 As with the other proposals, feedback from and about protected characteristics groups and other key demographics

	tended to express some concerns about travel and transport. The potential impacts on patients' loved ones was also noted, particularly older family members and carers 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.
	1.51 While there was support for a centre of excellence for stroke services, travel and access to the proposed site at Lincoln County Hospital was a concern for some organisations. The main worries were that: the additional travel time would mean more negative patient outcomes in the event of a time-critical incident like a stroke; it would be difficult for family and friends to visit, negatively impacting patients' recovery; and EMAS and non-urgent patient transport would be placed under considerable additional pressure.

Service	Transport Related theme
Orthopaedics	Equalities impacts concerns focused on travel and transport, with several specific demographic and protected characteristics groups mentioned, including: o Older and frail people o Those with lower incomes and/or without access to private transport o People with disabilities o Residents of rural areas more distant from specialist services
	NHS and public transport was described as poor, and some respondents recommended that the eligibility criteria for Patient Transport Services be reviewed to ensure access for those who need it, and that the service be expanded.

Service	Transport Related theme
Urgent and Emergency Care	Travel and access to reach A&E services, and to return home after discharge, was the most common concern, and this was reflected in comments about potential equalities and health inequalities impacts. Groups mentioned in this respect included older people, those with disabilities, and people living in more deprived communities and rural areas.
	Similarly, feedback from individuals with protected characteristics under the Equalities Act 2010 also focused on concerns about travel and transport to reach A&E services if the proposal for a 24/7 UTC was to go ahead.
	Mitigation measures focused on improving transport between hospital sites, and additional support for patients without access to private vehicles.

Service	Transport Related theme
Acute Medical Beds	No specific comments

Service	Transport Related theme
Stroke Services	Disagreement , which was strongest among those living closest to Pilgrim Hospital, Boston, was driven by concerns about loss of local stroke services, and longer travel times to reach Lincoln County Hospital.

	Potential challenges around travel for elderly family members were also raised, which some felt might also negatively impact patients' mental health and recovery if they are not able to have visitors.
	Mitigation measures tended to focus on addressing loss of local acute stroke services (e.g., air ambulance provision; increased community care to speed up discharge times)

CONSULTATION FEEDBACK THEMES – VERSION 9

Service	Transport related theme
Orthopaedics	Concerns about travel and transport to County Hospital Louth
	Concerns about travel and transport to Grantham and District Hospital
	Measure which might mitigate against challenges some service users might face around travelling to more distant or unfamiliar hospital sites e.g. Increased provision of patient transport services Working with local authorities to explore improvements to public transport links More follow-up appointments provided in community
	It is not the County Council's role to facilitate changes to public transport provision, solely and directly in response to changes to NHS services. Furthermore, the Committee has concerns over evening and overnight discharges when public transport does not
Urgent and Emergency Care	Impact on members of the public who might find it difficult to travel to and from Lincoln County Hospital and other locations due to poor transport links to Lincoln County Hospital and increased costs and journey times, particularly for those who rely on public transport or are discharged late at night
	Visitors if patients admitted to hospitals, both in terms of their own journeys and the potential impacts on patient recovery and wellbeing if they are isolated from family and carers.
	More patient transport options be offered between hospital sites, and to help patients to return home following discharge if they were transferred from the UTC to an A&E at a different hospital
	If proposal for 24/7 UTC goes ahead, ULHT should provide their own emergency and non-emergency transfer service to local A&E departments, so that East Midlands Ambulance Services are not affected
	There are climate change implications when patients have to travel to and from hospitals - Centralisation undermines government policy on 'zero-carbon' transport which will mean that fewer of the poor and vulnerable will have electric cars"
Acute Medicine	No specific comments related to travel and transport
Stroke	Travelling to Lincoln to visit patients would be difficult for many families and carers which was seen to be a cause of anxiety for many. poor infrastructure and a lack of public transport options make travelling to Lincoln difficult
General	Provision of a shuttle bus that would go between all of the three sites would help those with financial difficulty or who would not have a means of getting to the hospital.

Appendix J

Recommendations of East Midlands Clinical Senate

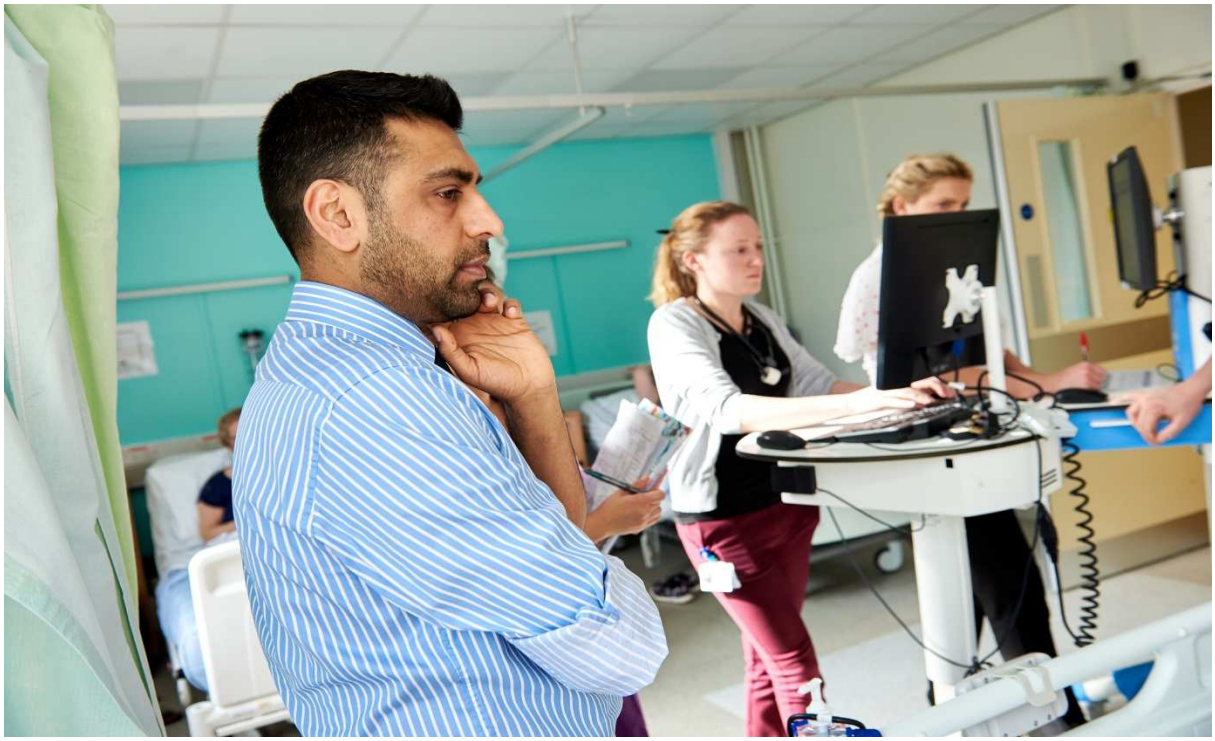
Please note that the eight service change proposals reviewed by the East Midlands Clinical Senate and set out in this report reflect the full scope of the Lincolnshire Acute Services Review Programme when it was established. .

Of these eight services four (Orthopaedics, Urgent & Emergency Care, Acute Medicine and Stroke) are the subject of this Decision Making Business Case and associated consultation with the public, due to not having sufficient capital funding to make all of the proposed changes happen at once.

Discussions are ongoing in the Lincolnshire health system in relation to how the other four service change proposals within the scope of the Acute Services Review programme progress.

East Midlands Clinical Senate

Lincolnshire STP – Acute Services Review



Report of the Independent Clinical Senate Review Panels (11th July 2018 and 12th September 2018)

October 2018

Confidential

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Glossary of abbreviations

STP	Sustainability and Transformation Partnership
ULHT	United Lincolnshire Hospitals NHS Trust
PCBC	Pre Consultation Business Case
RCPCH	Royal College of Paediatrics and Child Health
GIRFT	Getting It Right First Time
NICE	The National Institute for Health and Care Excellence
PSA	Prostate Specific Antigen
UTC	Urgent Treatment Centre
GP	General Practitioner
PAU	Paediatric Assessment Unit
EMAS	East Midlands Ambulance Service
A&E	Accident and Emergency
TIA	Transient Ischaemic Attack
LMS	Local Maternity System
CT	Computed tomography
MRI	Magnetic Resonance Imaging
OPD	Out Patient Department
CoMET	Children's Medical Emergency Transport
ANP	Advanced Nurse Practitioner

AHP	Allied Health Professional
HEE	Health Education England
HEI	Higher Education Institution
ONS	Office for National Statistics

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Executive Summary

The clinical review panel of 11th July 2018 strongly supported most of the proposals, including the consolidation of services, although several areas were highlighted where the panel had concerns and could not arrive at a conclusion based on some of the original evidence provided.

More information was requested to support the proposal for the medical beds at Grantham Hospital and Women's and Children's Services to enable the Clinical Senate to offer a more definitive clinical opinion on these models of care. The STP took the decision to remove Urology from their current proposals.

This report lays out in chronological order the key findings and recommendations of the clinical review panels on 11th July and 12th September, 2018.

Summarised below are the key recommendations from both clinical review panels and further detail of the key findings and the rationale for each recommendation can be found in sections five and eight:

- The panel recommends involving Health Education England early in the process regarding the training experience of junior surgeons.
- The panel were of the opinion that Lincolnshire STP is well placed on the East coast for a clinical trial around early (in ambulance) stroke management, and suggests that this could be explored further.
- The panel recommends that EMAS contributes to a system-wide review of transfer and potential diverted activity, to include any clinical associated risks and benefits. In addition, Lincolnshire STP should work with EMAS and other transport providers (i.e. CenTre Neonatal Transport and CoMET) to review Neonatal and Paediatric transport implications fully.
- Obstetric input into the community hubs needs to occur consistently and at an early stage in the STP's plans and the level of resource required needs

to be accurately identified. The panel is of the opinion that obstetric input into the community hubs will need to be increased but when this is achieved will address a number of outstanding issues including the identification of high risk patients.

- A plan for outcome based strategies should be developed, clearly articulating how clinical outcomes at Pilgrim will be improved.
- A head of nursing for paediatrics should be appointed to join the senior leadership team at ULHT with a major brief to develop the ethos of a “single team” and address the practical issues involved in its working.
- The opportunities that exist for the trainees needs to be considered and a holistic approach considered to address transport, remuneration and professional development issues to produce attractive posts and significantly reduce the reliance on locum positions. A number of suggestions were made by the panel and the STP team should also explore the other options it discussed.

1. Foreword by Professor Ashley Dennison, Clinical Review Panel Chair

Clinical Senates have been established 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.

Lincolnshire is one of five Sustainability and Transformation Partnerships (STPs) in the East Midlands. The Clinical Senate recognised the challenges the Lincolnshire STP faces in delivering their acute services reconfiguration work. The geography, size of the footprint and distribution of the population present a number of especially difficult challenges which require issues of access, equity of care and transport problems to be carefully balanced against quality, staffing, and financial constraints.

The Clinical Senate was pleased to be able to assist the Lincolnshire STP and wishes to thank all the constituent members for their time and input on both days.

The panel first met on 11th July 2018 and was composed of professionals covering all the areas discussed by the Lincolnshire STP team, were largely in support of the proposed changes; however a number of areas were highlighted where the panel had concerns or were not able to arrive at a definitive conclusion based on some of the original evidence provided.

The Clinical Senate was pleased to assist the Lincolnshire STP further by convening a supplementary clinical review panel on 12th September 2018, which gave the STP the opportunity to address the information and evidence gaps originally highlighted by the clinical review panel on 11th July, 2018. This enabled the Clinical Senate to offer a more definitive clinical opinion on the medical beds at Grantham Hospital and Women's and Children's Services.

Professor Ashley Dennison
Clinical Senate Chair

2. Clinical Senate Review Panel summary and key recommendations

On 11th July 2018, the clinical review team was asked to consider whether there is a clear clinical evidence base underpinning Lincolnshire STP's proposals. The review focussed on the clinical interdependencies and the totality of the changes proposed, as opposed to a more in-depth review of each clinical specialty. These proposals have been developed by the STP under the umbrella of Lincolnshire's Acute Services Review. Specifically, the clinical review team was asked whether it supported Lincolnshire STP's proposals based on clinical sustainability, workforce and clinical outcomes.

The panel concluded that whilst it was largely in support of the proposed changes, several areas were highlighted where the panel had concerns and could not arrive at a conclusion based on some of the original evidence provided.

The panel recommended that Lincolnshire STP proceeds with its proposals for the following clinical specialties:

- Breast Services
- General Surgery
- Trauma and Orthopaedics
- Stroke
- Haematology and Oncology

The panel were of the opinion that further work needed to be completed for the following clinical specialities:

- Urology
- Medical beds at Grantham Hospital
- Women's and Children's

In light of the original clinical review panel's comments on 11th July 2018, the STP subsequently confirmed that they intend to remove Urology from their current proposals and potentially revisit it at a future point. The Clinical Senate was further

engaged by the STP to give them the opportunity to address the specific points the original clinical review panel raised in relation to the medical beds at Grantham Hospital and Women's and Children's Services. This supplementary clinical review took place on 12th September, 2018.

The clinical review team was impressed with the amount of work that had taken place between 11th July and 12th September on the medical beds at Grantham Hospital proposal. 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. 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.

The panel acknowledged the ambition the system has to deal with the challenges it faces in relation to Women's and Children's Services, striving to balance access and inequalities with sustainable long term clinical outcomes. It is clear that concerns and suggestions raised by patients and the public have been carefully listened to in the development of the STP's proposals.

The LMS and the Better Births Strategy has some commendable aims, although more obstetric input into the community hubs is required early on.

The panel acknowledged the enormous amount of work that has been undertaken by the STP to identify the appropriate model that ensures access equality for the whole Lincolnshire population, which includes some areas of significant deprivation on the East Coast, while also addressing the need to maintain quality standards and solve the long term workforce problems.

Despite the considerable amount of work undertaken however, the panel were unanimously of the view that there must be a shift to improving key outcomes and the longer term workforce issues appear to remain insolvable.

3. Background and advice request

Over the last six months, commissioners in Lincolnshire have been leading work to agree the optimum configuration of acute care in the County. They have been examining in detail the potential impact on the population served and also considered any consequences for their neighbouring [adjacent] providers. This is referred to locally as the Acute Services Review. This work has involved the following:

- Gathered specialty specific information from United Lincolnshire Hospitals NHS Trust (ULHT) to establish the case for change and evaluate all the potential options which would facilitate this change.
- Developed a whole system activity and finance model to assess the impact on activity, finances and patient access of the different options.
- Held two Clinical Summits in February 2018 where over 100 key stakeholders from Lincolnshire's health economy were represented together with 12 representatives from the East Midlands Clinical Senate who provided independent clinician input and acted as facilitators. It was agreed that there was a strong case for change and considered a number of options for reconfiguration.
- The selection of a preferred option which has been agreed across the Lincolnshire STP, which will be detailed in a Pre Consultation Business Case (PCBC) due for completion by the end of September 2018 (this was rescheduled from July 2018 to incorporate the supplementary clinical review).

The clinical review team was asked to consider whether there is a clear clinical evidence base underpinning the STP's proposals. The review focussed on the clinical interdependencies and the totality of the changes proposed. Specifically, the clinical review team was asked whether it supported Lincolnshire STP's proposals based on clinical sustainability, workforce and clinical outcomes.

3.1 Description of current service model

There are currently four hospitals in Lincolnshire under the auspices of United Lincolnshire Hospitals NHS Trust: Lincoln County Hospital, Grantham and District

Hospital, Pilgrim Hospital in Boston, and County Hospital Louth. The current service model and configuration is outlined in the table below:

Speciality	Service model and configuration
Breast services	Lincoln and Pilgrim sites provide screening, triple testing and primarily outpatient and day case activity, whilst Grantham and Louth sites see minimal outpatient and day case activity
General Surgery	Provided across all sites with Lincoln, Pilgrim and Grantham currently providing non-elective and planned service provision
Urology	Provided across Lincoln and Pilgrim sites with Grantham currently providing non-elective general surgery service provision
Trauma and Orthopaedics	Provided across all sites with Lincoln, Pilgrim and Grantham currently providing non-elective and planned service provision. Louth also providing planned service provision
Grantham Hospital	Currently only provides accident and emergency services between the hours of 08:00 and 18:30
Stroke	In-patient hyper-acute (day 0-3 of the pathway) and acute stroke services (day 3 to discharge) offered at both Lincoln and Pilgrim. Grantham does not provide hyper-acute or acute stroke services but does have six beds presently allocated for stroke rehabilitation
Women's and Children's	<u>Paediatrics and Neonatology:</u> Lincoln and Pilgrim offer 24 hour Paediatric and Neonatal services, including emergencies, day cases and outpatients led by General Paediatricians

	Neonatal services are part of the East Midlands Neonatal Operational Delivery Network and there is a Local Neonatal Unit presently located at Lincoln County Hospital The Neonatal unit at Pilgrim is designated as a Special Care Baby Unit <u>Obstetrics:</u> There are presently consultant led maternity units at both Lincoln and Pilgrim Hospitals, but no designated midwifery led units
Haematology and Oncology	Radiotherapy and chemotherapy treatments are provided at Lincoln, with chemotherapy also provided at Pilgrim and Grantham. In-patient and outpatient cancer care is provided at Pilgrim and Lincoln for a range of different tumour sites

3.2 Case for change

Lincolnshire STP's specialty level analysis demonstrates that the sustainability challenges evident in their base case are significantly more acute and difficult in some specialties than others. Lincolnshire STP has therefore concentrated reconfiguration options for those priority specialities with a strong case for change:

Speciality	Case for change
Breast	Lack of a consistent model of care across the different sites and incomplete compliance with clinical guidelines, lack of breast radiologists and wider workforce issues
Trauma and Orthopaedics	Currently unsustainable service with significant workforce and financial challenges

General Surgery	Workforce challenges limiting ability to provide adequate cover across the geography; not meeting performance standards. Elective surgery issues
Stroke	Clinical standards and performance standards not being met, and significant workforce issues when considered against staffing levels suggested by clinical guidelines
Acute medicine	Significant workforce challenges impacting on the Trust's ability to deliver a safe, quality service. Operationally not sustainable in its current form
Women's and Children's including Obstetrics, Gynaecology, Neonatology and Paediatrics	Significant long-term staff shortages which are impacting on capacity and the ability to meet national staffing standards. Quality issues in Obstetrics and Gynaecology and viability of current birthing units configuration is in question
Urgent and Emergency Care pathways	Significant workforce issues impacting coverage. Ongoing four hour target and financial challenges
Haematology and Oncology	Heavy reliance on agency staff and lack of compliance with standards
Urology	Following a detailed piece of work to review Trust provision a reconfiguration solution was identified

3.3 Scope and limitations of review

Whilst Breast and A&E at Grantham will be considered in the round, in view of the fact that these clinical areas have been subject to previous, recent clinical senate reviews, a specific focus was not required by the clinical review panel.

4. Methodology and governance

4.1 Details of the approach taken

The sponsoring organisation (Lincolnshire STP) formally engaged the Clinical Senate on 1st June 2018 (Sarah Furley, STP Programme Director). It was agreed that a full day's review would be required, and in order to meet the STP's timeline for its PCBC (at that time), 11th July 2018 was agreed for the clinical review panel.

A pre-panel teleconference was scheduled for 4th July to review the supporting evidence. The Lincolnshire STP had not been able to submit their supporting evidence by Friday 29th June and therefore an extension was agreed. It was received and disseminated on Monday 2nd July. As the submission was quite substantial panel members did not have sufficient time to consider all the evidence and data in detail before the pre-panel teleconference. Nevertheless it was possible to obtain a good understanding of the overriding issues and potential solutions and these were discussed. Consequent upon these discussions further information was requested by the clinical review team to clarify areas of concern or consolidate data provided including:

- The recent Royal College of Paediatrics and Child Health (RCPCH) report or if not available at least a summary of the findings
- Draft report of the neonatal peer review
- Detailed workforce plan that addresses all specialities and particularly Women's and Children's
- Current vacancy rate data and breakdown of staffing including nursing, non-nursing and medical locums
- Reassurance around senior children's nursing leadership
- Retention strategy
- How patients are transported needs to be described

While the original Lincolnshire Acute Services Review submission (107 slides) was summarised and adjusted to facilitate presentation to the clinical review team on the day itself (which included vacancy rates per specialty), the Clinical Senate did not

receive all the additional information requested. It was explained by Lincolnshire STP that the RCPCH report had not yet been submitted to ULHT and was therefore not yet available to share with panel members.

A draft report (for the clinical review that took place on 11th July 2018) was sent to the panel members and the sponsoring organisation to check for matters of accuracy. Due to the extremely pressurised timeline, it was sent concurrently to the Senate Council for ratification.

Subsequently the sponsoring organisation proposed that we step away from the agreed schedule in the Terms of Reference in order to enable the STP to carefully consider the draft report and have further dialogue with the Clinical Senate.

Further to written communication from the STP Lead (John Turner) on 20th July 2018 to the Chair of the Clinical Senate, it was agreed that a supplementary (follow on) review would be scheduled to address the information and evidence gaps identified by the clinical review team, to enable the clinical senate to offer a more definitive clinical opinion on Women's and Children's Services and the medical beds at Grantham Hospital. The supplementary clinical review took place on 12th September 2018, and the findings and conclusions of this clinical review panel are documented in sections 8 and 9 in this report.

An updated draft report was sent to the panel members and the sponsoring organisation to check for matters of accuracy.

The original submission deadline (of the final report) was 28th September, although extra time was agreed to allow the clinical senate the opportunity to respond fully to matters of accuracy comments provided by the sponsoring organisation.

The final report was submitted to the Senate Council (and ratified on 3rd October 2018).
This report was then submitted to the sponsoring organisation, Lincolnshire STP, on 3rd October 2018.

East Midlands Clinical Senate will publish this report on its website once agreed with Lincolnshire STP.

4.2 Original documents used

The full list of documents provided by the sponsoring organisation for the 11th July 2018 clinical review panel can be found in Appendix B. The main submission included:

- Lincolnshire Acute Services Review.
- East of England Clinical Senate report for Grantham A&E.
- A paper examining Services at Grantham Hospital.

5. Key findings from the clinical review on 11th July

The panel heard that Lincolnshire is a large rural county, the fourth largest in England, with an aged and aging population and by 2021 the 75-84 year old population is predicted to increase by 20.1% (and the over 85 population by 19.6%) which is above the national average. In addition, Lincolnshire has the fourth most dispersed population which together with the geography of the county results in challenges, particularly in relation to travel times and equity of access to health services.

Rural deprivation is particularly in evidence on the edge of the county highlighted by access to many of the services provided in the county from the East coast. Furthermore, the system described its own position as “challenging” specifically around quality, staffing, and finances. It is also accepted that Lincolnshire is a system of concern nationally at a ministerial level and ULHT is in special measures for quality for a second time. Recruitment which has been a ubiquitous and significant long-term challenge for ULHT in all areas and a number of disciplines becomes even more acute towards the periphery of the county.

Lincolnshire STP acknowledged that their services are fragmented and largely reactive. The STP together with their 43 counterparts published its plan in December 2016 and integrated neighbourhood working was highlighted as their flagship programme with emphasis on the self-care agenda. Subsequently the STP has examined the totality of their health care system and the detail and comprehensive nature of the review has not previously been undertaken. Activity and finance modelling was completed for 32 specialties (10 of which were presented to the clinical review team), and the workforce resources required on each hospital site considered at an individual speciality level and then aggregated across ULHT.

The design principles which were agreed and which will underpin the system’s decision making and change are: quality, access, sustainability and deliverability. The STP aspires to provide care in closer-to-home settings and to minimise patient travel wherever possible and where quality can be maintained. The STP concluded that inevitably the system will have to centralise a number of its services as their

review has demonstrated that a “no change” scenario shows it is not sustainable from a financial, quality or clinical sustainability perspective and associated with significant clinical risk in the medium and long-term. The seven organisations in the Lincolnshire STP have all signed up to the preferred option and it has been through a robust governance process. In short, the system’s preferred option consolidates complex and acute services in Lincoln where possible. A large proportion of the elective and day case activity will be transferred to Grantham to become a centre of excellence for diagnostic, day case and short stay elective work. This will “ring fence” the elective beds for this activity and by avoiding the inefficiencies of mixed emergency/elective activity improve the throughput, decrease cancellation rates and achieve activity and quality guidelines.

The STP highlighted positive examples of their work around international GP recruitment, the Medical School which is part of the University of Lincoln and which will be launched in autumn 2019, and their work towards creating a National Centre for Rural Health and Care.

Breast Services

The panel understood the STP’s proposal to consolidate breast services at Lincoln to produce a centre of excellence. This has been subject to a previous East Midlands Clinical Senate review.

General Surgery

Grantham will become a hub for elective day case and short stay surgery as the service cannot be sustained with the current configuration. The panel heard that the on-call middle grade rota will be replaced with a general RMO (Resident Medical Officer) on-call model. This proposal aims to address a heavy reliance on agency and locum staff and the current vacancy rate of 10% medical staff and 13% nursing staff. Major selected colorectal surgery is presently undertaken at Grantham with excellent results and the facilities and expertise are clearly available to expand the surgical service. In addition this is an opportunity to provide an attractive opportunity for junior surgical trainees to have predictable access to high volume elective operating which is likely to aid recruitment.

Trauma and Orthopaedics

Grantham will become a hub for elective day case and short stay, surgery. The on-call medical model at Grantham will be altered as described above under General Surgery. This proposal aims to address the current vacancy rate of 24% for medical staff and 26% for nursing staff. The 'Getting It Right First Time' (GIRFT) report recommendations made by Professor Briggs support reconfiguration. The panel were informed that Louth had been utilising a similar model for a number of years.

The panel were also reassured that the Trauma and Orthopaedics Department had informed the Geriatric Department/Orthogeriatric colleagues of the change in configuration and increased demand for Orthogeriatric reviews to meet best practice tariffs at Lincoln and Pilgrim to abrogate the effect on respective workloads.

Urology

Grantham will become a hub for elective short stay, day case surgery. The panel heard a contradictory message around Urology as the professional opinion did not marry up with the supporting evidence submitted or the presentation slides. The consultant presenting the data provided by ULHT was sceptical about the modelling and in particular concerning the projected reduction in demand. His expectation was that the ULHT total projected activity by 2020/21 is likely to increase rather than decrease especially as the NICE guidance around PSA rates (urgent referral for investigation of suspected cancer when PSA levels are >=3 instead of 5) it is accepted will significantly increase urologists clinical workloads.

Grantham Hospital

The panel heard that Grantham would be re-designated as an Urgent Treatment Centre Plus (UTC+) with a full range of diagnostic services. The service will be managed and run by a lead community provider working in partnership with the acute trust. There would continue to be restricted criteria for emergencies that can access the UTC+. The exclusion protocol would be reviewed as part of the transition to the UTC+ although it is not anticipated that significant changes would be made. The UTC+ model would operate as a fully integrated centre with services running 24/7

incorporating current out of hour's services as well as a GP extended access hub. It is anticipated that the doors would close at 10pm and booked appointments would continue overnight via 111. Future workforce will comprise of middle grade doctors, GPs, nursing staff, minor illness/minor injury nurses and Advanced Nurse Practitioners.

Lincolnshire STP confirmed that there is a continued requirement for medical beds at Grantham, although further work needs to be completed before it will be possible to fully understand and predict the nature of this requirement in respect of number and acuity. Medical beds would be consultant-led with consultants on site between 8am and 6pm. Independent advice from Professor Jay Banerjee confirmed that 24/7 on site consultant availability would be required. It was confirmed that EMAS do not currently convey children to Grantham and this would not change with the new model. The current compliment of medical beds would be reviewed to determine how to appropriately reconfigure the provision for general medicine and care of the elderly.

Stroke

Lincolnshire STP described their proposal to consolidate hyper-acute stroke and acute stroke services at Lincoln, to align with the vision for the Lincoln hospital site which will accommodate "hubs" for a range of specialised services. In addition, to augment the hyper-acute and acute stroke changes, services will be developed to deliver an enhanced community-based stroke rehabilitation service with the aim of reducing hospital lengths of stay following an acute admission. The STP articulated their aspiration to improve patient outcomes through a culture of excellence. This proposal aims to address a heavy reliance on agency and locum staff and the current vacancy rate of 13% medical staff and 36% nursing staff at Pilgrim.

Women's and Children's

The panel heard the STP's proposal to move to a one team, two site staffing model. This model proposes two consultant-led obstetric units across Lincoln and Pilgrim with retention of both its neonatal units. The panel were informed that paediatric inpatient facilities would be consolidated at Lincoln and a 24/7 Paediatric Assessment Unit (PAU) would be opened at Pilgrim Hospital. This proposal aims to

address a heavy reliance on agency and locum staff and significant long-term recruitment issues across all levels.

The panel understood that the Lincolnshire system already has a Maternity Transformation Programme[1] and Lincolnshire STP aspires to have two co-located midwifery-led units at Lincoln and Pilgrim, as the vision in “Better Births” includes guidance that more women should be able to give birth in midwifery settings (Lincolnshire currently offers home births only). The panel were informed that the paediatrics nursing programme would be delayed until next September.

The current fragility of the paediatrics services was alluded to given the significant workforce issues at Pilgrim which is currently largely populated by a temporary workforce. The STP advised the panel that the proposed 24/7 Paediatric Assessment Unit (PAU) at Pilgrim Hospital Boston has a planned start date of 01/08/2018 with Consultant Paediatricians continuing as presently.

The panel were informed that an options appraisal had been undertaken by the STP and for a consolidated model displaced activity for maternity services was likely to be significant. It was predicted that potentially 1,000 out of 2,000 births would be displaced primarily to neighbouring providers, principally Cambridgeshire and Peterborough NHS Foundation Trust. The STP advised the panel that their enquiries had suggested that Cambridgeshire and Peterborough Trust do not feel that they presently have the workforce to take on an additional 1,000 patients.

EMAS also expressed concerns about the capability and capacity to deliver this option without the system investing in a Dedicated Ambulance Vehicle to provide a safe method of conveying patients. Lincolnshire STP would need to continue to work with EMAS on travel time modelling to fully understand the clinical nature and activity of the transfers. It is important that the travel/transfer consequences of all the changes proposed by the STP are understood especially as a number of these are clearly interdependent.

[1] In February 2016 Better Births set out the Five Year Forward View for NHS maternity services in England. Better Births recognised that delivering such a vision could only be delivered through locally led transformation, suitably supported at national and regional levels.

The STP informed the panel that there would be a requirement to increase the number of tiers of medical staffing to take account of activity consolidated onto one site although why additional tiers are required (not a feature of a two-site option), as opposed simply to additional numbers was not presented. The equality impact assessment of a consolidated model demonstrated the greatest impact given the demographics of the local population where 30% of families do not have access to a car.

In looking to provide a solution to balancing access issues for the local population, Lincolnshire STP cited North Cumbria CCG as an example of a similar model to the one proposed which has achieved the objectives and is working well and will be reviewed in 2019[2], in large part due to advances in digital technology. Although the full RCPCH report was not available to the Lincolnshire system on 11th July 2018, the STP informed the panel that the RCPCH understood the issues in respect of Lincolnshire's geography and the consequent access issues.

Haematology and Oncology

The panel heard the STP's proposal to consolidate haematology and oncology services to Lincoln to create more sustainable services and aiming to achieve a well-staffed service with the ability to be more flexible with the current consultant workforce. The panel were informed that this would improve recruitment and retention which is currently difficult especially at Pilgrim Hospital. This proposal aims to address a heavy reliance on agency and locum staff; the current vacancy rates are 39% for haematology medical staff and 14% for nursing staff across both haematology and oncology.

The panel heard that the proposal is closer to a centre of excellence model and it is optimistically expected to improve cancer targets. It was articulated that this proposal would free up outpatient appointments and improve capacity. It was confirmed that

[2] It is understood that the 12 month period to test Consultant-led maternity services at the West Cumberland Hospital in Whitehaven started in April 2018. An Independent Review Group has been established, which will assess progress over the 12 months. It is a timescale for the sustainability and safety of the service to be considered.

there would always be a consultant presence on site and the provision of consultant medical cross cover.

6. Conclusions and advice

The panel praised Lincolnshire STP for its introduction, which was clear and appropriately pitched with a candid delivery around the significant challenges Lincolnshire faces as a health care system. The introduction also highlighted that this has been a long process for the STP during a protracted period during which the STP has been the focus of significant political attention. Self-care was alluded to in the STP's plan but its position and potential impact following modelling were not clearly elucidated, and significantly more detail is required before its potential impact can be assessed. Additionally, there was significant emphasis placed on integrated neighbourhood working, which was asserted to be the foundation for the proposed changes which would facilitate significantly more community support. As a panel, concern was voiced that there did not appear to be sufficient planning or action to reassure the clinical review team that these community support mechanisms would be in place or the subsequent impact on service provision.

The clinical review team had been asked in the Terms of Reference whether after consideration of the proposed model it supports Lincolnshire STP's proposals based on an assessment of clinical sustainability, workforce and clinical outcomes. The panel (which had been specifically constituted to ensure that there was the necessary breadth of expertise to consider particularly the complex areas identified by the Senate) concluded that whilst there were some high quality presentations and it was largely in support of the changes proposed, several areas were highlighted where the panel had concerns or could not come to a definitive conclusion. In some areas this was due to insufficient data but there was also some disagreement with the conclusions presented within the STP.

It was also highlighted by the panel that further work should be undertaken by Lincolnshire STP in relation to the impact of each service change on older, frail service users.

<u>Breast Services</u>

As this was subject to a previous East Midlands Clinical Senate review and was largely considered in the round by the panel, the proposal for Lincoln to become a

centre of excellence was supported. There was complete agreement that, based on the evidence made available, this will improve the quality of care provided.

General Surgery

The proposal for Grantham to become a centre of excellence for short stay elective work was understood and the separation of elective and emergency services is a widely utilised and effective model. It was made clear to the panel that this elective activity for routine general surgery would be genuinely ring-fenced, and would therefore immediately improve clinical efficiency. The panel were concerned about the proposed general RMO on-call model although acknowledged it is working well for colorectal surgery. The panel advised that the detail around who ultimately has clinical responsibility needs to be clarified and consolidated and in the discussion at the end of the day it was explained to the panel that this will be the general surgical consultants.

Trauma and Orthopaedics

The proposal for Grantham to become a centre of excellence for short stay elective work was understood and had been very clearly articulated. It was explained to the panel that orthopaedic elective activity would be genuinely ring-fenced, and would therefore immediately improve clinical efficiency. Similar to general surgery the panel had concerns around the proposed general RMO on-call model although again acknowledged that it is presently working very well for colorectal surgery. The panel advised that the detail around who ultimately has clinical responsibility needs to be clear and similar to general surgery understands this will be the consultants. The potential for unintended effects which impact on other departments and colleagues, for example relating to medical Orthogeriatric reviews also needs to be factored into the modelling.

The panel advised that more detail is required around the STP's transport plan for patients that require it following the move of services but recognising that it is elective care which can almost always be planned in advance. Additionally, the STP should work with EMAS to ensure the impact on emergencies is factored in.

Recognising that the quality of after care is closely connected to acute care, the STP should provide more detail in its supporting evidence. The panel acknowledged that the STP's proposals would maximise the use of operating theatres and advised that this is an opportunity for junior surgeons to have an enhanced training experience and suggested involving the Health Education England School of Surgery early in the process.

Urology

Following the presentation of the proposed changes to the Urology service the unanimous feeling of the panel was that it was very difficult to clearly visualise the model that ULHT envisaged. This was in large part due to the dissonance between the opinion of the presenter and the presented supporting evidence and also within the consultant body. The data presented to the Senate prior to the panel visit alluded to this and stated that *"A review completed in 2012 by the Royal College of Surgeons suggests that there has been a failure of the consultant Urologists to function as an effective team, with lack of cohesiveness across the two sites, failure to engage in service development and a lack of agreement on appropriate care pathways".*

The clinician who presented on behalf of the STP had significant concerns about the conclusions relating to the future reduction in demand and particularly in the wake of the NICE guidance in respect of the level of PSA that triggers and urgent referral for investigation of presumed malignancy. It was not clear if the STP's proposals had been developed prior to changes in the NICE guidance. The presenter also highlighted that if the projected reduction in demand did not materialise then responding to the workforce demands would be very difficult in view of the national shortage of 130 Consultant Urologists.

These issues and the obvious ongoing discussions within the specialty meant that the panel did not feel that it was able to fully assess the proposals and draw any firm conclusions.

Grantham Hospital

The panel were aware of the controversy surrounding Grantham's A&E service. The panel did not feel that the presented proposals represented a paradigm shift from the current service being delivered at Grantham. The panel had concerns that the

medical take being proposed appeared to be “medicine lite” and that there was a potential risk that the majority if not all of the presently employed consultant physicians would transfer their contracts to a different community-based employer resulting in significant unintended workforce issues.

The panel understood that there would be a full range of diagnostics facilities available including laboratory investigations and imaging including cross CT and MRI. It was less clear however whether there would be appropriately trained specialists of sufficient seniority to facilitate treatment based on timely and accurate interpretation of the investigations.

As a core set of standards for urgent treatment centres have been established it is important to remain within the envelope that these delineate and the panel felt that the use of the word “Plus” after UTC was unwarranted and unhelpful. Guidance has been issued by NHS England which sets out the standards that is expected of STPs when implementing UTCs and the panel understood that this presents the STP with an opportunity to integrate wider primary care with urgent care. The panel felt it was important that assurances were received confirming that the new UTC would adhere to NHS England guidelines.

The panel praised Lincolnshire STP for its exclusion protocol which was clear, comprehensive and considered excellent. Although robust exclusion criteria were provided relating to paediatric attendances, there were no similar exclusions for older, frail patients. This group of patients may appear to fulfil inclusion criteria, however due to multi-morbidity and frailty are more likely to decompensate or deteriorate in unexpected ways. A specific example of this would be simple, low impact injury resulting in major trauma. Specific exclusion criteria should be developed to safeguard this group of patients.

The panel were clear that patient access had been addressed although the STP were less able to articulate what happens to a patient once they are in the UTC and what would happen if the centre could not deal with a patient. The STP failed to expand upon their frailty model in the community and workforce requirements to deliver safe care, and the subsequent management of older patients with multiple

morbidities. The frailty model was also cited as the method by which all admissions to all services were to reduce. No detail relating to this community based frailty model was given and therefore no conclusions could be drawn in respect of this.

Stroke

The panel praised the STP whose proposal for the management of hyper-acute stroke patients seemed to be well led clinically and from the evidence provided to the panel, it appeared that it had been well researched. It was clear that the proposed reconfiguration would reduce unwarranted variation in outcomes and would ensure a more consistent achievement of clinical standards and national guidelines. The only concern raised by the panel was that it is not ideal to add the management of patients with TIA (Transient Ischaemic Attack) symptoms to outpatient services, as guidelines for the management of TIA require a 7 day service with patients being seen within 24 hours. These guidelines could not be met if the TIA service was attached to a 5 day OPD service.

Women's and Children's

Whilst it was understood by the panel that the short term decision related to Pilgrim Hospital and the development of a PAU is not within the scope of this clinical review, the presented proposal raised some potential governance issues, particularly relating to the PAU being labelled as a 24/7 service. The panel would wish to see the operating plans to understand what would happen to children out of hours (which is also relevant to this clinical review, as the STP's proposal is to open a PAU with 24/7 paediatric cover at Pilgrim). The panel unanimously agreed that these potential short term governance issues and safety concerns should be brought to the attention of Lincolnshire STP. As this is beyond the scope of this clinical review, (and it was understood that the RCPCH were of the opinion that services at Pilgrim are maintained), this has subsequently been escalated to NHS England.

The panel concluded that whilst the LMS perspective presented was very positive, this was the only proposal where it appeared that geography had been allowed to overrule quality and staffing issues, described as two of its most significant challenges by Lincolnshire STP. The panel understood that this is clearly an emotive area. However, the panel were not assured that some of the solutions proposed

(digital technology and the Medical School) will solve Lincolnshire's challenges, particularly the workforce issues in either the medium or long term. A narrative around the Medical School, its offer and how students might be retained was not available as evidence to the panel. A detailed workforce plan, particularly around recruitment, was also not evident. The STP's intention to open a PAU would need to be much more clearly described, including evidence of a staffing model to support and underpin this proposal.

The panel had concerns around senior children's nursing leadership and an offer of support had been made previously by the Regional Senior Children's Nursing Leadership Group. The panel were informed by the STP that a head of nursing for paediatrics had been appointed and was waiting to be released. The panel's advice is that this should be a clearly defined role.

Evidence provided by NHS England Specialised Commissioning as part of this clinical review, highlighted that Lincoln Hospital neonatal unit has not met the service specification for a Local Neonatal Unit (LNU) for over 8 years, as they have not accepted babies at 27-28 + 6 weeks gestation due to staffing issues.

The panel concluded that it did not have sufficient data and supporting evidence to comment definitively on this proposal, particularly given the key workforce challenges that had been described in Lincolnshire STP's supporting evidence submission. Workforce shortages and issues relating to non-substantive staff are longstanding in paediatrics, Registered Sick Children's Nurses, Advanced Neonatal Nurse Practitioners, obstetrics and midwifery staffing and would clearly need to be addressed in order for the STP to safely and sustainably operate two specialist units (consultant-led obstetrics and neonatal units).

<u>Haematology / Oncology</u>

The panel praised the Lincolnshire STP for its proposal which was presented very clearly and explained how the consolidation of services at Lincoln would lead to service improvements. Concerns raised by the panel around consultant cover had clearly been considered and were adequately addressed by the presenter.

7. Recommendations

7.1.1 Recommendation 1

The panel recommends that Lincolnshire STP proceeds with its proposal for Lincoln to become a centre of excellence for breast services with support from the Clinical Senate.

7.1.2 Recommendation 2

The panel recommends that Lincolnshire STP proceeds with its proposal for general surgery to be consolidated at Grantham with support from the Clinical Senate, subject to the specific advice provided above.

7.1.3 Recommendation 3

The panel recommends that Lincolnshire STP proceeds with its proposal for trauma and orthopaedics to be consolidated at Grantham with support from the Clinical Senate, subject to the specific advice provided above.

7.1.4 Recommendation 4

The panel recommends involving Health Education England early in the process regarding the training experience of junior surgeons.

7.1.5 Recommendation 5

The panel recommends that the proposal for urology is revisited and further discussion take place within the department to gain support for the proposal from all the involved staff at all levels and of all disciplines. It is also important to confirm that the impact of changes in NICE guidance regarding PSA screening levels is fully understood. More detail around the STP's plans is required and alignment with ULHT consultants must be evident.

7.1.6 Recommendation 6

The panel suggested that the use of the word Plus in UTC is dropped. This was agreed by the sponsor on the day at the end of the session.

7.1.7 Recommendation 7

The panel recommends that Lincolnshire STP proceeds with its proposal for stroke services to be consolidated at Lincoln with support from the Clinical Senate, subject to the specific advice provided above.

7.1.8 Recommendation 8

The panel were of the opinion that Lincolnshire STP is well placed on the East coast for a clinical trial around early (in ambulance) stroke management, and suggests that this could be explored further.

7.1.9 Recommendation 9

The panel recommends that Lincolnshire STP proceeds with its proposal for haematology/oncology to be consolidated at Lincoln with support from the Clinical Senate.

7.1.10 Recommendation 10

The panel recommends that the Women's and Children's proposal is revisited, specifically around paediatrics, to take account of the clinical review team's concerns.

7.1.11 Recommendation 11

The panel recommends that EMAS contributes to a system-wide review of transfer and potential diverted activity, to include any clinical associated risks and benefits. In addition, Lincolnshire STP should work with EMAS and other transport providers (i.e. CenTre Neonatal Transport and CoMET) to review Neonatal and Paediatric transport implications fully.

Appendix A: Clinical Review Panel Terms of Reference

CLINICAL REVIEW: TERMS OF REFERENCE

Title: Lincolnshire STP clinical review

Sponsoring Organisation: Lincolnshire STP

Clinical Senate: East Midlands

NHS England regional or area team: Central Midlands

Terms of reference agreed by:

Name: E Orrock/A Dennison **on behalf of Clinical Senate and**

Name: S Furley **on behalf of sponsoring organisation**

Date: 21st June 2018

Clinical review team members

Chair: Ashley Dennison, Clinical Senate Chair and HPB and Pancreatic Surgeon at University Hospitals of Leicester

Panel members:

Name	Role	Organisation
Mandy Rudczenko	Patient representative	Senate Council
Mark Russell	Patient representative	East Midlands Academic Health Science Network
Chris Miller	Consultant in Geriatric Medicine and General Internal Medicine	University Hospitals Leicester / Clinical Senate Fellow

David Eveson	Consultant in Stroke Medicine	University Hospitals of Leicester NHS Trust
Eyad Issa	NIHR Clinical Lecturer in HPB Surgery/ Surgical Registrar	University Hospitals of Leicester NHS Trust
Dr Lucy Gavens	Specialty Registrar in Public Health	Derby Teaching Hospitals NHS Foundation Trust / Clinical Senate Fellow
Janet Ashworth	Consultant Obstetrician	Derby Teaching Hospitals NHS Foundation Trust
Craig Smith	Consultant Neonatologist Associate Postgraduate Dean, HEEM	Nottingham University Hospitals Health Education England
Jo Watson	Lead Nurse	Derbyshire Children's Hospital
Linda Hunn	Acting Director / Lead Nurse	East Midlands Neonatal ODN
Dr Nigel Ruggins	Consultant Paediatrician & Neonatologist	Derby Teaching Hospitals NHS Foundation Trust
Dr Dushyant Batra	Consultant Neonatology	Nottingham University Hospitals
Debbie Blaze	Clinical Services Manager, Community Integrated Neurology and Stroke Services (CINSS)	Community Health Services, Leicestershire Partnership NHS Trust

Dr Samia Latif	Consultant Communicable Disease Control	Public Health England – East Midlands
Pam Sizer	Midwifery Matron	East of England Clinical Senate
Dr Ann Boyle	Consultant Psychiatrist Associate Postgraduate Dean, HEEM	Health Education England
Simon Hardcastle	Divisional Head of Nursing Paediatrics and Neonates	Kettering General Hospital
Dr Emma Das-Gupta	Consultant Haematologist	Nottingham University Hospitals NHS Trust
Jomy Kurian	Trauma and Orthopaedics Surgeon	Sherwood Forest Hospitals NHS Foundation Trust
Ian Mursell	Consultant Paramedic	EMAS

Aims and objectives of the clinical review

The clinical review team is being asked to consider if there is a clear clinical evidence base underpinning the STP's proposals. The review will focus on the clinical interdependencies and the totality of the changes proposed. These proposals have been developed by the STP under the umbrella of Lincolnshire's Acute Services Review. Specifically, the clinical review team is being asked whether it supports, or not, Lincolnshire STP's proposals based on clinical sustainability, workforce and clinical outcomes.

Scope of the review

The model proposed by the Lincolnshire STP is to consolidate complex and high-acuity services in Lincolnshire as far as is possible. Low-acuity elective and day case activity transferred to Grantham will become a centre of excellence for diagnostic, day case and short stay elective work. Louth and Pilgrim activity to remain as is otherwise:

- Breast: Lincoln to become centre of excellence
- Elective Trauma & Orthopaedics: consolidate to make Grantham hub for elective short stay, day case surgery; to retain Lincoln and Pilgrim as non-elective sites
- Elective Urology: consolidate to make Grantham hub for elective short stay, day case surgery; to retain Lincoln and Pilgrim as non-elective sites
- Elective General Surgery: consolidate to make Grantham hub for elective short stay, day case surgery; to retain Lincoln and Pilgrim as non-elective sites with small elective workload
- Stroke: to consolidate hyper-acute and acute stroke at Lincoln only; with enhanced rehabilitation to be performed in the community
- Acute Medicine: create new integrated medical model for Grantham
- The development of a frailty model across the county
- Women & Children's: two consultant led-obstetric units across Lincoln and Pilgrim; retain two neonatal units (Level 2 at Lincoln and SCBU at Pilgrim), consolidate paediatric inpatient facilities at Lincoln, open a Paediatric Assessment Unit with 24/7 paediatric cover at Pilgrim, two co-located midwifery led units at Lincoln and Pilgrim
- A&E: Grantham changes from A&E Department to Urgent Treatment Centre plus
- Haematology/Oncology: to be consolidated at Lincoln
- Louth activity to remain as is
- Pilgrim activity to remain as is except for changes above

The clinical areas under consideration are: Trauma and orthopaedic surgery, general surgery, stroke, women's and children's, the frailty model proposed at Grantham Hospital and haematology/oncology.

<u>Out of scope</u>

Whilst Breast and A&E at Grantham will be considered in the round, as these clinical areas have been subject to previous clinical senate reviews, a specific focus is not required by the clinical review panel.

Clinical Review Panel considerations

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality[3])? For example, do the proposals reflect:
    - The rights and pledges in the NHS Constitution?
    - The goals of the NHS Outcomes Framework?
    - Up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? For example:
    - Do the proposals align with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies?
    - Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?
    - Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals meet the current and future healthcare needs of their patients?
- Do the proposals demonstrate good alignment with the development of other

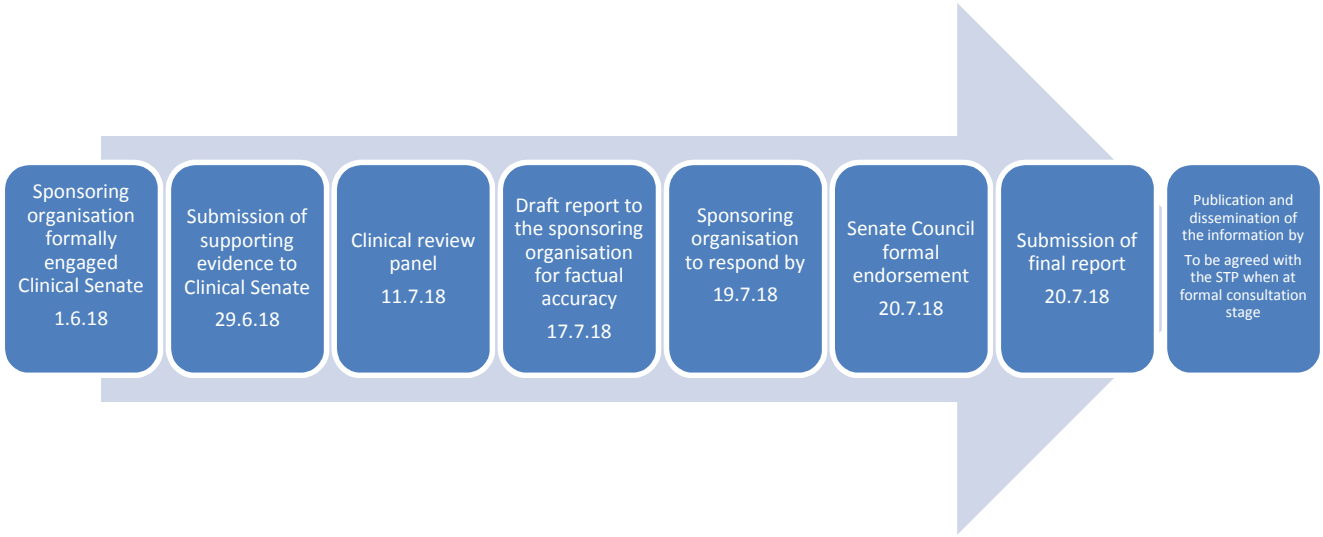
[3] Quality (safety, clinical effectiveness and patient experience)

health and care services?

- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Do the proposals consider the workforce requirements and transformation required to deliver this new model?

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline



Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The sponsoring organisation has agreed to collate and provide the following supporting evidence:

- Case for change and a summary of the current position and proposed alternative service/care model
- Impact of withdrawing/reconfiguring services, including risk register and mitigations
- How proposals reflect clinical guidelines and best practice, the goals of the NHS Outcomes Framework and Constitution
- Alignment with local authority joint strategic needs assessments and a narrative around health inequalities and demographics
- Evidence of alignment with STP plans
- Evidence of how any proposals meet future healthcare needs, including activity modelling, pathways, and patient flows
- Demonstrate how patient access and transport will be addressed
- Consideration to a networked approach
- Education and training requirements
- Implications on workforce (to be able to demonstrate alignment to new ways of working, and to describe how the future workforce will look to support any new models of care/reconfiguration proposed)
- Implications for the workforce (to describe how the workforce will be engaged, supported and motivated to work in new ways and in new places that support any new models of care/reconfiguration proposed)
- Implications for the clinical support services and those staff (e.g. clinical engineering, radiology, pharmacy)

Report

A draft clinical senate report will be circulated within 4 working days of the final meeting - to team members for comments, to the sponsoring organisation for fact checking.

Comments/ corrections must be received within a further 2 working days.

The final report will be submitted to the sponsoring organisation by 20th July 2018.

Communication and media handling

The Clinical Senate will publish the final report on its website once it has been agreed with the sponsoring organisation. The sponsoring organisation is responsible for responding to media interest once in the public domain.

Resources

The East Midlands clinical senate will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate's accountability and governance structure.

The East Midlands clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing with their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions)
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review
- submit the final report to NHS England for inclusion in its formal service change assurance process

Clinical senate council and the sponsoring organisation will

- agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical Senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and report and
- provide suitable support to the team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the

report. The team will subsequently submit final draft of the report to the Clinical Senate Council

- keep accurate notes of meetings

Clinical review team members will undertake to

- Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix B: Summary of documents provided by the sponsoring organisation as evidence to the panel

- Lincolnshire Acute Services Review Evidence Submission for East Midlands Clinical Senate Review (2nd July 2018)

- Services at Grantham Hospital paper written by Dr Dave Barker on behalf of the CCGs (2nd July 2018)

- Review of Accident and Emergency Services at Grantham and District Hospital (United Lincolnshire Hospitals NHS Trust) Report of the Independent Clinical Senate Review Panel – 22nd November 2017 (East of England Clinical Senate)

- Lincolnshire Acute Services Review Evidence Submission for East Midlands Clinical Senate Review (11th July 2018) Submitted to the panel on the review day (11th July 2018)

In addition, NHS England Specialised Commissioning submitted evidence to the panel:

- Specialised Commissioning Midlands and East Neonatal Service Model for Lincolnshire 21/8/2017

- Schedule 2 – the services (Service Specifications)

Appendix C: Clinical review team members and their biographies, and any conflicts of interest

Name	Role	Organisation	Conflict of interest
Professor Ashley Dennison	Clinical Senate Chair and HPB and Pancreatic Surgeon	University Hospitals of Leicester	None
Mandy Rudczenko	Patient representative	Clinical Senate Council	None
Mark Russell	Patient representative	East Midlands Academic Health Science Network	None
Dr Chris Miller	Consultant in Geriatric Medicine and General Internal Medicine	University Hospitals Leicester / Clinical Senate Fellow	None
Dr David Eveson	Consultant in Stroke Medicine	University Hospitals of Leicester NHS Trust	None
Mr Eyad Issa	NIHR Clinical Lecturer in HPB Surgery/ Surgical Specialist Registrar	University Hospitals of Leicester NHS Trust / Clinical Senate Fellow	None
Dr Lucy Gavens	Specialty Registrar in Public Health	Derby Teaching Hospitals NHS Foundation Trust / Clinical Senate Fellow	None
Dr Janet Ashworth	Consultant Obstetrician	Derby Teaching Hospitals NHS Foundation Trust	None

Dr Craig Smith	Consultant Neonatologist Associate Postgraduate Dean	Nottingham University Hospitals Health Education England	Neonatologist within same clinical network Work in same network Share patients Remain
Jo Watson	Lead Nurse	Derbyshire Children's Hospital	None
Linda Hunn	Acting Director / Lead Nurse	East Midlands Neonatal ODN	None
Dr Nigel Ruggins	Consultant Paediatrician & Neonatologist	Derby Teaching Hospitals NHS Foundation Trust	None
Dr Dushyant Batra	Consultant Neonatology	Nottingham University Hospitals	Indirect non-pecuniary interest Consultant Neonatologist in Nottingham. Tertiary lead centre in neonatology. There may be a change in number of patients moving towards lead centre as a consequence of decisions Senate aware of affiliation to

			Nottingham University Hospitals NHS Trust
Dr Samia Latif	Consultant Communicable Disease Control	Public Health England – East Midlands	None
Pam Sizer	Midwifery Matron	East of England Clinical Senate	None
Dr Ann Boyle	Consultant Psychiatrist Associate Postgraduate Dean	Health Education England	None
Simon Hardcastle	Divisional Head of Nursing Paediatrics and Neonates	Kettering General Hospital	None
Dr Emma Das-Gupta	Consultant Haematologist	Nottingham University Hospitals NHS Trust	None
Mr Jomy Kurian	Trauma and Orthopaedics Surgeon	Sherwood Forest Hospitals NHS Foundation Trust	None
Ian Mursell	Consultant Paramedic	East Midlands Ambulance Service	None

Clinical Senate Support Team

Ms Emma Orrock – Head of East Midlands Clinical Senate, NHS England

Miss Lara Harrison – Clinical Senate Administrator, NHS England

Biographies

Professor Ashley Robert Dennison MB, ChB, MD, FRCS

Consultant Hepatobiliary and Pancreatic Surgeon at University Hospitals of Leicester NHS Trust

Professor of Hepatobiliary and Pancreatic Surgery, University of Leicester

Clinical Senate Chair

Ashley graduated with MB, ChB from Sheffield University in 1977, obtained his FRCS in 1982 and his MD (Sheffield) in 1985. He was a Wellcome Research Fellow in Oxford from 1983-85, and from 1990-92 worked in Switzerland with Professor Blumgart, Paris with Professor Bismuth and Hannover with Professor Pichlmayer. Since 1994 he has been a consultant hepatobiliary and pancreatic surgeon at the University Hospitals of Leicester NHS Trust. He is the chief investigator and responsible for all research supervision and collaboration with external centres (national and international). He is also the lead clinician responsible for “sense checking” initiatives for service improvement and delivery. His main clinical and research interests relate to the metabolism and anti-cancer properties of intravenous lipid emulsions, the treatment of colorectal metastases and pancreatic adenocarcinoma and islet cell autotransplantation following total pancreatectomy for chronic pancreatitis. He has investigated ablative techniques for the treatment of colorectal metastases and the anti-inflammatory and anti-cancer effect of infusions of lipid emulsions containing omega-3 fatty acids. He has the largest European experience of pancreatectomy followed by islet cell auto-transplantation for chronic pancreatitis and is at present investigating the potential clinical applications of pancreatic ductal cells (intermediate cells). His interest in lipids has recently resulted in trials in acute pancreatitis, sepsis in the intensive care setting, colorectal liver metastases and pancreatic cancer.

He is the Professor of Hepatobiliary and Pancreatic Surgery at the University of Leicester and is presently President of the Pancreatic Society of Great Britain and Ireland (PSGBI), President of the Great Britain and Ireland Hepataopancreaticobiliary Association (GBIHPBA) and National Lead for HPB Surgery for AUGIS (Association of Upper GI Surgeons).

Amanda Rudczenko

Patient representative

A former mental health nurse and adult education tutor, Mandy has been helping her son to manage his Cystic Fibrosis for the past 17 years. She first became involved in Patient and Public Involvement work as a lay member on a Clinical Reference Group for Cystic Fibrosis. Over the past 4 years Mandy has become an active campaigner for the co-production of health and social care services, person-centred care, shared decision making, and self-management of long term conditions.

As a member of the Co-Production Team with the Coalition for Collaborative Care, Mandy has contributed to the design and co-production of many projects, including The Reading Well scheme. Mandy has also served as an Expert by Experience on NHS England's Five Year Forward View People and Communities Board, helping to co-design the 'six principles for engaging people and communities'. Mandy is an active member of The Q Community (The Health Foundation). Her work has included co-convening the Special Interest Group in Coproduction, contributing to the QLab project on Peer Support; chairing tweet chats. As a member of the East Midlands Patient and Public Involvement Senate, Mandy has co-designed and delivered training in Coproduction. She is also a public contributor on a research panel with the National Institute for Health Research.

Mark Russell

Mark is a patient and carer, the Co-Chair of the East Midlands Public & Patient Senate, the Lay Member (Public and Patient Engagement) representative on the Governing Body of Bassetlaw Clinical Commissioning Group (CCG), Chair of Patient Reference Group of Nottingham West CCG, and a member of the Citizens Advisory Group to Greater Nottingham Transformation Partners. He chairs/participates in other groups, locally and regionally. Previously he had 33 years NHS experience in various senior manager roles (including as Chief Executive). He operates an Organisational Development Consultancy.

Dr Christopher James Miller MBBS MRCP (Geriatrics) PGDip

Chris is a Consultant Geriatrician at University Hospitals of Leicester NHS Trust specialising in front door interface and community geriatric medicine. Chris currently

holds roles as a Clinical Fellow for the East Midlands Clinical Senate, and as an Honorary Fellow at the University of Leicester.
Chris is concluding his studies towards a Masters Qualification in Medical Leadership and Management from Swansea University.

Dr David Eveson

David is Head of Service and Consultant in Stroke Medicine at University Hospitals Leicester NHS Trust. David holds specialist accreditation in Geriatric and General (Internal) Medicine and was one of the first UK graduates to receive specialist accreditation in Stroke Medicine. His MD thesis was conducted under the supervision of Professor John Potter at the University of Leicester, studying blood pressure control mechanisms in acute stroke and the response to ACE inhibition, leading to the award of a Young Investigator Prize by the British Hypertension Society. Basic medical training took place in London, where he graduated with honours in medicine, clinical pharmacology/therapeutics and physiology. David is a fellow of the Royal College of Physicians, a member of the European Stroke Organisation and holds a level 4 clinical excellence award. He has particular interests in measuring and adapting clinical service delivery to meet the highest standards of healthcare, and managing multi-centre clinical stroke trials. He is proficient in SQL Server, NET, C#, HTML and AngularJS, and has developed several business-critical applications for the clinical workplace.

Mr Eyad Issa

Eyad is an NIHR Academic Clinical Lecturer at the University of Leicester and an Honorary Specialty Registrar in Hepato-Pancreato-Biliary Surgery at Health Education East Midlands.
Eyad graduated from Damascus University's School of Medicine with an MD degree before completing basic training in Emergency Medicine in Manchester. He then started his surgical training in Yorkshire and was awarded the National Institute for Health Research (NIHR) Academic Clinical Fellowship at the University of Leeds where he worked on exploring the role of angiopoietins in metastatic GI cancers. In 2015 he was awarded a PhD degree from the University of Leicester for developing a novel therapeutic ligand for vascular normalization under the supervision of Professor

Nicholas Brindle. In 2016 he won the NIHR Academic Clinical Lectureship award at the University of Leicester.

Academically he is working under the supervision of Professor Ashley Dennison, Professor Karen Brown and Professor Jacqui Shaw. His main research interest is in the early detection of pancreatic cancer as well as developing novel therapeutic molecules for cancer prevention. Eyad has special interest in medical education and has been awarded a PG Dip in medical education from the University of Nottingham.

Eyad is currently studying the role of human factors in surgical errors.
Clinically, he is working at the University Hospitals of Leicester NHS Trust as an honorary Speciality Registrar undertaking his surgical training with special interest in liver and pancreatic surgery under the supervision of Professor Ashley Dennison.

Dr Lucy Gavens

Lucy is a Specialty Registrar in Public Health with over 10 years' experience in Public Health Research and Practice.
Lucy's expertise is in assessing the health and healthcare needs of populations and developing strategies to meet those needs. Lucy works with stakeholders across a number of organisations including Local Authorities, Public Health England, NHS Commissioners, NHS Providers, and the Community and Voluntary Sector, to advise on and influence the commissioning and delivery of a range of public health and healthcare services. Lucy operates across a broad range of Public Health priority areas; her specialist interests are in the fields of substance misuse and physical activity.

Lucy has considerable research experience, having worked on a range of quantitative and qualitative research projects in the field of substance misuse at the University of Sheffield. Lucy has a PhD in Public Health, completed in 2013, during which she examined psychological theories of health behaviour with reference to alcohol consumption in older adults.

Dr Janet Ashworth BM BS BMed Sci (hons) DM FRCOG

Janet is a Consultant Obstetrician and Sub-specialist in Fetal and Maternal Medicine at Derby Teaching Hospitals NHS Foundation Trust since 2003, and Assistant Clinical Director, Lead Obstetrician since 2012.

Janet graduated in 1990 from the University of Nottingham and received a Doctorate of Medicine from there in 1998, with research in vascular physiology in high risk pregnancy.

Janet is a Member of the RCOG from 1999 and fellow since 2011, and a member of the Derbyshire LMS steering group.

Dr Nigel Ruggins

Nigel is a Consultant Paediatrician and Neonatologist at Derbyshire Children's Hospital, Royal Derby Hospital with now over 20 years clinical experience in that role. Nigel qualified in medicine at UCH, London and commenced his paediatric training in London at Northwick Park Hospital. Nigel moved to the Midlands at Paediatric Registrar level rotating between Derby Children's Hospital and Nottingham. He spent 2 years in the Children's Respiratory Unit at University Hospital Nottingham researching neonatal apnoea, SIDS and paediatric asthma treatment. Although he has sub-specialty interest and clinical commitments in Neonatology and Children's Respiratory disease, including cystic fibrosis, he maintains an interest and commitment to General Paediatrics so has a broad clinical experience.

Nigel has had managerial experience at a high level within his Trust as Service Director for Children's Services for 9 years. Within this role he has worked in wider aspects of the NHS with other providers and commissioners. He has been a part of many of the changes within the NHS and has had to drive them through locally within the Service and see them become established.

Nigel was appointed as Clinical Lead for Transition within the East Midlands Maternity and Children's Strategic Clinical Network in August 2014 and spent over 2 years in this role establishing and promoting good practice in Transition throughout the region. He is also Chairman of the national Newborn and Infant Physical Examination (NIPE) Advisory Group hosted by NHS England and has been in this role since February 2015. This group is driving the introduction of the NIPE screening

examination throughout the country and ensuring it remains updated and fit for purpose enabling the assessment of outcomes from this national screening programme to ensure real clinical differences.

Dr Dushyant Batra MBBS, MD (Paediatrics), MRCPCH
Consultant Neonatology and Deputy Chair, Neonatal Clinical Service Unit (CSU), Nottingham University Hospitals NHS Trust
Dushyant is a Consultant Neonatologist based at Nottingham University Hospitals since 2011. He graduated in India in 1996. Dushyant completed his registrar training in London Deanery and has been on specialist register since 2010. Dushyant is Deputy Chair for neonatal CSU in his hospital.

Dr Samia Latif (MBBS, MPH, Fellow Faculty of Public Health UK)
Consultant Communicable Disease Control
Public Health England
Samia trained in Public Health in the UK and has experience in health protection, health improvement and healthcare public health.
Samia is currently a Consultant of Communicable Disease Control at Public Health England in the East Midlands. As a consultant she is the patch lead for Northamptonshire. She is also the health protection team's Migrant Health lead and Air Quality lead.
Her areas of interest are health protection, in particular, communicable diseases and global public health, public mental health, health improvement and health inequalities.

Samia has been involved in the response to various local, regional and national outbreaks including both the swine flu pandemic and Ebola outbreak in West Africa. Samia is also a member of the UK Faculty of Public Health's Global Health Committee and is a member of the Faculty's Special Interest Groups on Pakistan and Global Violence Prevention. Samia sits on the East Midlands Clinical Senate Assembly and has been involved in regional reviews of healthcare services.
Her skills include public health expertise, surveillance and risk assessment, evidence based decision making, collaborative working and leadership skills.

Samia is a GMC appraiser, an educational supervisor and an accredited mentor in healthcare. Research interests are in the areas of health protection and global public health.

Pam Sizer

Pam has worked in the NHS as a nurse and midwife for over 32 years in a number of clinical settings. Currently Senior Midwifery Matron for community services and co-located midwife led birthing unit, working with many acute and primary partners to provide best pathways for women and their families.

Dr Craig Smith

Craig is an Associate Postgraduate Dean and Consultant Neonatologist in Nottingham. Craig is a former Clinical Director of Neonatal Services in Nottingham, a RCPCH Regional Advisor and Head of the East Midlands Postgraduate School of Paediatrics. Craig has led service improvement reviews of Accident and Emergency Services and Paediatric Services at other Trusts within the East Midlands.

Jo Watson

Jo is a children's nurse with over 20 years' experience working with children and young people.

Jo has experience of working in a number of different areas across both acute and community sectors. Jo spent a significant period working at Birmingham Children's Hospital as Deputy Head of Nursing where she developed a number of new services including a Hospital at Home team and a regional long term ventilation team. Jo is now Lead Nurse for Paediatrics at the University Hospitals of Derby and Burton and is now overseeing the recent merger of both trusts within all children's areas.

Jo completed her first Masters at the University of Manchester in Advancing Nursing Practice in 2012. Since then she has completed a Post Graduate Certificate in Strategic Workforce Planning and is currently completing a further Masters in NHS Leadership at the University of Birmingham on the Elizabeth Garrett Anderson Programme, with the NHS Leadership Academy.

Linda Hunn

Acting Director / Lead Nurse East Midlands Neonatal Operational Delivery Network

Linda is a Registered General Nurse and a Registered Midwife and is qualified in speciality for neonatal intensive care. Linda also holds an MSc in Public Services Management. Linda has worked extensively across midwifery, neonates and transitional care for many years in Cambridge and across the Midlands. Linda ensures that the baby and family are integral to all Network projects and works collaboratively with parents to achieve that aim. As Lead Nurse for the Network, she is constantly striving to ensure consistency and to ensure that the highest possible level of care is delivered across all the constituent Network Neonatal Units. Linda has participated in numerous national projects, standards and documents related to neonatal care. Linda is passionate about the importance of nursing development and standards, and actively encourages education and development opportunities for nurses at all levels. She particularly focuses on the importance of preparing nurses appropriately to undertake management roles.

Dr Ann Boyle MB BCh BAO National University of Ireland MRCPsych FRCPsych

Honorary Associate Professor Leicester Medical School

Ann is a Consultant old age psychiatrist employed at Leicestershire Partnership NHS. Ann has been involved in medical education throughout her consultant career across the continuum of undergraduate and postgraduate training working as a clinical tutor, training programme director and Head of school of Psychiatry. Ann is currently working as an Associate Postgraduate Dean at Health Education East Midlands and as clinical block lead for Integrated Care Block at Leicester Medical School. Ann contributes nationally as the Specialist Advisor for the Foundation Programme at the RCPsych.

Simon Hardcastle RNCB, MSc

Simon is a children’s nurse with over 20 years’ experience working with children and young people.

Simon has worked in a number of areas including the acute hospital setting, child and adolescent mental health services, children and young people's palliative care, children's community services and most recently has worked as a Senior Quality Improvement Manager with the East Midlands Clinical Network NHS England, with a responsibility for children and young people's mental health and IAPT. Simon was also one of two Clinical Leads for Transition for the East Midlands Clinical Network, and held this position for over two years.

Simon is now Divisional Head of Nursing Paediatrics at Kettering General Hospital. Simon aims to bring his quality improvement knowledge and skills back into an acute setting, with the hope of moving a service which has been rated as inadequate by the CQC in 2016 to outstanding.

Simon is extremely passionate about transition and has been involved in a number of local, regional and national projects on transition, most recently with the development of the Together for Short Lives Stepping Out Transition Guidance and the Open University and Together for Short Lives Talking about sex, sexuality and relationships guidance and standards.

Simon completed his Masters in Advanced Nursing at the University of Nottingham in 2016 with the completion of his dissertation research on exploring the transition experiences of parents of young people with life limiting conditions not expected to live into adulthood. Simon hopes to publish his research later on this year.

Dr Emma Das-Gupta DM, FRCP, FRCPath

Emma is a consultant haematologist and clinical lead for the Haematological Malignancy Diagnostics Service at Nottingham University Hospitals NHS Trust (HMDN). Emma has worked clinically in the fields of stem cell transplantation, acute leukaemia, myelodysplasia and myeloma. She is passionate about delivering high quality services, underpinned by evidence-based research. Her prior experience of committee work includes:

- NCRI AML Working Party 2006-2015
- NCRI MDS Clinical Trials Committee 2005-2017
- MDS Forum Executive Committee 2008-2017

- BSBMT Clinical Trials Committee 2003-2017
- Scientific Advisory Panel for the BSH 2008-2011
- British Committee for Standards in Haematology MDS Guidelines writing group 2012-2013
- UK Photopheresis Society Acute GVHD guidelines writing group chair 2013-2014
- EBMT complications and quality of life working party 2013-2017
- NICE Diagnostic Services Guideline Committee 2016-2017

Emma is currently the clinical lead for HMDN, which was established as a new service to Nottingham in 2017. This service delivers integrated diagnostics for haematological malignancies and her focus is now on developing this into a regional service. Her current clinical interest is in plasma cell myeloma and in this capacity she works as a consultant within the NUH myeloma team. She has recently been appointed as the Royal College of Pathologists Regional Specialty Representative for Haematology in the East Midlands.

Mr Jomy Kurian FRCS Tr & Orth
Consultant Trauma & Orthopaedics
Sherwood Forest NHS Hospitals Foundation Trust

Jomy is an Orthopaedics consultant specialising in Shoulder & Elbow surgery at Sherwood Forest Hospitals NHS Foundation Trust. Jomy was appointed as consultant in February 2007. Jomy graduated MBBS in 1989 from Kerala university, India. He obtained FRCS from RCSP Glasgow in 1998. Jomy completed the Trauma and Orthopaedics training programme in Wessex deanery based at Southampton university hospitals and obtained FRCS Tr & Orth in 2005. After completing upper limb fellowship at Derby he was appointed as consultant at Sherwood Forest Hospitals. Jomy is a member of Orthopaedics STC at Nottingham. Jomy is currently the T and O Service Director at Sherwood Forest Hospitals for the last two years.

Ian Mursell
Consultant Paramedic, East Midlands Ambulance Service

Ian is a Consultant Paramedic with East Midlands Ambulance Service NHS Trust. As a senior clinician, Ian is responsible for clinical leadership across the East Midlands and for the development of strategy and care in the areas of care of the

dying, long terms conditions and medicines management. Ian has a background as an advanced practitioner and academic teaching on a range of Paramedic and Nursing related programmes related to his specialist fields. As a proactive member of his profession, Ian is a member of the Faculty of Higher Education, a published author and contributes to wider healthcare issues through the East Midlands Clinical Senate, guideline development for the Joint Royal Colleges Ambulance Liaison Committee and as a co-optee for NICE in the development of care of the dying guideline. As a practicing Paramedic, Ian works alongside multidisciplinary teams to provide clinical care across the spectrum of acuity. This is complimented by his role as an examiner for the Royal College of Surgeons of Edinburgh Diploma in Immediate Care and active role in research and development.

Mr Matt Day FFPH

Consultant in Healthcare Public Health

Matt provides public health leadership to the NHS through his current and previous role. Matt served as vice-chair of the national specialised commissioning network and led for PHE on NHS clinical policy in cancer and mental health initiating and chairing the first ever national prevention reviews for specialised mental health on smoking, CAHMS, obesity, and new psychoactive substances. Locally, Matt is leading on service reconfiguration work for the Clinical Senate and STP leaders, and manages a team responsible for public health screening, dental public health, and specialised services advice to the NHS. Matt has published extensively on cancer and public health leadership and workforce. Matt has recently been appointed as a member of the national ACRA Technical Advisory Group, which advises Ministers on health resource allocation.

Judith Foxon RGN, RSCN, MA

Education and Project Lead, East Midlands Neonatal Operational Delivery Network

Judith is a Registered General Nurse, Registered Sick Children's Nurse and is Qualified in Specialty in Neonatal Special and Intensive Care. Judith gained an MA in Independent Practice (Health) from Leeds University in 2006.

Having nursed in a variety of adult and paediatric settings in Bristol and Leicester, Judith chose to specialise in neonatal nursing and worked for 30 years in a number

of roles within the Leicester Neonatal Service. Judith was Matron of the service for over 12 years during which she was responsible for the clinical management of this large tertiary neonatal service.

Currently Judith is the Education and Project Lead for the East Midlands Neonatal Operational Delivery Network. Judith is particularly interested in developing high quality neonatal care and improving parent experience through the education, training and development of staff. Judith is currently working to develop the quality of, and accessibility to, post registration neonatal education and training programmes. Judith is also a visiting lecturer at De Montfort University providing academic teaching to nurses and midwives.

Dr Cathryn Chadwick

Cathryn qualified from London in 1987 and trained in paediatrics in the East Midlands and Oxford. Cathryn has been a consultant paediatrician with an interest in Neonatology in Northampton since 2004. Cathryn has been involved in education and training in the East Midlands for nearly 10 years, initially as a training programme director and now as Head of School for Paediatrics. Cathryn is an examiner for MRCPCH and sits on the education and training committee at the RCPCH.

8. Key findings of the supplementary Clinical Review Panel

The panel heard that Lincolnshire STP had continued to involve senior clinicians in the system's proposals since the previous clinical review on 11th July, 2018. The STP informed the panel that they would be presented with sound clinically-based proposals for their population that will deliver on the system's ambitions for the people of Lincolnshire.

Grantham Hospital

The panel were informed that there was now a clear proposal for the future of medicine at Grantham Hospital. This proposal reflects the views of senior clinicians and managers across the STP. The model had been developed collaboratively across the different partners in the system and it is considered suitable for the Grantham population and may have wider applicability. The model is integrated community/acute provision that will 'uncouple' ULHT from direct provision of non-elective care on the Grantham site thus protecting elective services at times of surge in non-elective admissions. The model will be delivered by a community provider and there will be a shared integrated response on the site to deteriorating patients regardless of who is providing care.

Whilst it was accepted that the model is not yet at a final endpoint, it was agreed that NEWS[4] (National Early Warning Score) is an accepted model of detecting how acutely ill a patient is. A clinical audit was undertaken as part of the development of this clinical model of care, which included reviewing a year's worth of NEWS data and a review of a cohort of patients' Clinical Frailty Score. The intention is to minimise the number of patients being transferred and it was explained that those patients who are severely frail, very severely frail or terminally ill will remain on the Grantham site[5]. A recommendation from the STP's audit was that a combination of the NEWS and Frailty Score would provide a clear evidence base for identifying acutely ill patients, and that a review of the Grantham Hospital Exclusion Criteria

[4] The NEWS has been shown to be a highly effective system for detecting patients at risk of clinical deterioration or death, prompting a more timely clinical response, with the aim of improving patient outcomes in the NHS

[5] Clinical Frailty Scale Dalhousie University, Canada

would be required as some patients would be better met on an alternative site. The amendments to the Exclusion Criteria were explained to the panel.

It was explained to the panel that non-elective care at Grantham will be fully integrated with the neighbourhood team and that patients would be discharged home with a clear treatment plan. It is proposed that Grantham will have access to Care of the Elderly Consultants and specialist advice from ULHT. It is not anticipated that on-call would be required overnight and RMO staffing would be in place for overnight cover. An appropriate response team would be put in place at Grantham including clinicians with anaesthetic and critical care competencies. A named physician will be able to determine if a patient requires a medical bed. These beds will be run by Advanced Care Practitioners with support from GPs (GP referrals already go through an Emergency Assessment Unit Consultant). It has also been agreed that Grantham will accept stepped down patients from Lincoln County.

There are currently 70 medical beds at Grantham. Bed modelling (activity assumptions based on audit) has determined how many will need to be accessed in the future model, which will see the bed base reduce from 70 to between 48 and 55.

A single provider will be looking after the bed base and the community model. The panel heard that existing ULHT clinicians would be happy to transfer to a community provider. The ultimate clinical responsibility for patients would be under the care of the relevant community consultant run by the community provider. The model will allow patients to be moved between services and therefore will be a fluid approach.

Grantham Hospital will likely be open from 10am to 10pm 7 days a week. As the same provider will be looking after the bed base and the community model, patients can be maintained at home for 24 hours before being admitted to hospital as an inpatient. Whilst EMAS does not bring paediatrics to Grantham Hospital, it is acknowledged that babies and children may be brought in by a parent (or otherwise) as a walk-in when the child may be more acutely ill than is known by the parent. These patients would be transferred by blue lights if necessary.

The panel heard about the progress of neighbourhood teams across the county. It was explained that it is a 3-4 year programme which the STP has been developing for approximately 18 months to date. During this time, support from GPs, the Community Trust and the Community Mental Health Trust has been secured and there is strong team ethos and evident cohesion relating to all the issues affecting Grantham. Leads for each team are in place, and the clinical governance framework and outcome measures have been agreed.

Finally, the panel were also informed that staff will be upskilled in terms of frailty training. There is a frailty unit at Lincoln County Hospital and the University of Lincoln has a faculty of frailty, and advanced frailty training is available in Lincolnshire. Job plans will be bespoke, tailored to meet the needs of the patients being treated and the workforce will be blended; a combination of ANPs, medical staff and AHPs. Additional advanced clinical practitioners will also be employed and Lincolnshire historically is oversubscribed in terms of recruiting to this workforce. It was also confirmed that the system has a substantial amount of support from HEE with five HEI training providers and LWAB[6] support to the STP.

Women's and Children's Services

The panel heard that the work undertaken by the STP has happened in conjunction with EMAS, HEE, Specialised Commissioning, NHS England and NHS Improvement. The STP reiterated to the panel the geographical challenges, which are significant and principally due to the rural and dispersed nature of the population, combined with Lincolnshire's most deprived communities being located on the East coast (Skegness and Mablethorpe). The STP has been very mindful of all of these factors when considering the future of women's and children's services. The panel also heard that length of stay is relatively short and therefore this increases the need for ease of access for the STP's population.

It was explained to the panel that it had not been the STP's intention to imply that digital technology, the Medical School and the National Centre for Rural Health and Care would be the "magic silver bullet" that solves Lincolnshire's recruitment and workforce challenges, and sought the opportunity to clarify this. The 'pilot' model for

[6] The Lincolnshire Local Workforce Action Board is jointly chaired by HEE and ULHT

the current issues has now been in place since 1st August, 2018 (One Team, Two Site). It is proposed that this will be a transitional approach and that the STP is clear minded about how it will meet the sustainability challenge.

ULHT comprises three main acute hospital sites (Lincoln County, Pilgrim and Grantham and District), and at times services are fragile. A single team across two sites will give ULHT a resilient base for training and development. The panel were informed that this is a successful model which has worked elsewhere within ULHT and which is now being rolled out for women's and children's services. Lincoln County has a more acute focus, more beds than Pilgrim Hospital (32 and 18 antenatal and postnatal beds and 11 and 8 delivery suite beds respectively), and a more established neonatal service (Lincoln County is designated as a Local Neonatal Unit and Pilgrim is designated as a Special Care Baby Unit). Pilgrim Hospital on the other hand is more likely to admit short stay patients with more routine, daily medical issues. ULHT will create Job Plans that match capability.

The transport analysis that has been completed by EMAS to include age profile and the STP's Equality Impact Assessment of their East coast population has been considered within the model.

The Better Births Strategy and Implementation Plan for Lincolnshire sets out the STP's five year plan for maternity and neonatal services, including the establishment of four community hubs (Lincoln, Stamford, Gainsborough and Mablethorpe). Roll out of these community hubs is predicated on patient and public engagement where women and their families have said that they would prefer care closer to home. The model of care proposed for Lincolnshire will ensure that every woman has a personalised maternity care plan led by a healthcare professional, to ensure continuity of carer and care is delivered as close to home as possible through local community midwifery teams. Whilst the panel acknowledged that the strategy has the potential to significantly increase home births, which is laudable and in line with the national report, the panel were of the opinion that there are some evidence gaps particularly in relation to the community hubs. It was felt that there would need to be a very careful selection process to identify high risk patients and potentially complex deliveries. How patients will be assessed and supported by secondary care team

also needs to be described but there is an opportunity to increase consultant obstetric involvement which would address the majority of these issues.

In respect of the delivery of care it was not clear to the panel exactly who and where this will be delivered and with high levels of social deprivation and rates of obesity the population served by the STP has a high risk population where circumstances can change rapidly and dramatically in those women initially considered low risk. It was acknowledged by the STP that the detailed project plans are not in the Better Births document that was submitted to the panel as evidence.

Elements of the Maternity Quality Dashboard also concerned the panel. While it was recognised that a balance between access and sustainable long term clinical outcomes is an essential driver, some particular areas of ULHT's indicators were highlighted by a number of members of the panel. Under workforce, ST3 and above attendance is red across the performance dashboard from April 2017 to March 2018 (where green is >90% as determined by the Trust) with a Year To Date average of 44.38%. The quality of the data is unknown although it was accepted by the panel that more data is generally useful in its deliberations. Additionally, the stillbirth rolling 12 months rate and expressed as perinatal deaths per 1000 total births all are increasing according to the dashboard presented as evidence to the clinical review team (where the national ONS rate is <4.4/1000 births and <5.9/1000 births respectively).

An overriding concern for the panel was where the balance falls between access and clinical outcome inequalities. The STP explained that the instability in the service and the decision to consolidate services onto one site in 2016 had, had a dramatic effect on staff morale and ULHT's ability to recruit. This was highlighted in the RCPCH draft Executive Summary presented as evidence to the panel. The STP was of the opinion that a co-located midwifery led unit within the Lincolnshire LMS footprint will reverse this trend and have a positive impact on clinical outcomes.

Further explanation was sought by the panel on North Cumbria which was cited to the panel previously as a model that is working well. The panel understood that Dr Shortland at the RCPCH and Dr Mel Isles from NHS Improvement had discussed this issue. Due to the pressurised timeline, the panel were not in a position to formally

corroborate the explanation provided, and written evidence was not submitted to the panel.

The workforce plan was submitted as evidence to the panel although the STP acknowledged that the detail is not yet available, including the specific data around obstetrics. The ambition to provide a more attractive and rewarding workplace which is underpinned by a strong, vibrant transformation programme did not adequately reassure the panel in respect of its concerns about the STP's ability to address the requirement for medical staff 24/7 over the medium and longer term. The significant reduction in nursing trainees was also recognised by HEE who confirmed that it is high on the agenda of their executive. Nottingham University Hospitals NHS Trust has also withdrawn their support as they did not want a large placement circuit (this was not related to quality of paediatric training), although this was not the case for midwifery.

It was explained to the panel that the STP is moving to a model where Pilgrim will deal with the less acute patients with the consequent reduced workforce demands. It was reiterated by the STP that the system has support from HEE including trainees rotating to Pilgrim, although the panel were concerned that relying on trainees (or any form of blended workforce) will be problematic for the STP in the longer term. The financial implications of less night time and weekend work for trainees on lower bands would also need to be considered as the panel were of the opinion that this is neither sustainable nor attractive to trainees at the moment and in the longer term, the workforce will need to come from non-training grades, and that the training offer needs to be made attractive (such as a rural enhancement) otherwise trainees may opt to go elsewhere.

The panel were informed that there had been some success with overseas recruitment. The draft RCPCH Executive Summary suggests that if there is not sufficient progress after a year then the contingency plan of moving all inpatient services to Lincoln County will need to be planned for.

The panel understood that culture change is difficult and takes a long time and heard that ULHT has had some success already with other services that now operate as a single team across multiple sites.

The panel heard that the pilot has been reasonably successful so far although data related to out of hours was not available to allow the panel to comment on this specifically. The panel were informed that the activity coming through the PAU had been lower than anticipated, although the service has not yet experienced the pressures associated with the additional clinical workload which occurs in the winter. Fifty patients have been transferred in the last 6 weeks (just over one per day since 1st August) contrasting with the STP's previous modelling which predicted 4 per day. Presently, patients that require a stay longer than 12 hours are automatically transferred to Lincoln County.

9. Conclusions and advice of the supplementary Clinical Review Panel

Grantham Hospital

The clinical review team were impressed with the amount of work that had taken place between 11th July and 12th September on the medical beds at Grantham Hospital proposal. At the previous clinical review panel on 11th July, the panel did not get a clear idea of the proposals, particularly around the medical beds and the intrinsic link with the integrated neighbourhood teams.

The panel 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 that the proposal had changed significantly in the short time since the previous panel visit. The model combining frailty and NEWS scores described to the panel is innovative and the STP believes that it is possibly unique in the UK (the panel specifically asked about wider clinical evidence and comparable sites). In this regard, it appeared to the panel that the Grantham model achieves an excellent balance between access and sustainable long term outcomes, although clearly requiring substantial changes to the present system. All previous concerns were adequately addressed and the proposal was considered clinically acceptable by the panel and particularly in light of comparisons with County Hospital Louth where a similar model has been working effectively for 7 years.

Women's and Children's Services

The panel acknowledged the ambition the system has to deal with the challenges it faces and recognised that this is a result of the energy displayed by a number of very hard working individuals who are motivated and passionate in their approach to the issues. The panel is under no illusion about the significant public pressures that the STP faces and while it is recognised that this is often an important surrogate marker for the needs of the population being served it remains crucial to balance access and inequalities with sustainable long term clinical outcomes. This balance is clearly particularly difficult when considering this service and brought into stark contrast when compared with the other areas considered in the STP's reconfiguration plans. In this respect plans for women's and children's services are not consistent with the

other areas that the clinical review panels have considered both on 11th July and 12th September. Additionally, the STP's description of the socio-demographic make-up of the county has been clearly articulated and it is clear that patients and the public have been involved in the development of proposals. The work undertaken on transport modelling with EMAS was also noted.

The panel recognised that the system has undertaken changes in respect of the PAU although this does not appear to have addressed the workforce issues the system faces. The LMS and the Better Births Strategy has some commendable aims, although more obstetric input into the community hubs will be required at an early stage.

The panel accepted that there have been extensive deliberations and work over several years during which the STP considered a number of potential solutions, which were examined in detail and discussed widely within the Trust and in the community. This has led them to the conclusion that the only model which delivers on their ambitions for their population in the context of the difficult geography and levels of deprivation that are particularly prevalent on the East coast is a single service on two sites. The panel however were not convinced that the Trust has fully embraced the concept of "single service multiple sites" and it is imperative that obstetrics and paediatrics become cohesive, equitable teams. There is also still no evidence relating to the provision of sufficient obstetric input and how the Pilgrim workforce will be managed and the increased demand at Lincoln County addressed. This needs to be elucidated.

The panel were also of the view that rather than the Trust adopting an outcomes based approach, workforce and rare case management appear to be driving the proposals. The panel were of the view that there must be a shift to improving key outcomes as the evidence submission does not currently demonstrate or predict how the one team, two site model will achieve this.

The panel remained unclear about nursing leadership for paediatrics. A head of nursing for paediatrics is an important requirement, to provide leadership for the service as the single team dual site concept is created and develops. The children's improvement manager introduced to the panel is felt to address different issues and fulfil a very different role.

The longer term workforce issues, in addition to the readily acknowledged short term problems, remain intractable in the opinion of the panel. While these longstanding workforce issues exist the inevitable threat of a tipping point that may force the Trust to reconsider the options for this service remains.

The model presented does not represent a paradigm shift or represent the result of a novel or innovative approach and as a consequence although clearly felt by the Trust to be the only appropriate approach to addressing the significant constraints imposed by the demographics and public pressure, the panel feel that considerable work will be required in order to make it sufficiently attractive to trainees to address the workforce issues.

Finally the STP needs to continue to focus on their ambition for improving the healthcare of children in the Trust rather than responding solely to workforce pressures.

10. Recommendations

10.1.1 Recommendation 1

The panel recommends that Lincolnshire STP proceeds with its proposal for the future of medicine at Grantham Hospital with support from the Clinical Senate.

10.1.2 Recommendation 2

Obstetric input into the community hubs needs to occur consistently and at an early stage in the STP's plans and the level of resource required needs to be accurately identified. The panel is of the opinion that obstetric input into the community hubs will need to be increased but when this is achieved will address a number of outstanding issues including the identification of high risk patients.

10.1.3 Recommendation 3

A plan for outcome based strategies should be developed, clearly articulating how clinical outcomes at Pilgrim will be improved.

10.1.4 Recommendation 4

A head of nursing for paediatrics should be appointed to join the senior leadership team at ULHT with a major brief to develop the ethos of a "single team" and address the practical issues involved in its working.

10.1.5 Recommendation 5

The opportunities that exist for the trainees needs to be considered and a holistic approach considered to address transport, remuneration and professional development issues to produce attractive posts and significantly reduce the reliance on locum positions. A number of suggestions were made by the panel and the STP team should also explore the other options it discussed.

Appendix D: Clinical Review Panel Terms of Reference (12th September)

CLINICAL REVIEW: TERMS OF REFERENCE

Title: Lincolnshire STP supplementary clinical review

Sponsoring Organisation: Lincolnshire STP

Clinical Senate: East Midlands

NHS England regional or area team: Central Midlands

Terms of reference agreed by:

Name: E Orrock/A Dennison **on behalf of Clinical Senate and**

Name: S Furley **on behalf of sponsoring organisation**

Date: 7th August 2018

Clinical review team members

Chair: Ashley Dennison, Clinical Senate Chair and HPB and Pancreatic Surgeon at University Hospitals of Leicester

Panel members:

Name	Role	Organisation
Mandy Rudczenko	Patient representative	Senate Council
Dr Chris Miller	Consultant in Geriatric Medicine and General Internal Medicine	University Hospitals Leicester / Clinical Senate Fellow
Dr Janet Ashworth	Consultant Obstetrician	Derby and Burton Teaching Hospitals NHS Foundation Trust
Dr Craig Smith	Consultant Neonatologist Associate Postgraduate Dean	Nottingham University Hospitals Health Education England

Jo Watson	Lead Nurse	Derbyshire Children's Hospital
Dr Nigel Ruggins	Consultant Paediatrician & Neonatologist	Derby and Burton Teaching Hospitals NHS Foundation Trust
Dr Dushyant Batra	Consultant Neonatology	Nottingham University Hospitals
Simon Hardcastle	Divisional Head of Nursing Paediatrics and Neonates	Kettering General Hospital
Judith Foxon	Education and Project Lead	East Midlands Neonatal ODN
Dr Cathryn Chadwick	Head of School for Paediatrics	Health Education England
Matt Day	Consultant	Public Health England
Ian Mursell	Consultant Paramedic	EMAS
Eyad Issa	NIHR Clinical Lecturer in HPB Surgery/ Surgical Registrar	University Hospitals of Leicester NHS Trust / Clinical Senate Fellow
Mark Russell	Patient representative	East Midlands Academic Health Science Network

Aims and objectives of the clinical review

The clinical senate was previously commissioned by the Lincolnshire STP and a clinical review panel was held on 11th July, which focused on the clinical interdependencies and the totality of changes proposed by the STP. Specifically, the clinical review team was asked whether it supports, or not, Lincolnshire STP's proposals based on clinical sustainability, workforce and clinical outcomes.

It has subsequently been agreed to hold a supplementary review to look in more detail at Women's and Children's Services and Grantham Hospital to address the specific points raised by the original clinical review team on 11th July. The aim of this supplementary (follow on) review is for the sponsoring organisation to address the

information and evidence gaps identified by the original clinical review team to enable the clinical senate to offer a more definitive clinical opinion on these two proposals specifically.

Scope of the review

- Women's and Children's Services
- Grantham Hospital

With regards to Women's and Children's Services, the STP's longer term proposal is for two consultant-led obstetric units in Lincoln and Pilgrim Hospitals with retention of both its neonatal units. Paediatric inpatient facilities would be consolidated at Lincoln Hospital and a 24/7 Paediatric Assessment Unit would be opened at Pilgrim Hospital. The question posed to the clinical review team specifically is in reference to the STP's longer term proposal and to test whether there is a clear clinical evidence base underpinning the proposal before the STP proceeds to public consultation. The clinical review team is to advise the STP if there are any gaps in the clinical evidence base. The current short term changes to the Pilgrim Hospital paediatric service is outside of the scope of this review.

The specific original focus for Grantham Hospital was the Urgent Treatment Centre and the medical beds model. In addition, the original clinical review team identified that exclusion criteria for older, frail patients should be developed, and the community based frailty model also should be clearly described to enable the clinical senate to be able to offer a more definitive opinion on the STP's proposals.

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality[7])? For example, do the proposals reflect:
    - The rights and pledges in the NHS Constitution?
    - The goals of the NHS Outcomes Framework?
    - Up to date clinical guidelines and national and international best

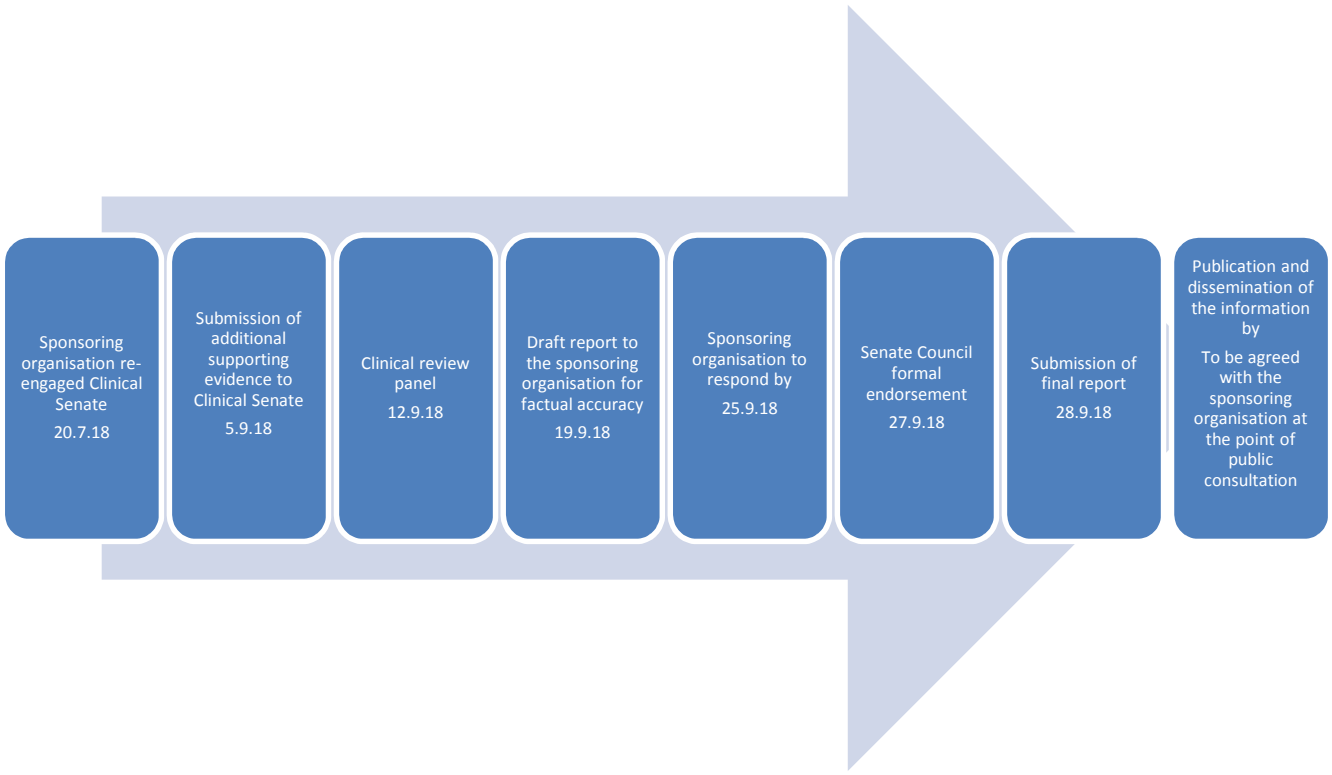
[7] Quality (safety, clinical effectiveness and patient experience)

practice e.g. Royal College reports *(RCPCH)*?

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? For example:
    - Do the proposals align with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies?
    - Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?
    - Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals meet the current and future healthcare needs of their patients?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Do the proposals consider the workforce requirements and transformation required to deliver this new model?

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline



Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The sponsoring organisation has agreed to collate and provide the following additional supporting evidence:

- For Women's and Children's Services;
    - ❖ The recent Royal College of Paediatrics and Child Health (RCPCH) report
    - ❖ Draft report of the neonatal peer review
    - ❖ The workforce plan for Women's and Children's Services

- ❖ Operating plans of the PAU to achieve relevant standards
- ❖ Retention strategy
- ❖ Plans to transport patients between Pilgrim and Lincoln Hospitals
- ❖ Better Births strategy, which will include reference to the integrated neighbourhood working model.

- Grantham Hospital;
  - ❖ Configuration of beds at Grantham Hospital including community based frailty model
  - ❖ Plans to transport patients between sites if required
  - ❖ Expanded exclusion criteria

Expected longer term impact of the Medical School will be provided as part of the supporting information to the clinical review team, although it is recognised that this is early in development (applications for 2019 entry will open on 1st September 2018).

Report

A draft clinical senate report will be circulated within 5 working days of the final meeting - to team members for comments, to the sponsoring organisation for fact checking.

Comments/ corrections must be received within a further 4 working days. This will include fact checking of the original draft report.

The final report will be submitted to the sponsoring organisation by 28th September, 2018.

Communication and media handling

The Clinical Senate will publish the final report on its website once it has been agreed with the sponsoring organisation. The sponsoring organisation is responsible for responding to media interest once in the public domain.

Resources

The East Midlands clinical senate will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate's accountability and governance structure.

The East Midlands clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing with their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments)
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review
- submit the final report to NHS England for inclusion in its formal service change assurance process
- arrange and bear the cost of suitable accommodation (as advised by the Clinical Senate office) for the panel and any panel members

Clinical senate council and the sponsoring organisation will

- agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical Senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and report and
- provide suitable support to the team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
- keep accurate notes of meetings

Clinical review team members will undertake to

- Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team

- comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix E: Summary of documents provided by the sponsoring organisation as evidence to the supplementary panel

- Lincolnshire Acute Service Review Presentation for East Midlands Clinical Senate Review (12th September)

- EMAS Letter of support

- Grantham evidence pack
    - Report on the Grantham Clinical Summit 4.9.18
    - Appendix 2 Grantham 'at a glance' proposal summary
    - Appendix 3 GDH Current exclusion protocol
    - Appendix 4 Clinical Frailty Scale
    - Appendix 5 Clinical Audit Grantham Hospital
    - Appendix 6 Guideline for the assessment of Acute Chest Pain of possible cardiac origin
    - Appendix 7 Final Grantham Future Medical Beds
    - Appendix 9 Dr Jay Banerjee presentation
    - Appendix 10 Final Revised GDH Exclusion Protocol September 2018

- Women's and Children's evidence pack
    - Clinical Senate Data Pack
    - Clinical Senate Evidence Pack
    - Appendix 1 ULHT CQC report
    - Appendix 2 QST report improvement plan
    - Appendix 3 Better Births report
    - Appendix 4 Draft Lincolnshire's Integrated Children and Young People Health Strategy and transformation board terms of reference
    - Appendix 5 Maternity dashboard
    - Appendix 6 Pilgrim Paediatric Assessment Unit data weekly monitoring reports
    - Appendix 7 Royal College of Paediatrics and Child Health Executive Summary
    - Appendix 8 ORH report transport and travel (Paediatrics and Obstetrics modelling)
    - Appendix 9 Maternity Transformation IT solution for Lincolnshire
    - Appendix 10 Children's and Young People Assessment Unit (CYPAU) Standard Operating Procedure
    - Appendix 11 Lincolnshire Child Health Profile
    - Appendix 12 CQC Children and Young People under 16 Survey
    - Appendix 13 Rapid Response Paediatric Service for the Acutely Unwell Child service specification

- Appendix 14 Maternity Services data set May 2018
- Appendix 15 EMAS Interim arrangements for conveyance of children under 18 years in Lincolnshire
- Current workforce compliance and proposals

- Medical School
  - BMBS Overview
  - Medical School in Lincoln briefing paper April 2018

Appendix F: Clinical review team members and their biographies, and any conflicts of interest (12th September)

Name	Role	Organisation	Conflict of interest
Professor Ashley Dennison	Clinical Senate Chair and HPB and Pancreatic Surgeon	University Hospitals of Leicester	None
Mandy Rudczenko	Patient representative	Clinical Senate Council	None
Mark Russell	Patient representative	East Midlands Academic Health Science Network	None
Dr Chris Miller	Consultant in Geriatric Medicine and General Internal Medicine	University Hospitals Leicester / Clinical Senate Fellow	None
Mr Eyad Issa	NIHR Clinical Lecturer in HPB Surgery/ Surgical Specialist Registrar	University Hospitals of Leicester NHS Trust / Clinical Senate Fellow	None
Dr Janet Ashworth	Consultant Obstetrician	Derby Teaching Hospitals NHS Foundation Trust	None
Dr Craig Smith	Consultant Neonatologist Associate Postgraduate Dean	Nottingham University Hospitals Health Education England	Neonatologist within same clinical network Work in same network Share patients Remain

Jo Watson	Lead Nurse	Derbyshire Children's Hospital	None
Judith Foxon	Education and Project Lead	East Midlands Neonatal Operational Delivery Network	None
Dr Nigel Ruggins	Consultant Paediatrician & Neonatologist	Derby Teaching Hospitals NHS Foundation Trust	None
Dr Dushyant Batra	Consultant Neonatology	Nottingham University Hospitals	Indirect non-pecuniary interest Consultant Neonatologist in Nottingham. Tertiary lead centre in neonatology. There may be a change in number of patients moving towards lead centre as a consequence of decisions Senate aware of affiliation to Nottingham University Hospitals NHS Trust

Simon Hardcastle	Divisional Head of Nursing Paediatrics and Neonates	Kettering General Hospital	None
Ian Mursell	Consultant Paramedic	East Midlands Ambulance Service	None
Dr Cathryn Chadwick	Head of School for Paediatrics	Health Education England	As head of school [East Midlands] my trainees are placed at ULH
Matt Day	Consultant	Public Health England	None

Clinical Senate Support Team

Ms Emma Orrock – Head of East Midlands Clinical Senate, NHS England

Miss Lara Harrison – Clinical Senate Administrator, NHS England

Appendix K

Minutes of joint meeting of the ICS Clinical & Care Directorate and CCG Clinical Policies Sub-Group

NHS
Lincolnshire
Clinical Commissioning Group

Minutes of the Joint Meeting of the ICS Clinical and Care Directorate and CCG Policies Sub-Group Meeting
Thursdayy 21st April 2022 – 3.00 pm via MS Teams

Present:	Dr Sunil Hindocha	Chair Primary Care Network Alliance (Chair)
	Dr Dave Baker	Clinical Leader, NHSL CCG
	Ms Sarah Bates	Deputy Board Secretary, NHSL CCG
	Ms Donna Baxter	Strategy Support Manager, ULHT (UEC discussion only)
	Mr Pete Burnett	System Strategy and Planning Director, NHSL CCG
	Dr Ananta Dave	Medical Director, LPfT
	Mr Tom Diamond	ICS Associate Director of Strategy, NHSL CCG
	Mr Martin Fahy	Director of Nursing and Quality, NHSL CCG
	Ms Steph King	Strategic Comms and Engagement Lead, NHSL CCG
	Ms Carolyn Knight	Head of Service Quality and Standards, LCC
	Mr Amardeep Nahal	Medicines Management Pharmacist, NHSL CCG
	Dr Yvonne Owen	Medical Director, LCHS
	Mr Carl Ratcliff	Medical Director, Medicine ULHT
	Dr Sameedha Rich-Mahadkar	Director of Improvement and Integration, ULHT
	Dr Ciro Rinaldi	Divisional Clinical Director Medicine, ULHT
	Ms Kate Scheele	Head of Service Respiratory Medicine, ULHT
	Dr Anne-Louise Schokker	Deputy MD ULHT and Consultant Geriatrician, ULHT
	Ms Maxine Skinner	Lead Nurse UEC, ULHT
	Ms Cheryl Thomson	General Manager UEC, ULHT
	Mr Terry Vine	Deputy Director of Nursing, NHSL CCG
	Ms Tracey Wall	Divisional Lead Nurse (UEC), ULHT
	Mrs Vanessa Wort	Associate Director of Nursing and Quality, NHSL CCG
Apologies:		
22/003	None noted	

Dr Hindocha welcomed members to the meeting and advised that this is the second meeting of a series of three meetings relating to the ASR review process and clinical overview and that this is a joint meeting of the ICS Clinical and Care Directorate and CCG Clinical Policies Sub Group.

Mr Burnett thanked members for attending the meeting and advised that these proposals have been in development for some time and that members from ULHT (United Lincolnshire Hospitals NHS Trust) and LCHS (Lincolnshire Community Health Services NHS Trust) are attending the meeting to provide support and answer any queries that are raised regarding the proposals. It was noted that the Clinical Policies Sub Group is the governance structure that will take the feedback from the meeting into the CCG QPEC (Quality and Patient Experience Committee) before submission to the CCG Board.

22/004 PURPOSE OF THE MEETING

Mr Burnett advised that the meeting is a Joint Meeting of the Clinical Policies Subgroup and the ICS Clinical and Care Directorate, and the key purpose is to provide an assessment on the Urgent and Emergency Care proposals and Acute Medicine proposals in light of the feedback received from the public consultation and the work completed in response to it. Mr Burnett referred to the national and local assessment criteria and the requirement for members to consider and agree if the proposals are fully met, partially met or not met in terms of the Quality, Access and Clear Clinical Evidence Base criterion.

Mr Burnett stated that the sources of evidence for the assessment against these three criteria are the recommendations of the East Midlands Clinical Senate, feedback from the public consultation, responses to the public feedback, Quality Impact Assessments and Equality Impact Assessments.

Dr Rich-Mahadkar raised a query that if members are not assured that there is sufficient evidence what is the process? Mr Burnett responded and advised that if this situation was to be presented that additional evidence would need to be sourced and the detail shared with members. Dr Hindocha added that if members identify additional evidence that could be of value to the process to highlight this and it will be incorporated into additional evidence.

Mrs Wort referred to the Clinical Senate report and the Terms of Reference and that the questions asked were slightly different to those of the assessment and included: clinical sustainability, workforce and outcomes and queried if these areas read across and how this is interpreted into the decision making. Mr Diamond responded and stated that the 'starting point' for the groups consideration was the overall recommendation from the Clinical Senate for the system to progress with each of the proposals.

Mr Fahy queried if the review of the assessments will be presented to the Clinical Senate again at a later date. It was noted that these would not be presented again to the Clinical Senate.

22/005 URGENT AND EMERGENCY CARE PROPOSALS

Mr Diamond presented the UEC (Urgent and Emergency Care) proposal and stated that the proposal for change is to establish a 24/7 UTC (Urgent Treatment Centre) at Grantham and District Hospital, in place of the current A&E (Accident and Emergency) Department, and up to this point there are no plans to change the proposal based on the work completed to respond to the public consultation feedback. However, this is to be tested further by this group.

Mr Diamond provided an overview of the East Midlands Clinical Senate process and that the team were asked to consider whether there is a clear clinical evidence base underpinning the proposals, specifically if support was provided for the proposals based on clinical sustainability, workforce and clinical outcomes. It was noted that the Senate only made one recommendation in relation to the proposed service model which was the word "Plus" tobe omitted from the proposed UTC name, this was agreed on the day of the session. Mr Diamond stated that the panel considered the proposed exclusion criteria to be clear, comprehensive and excellent.

Mr Diamond referred to the public consultation feedback and that from the consultation questionnaire 61% of NHS staff and 50% of other individuals agreed or strongly agreed with the proposals and 81% residents from the telephone survey agreed or strongly agreed with the proposals. It was noted that there were differing views on the proposals between those living in different areas of Lincolnshire which was particularly marked in the questionnaire responses in which just over half 51% of respondents living closest to Grantham and District Hospital expressed disagreement with the proposal, compared to 44% that agreed. Furthermore, the residents telephone survey indicated that there is majority support including those living closest to Grantham and District Hospital 75% of who agree with the proposals. It was noted that there was evidence of concern with 24% of residents disagreeing with the proposals.

Mr Diamond advised that feedback received from the Lincolnshire Local Medical Committee had indicated that in terms of the proposal Grantham does not have the population to justify a full ED (Emergency Department) and associated required services, thus a 24/7 UTC is proportionate.

Mr Diamond stated that the public consultation feedback had been themed into the following eight themes:-

- Conditions that would be treated at 24/7 Grantham and District Hospital UTC.
- Full A&E and hospital service provision at Grantham and District Hospital.
- Ambulance conveyance.
- Workforce and organisational integration.
- Travel and transport.
- Equalities and health inequalities.
- Similar UTC provided at Stamford and Spalding.
- New specialist hospital.

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

Mr Diamond referred to the summary of the public consultation feedback in relation to the conditions that would be treated at a 24/7 UTC and the following support was noted:-

- It was acknowledged that evening and overnight visitors to A&E departments at Lincoln or Peterborough Hospitals could be treated at a more local UTC.
- 24-hour access to walk in UTC might relieve pressure on Lincoln Hospitals A&E as well as benefiting those living near to Grantham.
- Represents a reasonable 'real world' compromise – need to ensure local residents are made fully aware of what services a UTC would provide

The following was noted in support and opposition of the proposal:-

- Reassurance a 24-hour URC would be appropriate for vast majority of patients requiring out of hours assessment and treatments
- Recognition that most people who would require full A&E services, such as trauma patients, would in any case be transported by ambulance to the nearest appropriate site.

The following opposition to the proposals was noted:-

- Linked the proposal for orthopaedic surgery to changes in urgent and emergency care provision.
- Concerns had been raised that the quality of care provided at A&E departments at Lincoln and Pilgrim hospitals, as well as long wait times some respondents had experienced.

In addition to the feedback received from the consultation, a member of the public submitted information that they felt the statement that Grantham and District Hospital did not have a Level 1 A&E from 2007/08 as inaccurate.

Mr Diamond referred to the summary of conclusions and actions of the working group considering the consultation feedback in this theme:-

- Grantham and District Hospital has had an exclusion criteria in place since 2007/08 and since this time patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions have been taken by ambulance to neighbouring hospitals where more specialist services are located.
- The exclusion list is well understood and if patients do present staff have the capabilities to stabilise the patient pending transfer.
- Having the skills and experience to manage patients with high acuity before transferring does not define Grantham and District Hospital as Level 1. This has been confirmed by independent external review.
- Under the change proposal Grantham and District Hospital would have the ability to manage all presentations including those requiring stabilisation and transfer as it does now.
- Activity modelling has estimated that with the proposed change and refinement to the exclusion criteria c.3% of those patients currently attending Grantham and District Hospital will be impacted, approximately c.2 patients a day on average. Those additional patients who would be seen at a different site under the proposal would have a NEWS of >7 and a frailty score <5 and likely have an acute medical condition.Comparing the activity between Grantham and District Hospital A&E and the temporary UTC shows the temporary UTC when it was open seeing more patients a day on average compared to the Grantham and District Hospital A&E for the same period for the previous year If the proposed change is implemented this analysis will be kept under review.
- If the service change proposals are agreed, a comprehensive communications plan will be rolled out for members of the public to ensure local residents are made fully aware of what services the 24/7 UTC would be able to provide.
- In addition, all relevant health and care providers including 111, East Midlands Ambulance Service Trust, primary and community care providers will be engaged and information provided detailing the full list of exclusion criteria.

Dr Baker stated that a significant amount of work has taken place on the proposals for a number of years and that the East Midlands Clinical Senate has supported these and that the majority of the public is content with the proposal.

Dr Owen added that during the second wave of the Covid-19 pandemic temporary UTC arrangements had been put in place at Grantham and District Hospital and that the arrangements were monitored on a daily basis. It was noted that there was no significant difference to the transfer activity as to when the department was operating as an A&E.

Mr Fahy queried the details regarding the 733 patients that had been transferred and if the outcomes were normal and these were via ambulance. Dr Owen responded and advised that a high number of these transfers were to surgical specialties and following a cross check of the historical data there was no significant difference.

Dr Baker stated that the proposed model is based on a different acuity NEWS (National Early Warning Score) score to the temporary UTC put in place in response to Covid-19,this was 3 and the proposals are for this to be 6.

Mrs Wort queried the ability to manage the same level of acuity over the 24/7 period and referred to the workforce of middle grade staff and how would consistency be achieved. Dr Baker advised that the plan is to retain the current middle grade doctors, and if the change proposal is agreed there would be further detailed work on the staffing model.. All staffing would be kept under review if the change is agreed and implemented. It was further discussed that the staffing model will be developed and that this will be regularly refreshed and will include detail in relation to medical, nursing, ACP and HCA staff. Dr Baker confirmed the current arrangement is for ambulances not to go to the Grantham and District hospital site at night, and that if the change proposal is agreed these arrangements would need to be reviewed prior to implementation and then ongoing to ensure alignment with the staffing model.

Action (if change proposal agreed): Detailed staffing model developed, and ongoing review and alignment of staffing model and ambulance conveyance arrangements for Grantham Hospital Site - Service delivery team
Dr Owen added that following a historic review of the data the number of patients that attend during the night is low and that there is medical staff that are available and on site.

Mrs Wort stated that the messaging to the public will need to be clear outlining what is and what is not appropriate to present with and queried if there is sufficient and appropriate workforce to meet the needs of when patients access the service. Mr Burnett responded and advised that a comprehensive communications plan will be developed. Dr Owen added that it may be easier to advise what not to present with and to reiterate and encourage members of the public to contact 111 in the first instance.

Dr Dave commented that the communications plan needs to place an emphasis on what is the appropriate conditions to present with. It was discussed that it would be beneficial to consider staffing models of other UTC's for benchmarking purposes. Dr Dave sought clarification regarding patients that present with mental health crisis and if this is included as part of the exclusion criteria. Dr Owen advised that for acute mental health patients there is a clear pathway in place via CAS and patients will be triaged by Clinicians via CAS and arrangements made for them to be seen and treated. Mr Diamond confirmed that it was stated during the public consultation that the Mental Health Liaison Service currently provided at Grantham and District Hospital would not be impacted by the proposed service changes and would continue to provide services as it does now.

Mr Ratcliff reiterated that the communications material needs to be clear as to who can access the service and when.

Dr Rich-Mahadkar stated that as the workforce model has not been developed yet and that this will evolve, this shows the transparency and openness of the proposals and that there is a balance in addressing all the comments.

Mr Fahy referred to the support for strengthened communications and meeting the public expectation. Furthermore, there needs to be clear language and terminology in particular with the wording for A&E, UTC and Walk in Centre.

Dr Sunil Hindocha queried the confidence in the right skill mix which is competent to stabilise and transfer whatever presents. From a clinical evidence point of view and NEWS 6 this was set following a clinical review on the case mix and this was well supported by the Clinical Senate.

Dr Owen commented that the Louth and Skegness UTC's do not have overnight cover and that they do have patients that present in the night particularly children and that these patients are stabilised for transfer by ACP staff. It was discussed that there is a requirement to develop the detailed staffing model and that this will be subject to ongoing review if the change proposal is agreed.

Mr Ratcliff added that the UTC is an enhanced offer and that most of these are operated by ACP staff without medical provision.

Action (if change proposal agreed): 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 - Service delivery team

Full A&E and hospital service provision at Grantham and District Hospital.
Mr Diamond referred to the full A&E and hospital provision at Grantham summary feedback and highlighted the support for the proposal that for many respondents, a 24-hour UTC was viewed as preferable to the current limited A&E department service operating 8.00 am – 6.30 pm.

In terms of the opposition the following was noted:-

- The vast majority of those who rejected the proposal did so, not on the basis they favour the status quo of current service provision, but because they would like a full A&E department in place of the current service and feedback included:-
  - Seen as a continuation of under-investment and a process of service reduction over a number of years.
  - Services at Grantham needs to be protected and expanded.
  - Lack of trust for changes and is another step in deliberate "downgrading".
  - Proximity of A1, major railway links and airports increase risk of a major incident that may overwhelm remaining services.
  - Strength of feeling from some members of the public which was further evidenced by the submission of two petitions with a combined total of 1,818 signatures or online indications of support.
  - Proposals do not take into account or properly address growing and ageing population in Grantham

In relation to alternative options the following was noted:-

- Current part time limited A&E to be replaced by a full Type 1 A&E.
- A&E services should continue to be offered during the day, with a UTC in operation overnight.
- Should build the A&E capabilities at Grantham to cut transfer times, reduce risk for patients, make it attractive for staff.
- Maintain A&E services at Grantham and provide dedicated, separate walk-in services run by nurse specialists in addition.

In terms of mitigation:-

- Train additional Advanced Nurse Practitioners (ACPs) to compensate for the shortage of Consultants.

Mr Diamond referred to the summary of conclusions and actions of the working group considering the consultation feedback in this theme:-

- A number of combining factors led to the consultation 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 sustainability 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.
- The proposed service change is in line with clinical guidance i.e., network arrangements where some acute hospitals provide a broader range of specialist services to a larger population "unselectively" and some provider a narrow range of services to a smaller population "selectively" and work in close partnership with adjacent services to access specialist services not available on site.

- 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.

Dr Hindocha added that from a clinical view the population has access to the services in the County and by 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 and there is a need for specialisms to be concentrated in certain areas.

Dr Baker referred to the evidence and stated that it is clear that patients attend the right hospital the first time. Dr Owen added that there is not the demand for this service in Grantham. Dr Baker stated that this would require six ED Consultants and a critical care rota.

Mr Ratcliff queried the right clinical model and the opportunity to be able to book an appointment.

Ms Wall referred to the current Lincolnshire nursing vacancies for emergency care at approximately c. 40 registered nurse vacancies and that this would increase the numbers and make the situation even more challenging.

Ambulance conveyance.

Mr Diamond presented the public consultation feedback in relation to ambulance conveyances and the support and opposition including:-

- Concerns of risk to life as a result of increased travel times in life-threatening emergencies – concerns about ambulance conveyance times to more distant A&E departments,
- The rurality of Lincolnshire leads to concerns regarding acute and emergency health service provision becoming more spread out at a time when the population is growing, particularly around Grantham.

Points for additional consideration include:-

- NHS 111 needs to be informed that this is being proposed so that patients if needed treatment are transferred to Grantham rather than being taken to A&E departments further away.

In terms of the summary of conclusions and actions of the working group considering the consultation feedback in this theme the following was presented:-

- Grantham and District Hospital has had an exclusion criteria in place since 2007/08 and since this time patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions have been taken by ambulance to neighbouring hospitals where more specialist services are located.
- The exclusion list is well understood by the local healthcare system including primary care, community providers and the ambulance service. If patients do present with conditions that are listed within the criteria the staff have the capabilities to stabilise the patient pending transfer.
- Based on actual ambulance travel times (2019/20) the average time to a hospital other than Grantham and District from the wards closest to Grantham Hospital is below the 45 minutes travel threshold set by the local health system for this type of activity. The highest average travel time from a ward closest to Grantham Hospital is just over 50 minutes.
- On average approximately 733 patients per year require transfer by the ambulance service from Grantham Hospital to another hospital.
- Under the proposed model of a 24/7 UTC at Grantham Hospital the exclusion criterion for the Grantham Hospital site would be refined, meaning a relatively small number of patients (c.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 and therefore their travel time could be less than 45 minutes.
- Two key foundations of the proposed care model are to:-

  - Make sure patients get to the definitive treatment first time whether that be Grantham Hospital or an alternative site.
  - Reduce the number of intra hospital transfers to another site, so demonstrating that the patient is 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 outweigh the potential increases in ambulance travel time.
- 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 GDH 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.
- If the change proposal is implemented the additional ambulance hours required to maintain current performance levels will be reflected in the ambulance provider contract.

It was discussed that there needs to be clear communications both with the public and healthcare providers about what can and cannot be taken to Grantham Hospital.
Dr Owen commented on ensuring that the DOS (Directory of Services) profile is updated and that this process has recently taken place for the UTCs.

Mr Ratcliff stated that the transit times have to be clear and for those patients that are over the 45 minutes if the patient is stabilised they can be taken to an alternative site. Mr Ratcliff reiterated that it is vitally important "event to treatment" time and treating the patient in the right place first time.

Mrs Wort queried for walk in centre patients if there is anything that raises concerns in terms of timeliness of transfer to the appropriate site or moving to keep patients safe if there are any delays in the process. Dr Dave queried if there had been any SI's loaded onto Datix.

Dr Owen recognised that there are delays in ambulance transfers from UTCs and that this item is on the LCHS Corporate Risk Register and that there is a long list of mitigations in place. Dr Owen added that the staff have a very clear process that includes an escalation process and a clear pathway on the chain of command.

Ms Wall added that in terms of additional mitigations and the pre-hospital medicine lifesaving medicines can be administered that would help to stabilise the patient and that this needs to be included as a mitigation. It was discussed that if a patient is with a clinician, they are deemed less at risk than on their own. It was discussed that CAT 1 is nationally mandated. Mr Ratcliff stated that the place of safety can be a challenge and that there has to be a balance of safety.

Dr Rich-Mahadkar stated that this issue needs to be considered at a later date dependent upon the approval of the proposals.

Action: Ongoing review of ambulance transfer protocols and ensure clear process is in place, including risk assessment and mitigations - Service delivery team (if proposal agreed)

Workforce and organisational integration

Mr Diamond referred to the Workforce and Organisational Integration feedback regarding opposition and additional considerations:-

- Recruiting and retaining staff to the proposed UTC will not be straightforward, the issue of staff recruitment is not just specific to A&E doctors, UTC's experience staff shortages mean there are barely enough to safely staff the existing UTC's. There is concerns over where the experienced ACP's will be found to fill these vacancies.
- There may be times in future whereby staff are re-allocated from the UTC to support A&E departments, thus reducing the capacity of the proposed Centre.
- When the temporary UTC was in place at Grantham, there was a disconnect between LCHS and ULHT in terms of safeguarding oversight and IT systems not working together. This needs to be resolved in a permanent model.

The summary of conclusions and actions of the working group considering the consultation feedback in this theme were noted:-

- Building on the workforce modelling in the PCBC (Pre-Consultation Business Case) the workforce modelling for the new provider would need to be mapped to cover a new 24/7 UTC.
- 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.
- It is not expected that staff would re-allocate between a UTC and A&E due to the difference required in skillset.
- 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.
- The new provider would continue to host their own electronic health records which would align to the standards of a UTC. The new provider would need to work closely with new IT solutions.

There were no comments made by members.

Equalities and travel and transport

Mr Diamond presented the detail in relation to equalities and transport and highlighted the following feedback:-

- The analysis of questionnaire and survey responses did not indicate that there were any strong differences in views of specific concerns being expressed by respondents from groups with protected characteristic under the Equalities Act 2010. 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.
- Where concerns were raised in feedback about particular groups, the focus was predominantly on travel and transport, particularly for those with limited access to private transport.

- 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 with proposals around urgent and emergency care Grantham and District Hospital than other residents, it should be noted that the feedback indicated that concerns about the proposal was again focused on concerns about travel and access to alternative sites, and the need for local acute emergency services at all hospitals.
- There were concerns regarding accessibility for specific groups including: people with personal access to a vehicle, people visiting friends/family, peoples 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.
- Impact on members of the public who might find it difficult to travel to and from Lincoln County Hospital and other locations due to poor transport links to Lincoln County Hospital and increased costs and journey times, particularly for those who rely on public transport or are discharged late at night
- Visitors if patients admitted to hospitals, both in terms of their own journeys and the potential impacts on patient recovery and wellbeing if they are isolated from family and carers.
- There are climate change implications when patients have to travel to and from hospitals – centralisation undermines government policy on 'zero-carbon' transport which will mean that fewer of the poor and vulnerable will have electric cars

- More patient transport options be offered between hospital sites, and to help patients to return home following discharge if they were transferred from the UTC to an A&E at a different hospital.
- If proposal for 24/7 UTC goes ahead, ULHT should provide their own emergency and non-emergency transfer service to local A&E departments, so that East Midlands Ambulance services are not affected.

Mr Diamond referred to the summary of conclusions and actions of the working groups considering the consultation feedback in this theme relating to the equalities and transport:-

- 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 Grantham and District Hospital A&E department would continue to be seen and treated at the 24/7 Urgent Treatment Centre.
- 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 c.3% of the current activity, and the displacement is due to their care needs being better met in a more specialised service and an alternative hospital.
  - Under the proposed changes it is estimated that of these displaced patients c.375 (based on 2019/20) 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 minutes.
- Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS.
- 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 so that the impact of the proposed service changes on ambulance capacity is negligible.
- (NEPTS) Non-emergency patient transport is provided for patients who meet nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for patients who are going to hospital for outpatient appointments, diagnostics or treatment or for admission, and for patients who are eligible for transport from hospital following outpatient or diagnostic appointment or day case or inpatient care and treatment.
- It is therefore 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 current patient transport service is required to signpost patients who do not meet the eligibility criteria for patient transport to alternative transport providers and this is also a requirement in the new contract. Lincolnshire CCG could commission bespoke service for patients impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is therefore not seen as a viable solution.
- Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements
- 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.
- 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.
- 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.

Mr Fahy commented on the equity and consistency across the system and that there are a number of patients and patients families that do not meet the criteria who have to make the journey elsewhere and which may not be in the County. It was highlighted that there is a challenge in the system and that discussions are taking place with the local authority regarding supporting existing transport schemes and a commitment to working together to implement solutions.

Mr Fahy referred to the QIA template assessment that had been submitted and stated that this needs reviewing as there cannot be a score of 0/0. It was agreed that Mr Fahy would review this with Mrs Wort.

Action: Review QIA scoring - Mr Fahy/Mrs Wort

Dr Rich-Mahadkar stated that she supported the conclusions and commented on the responsibility to the local population.

Similar UTC provided at Stamford and Spalding

Mr Diamond presented the summary public consultation feedback in relation to a similar UTC provided at Stamford and Spalding

Additional considerations:-

- A similar urgent treatment service to be provided at Stamford to cover areas south of Grantham.
- Why have we not run a pilot to see if the same level (24 hour) should be provided at Spalding UTC?

The summary of conclusions and actions of the working group considering the consultation feedback in this theme included:-

- The national Urgent Care Strategy set out the need for transformational change in service provision to sustainably support current and future generations.
- A local Lincolnshire Urgent Care Strategy has been developed in line with the national strategy and is already delivering system transformation.
- 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.
- The Lincolnshire Urgent Care Strategy is under constant review and development to ensure urgent care services best meet the needs of all Lincolnshire residents.
- 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 focussed on the provision from Grantham and District Hospital.
- Services provided at Stamford and Spalding were not part of the public consultation.
- At present, there are no additional plans to replicate or pilot this model in other locations across the county.

There were no comments made by members.

New specialist hospital

Mr Diamond referred to the feedback in relation to a new specialist hospital and advised of the following:-

Alternative option:-

- A new specialist hospital be built near Sleaford to deal with all emergency care, leaving other hospitals in Lincolnshire to deal with routine and planned care.

Summary of conclusions and actions included:-

- Through the work that has taken place to date on the Lincolnshire Infrastructure Plan, it was agreed that a new site at Sleaford is not a viable option and the focus will be 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 of maintenance.
  - Workforce availability and issues would impact on the operational deliverability of the scheme.

There were no comments made by members.

Following a lengthy debate, the recommendations made by members in relation to the Urgent and Emergency Care proposal included:-

Criteria	Outcome	Comments
Quality	Met	Met, however if service change is agreed key requirements for implementation and delivery are:

		• Detailed staffing model developed, and ongoing review and alignment of staffing model and ambulance conveyance arrangements for Grantham 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	Met	No comments
Access	Partially Met	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

22/006 ACUTE MEDICINE

Mr Diamond referred members to the overview of the proposal and the:-

- Proposal for change is to establish integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.
- It was noted that 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.
- 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.

Up to this point there are no plans to change the proposal based on the work completed to respond to the public consultation feedback. However, this is to be tested further by this group.

The feedback from the East Midlands Clinical Senate was shared:-

- The East Midlands Clinical Senate has been involved all the way through the options development and appraisal process for Acute Medicine. This included an independent clinical review, prior to commencing public consultation, where they were asked to consider whether there is a clear clinical evidence base underpinning the proposal.
- The East Midlands Clinical Senate panel described the proposal as innovative and achieved an excellent balance between access and sustainable long-term outcomes.
- Through this review the East Midlands Clinical Senate supported the proposal for Acute Medicine and made no further recommendations

In terms of the responses received from the consultation questionnaire and telephone survey the following was noted:-

- 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.
- 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 two fifths and a quarter of respondents neither agreed nor disagreed with

these proposals.
- 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.

The feedback from the Local Medical Committee was shared:-

- Having community hospital beds for step-up and step down will provide care close to home for these patients, whilst also providing a pressure valve for the acute beds at Lincoln.

It was noted that the public consultation feedback had been based on the following themes:-

- Quality and workforce.
- Conditions that would be treated at 24/7 Grantham and District Hospital UTC.
- Full A&E and hospital service provision at Grantham and District Hospital.
- Acute Care Unit (ACU).
- Ambulance conveyance.
- Facilities
- Equalities and Health Inequalities.
- Travel and transport.
- Alternative Suggestions.
- Criticism over lack of detail.
- Additional considerations.

Quality and workforce

Mr Diamond provided the feedback received in relation to quality and workforce including:-

Support:-

- Provide benefits such as more efficient care, with patients being discharged more quickly while continuing to receive treatment and care in their communities.
- Likely to improve recruitment and retention of consultants and middle grade doctors
- Support received from Chartered Society of Physiotherapy, however identified an additional consideration that adequate staffing and resourcing must be provided

Opposition:-

- Proposal will place elderly patients with complex needs out of secure hospital environment supported by specialist consultants and either move them to an alternative hospital site requiring considerable journeys with associated risk, or, place them into community care which is known to be fragmented and where monitoring patient progress and outcomes is more of a challenge.
- No reference to Grantham and District Hospital as a training hospital in the new plans and dissatisfied staff and consultants will make the future of hospital services across the county les sustainable.

Support & Opposition:-

- Concerns other services need to be involved to facilitate the change e.g. adult social care and primary care, and these services are already overwhelmed.
- Concerns about cost of implementing changes and increased workload required.
- Community staff in short supply as well as hospital staff.

Mitigations:-

- Reduce demand for hospital beds by ensuring access to GPs.
- Huge recruitment drive needed for clinicians, care-works and therapists.

A summary of the conclusions and actions of the working group considering the consultation feedback in this theme were presented:-

- EM Clinical Senate described proposal as innovative and achieved an excellent balance between access and sustainable long-term outcomes.
- Integrated community/acute medical beds would be delivered through a partnership model between a community health care provider and ULHT – care of patients would still be led by consultants and their team of doctors, practitioners, therapists and nursing staff.
- Change proposal would deliver a more comprehensive local service provision and would enable Grantham and District Hospital to build a centre of excellence for integrated multidisciplinary care (particularly for frail patients), which supports improved community-based management of LTCs (long term conditions).
- Anticipated change would impact c.10% of patients currently receiving care in acute medical beds at Grantham and District Hospital . This is equivalent to c.1 patient a day on average. These patients would receive care at an alternative hospital with the right skills/facilities to ensure best possible outcomes.
- 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.
- 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.
- This innovative care model will put Lincolnshire in a position to attract a high-quality workforce into the future and to build further on current medical, nursing and AHP training provision within the county.
- An increase in financial cost of the service has been modelled and this includes an increase in staff numbers
- In Lincolnshire recruitment and retention, initiatives continue throughout all service lines, to attract and retain staff. Staff will be fully supported in terms of recruitment where required, use of temporary staff, full training and support.
- Lincolnshire currently offers GPs easier pathways to access minor illness and injury pathways.; new models of access have been developed during the pandemic with increased availability of online, video and telephone appointment where appropriate; From Autumn 2022 there will be new enhanced arrangements for primary medical services which will reduce variability across the county.

Mrs Wort raised a query regarding understanding the concept and how this works and the areas that would sit with the responsibility with the community provider and the workforce arrangements and the levels of confidence that the model attracts in and retains. There is likely to be some complexity for governance and accountability arrangements.

Dr Baker responded and advised that the detailed workforce planning has yet to be undertaken and if the proposal was to be approved a working group would be formed with all the relevant stakeholders regarding the model. It is anticipated that it will be approximately 12 months before implementation.

Action (if service change proposal is agreed): Detailed workforce planning for proposal, and ongoing review - Service delivery team

Mr Ratcliff stated that one of the previous concerns raised related to the management of frail elderly patients and subsequent to this a Frail Elderly Unit has been put in place. This facility would provide step up beds for GP's which patients can be admitted to and this is the start of the model that puts the patient at the centre.

It was further discussed that this may provide an opportunity for alternative recruitment and retention models such as PCN's employing the necessary staff.

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

Mr Diamond referred to the feedback received in relation to the conditions that would be treated at 24/7 Grantham UTC. The additional considerations included:-

- There are concerns that if the proposed UTC is developed, with an extended range of services compared to other similar centres, there is a risk that withdrawing any of these services would impact on the arrangements for acute and community beds.

The mitigations included:-

- NHS 111 needs to be fully informed of who they can send to Grantham instead of an A&E department further afield.

The summary of conclusions and actions of the working group considering the consultation feedback in this theme included:-

- The exclusion list is well understood by the local health system. If patients do present at Grantham hospital with conditions the hospital is unable to treat, staff have the capabilities to stabilise the patient pending transfer.
- Those additional patients who would be seen at a different site under the proposal 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.

There were no comments made by members.

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

In relation to the full A&E and hospital service provision at Grantham it was noted that the opposition included:-

- Grantham and District Hospital should be a fully serviced hospital with acute medical beds.
- Proposal does not take into account or properly address the growing and aging population in Grantham
- Concerns about negative impacts on the quality of care provided, and the potential for increased pressure on other hospitals.

The summary of conclusions and actions of the working group considering the consultation feedback in this theme included:-

- 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 – as set out in the consideration of the Urgent and Emergency Care proposal consultation feedback

There were no comments made by members.

Acute Care Unit (ACU)

In terms of the Acute Care Unit the opposition received included:-

- Clarification is required in relation to the situation with the Acute Care Unit beds at Grantham and District Hospital and why they had been closed.
- Lincolnshire CCG propose not to replace the Acute Service Unit which provided vital medical expertise to critically ill patients and included beds commissioned by the East Midlands Critical Care network. The CCG propose to leave a minimum number of 'integrated community/acute medical beds' shared with other non-medical departments. This will result in fewer patients being admitted into Grantham Hospital.
- Specific concerns about lack of provision of Level 2 Respiratory beds at Grantham and District Hospital

Alternative option:

- Suggested that respiratory ACPs could manage respiratory beds with support from anaesthetists and additional funding for recruitment and training.

The summary of conclusions and action of the working group considering the consultation feedback in this theme included:-

- The 12 bedded Acute Care Unit at Grantham and District Hospital (also described as a L1 bed function) has now been split into 8 surgical and 4 medical beds on the specialist wards to provide better care for the patients.
- This was implemented when the site moved to a green model to support IPC requirements but has been kept in place, as the medical and surgical patients are better cared for by being in the relevant specialities. The L1 beds will remain in place as currently provided, regardless of the outcome of the decision on the change proposal.
- 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. The splitting of the ACU beds into the two medical and surgical groups was done to provide better care for both sets of patients. This was not done in any way to pre-empt the decision on the proposed model and has no impact on the deliverable care for the patients.
- 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.
- Level 2 Respiratory Beds:
    - There are not and have not been critically care trained consultants at Grantham. There have not been nor are there any anaesthetists based at GDH on the critical care specialist register. The anaesthetists at GDH are not trained to deliver or supervise NIV as per BTS national guidelines. 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 5 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.

Dr Dave queried further detail in relation to the respiratory beds. Ms Scheele advised that the British Thoracic Society Guidelines indicate that Level 2 respiratory care should be provided in an environment where nurses are familiar with the procedure and maintain competency. Patients are to be reviewed 1-2 a day preferably by a Consultant who specialises in ventilation. This has not been at Grantham since 2016. It is about the appropriateness. If patients have Type 2 respiratory failure, they would not meet the criteria for EMAS to bring them to Grantham and would have a higher NEWS score.

Dr Baker added that currently this provision is not provided at Grantham and District Hospital as there is no substantive respiratory Consultant at Grantham and that in an ideal world this would be delivered however it is not safe at the moment and the position would be kept under review.

Ms Scheele added that in terms of recruitment there are issues nationally and currently there is approximately a third of this provision lacking in the County as indicated in GiRFT. It was noted that Consultant posts are still vacant 18 months later. Dr Schokker stated that these patients require a critical care facility for non-invasive ventilation.

Dr Dave added that there needs to be confidence that the current arrangements meet the requirements.

Ambulance conveyance

In relation to ambulance conveyance the feedback received included:-

- There will be an additional impact onto East Midlands Ambulance Service to transfer people to the nearest hospital with an acute bed.

The summary of conclusions and actions of the working group considering the consultation feedback in this theme included:-

- Independent analysis identified that in order to mitigate any reduction in current performance 2 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.
- If the change proposal is implemented the additional ambulance hours required to maintain current performance levels will be reflected in the ambulance provider contract.

There were no comments made by members.

Facilities

Mr Diamond provided the feedback in relation to the Facilities element and advised that:-

Support & Opposition:-

- Further clarity sought on impact of the proposals on overall bed space at Grantham and District Hospital.

In terms of summary of conclusions and actions:-

- Bed demand and capacity modelling formed a key part of the underpinning analysis to assess the proposed service change.
- The modelled bed requirement by 2023/24 is comfortably within the current acute medicine bed capacity at Grantham Hospital, however there are no intentions to reduce the number of acute medicine beds at Grantham and District Hospital.
- It is to be noted that only one acute ward is being used currently due to the inability to safely staff this ward from both a nursing and medical perspective. This is reflective of recruitment challenges for all acute sites but worse at Grantham.

Mr Fahy stated that for ease of clarity could the detail in relation to the bed base numbers before and after be included in the documentation. Mr Diamond confirmed it was in the papers shared and all of these would be included in an appendix to the Decision Making Business Case.

Mrs Wort referred to the detail in relation to the reduction in bed numbers however the proposals reference that 10% of patients that are currently cared for at Grantham will not be in the future and reducing LOS (length of stay) and affecting occupancy rates how does this triangulate in particular with looking after the extended cohort of patients. Mr Diamond stated that no reduction in the bed capacity is planned at Grantham Hospital under the proposal and the capacity will be utilised in a different way such as step-up beds..

Mr Ratcliff added that by having a second ward will allow for patients to be brought back from Grantham postcodes. The provision will include step up, lower acuity and rehab beds and enhance services at Grantham and District Hospital.

Dr Baker stated that there are a number of patients from Grantham that are being cared for in other parts of the County and by implementing a rehab ward which is therapy led with Consultant support and potential to transfer from Lincoln is a solution.

Action (if service change proposal agreed): Ensure existing bed capacity is optimised and cohorts extended in line with detailed workforce planning - Service delivery team

Equalities and Travel & Transport

Mr Diamond referred to the equalities and transport feedback, the following was noted:-

- 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.
- 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.
- 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.

- 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.

- 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.

Additional considerations included:-

- Non urgent hospital transfer may also be affected, as people live further away from the hospital they are admitted to.

Mr Diamond referred to the summary of conclusions and actions of the working groups considering the consultation feedback in this theme relating to the equalities and transport:-

- 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 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.
    - This is equivalent to c10% of the current activity, and the displacement is due to their care needs being better met in a more specialised service at an alternative hospital.
    - Under the proposed changes it is estimated that there will be no increase in the number of patients travelling more than 60 minutes by car, the threshold agreed for this type of activity
    - However, in reality given the existing exclusion criteria and current usage of the Grantham Hospital site many of the patients who would no longer attend Grantham Hospital would actually travel by ambulance and therefore their travel time would likely to be less than 60 minutes.
- Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS.
- 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 so that the impact of the proposed service changes on ambulance capacity is negligible.
- (NEPTS) Non-emergency patient transport is provided for patients who meet nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for patients who are going to hospital for outpatient appointments, diagnostics or treatment or for admission, and for patients who are eligible for transport from hospital following outpatient or diagnostic appointment or day case or inpatient care and treatment.
- It is therefore 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 current patient transport service is required to signpost patients who do not meet the eligibility criteria for patient transport to alternative transport providers and this is also a requirement in the new contract. Lincolnshire CCG could commission bespoke service for patients impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is therefore not seen as a viable solution.
- Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements
- 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.

- 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.
- 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.

Dr Hindocha commented that a distinction needs to be drawn between these proposals and the UEC proposals as these are based on admitted patients.

Mr Ratcliff added that some patients may have to travel and that Grantham patients can be repatriated. Furthermore, patients with long term conditions care should be provided with care closer to home and not in acute beds.

Dr Dave referred to the equalities and protected characteristics and that within the detail there is no reference to digital access recognising that there are some issues with this in the coastal and rural areas. Dr Schokker responded that there are other systems and strategies that are addressing the digital poverty in areas over the County whilst exploring opportunities such as virtual wards and telemonitoring.

Action (if service change proposal agreed): Ensure service model optimises the opportunities of digital access- Service delivery team

Mr Ratcliff referred to the support for patients in the step-up beds and support in the wider community and that this is outside the scope of the consultation. This is seen as a driver and will enhance the model.

Mr Fahy commented on the restricted visitors during Covid-19 and finding alternative ways for relatives to see their families and the use of I-PADS and that this needs to be included within the mitigations.

Dr Owen stated that this strengthens the integration between inpatient and community and lends to the care closer to home agenda also strengthening the virtual wards.

Alternative Suggestions

Mr Diamond referred to the alternative suggestions and the feedback received including:-

Alternative options:-

- If acute and community beds are available at Grantham, blood tests should be available there too.
- Establish acute and rehab pathways:-
  - Acute pathway (for acutely/medically unstable patients) that would be EAU (assessment unit) and one more medical ward to allow patient flow with MDT discharge facilitation
  - Rehabilitation pathway: step down from acute beds and step up from community. The Rehab Ward should include stroke rehab beds and general rehab beds for patients with any other conditions including frail elderly and post-Covid patients.
  - Establishing a rehabilitation ward in Grantham and District Hospital would allow service provision for patients closer to their home and access for visitors.

- Provide 'halfway house' care wards for those who are medically well but unable to cope with going home at present, offering convalescence and low dependency beds. Occupational therapy could be an added service.
- Hospital and ongoing social care should be staffed by fully integrated multidisciplinary teams to facilitate seamless transfer of patients into the community. This would involve integrated social services and hospital financial structures to end delayed discharge.
- Acute medical beds should not be provided at Grantham, given the limited support and other services there. Grantham should be an elective surgery and community hospital providing high quality care outside an acute setting.

In terms of the summary of conclusions and actions of the working groups considering the consultation feedback in this theme the following was noted:-

- Bloods are currently taken by ward nurse/medical staff and processed on site or sent to other sites if specific analysis in required. This model would be replicated if the change proposal is agreed. The pathology service that provides blood test analysis is provided by NLAG and this provision would remain unchanged.
- The feedback received in relation to acute and rehab pathways and 'halfway house' care wards aligns to the proposed service change.
- Establishing fully integrated multidisciplinary teams is at the heart of the change proposal.
- As part of the options appraisal, the option of Grantham and District Hospital not providing medical beds was considered. Following an evaluation by a clinically led stakeholder group this was not identified as a preferred way forward.

There were no comments made by members.

Criticism over lack of detail

In relation to criticism over lack of detail the following was noted:-

Additional consideration:-

- Criticism over lack of detailed information on the integrated model in the consultation document

In terms of the summary of conclusions and actions of the working groups considering the consultation feedback in this theme the following was noted:-

- 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.
- 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.
- Recognising some people may want more information 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.
- Additional material was made available during the consultation period to provide responses to some of the common requests for clarity received.

There were no comments made by members.

Additional considerations

Mr Diamond referred to the additional considerations:-

- Staff and PPG representatives would like to see this kind of model replicated across the trust.
- Mental health beds should be treated as a priority in future planning.
- Develop research and development linked to university and attracted graduates by asking them what they need.
- Patients with chronic health conditions and co-morbidities e.g., obesity, should be centralised in one location in the county to allow staff to develop specialisms.

The summary of conclusions and actions of the working groups considering the consultation feedback in this theme included:-

- 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:-
  - If the change proposal is agreed and implemented, 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.

- 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.
- United Lincolnshire Hospitals NHS Trust is committed to become a University hospital with links to Lincoln University and its medical school to attract graduates. This in turn will lead to enhanced research and related activities.
- 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.

There were no comments made by members.

Mr Fahy referred to the Quality Impact Assessment and the scoring: consequence = 5 which is catastrophic and requires revisiting and renumbering.

Action: Review QIA scoring - Mr Fahy/Mrs Wort

Members considered the proposals and the assessment criteria:-

Criteria	Outcome	Comments
Quality	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. 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 • Existing bed capacity is optimised and cohorts extended in line with detailed workforce planning
Clear Clinical Evidence Base	Met	No comments
Access	Met	No comments

Mr Burnett thanked members for attending and for their engagement and that this reaches the critical step in the proposals being taken forward. It was noted that the meeting on 28th April 2022 will focus on the Orthopaedics and Stroke proposals.

22/007 DATE AND TIME OF NEXT MEETING

Thursday 28th April 2022 – 3.00 pm – 5.00 pm

NHS
Lincolnshire
Clinical Commissioning Group

Minutes of the Joint Meeting of the ICS Clinical and Care Directorate and CCG Policies Sub-Group Meeting
Thursday 28th April 2022 – 3.00 pm via MS Teams

Present:	Dr Sunil Hindocha	Chair Primary Care Network Alliance (Chair)
	Dr Reid Baker	Medical Director, LMC
	Ms Sarah Bates	Deputy Board Secretary, NHSL CCG
	Ms Donna Baxter	Strategy Support Manager, ULHT
	Mr Pete Burnett	System Strategy and Planning Director, NHSL CCG
	Ms Catherine Capon	Deputy Divisional Nurse Surgery, ULHT
	Mr Tom Diamond	ICS Director of Strategy, NHSL CCG
	Dr Abdul Elmarimi	Stroke Consultant and Clinical Lead, ULHT
	Ms Chris Erskine	Principal Social Worker, LCC
	Ms Cathy Geddes	NHSE/I Improvement Director
	Mr Martin Fahy	Director of Nursing and Quality, NHSL CCG
	Dr Colin Farquharson	Medical Director, ULHT
	Mr Paul Hinchcliffe	Deputy Director Strategy & Planning, ULHT
	Mr Amardeep Nahal	Medicines Management Pharmacist, NHSL CCG
	Dr Yvonne Owen	Medical Director, LCHS
	Dr John Parkin	Clinical Leader, West Locality, NHSL CCG
	Mr Carl Ratcliff	Medical Director, Medicine ULHT
	Dr Sameedha Rich-Mahadkar	Director of Improvement and Integration, ULHT
	Dr Ciro Rinaldi	Divisional Clinical Director for CSS & Medicine, ULHT
	Dr Vel K Sakthivel	Clinical Lead and Consultant Orthopaedic Surgeon, ULHT
	Dr Anne-Louise Schokker	Deputy MD ULHT and Consultant Geriatrician, ULHT
	Mrs Angela Shimada	Deputy Director Allied Health Professionals, LCHS
	Mr Terry Vine	Deputy Director of Nursing, NHSL CCG
	Mrs Vanessa Wort	Associate Director of Nursing and Quality, NHSL CCG
Apologies:		
22/008	Dr Catherine Grainne O'Dwyer	Divisional Clinical Director for Surgical Division.

Dr Hindocha welcomed members to the meeting and advised that this is the last of the meetings relating to the ASR review process and clinical overview and that this is a joint meeting of the ICS Clinical Care Directorate and CCG Clinical Policies Sub Group.

22/009 PURPOSE OF THE MEETING

Mr Burnett thanked members for attending the meeting and advised that these proposals have been in development for some time and that the purpose of the meeting is to have a clinical overview of the proposals following the feedback received. Mr Burnett added that the aim of the meeting is to provide an assessment in light of the feedback received and subsequent considerations. It was noted that the assessment includes both local and national criteria and that the three areas for assessment are: quality, clear clinical evidence and access.

Mr Burnett stated that the outcome from the meeting will be fed into the CCG QPEC (Quality and Patient Experience Committee) and ultimately the CCG Board for decision making. Mr Burnett shared with members the assessment criteria and if the proposals are not met, partially met or fully met.

22/010 ORTHOPAEDICS PROPOSALS

Mr Diamond presented the overview of the Orthopaedic proposal and that the proposal for change is to establish a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital and to have a dedicated day case centre at County Hospital Louth. It was noted that outpatient clinics would be unaffected and would mean that Grantham and District Hospital would not provide unplanned orthopaedic surgery.

Mr Diamond added that 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.

It is anticipated the change would affect on average:-

- Between 3 and 4 patients a day for planned orthopaedic surgery, these patients would receive treatment at either Grantham and District Hospital or Louth hospital; and
- Around 1 patient a day for unplanned orthopaedic surgery, these patients would have previously received care at Grantham and District

Following consideration of the public feedback on this change proposal there are no plans to alter the proposal.

Mr Diamond referred to the feedback received from the East Midlands Clinical Senate review and advised that the Team were 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. The clinical review team supported the proposal for Orthopaedic services and recommended the health system proceed with it.

Mr Diamond added that the East Midlands Clinical Senate had proposed a number of recommendations and referred members to the progress section and the position at the time of the PCBC (Pre-Consultation Business Case).

Mr Diamond provided an update on the responses received through the public consultation and that the consultation questionnaire identified that 68% of NHS staff and 61% of other individual respondent either tended to agree or strongly agreed with the proposals. In terms of the telephone survey 78% of residents agreed with the proposals.

Mr Diamond referred to the feedback received from the Local Medical Committee which indicated that dedicated planned care centre and day case centre will insulate it from acute activity and thus provide cleaner facilities and less risk of cancellation.

Mr Diamond outlined the summary of the key themes of feedback received through the consultation, and advised that working groups were formed to give conscientious consideration of the feedback received. The themes consisted of:-

- Quality/Workforce.
- Access.
- Interdependency with Urgent and Emergency Care.
- Travel and Transport.
- Equalities and Health Inequalities.
- Facilities.

Quality/Workforce

Mr Diamond summarised the feedback in relation to the Quality and Workforce theme:-

Support:-

- Improvements in quality of care.
- Improvements in staff recruitment and retention.

Opposition:-

- Negative impact on quality and timeliness of emergency orthopaedic care.
- Impact on ambulances.
- No provision for unforeseen emergencies arising from routine surgery.

Concerns:-

- Challenges to staffing the model
- Improvements to recruitment and retention not being achieved.
- Is a short-term contingency plan that does not address underlying issues.
- Lack of evidence and information on proposed changes and how performance is measured.
- Grantham will be able to cope with increased demand.

Additional considerations:-

- Length of stay is increasing due to insufficient rehab, particularly weekends.
- Choice should still be available at point of referral.
- Communication between different parts of NHS needs to be addressed.
- Should work/learn from private hospitals.

Mr Diamond presented the summary of conclusions and actions of the working group considering the consultation feedback in this theme:-

- Patients will still be offered a choice of provider at point of referral.
- Success factors agreed at start of pilot; performance against these has been regularly monitored; moving forward intention is to have them in a reporting dashboard.
- Orthopaedic pilot showed very positive results including high patient satisfaction, reduced lengths of stay and increased day rates, with performance outperforming peers.
- At the start of the pilot weekend trauma lists and weekday trauma slots put in place at Grantham. However, became clear these were significantly underutilised and that emergency patients were best cared for at Lincoln and Pilgrim Hospitals.
- 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. Thereby keeping orthopaedic trauma patient transfers to a minimum.
- Already agreed investment for additional physiotherapy support and a business case developed for additional physiotherapy and occupational therapy staff to provide services over the weekend to improve patient recovery, facilitate protocol led nurse/physiotherapy discharge.
- The orthopaedic pilot demonstrated positive benefits in relation to establishing a sustainable orthopaedic workforce.
- Consultations held with staff prior to the pilot and continually through it. Initial concerns raised, discussed and addressed and over the period of the pilot no additional concerns raised. There will be further formal engagement if the proposal is agreed.
- Since start of the pilot all health services are working more collaboratively and communicating well and in a timely manner.

- There is continuous learning from private hospitals as several orthopaedic surgeons at ULHT also undertake work in the independent sector. Key learning is 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.
- Pilot showed consolidation of elective activity 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 shown people are prepared to travel for their surgery.
- Pilot operating by maximising current capacity at Grantham and Louth. If change proposal is implemented and more planned orthopaedic surgery capacity became available at Grantham and Louth more patients could be seen at these sites and benefit.
- Grantham and District Hospital would continue to provide some unplanned orthopaedic treatments such as simple fractures and dislocations and that this is ongoing work with the current UEC/A&E proposals.
- Estimated 1 patient a day, on average who would have previously been admitted to Grantham and District Hospital for unplanned orthopaedic surgery would receive care at an alternative hospital. The increased demand at Boston and Lincoln is balanced with non-emergency activity going to Grantham and Louth.
- When pilot was started dialogue had with East Midlands Ambulance Service NHS Trust about transport of fractured neck of femur to Lincoln County Hospital. No concerns about these arrangements have been raised by EMAS. There have been no issues with EMAS during the pilot and non are anticipated going forward.
- 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. The resident on-call at Grantham can contact the Orthopaedics team on-call at these sites and a transfer can be arranged if required.
- 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. 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 there has not been a requirement to transfer any orthopaedic patients post-operatively from the Grantham site.

Dr Sakthivel provided clarification in relation to the second to last bullet point and the detail presented regarding middle-tier resident on call and that this is provided at Lincoln and Pilgrim and that there is a core trainee on call at Grantham who can contact Lincoln or Pilgrim. It was noted that this is similar to the model that takes place at the private hospitals.

Dr Owen raised a query in relation to the pilot and that the model was developed pre-pandemic and how confident are the proposals and that this will have the capacity to provide services for the recovery and to achieve the productivity targets.

Dr Sakthivel responded and advised that the present model supports the required the capacity for the increase in demand for recovery. In addition, ULHT is the best performing system in the region in terms of recovery and that there are is only 1 104-week waiters who will be treated in May and that the Trust is providing mutual aid to neighbouring Trusts and bringing in additional activity.. Dr Sakthivel stated that there are some patients with co-morbidities who continue to have their surgery at the Lincoln or Pilgrim site where ITU facilities are available. Dr Sakthivel concluded that Grantham can cope with the increase with the elective recovery demands.

Dr Hindocha referred to the MSK work that is taking place across the system and that United Lincolnshire Hospitals NHS Trust is one of the best performing Trusts in relation to waiting times in the region. Dr Hindocha added that when colleagues are making their decision this should be kept in mind also the outcomes that have been proven so far.

Dr Parkin stated that when the ASR proposals were initially developed there was no Medical School and sought clarification that there is no compromise to the Medical School with the move to Grantham and how integrated is the rest of the training.

Dr Sakthivel responded and stated that in terms of Registrar and Junior Doctor training people have an expressed an interest to come and work at Grantham given the increased training opportunities due to more procedures being completed and reduced cancellations. Furthermore, Fellowships are being explored and that the orthopaedic training has improved. It was noted that medical student training is bolted on top which does not compromise the Medical School training and that students have been coming from Leicester and Nottingham to Lincolnshire. Dr Sakthivel added that there is no compromise with the Medical School training.

Dr Rich-Mahadkar referred to the capacity discussions and the provision of new theatres at Grantham which will provide additional capacity at the site. In terms of the Medical School this will enhance placements and be in a position to attract and retain. Dr Rich-Mahadkar added that the long-term ambition is for the Trust to be a University Teaching Hospital.

Ms Capon stated that at Grantham there is a Surgical Unit that takes in surgical patients and a ward for orthopaedic patients and that this has never been at full capacity and that there is plenty of scope for additional activity. In particular with the increase in theatres this will provide even more capacity.

Dr Sakthivel clarified that 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.

Access

Mr Diamond referred to the access theme and the feedback received:-

Support:-

- Benefits of access to a specialist centre of excellence outweighed increases in travel time.

Opposition:-

- Planned and unplanned orthopaedic surgery should be available at all sites.
- Specialist orthopaedic services should be rotated between sites.

Concerns:-

- Reassurance required pre-operative assessments, post-operative care and related services such as fracture clinics would be available at local hospitals or in community.

In terms of the summary of conclusion and actions of the working group considering the consultation feedback in this theme the following was noted:-

- The orthopaedic pilot has 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.
- 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 and are on a better pathway.
- 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 home.
- Rotating the Elective IP and Day Case Orthopaedic Services provision across the sites would spread the service and resources too thin and therefore we would not be able to provide the best quality of care at any of the sites. Undertaking elective orthopaedic activity on acute (hot) sites significantly increases the risk of delays and cancellations and a poor patient experience.

- 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.
- 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.

There were no comments made by members.

Interdependency with Urgent and Emergency Care

Mr Diamond provided the feedback in relation to the Interdependency with Urgent and Emergency Care:-

Opposition:-

- Orthopaedic proposal is linked to changes to urgent and emergency care in Grantham.

Concerns / alternative options:-

- Complex fractures require urgent specialist treatment – however those with less serious fractures will travel to other hospitals potentially incurring further injury en-route.
- Emergency orthopaedic surgery should be retained at Grantham and District Hospital.
- Unplanned orthopaedic procedures should remain at hospitals with A&E departments and intensive care to reduce cost of transfer to proposed new centres and reduce risk for patients with underlying health conditions.
- Grantham Hospital should be a centre of excellence for all services.

The summary of conclusions and actions of the working group considering the consultation feedback in this theme included:-

- 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
- The proposed exclusion protocol identifies simple procedures.
- Following on-going 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:-

    - 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.

Dr Hindocha reiterated the importance of the stabilisation of patients who require onward admission to an alternative site and the confidence to manage patients who may experience complications from elective surgery. Dr Sakthivel responded and advised that from an elective procedure perspective the patient selection is very strict in terms of other medical co-morbidities. It was noted that since 20th August 2018 there has only been one patient who required transfer due to a post op complication to Lincoln with a suspected venous thrombolism. This demonstrates a fair reflection on how robust the selection criteria is.

In terms of the trauma and non-elective patients, prior to the reconfiguration an assessment took place and on average one patient a day requires treatment at Grantham, for example fracture neck of femur, Lincoln and Pilgrim treat approximately 350-375 patients a year whereas Grantham was performing 100 patients a year and therefore it made sense to move the activity around and with EMAS being engaged with the plan there has been no challenges or issues with patients moving to the hot sites.

In terms of other patients being seen and treated at Grantham at the start of the pilot a staff consultation group took place where all had consulted on various services and which site would undertake which procedure and that this was based on 12 parameters out of which four were not agreed upon as there was insufficient evidence and that the pilot would be adjusted over time. One of these related to acute/trauma operating at Grantham and therefore one list of two hours a day was kept aside for trauma operations. It soon became apparent that this was not being utilised and that for the weekend operating list over a period of six weeks only one patient had been treated with the removal of a foreign body. Dr Sakthivel stated that over time this has been refreshed and that no trauma is undertaken at Grantham. 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.

Dr Hindocha added that the treatment of only one patient and the safe transfer needs highlighting within the evidence.

Action: Update Orthopaedics: Access public feedback consideration document with patient safe transfer evidence – Orthopaedics: Access Working Group

Ms Capon added that the trauma system is utilised and that and there are Co-ordinators at Lincoln and Boston who manage and co-ordinate these patients.

Dr Sakthivel referred to the virtual clinical review of patients referrals from ED and that that these are displayed on a dashboard. It was noted that one in five patients do not have to travel to hospital. Accessing clinics at Grantham has had some issues and that work is taking place to identify a new design model at Grantham which will provide additional slots.

Equalities and travel and transport

Mr Diamond highlighted the feedback received in relation to equalities and transport. The following was noted:-

- 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.
- 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.
- 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.

- 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 – is there any specific extra service for hard of hearing?
- 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.
- 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.

The summary of the conclusions of the working group considering the consultation feedback in this theme was presented:-

Support & Opposition:-

- Concerns about travel and transport to County Hospital Louth and Grantham and District Hospital.

Concerns:-

- It is not the County Council's role to facilitate changes to public transport provision, solely and directly in responses to changes to NHS services.
- Over evening and overnight discharges when public transport does not run.

Mitigations:-

- Increased provision of patient transport services.
- Working with local authorities to explore improvements to public transport links.
- More follow-up appointments provided in community.

Mr Diamond referred to the Equality Impact Assessment and Travel Report and stated that:-

For all patients (including those with protected characteristics), and based on public consultation feedback those specifically in the Age, Disability and Economically Disadvantaged groups:-

- 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.

- Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS.
- 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 so that the impact of the proposed service changes on ambulance capacity is negligible.
- Non-emergency patient transport (NEPTS) is provided for patients who meet nationally set eligibility criteria for NHS funded patient transport services. Typically, this is for patients who are going to hospital for outpatient appointments, diagnostics or treatment or for admission, and for patients who are eligible for transport from hospital following outpatient or diagnostic appointments or daycase or inpatient care and treatment.
- It is therefore 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 current patient transport service is required to signpost patients who do not meet the eligibility for patient transport to alternatives transport providers and this is also a requirement in the new contract.

Mr Diamond referred to the Equality Impact Assessment and Travel Report summary of conclusions and actions of the working group considering the consultation feedback in this theme and highlighted that:-

Carers of those in the 'Age', 'Disability' and 'Economically Disadvantaged' as well as patients who are ineligible for non-emergency patient transport and transport for 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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services.
- Lincolnshire CCG could commission bespoke service for patients impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is therefore not seen as a viable solution.
- Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary car schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements

All transport impacts

- 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 and will be subject to ongoing review.
- 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 and that there is a commitment to the Green agenda.

Specifically for those in the 'Disability' group

- 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.
- It can also be confirmed the provision of additional support for deaf service users is the same at all of ULHT's hospitals.

Ms Wort wished to clarify the ITT process for patient transport that took place in February/March 2021 and the outcome of this.

Mr Diamond stated that the service was tendered for and an alternative provider sourced but that this had been challenged by the current provider. Mr Fahy added that the timeframe with TASL has been extended for an additional 12 months and that the legal impasse has now concluded.

Mr Fahy referred to the QIA and that consistency needs to be applied with the scoring and that a score of 0/0 cannot be included. It was noted that this will need re-visiting for the staffing expectations and clinical effectiveness and outcomes.

Action: Review QIA scoring - Mr Fahy/Mrs Wort

Mrs Wort stated that there are a proportion of patients that are being seen and treated outside of the County and travelling longer distances as they cannot be cared for in Lincolnshire. In terms of the outcomes and positive outcomes from an access and transport perspective will these patients be brought back into Lincolnshire. Mr Burnett confirmed this and stated that with additional capacity within the County more patients could be treated.

Ms Capon advised that following a review of those patients that had to travel that there had only been one informal complaint raised about transport.

Dr Sakthivel referred to the market share and that this was initially 42% at ULHT and that one of the aims is to increase this and prior to Covid-19 prime provider status had been sought. It was noted that during the initial discussions that some patients from Louth travelled to Grimsby however with the improvement of services at ULHT, lack of cancellations, improved outcomes and reduced length of stay patients will travel to Grantham. It was noted that clinics take place in other sites and that the patient only has to travel once for the operation.

Mr Fahy referred to the complaints process and that he is accountable for signing these off for the CCG and that he believed there had been no complaints highlighted in relation to transport, but would double check this

Action: Review CCG complaints in relation to travel for elective orthopaedics services - Mr Fahy/Mrs Wort. Post meeting note: NHS Lincolnshire CCG has not received any formal complaints in relation to orthopaedic changes from 2018 to date.

Dr Sakthivel added that from a Business Unit point of view patients are followed up and the Matron at Grantham has one of the team members call the patient following their procedure to check their progress. It was noted that during the course of these discussions there has been some reference made to transport however this has been superseded with the positive comments in relation to the surgery and length of stay. It was noted that the issue of transport had been raised at a Health Scrutiny Committee however there have been no formal complaints or incidents highlighted on Datix.

Facilities

Mr Diamond provided an overview of the feedback received in relation to facilities:-

Additional consideration and alternative option:-

- The Grantham and District Hospital is in a poor state of maintenance, and it would be more cost effective in the long run to build a brand new centre for orthopaedic services.

The summary of conclusions and actions of the working group considering the consultation feedback in this theme were detailed:-

- 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. For example, patient environment improvements such as decoration and flooring, 2 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.

There were no comments made by members.

Mr Fahy referred to the QIA and reiterated that the scores will need to be re-visited. It was noted that this is a living document and was developed for the PCBC and that ongoing refinement will take place before the final version is submitted.

Mr Burnett asked members to consider the themes and the feedback in order to undertake the assessment. The following was noted:-

Criteria	Outcome	Comments
Quality	Met	No comments.
Clear Clinical Evidence Base	Met	No comments.
Access	Met	This could potentially not be fully met due to the travel and transport issues but that this does not impact on moving the proposal forward and that the criteria is met in terms of timeliness of access. Patients are travelling further and that there may be argument that for a large proportion of patients if these are repatriated from a baseline of 42% up to 80%, it is 40% better off in terms of travel time and to be treated inside the County and not outside of it. The proposal will improve access including transport by a change in process as well as bringing patients back into the county. Patients actively choose to travel to other providers such as Barlborough and the travel to the Grantham model is not any different to the ones already in place and is not a barrier to access. In terms of the patient pathway the patient will only have to travel once for the procedure and the remaining pathway seen at their local provider. If patients go out of county to the independent sector then pre and post op clinics will also be out of the county. 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.

22/011 STROKE PROPOSALS

Mr Diamond referred members to the overview of the proposal and the service change proposal:-

- The proposal for change is to establish a 'centre of excellence' for hyper-acute and acute stroke services at Lincoln County Hospital.
- Which would be supported by increasing the capacity and capability of the community stroke rehabilitation service.
- TIA (Transient Ischaemic Attack) clinics would be unaffected at Pilgrim Hospital, Boston.
- This would mean hyper-acute and acute stroke services would be consolidated at Lincoln County Hospital.
- It is anticipated the change would affect, on average, 1 to 2 patients a day. These patients would receive hyperacute and acute stroke services at an alternative hospital.
- Following consideration of the public feedback on this change proposal there are no plans to alter the proposal.

Mr Diamond referred to the feedback from the East Midlands Clinical Senate review and that the model was:-

- Praised that it seemed to be well led clinically, and from the evidence provided to the panel, appeared it had been well researched.
- 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.
- The clinical review team supported the proposal for stroke services and recommended the health system proceed with it. The East Midlands Clinical Senate also made a couple of recommendations that related to the management of patients with a TIA are met and that Lincolnshire is well placed on the East Coast for a clinical trial around early (in ambulance) stroke management.

Mr Diamond provided an update on the public consultation feedback and that:-

- 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, just over half of whom expressed agreement (51%) and just under two fifths (38%) disagreed.
- 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.
- There is, however, evidence of differing views on the proposal between those living in different areas of Lincolnshire.
- 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.
- The residents telephone survey, indicates that there is majority support from the overall resident population, including among those living closest to Pilgrim Hospital in Boston, where more than two thirds (69%) agree with the proposals.

Mr Diamond referred to the feedback received from the Local Medical Committee which included:-

- Examples such as the Heart Centre at Lincoln illustrate that having specialist services concentrated leads to better outcomes. System does need to be mindful though that transport times to other neighbouring specialist centres may be less than to Lincoln so this needs to be built into any plans.

Mr Diamond added that following the review of the public consultation feedback this was categorised into a number of themes including:-

- Outcomes and Quality.

- Workforce.
- Travel Time/Ambulance Conveyances.
- Facilities.
- Equalities and Health Inequalities.
- Travel and Transport.
- Alternative Suggestions – Hyper Acute and Acute Wards.
- Additional Suggestions – Rehabilitation.
- Additional Consideration.

Outcomes and Quality

Mr Diamond provided an update on the feedback received in relation to Outcomes and Quality:-

Support:-

- Agreement with the principle of a specialist centre for hyper-acute and acute stroke services
- The proposals would likely tackle many of the challenges that the NHS Lincolnshire services currently face
- Increased expertise and quality of care
- Could lead to future investment into NHS Lincolnshire as a result

Opposition:-

- Until 18 months ago Pilgrim ran a safe high quality stroke service, achieving higher targets than Lincoln. Lincoln is not a centre of excellence.
- Removal of life-saving local services – changes are being made to the detriment of Boston
- Basing figures on the last two years will provide false data as prior to COVID pilgrim saw a spike in admissions over the summer months with increased holiday makers. This is based on different activity profiles.
- If the population of Boston is to increase at its current trajectory, stroke services would be required.
- Proposal will lead to worsened rehabilitation outcomes as patients requiring longer periods of inpatient specialist rehab will not receive it.

Additional consideration:-

- Integrated pathways of care should start from day 1 of the condition
- Clarification of pre-hospital treatment of stroke

Mitigation:-

- Social care provision needs to be strengthened in order to reduce length of stay

Mr Diamond highlighted the summary of key conclusions and actions of the working group considering the consultation feedback in this theme:-

- National evidence shows centralising hyper-acute stroke treatment on a smaller number of sites, that meet recommended critical mass, has considerable benefits including reduced mortality, faster recovery, shorter LoS and improved workforce sustainability.
- East Midlands clinical senate feedback was 'the proposed reconfiguration would reduce unwarranted variation in outcomes and would ensure a more consistent achievement of clinical standards and national guidance'.
- Feedback from the Lincolnshire Local Medical Committee was 'Examples such as the Heart Centre at Lincoln illustrate that having specialist services concentrated leads to better outcomes'.
- The experience of the temporary change made due to the pressures of Covid-19 has demonstrated 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:

- 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 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 the Lincoln County Hospital was one of only 6 sites that achieved 8 Key Indicators out of 10. Only 1 site achieved 9 Key Indicators and no site achieved 10. All the remaining sites achieved less than 8 Key Indicators.

- Consolidation of the hyper acute stroke service at Lincoln has also brought closer alignment with other co-specialities such as Cardiology, which also has its acute service provided at Lincoln. 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/angio time.
- The Lincoln Hospital site has reduced its average door to angiogram time from 67 minutes in 2019 to 34 minutes in 2021.
- The stroke team at Lincoln Hospital has also developed an excellent working relationship with the Queens Medical Centre (QMC) Nottingham thrombectomy team, and became one of the best referring sites in the region.
  - Since the service started in 2018 and up to April 2020, Lincoln Hospital had referred 19 patients for the procedure in Nottingham, compared to a single patient from the Boston Hospital site within the same timeframe.
  - In 2021, 14 patients from the Pilgrim Hospital catchment were sent to QMC for thrombectomy, again demonstrating the net benefit to all patients going to a single, better staffed site.
- 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.
- 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 and joint working with social care. It was noted that recruitment has commenced.
- 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.
- Activity baseline data used in the Pre-Consultation Business Case that set out the analysis and recommendations for the proposed service changes used was 2019/20 (i.e. pre temporary Covid changes). Based on ONS population projections Boston Pilgrim, hospital would not achieve 600 stroke admissions per annum by 2030.
- Standard operating procedures have been put in place for any patient having a suspected stroke, the ambulance service will call ahead to Lincoln hospital to discuss so that the team are ready to receive the patient on their arrival.
- The NHS in Lincolnshire has a collective and integrated ambition for health and care services in the east of the county, with Pilgrim Hospital playing a full, relevant and dynamic role in the provision of care for the local population and wider local economy. Significant investment has been made and more is planned.

Mrs Wort raised a query regarding the consolidation and that this means that there are some areas within Lincolnshire where patients would be transferred for their acute stroke care maybe outside of the County and queried if there are processes in place in terms to understand the impact and outcomes for these patients.

Mr Burnett advised that patients predominantly to the south of Boston already have their stroke pathways into NWaFT, which took place regardless of the change. It was noted that these patients are from areas such as Market Deeping. Additional patients have been attending for the past two years since the temporary change made by ULHT to consolidate hyper-acute stroke on the Lincoln site and that there have been no concerns raised. Mr Burnett advised that ongoing dialogue takes place with NWaFT. It was noted that there were some initial issues with EMAS and the turnaround times but that these have been rectified.

Mr Diamond added that when the Pre-Consultation Business Case was developed a set of scenarios was run for a preference for the Lincoln Hospital site and a baseline of patients attending the nearest site and preferences on the Lincoln site for 5, 10, 15 and 20 minute additions. This modelling estimated no patients would travel more than 60 minutes which was the threshold that had been set by the Lincolnshire health system in previous service change programmes. Therefore, the business case was predicated on patients travelling to Lincoln with a 15-minute preference which reduces the number of patients that would go out of the County.

The modelling identified that based on a 15 minute preference for Lincoln c.80-90 patients would be treated at Peterborough, which is on top of an existing patient flow which is not insignificant for the CCG. It was discussed that the CCG monitors the quality and outcomes for these patients through the existing contracts with all providers.

Dr Hindocha added that these proposals are crucial and stated that careful consideration needs to be given to the proposals in particular the time from event to needle and that this was an hour which may have since changed. Dr Hindocha sought clarification that of the approximate 490 patients that have had strokes in the Boston area how many patients would not get to the needle and therefore what are the outcomes. Furthermore, how many of these patients would be due for thrombolysis in time and what are the outcomes from this and how many of these would be due for thrombectomy at a different centre, and is there a compromise with how many patients that are seen and treated.

Dr Elmarimi stated that he has data showing data prior to the temporary consolidation for six months between January and June 2019 comparing it to January to June 2021, and that this is the same number of patients (226) for the same time period. It was noted that the data sources were different. For example onset to first arrival to Pilgrim Hospital in the previous year was 10 hours on average compared to referral by EMAS to arriving in Lincoln was one hour and one minute. For arrival to stroke review this was one hour and 27 minutes and this was reduced to half by having Stroke ACP's seeing patients on arrival rather than waiting for A&E to see a patient and then refer to the stroke team. The other point to note is the access to CT scanning and again the timings were reduced.

Dr Elmarimi stated that on arrival to the stroke unit was more difficult due to the limitation of beds during the Covid-19 pandemic. At Lincoln Hospital the door to angiogram time has been cut from 67 minutes to 34 minutes and that patients were scanned quicker so that they fit in within the timeframe of the thrombectomy service as this is only available from 8.00 am – 6.00 pm with an hour of travel which limits this to 5.00 pm. Thrombolysis numbers decreased slightly which is not due to transport but mainly due to late presentation by the patient. Furthermore, the length of stay for stroke patients in hospital has been reduced which is another important factor on the stroke unit.

Dr Hindocha welcomed the data and stated that if a patient has a stroke in Boston and the ambulance is called and the patient transferred to Lincoln is there enough time. In particular if they were going to have thrombolysis or be eligible for it and that this could be administered within the timeframe of the SPC of the drug and that the SPC of the drug is the crux of the issue for meeting the threshold for the patient on the East Coast.

Mr Burnett stated that in terms of travel time work had taken place with ORH and EMAS for the Pre-Consultation Business Case on their performance data and that only one patient was identified that would have travelled longer than one hour. Subsequently, further analysis of EMAS during the temporary consolidation of hyper-acute stroke services on the Lincoln Hospital site showed the average travel time is around 45 minutes for the old Lincolnshire East CCG footprint, and further analysis is currently underway to look at the impact on a more granular level It was noted that the issue with ambulance is the pre-despatch of the ambulance as these are categorised as CAT 2 responses and the delay with an ambulance being sent may impact on the figures regardless of where the stroke unit is based.

Dr Elmarimi stated that the latest guidance on the SPC is 4½ hours and within the region if a patient calls and presents within the required timeframe thrombolysis and thrombectomy can be undertaken. 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. If a patient presents at Lincoln 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. It was noted that there is a very straightforward pathway with QMC and that there are no delays. It was noted that there has been no patients that have missed thrombolysis because they arrived late.

Dr Hindocha stated that this needs to be captured as all the feedback over the last few years has indicated this to be the issue as the SPC was much tighter of about three hours five years ago and that this extension is imperative to be captured and the thrombectomy is an additionality that was not available previously.

Dr Elmarimi stated that the ASR is not just for thrombolysis but for all of stroke and that Lincolnshire thrombolysis approximately 10% compared to a national average of 8%-15% of ischaemic stroke patients. Dr Elmarimi stated that if these patients are admitted to a well-staffed unit their outcomes are much better.

Dr Owen raised a query regarding CT scanning resilience accepting that access to CT scanning is critical in the assessment and management of acute stroke patients and with the proposals to consolidate acute stroke services on one site it was queried if there any plans to increase the resilience of 24/7 CT access of which has been prompted on the recent fire incident at the Lincoln sire which did impact on the stroke pathway in the first 24-36 hours.

Mr Ratcliff stated that there is always the likelihood of these once in a lifetime events and that most CT scanners in Trusts are designed back-to-back due to the staff efficiencies and that normally there is the back up and continuity and that currently Pilgrim Hospital has only the one scanner and therefore consolidating at Lincoln will make the case easier for additional scanners. Mr Ratcliff added that there is further work to do in Lincolnshire as there are over diagnostic requests.

Dr Owen referred to the consolidation of services on the one site and there has been experience of a rare event and if the CT scanning had been offered on two sites the impact on pathways would have been different and that this needs to be taken into account. Mr Ratcliff stated that this is being addressed through the business continuity management processes.

Mr Ratcliff referred to the travel time for Pilgrim Hospital and that overall from event to treatment time is more important, and the reason these proposals have been put forward is due to the limited ability to recruit Stroke Consultants of which nationally there is a 50% vacancy gap and this is about what can routinely and safely be provided as a Trust and system and thereby consolidating resources it is not the travel time, it is the revascularisation and treatment time of patients that has improved. It was noted that with these improvements have improved the outcomes for patients and that this is key to the proposal and that it is the ability of ULHT and that Dr Elmarimi is the only substantive Stroke Consultant at the Trust with the rest made up of Locums.

Dr Elmarimi stated that this is about survival at this point and when this can be built on a single site and can be staffed more effectively as currently there is not enough work for two centres, as the numbers per site now verge to the 1,000 (not 600) and if there is not the critical mass of patients it is unlikely that the organisation will be attractive to recruit and retain staff. Dr Elmarimi added that there are challenges with stroke more than any other service known in England with 51% of jobs that are empty and that locums are having an impact on budgets and services. Dr Elmarimi reiterated the previous discussions regarding surviving before building new models and creating a solid structure.

Dr Farquharson stated that he has been party to a number of discussions in the past regarding the advantages and disadvantages of consolidating services. Dr Farquharson stated that 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. It was discussed that 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 that it is crucial that a high level 7-day service is provided from the one site.

Mr Ratcliff referred to mirroring the cardiology model and the way that organisations have consolidated services based on syndromes/diseases that need the 7-day Consultant led service.

Dr Elmarimi added that when the Covid-19 pandemic commenced this coincided with the retirement of one of the other single substantive Consultant and almost overnight there was a significant change to the staffing rotas with four people running the service for the entire Trust of which three were Locums and that this demonstrates the fragility of the service.

Dr Hindocha stated that the discussions are the clinical response to the public consultation. Dr Hindocha added that the debate is coherent and cogent providing reasons why the proposals are being considered. It was discussed that the 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. Dr Hindocha stated that this message needs to be made clear and reiterated as there may be a potential for push back.

Dr Rinaldi referred to the feedback from the consultation and the discussions relating to transport and that the public could understand the reasoning behind the proposals in particular the challenges with workforce and running a fragile service across two sites. Concern was raised regarding the ability of EMAS in transporting patients to the right site and within the specified timescales. Dr Rinaldi suggested that if there are any solutions to enhance the level of security and reiterate the use of one site and a clearer pathway this would be beneficial. Dr Rinaldi commented that there may well be push back and that the data and evidence needs to be presented to demonstrate the benefits of consolidation.

Dr Elmarimi referred to the treatment for stroke and since commencing the pilot and starting the model with the ACP's in Lincoln when a call is received from the Paramedics the ACPs review all the previous medical history and the decision for treatment will commence as soon as the patients arrives at the hospital. It was discussed that this saves an inordinate amount of time and the time in the ambulance has not been wasted since the commencement of the ACP's being pre-alerted by EMAS. Dr Elmarimi referred to the reduction in time for the patients travelling to the hospital and receiving scans and that this makes up for the journey time regardless.

Action: 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 - Service delivery team (if proposal agreed)

Note: action was developed by the Chair of the ICS Clinical and Care Directorate after the meeting

Mr Diamond commented on the process and advised it would be worth including the data presented by Dr Elmarimi to the consideration document in order to make the case more explicit and that the detail is appended to the Decision-Making Business Case.

Action: Update Stroke Outcomes/Quality public feedback consideration document with additional information – Stroke Outcomes/Quality consultation feedback working group

Dr Parkin commented that the proposals are the right thing to do and queried if there is further work that can be built onto this and that there is an aspect that there is no Neurology service in Lincolnshire and that further work needs to take place. Mr Burnett stated that this would have to go through a process of service change and is not a discussion for today. Mr Ratcliff stated that there is a Neurology service in ULHT that is primarily outpatient focussed. Mr Ratcliff agreed to have a discussion offline with Dr Parkin.

Mr Ratcliff stated that there will inevitably be emotive feelings relating to Pilgrim Hospital and that the response needs to indicate that by taking the acute stroke and hyper acute stroke from the site there will be no impact on the overall level of service provided at the Pilgrim Hospital. It was further discussed that if the proposals are successful that the estate will soon be utilised for other areas. Mr Ratcliff requested that it is made clear that with these proposals this will not critically unstable Pilgrim Hospital and that this is based on the best outcomes for patients and this is the focus.

It was noted that Lincolnshire division of EMAS has the most efficient on scene time for suspected stroke patients of all East Midlands divisions helping to reduce overall call to definitive treatment timescales.

Mr Burnett referred to the additional ORS analysis of EMAS data during the temporary change that had just been received during the meeting, and identified that there are a small number of wards with an average travel time over 60 minutes to Lincoln Hospital. For all but one the average travel time is under 65 minutes, the last ward is at 69 minutes. It was noted that the data demonstrates that the number of patients travelling to NWaFT is in line with the modelled scenario of a 15-minute preference for Lincoln Hospital. Mr Burnett added that further detailed analysis on this data needs to take place.

Action: Update Ambulance Conveyance public feedback consideration document with additional information – Stroke Ambulance Conveyance consultation feedback working group

Workforce

Mr Diamond presented the workforce theme and advised that:-

Support and Opposition:-

- Presumption that specialist stroke staff will be able to move from Pilgrim to Lincoln is unrealistic.
- An increase in the number of patients at Lincoln.
- Lack of additional specialist staffing proposed for the Lincoln site.
- Increase in stroke patients out-lied to non-specialist wards.
- Management of more complex patients who require more intensive input.
- Availability (or lack thereof) of community beds and specialist stroke management within community hospitals.

Opposition:-

- Not convinced proposals will lead to improvements in recruitments and retention of staff.

Mitigations:-

- Improve recruitment with higher wages/benefits.
- Increase staff numbers to ensure there are enough staff with thrombolysis training.
- Increase bed numbers and resources.
- Introduce a telemedicine system whereby other staff members could be upskilled to initiate investigations and treatment plans.
- Stroke unit requires sufficient qualified therapy staffing to allow timely assessment and discharge planning.
- Stroke community team are struggling to hire therapists in some locations – has this been considered?

The summary of key conclusions and actions of the working group considering the consultation feedback in this theme was presented:-

- Currently 28 stroke beds in Lincoln County Hospital stroke unit. To manage expected increase in activity under proposal an increase of 7 beds is planned.
- 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 Hospital, and ensure the unit is staffed according to agreed national guidelines for medical, nursing and allied health professional staff.
- Proposed future model of acute stroke services supports a more sustainable and resilient workforce, particularly in the medical consultant and nursing groups.

- Over 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.
- Recruitment of more ACPs provide further mitigation to the stroke consultant recruitment challenges in the short and medium term.
- 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. Recruitment is under way as part of COVID response.
- 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.
- 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.
- ULHT's stroke services are working within the NHS pay 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.
- The proposed model supports the consolidated number of nursing and medical staff that will then be appropriately trained, including in thrombolysis
- ULHT is working within a regional Integrated Stroke Delivery Network group exploring and moving forward on plans to provide a telemedicine service within Lincolnshire.

There were no comments made by members. It was acknowledged that the discussion on Quality and Outcomes had covered this.

Mr Diamond provided an update on the Travel Time/Ambulance Conveyances:-

Support:-

- Agreement with the principle of a specialist centre for hyper-acute and acute stroke services.
- The proposals would likely tackle many of the challenges that the NHS Lincolnshire services currently face.
- Increased expertise and quality of care.
- Could lead to future investment into NHS Lincolnshire as a result.

Support & Opposition:-

- Increased travel times that Boston residents would have to travel to Lincoln in the event of a stroke.
- Travel time, including by ambulance to reach Lincoln are too long – 'Time is of the essence' and people living in places outside the 'Golden Hour' of travel to Lincoln, will be disadvantaged by these proposals.
- Concerns about centralising model is a risk in England's second largest county where there are infrastructure issues, particularly when treatment time is so critical for stroke patients.
- Less availability of ambulance in Boston if they are having to make the journey between sites.

Mitigation:-

- The availability of an air ambulance would be supported.
- Provision of a mobile stroke unit.

The summary of conclusions and actions of the working group considering the consultation feedback in this theme were presented:-

- Previous Lincolnshire health system service reconfiguration programmes determined stroke services should be accessible within a 60 minute threshold.

- Travelling time scenario modelling for the Pre-Consultation Business Case (PCBC) estimated that under the change proposal no patients would travel more than 60 minutes by ambulance.
- Sensitivity analysis of this modelling identified that even with a 15 minute preference for Lincoln hospital no patients would travel over 60 minutes.
- Temporary consolidation of acute stroke services on the Lincoln site (from start of April 2020) provides some additional insight into travel times for proposed changes. An analysis of EMAS journey times for stroke patients was conducted based on the four old CCG footprints – using Lincolnshire East CCG s a proxy for those stroke patients who would have gone to Pilgrim Hospital prior to the temporary change.
- This identified that 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 in line with the modelling completed for the PCBC.
- If the proposed stroke changes went ahead, the impact on travel times would be kept under constant review.
- In terms of on scene time for conveyed stroke patients, 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.
- 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.
- The golden hour for stroke services refers to the door to needle time, however it is a target and has no clinical significance to outcome. 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.
- The experience of the temporary change made due to the pressures of Covid-19 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. As highlighted in Outcomes and Quality section.
- 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.
- Modelling has identified the number of additional shifts that would need to be introduced to restore the base position performance and utilisation across Lincolnshire as 12 ambulance hours per week.
- The air ambulance does not respond to stroke patients.
- The option of a mobile stroke unit will be explored as part of further improvement to the provision of hyperacute stroke care.

There were no comments made by members. It was acknowledged that the discussion on Quality and Outcomes had covered this.

Mr Diamond referred to the facilities feedback:-

Support and Opposition:-

- Concern over capacity and infrastructure at Lincoln County Hospital and questioned whether the site would be able to work effectively and efficiently with increased demand.

Mr Diamond shared the summary of conclusions and actions of the working group considering the consultation feedback in this theme:-

- 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 Hospital site was identified.
- The preferred option identified at that stage was to build an extension to the existing unit. An extension to the existing unit has been scoped at a high level with support from external design and architectural consultants.
- The identified cost for this was £7.5m (at the time of producing the Pre Consultation Business Case).

- 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.

There were no comments made by members.

Mr Diamond presented the Equalities and Transport feedback of the working group considering the consultation feedback in this theme and advised that:-

- The proposal could, some felt, widen health inequalities and negatively impact patient access as services would be removed from a deprived area.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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).

A summary was provided in the Equality Impact Assessment and Travel Report summary of conclusions and actions:-

- 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
- Work is well planned with EMAS to be able to support the proposed changes and there is a high degree of confidence that the changes will be fully and appropriately supported by EMAS.

Carers of those in the 'Age', 'Disability' and 'Economically Disadvantaged' groups as well as patients who are ineligible for non-emergency patient transport and transport for 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. Considerations include the shape and scope of any additional services commissioned by the CCG to supplement existing public and community transport services.
- Lincolnshire CCG could commission bespoke service for patients impacted by the proposals however key issue of 'fairness' and 'equity' for all patients, carers and visitors. It is therefore not seen as a viable solution.
- Public transport is the responsibility of the Local Authority; solutions already exist such as voluntary care schemes and daily bus services between Lincoln Hospital and Pilgrim Hospital and Lincoln Hospital and Grantham Hospital; a transport paper needs to be developed more broadly than in only responding to the public consultation and reflect findings of the County Council 'County Views' exercise; key is to strengthen current arrangements.

Mr Burnett referred to the proposals and that this is the same as the Cardiology pathway in terms of a centralised unit. Dr Rich-Mahadkar stated that there is something about the public transport and recognising that this not the responsibility of the CCG and that as part of the ASR proposals a review should be considered as part of the new ICS and provider collaborative that addresses some of the fundamental transport issues and a collective solution identified. It was further discussed that the current provision could be enhanced with partners.

Mr Diamond provided an overview of the Alternative Suggestions: Hyper-Acute and Acute Wards:-

Alternative suggestions:-

- Both Lincoln County Hospital and Pilgrim Hospital, Boston should be a centres of excellence for stroke, attracting good staff to manage them. There should be a focus on recommended speed for treatment rather than numbers of patients.
- Keep the hyperacute at site; make consultants and ACPs work pan-trust and put money into ACP training for experienced stroke nurses.
- Locating stroke services in Boston was seen by some to suit the overall needs of the population better than Lincoln.
- Train teams stepping into hyper acute care in a timely way; for example Specialist Strokes and Registrants stepping onto ACP University courses using LBR funds or Apprenticeship Levy. Also HCAs have upskilled using Stroke.org.
- If there is to be a second ward at Lincoln this should be a small hyperacute ward (close to the stroke unit) and use the current stroke unit for acute/rehab as this already has several therapy rooms. Therapy teams would work across the two wards to provide consistency of care and help maintain cover during annual leave/staff absence etc.
- It would be beneficial to have a dedicated MDT/discharge coordinator(s).
- A standard operating procedure should be in place that allows thrombolysis to be given in the emergency department if time to transfer to HASU is >45 minutes (in the same manner Major Trauma patients divert to local TUs if an MTC cannot be reached in 45 minutes). Patients should then be transferred to HASU post thrombolysis. This is supported by NICE and there are examples of this working in practice elsewhere in the country.
- Develop a centre of excellence at Peterborough, Grimsby and Nottingham and don't have anything in Lincolnshire at all.

Mr Diamond shared the summary of conclusions and actions of the working group considering the consultation feedback in this theme:-

- Both Lincoln Hospital and Pilgrim Hospital providing hyper-acute and acute stroke services was considered as part of the options appraisal process. At the clinical led evaluation workshop the consensus was the preferred option was to consolidate services on the Lincoln County Hospital site.
- The major driver for moving to a single site is the hospital based stroke service does not have enough doctors or nurses. The national standards state services cannot rely on ACPs to deliver the service it is not possible to run a rota with just consultant nurses, even if there were 10 of them.
- Locating a single hyper-acute and acute stroke unit at Lincoln Hospital rather than Boston Pilgrim Hospital has a number of advantages including:-
  - Co-location with the heart centre
  - At Lincoln there is an established ACP service
  - Increase opportunity for Lincoln to provide mechanical thrombectomy in the future
  - Experience has shown it's easier to recruit to Lincoln Hospital
  - More Lincolnshire residents would receive their care out of county if stroke services were consolidated at Pilgrim Hospital.
- Within ULHT opportunities exist for people to improve their skills – there is an active training package in place for all ACPs ending in them ultimately obtaining their Masters degree and qualifications. HCAs also can have enhanced skills.
- A dedicated MDT/discharge coordinator role would be beneficial to explore to lead the interface between ward/community.

- An initial estates solution has been identified. If the service change 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 the best use of a new build.
- Since the introduction of the temporary change to consolidate hyper-acute and acute stroke services on the Lincoln Hospital site, the process for patients attending the emergency department at Pilgrim Hospital who require thrombolysis is for the patient to be 'blue-lighted to Lincoln 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.
- 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.

There were no comments made by members.

Mr Diamond presented the Alternative Suggestions: Rehabilitation:-

Alternative suggestions:-

- As time is critical for stroke patients, Grantham should have the rehabilitation service but only have an acute service if there is an A&E unit there.
- Ringfence specialist beds at Boston to create a hub and spoke stroke rehabilitation service across Lincolnshire.
- An appropriate stroke rehab ward would ensure throughput sufficient to allow new patients to be admitted and longer term patients to receive the stroke rehabilitation they require.
- Community rehabilitation services need to be in place for stroke and other neurological conditions, especially brain injury. Also, a step up/step down inpatient/outpatient unit where all patients can go to regain lost skills: able to learn to walk again, talk, eat, swallow etc.
- Provide step down beds in Pilgrim and GDH to allow a manageable caseload for LCH and so that patients receive specialist stroke rehabilitation closer to home. ADSS/community stroke services will not be able to provide an effective service to all patients as stroke rehabilitation requires specialist facility and equipment.
- There is no mention regarding the link to community rehab beds within care homes or community hospitals. Is there a risk for those patients with dysphagia etc, as a result of a stroke, will be 'stuck' in Lincoln acute stroke beds.
- Why are brain and head injury rehabilitation kept separate from stroke rehabilitation – these services should align better
- Beds in community hospitals are rarely available and there is lack of specialist stroke management, meaning patients do not reach their full potential/outcomes.
- Funding is maintained for the number of beds at Pilgrim Hospital to enable patient flow.

Mr Diamond shared the summary of conclusions and actions of the working group considering the consultation feedback in this theme:-

- 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.
- 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.
- 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.
- 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.
- The service will support community hospitals, which will be health & 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.

- 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.
- The appropriate training needs 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.
- Neurological conditions and a step up/down inpatient/outpatient unit were not part of the change proposals consulted on.
- 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.

Mrs Wort wished to make an observation in terms of explaining that in the acute phase there is different approach to managing the condition whereas comparing the pathway and the neuro therapy and that there is overlap and that this needs to be taken into account when it is described.

Dr Parkin commented that the rehabilitation element is an important part of the whole process and if there is a Centre of Excellence then there will also be for rehabilitation and that this is crucial to the development of community services.

Dr Elmarimi responded and stated that currently over the past few years approximately 49% of patients are discharged within 7 days of the total stroke workload and that there are patients who have minimal rehabilitation requirements. For those patients who require a feeding tube or who live on their own have a different set of requirements. Dr Elmarimi stated that it is a very wide spectrum for the needs of these patients and that hospital is not the best place for a majority of these patients and the best place for rehab is in the patient's own home and they can progress with the right level of support. It was noted that the longer a patient stays in hospital the more deconditioned the patient becomes and is more dependent. It was discussed that there are challenges are the community teams are not fully staffed and require the right disciplines.

Mr Ratcliff referred to the phases and the acute phase where intensive support is required and require a bed in a Trust, support at home which can be a mixed model. In terms of the Centre of Excellent and trauma there is the Ashby Ward which has patients with a more profound length of staff. Mr Ratcliff added that there are other centres for rehab that are being built towards Nottingham.

Dr Parkin commented on the training for AHP's that go into the community and that there still needs to be the training facility and Centre of Excellence.

Mr Ratcliff added that ideally it would be good to have the models where staff can rotate between the acute and community and can build on their experience and skillset.

Ms Shimada referred to the discussions relating to the Centre of Excellence and queried if there are concerns that the Therapists are not receiving the right training. Ms Shimada added that training is undertaken across a number of areas for rehabilitation in particular for swallowing disorders and that this training can be undertaken within the community and also takes place on inpatient wards and Ashby Ward. In terms of stroke rehabilitation there will always be a need for this in the acute setting and that rotational posts are being explored and that there are a number of these for other pathways within the County.

Mr Ratcliff referred to the work being undertaken in relation to the development of AHP Consultant posts.

Ms Shimada referred to the work that is taking place to support MSK and working the profession across different pathways in order to achieve the right skill set. Mr Ratcliff added that the proposals will attract staff brining in a higher skilled workforce which will ultimately improve the patient outcomes and develop the MDT approach.

Mr Diamond presented the Additional Consideration feedback:-

- Although this consultation is on treatment services there is a need to consider prevention. Smoking, high blood pressure, diabetes, heavy drinking, high salt and high fat diets and lack of exercise increase the risk of stroke. These are health concerns in Boston, South Holland and East Lindsey.

Mr Diamond referred to the summary of conclusions and actions of the working group considering the consultation feedback in this theme:-

- One You Lincolnshire (OYL) was commissioned in 2019 as the Integrated Lifestyle Service (ILS) for the county. This is a county wide offer.
- 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.
- One You Lincolnshire have a high-level partnership with the Office for Health Improvement and Disparities 'Healthy Weight' Lead for Midlands.
- 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.

Dr Hindocha referred to the AF risk for stroke patients in early detection and treatment rates for Lincolnshire and this has increased significantly and near the top for the region.

Dr Elmarimi said ULHT have noticed a decrease in patients with stoke with AF and cases have dropped from 24% to 17% and continues to decrease by having early detection and treatment.

Dr Parkin referred to the AF prevalence overall which is approximately 2.7% in April 2021 and this is slightly below the excepted prevalence and if a further 4,000 patinets are identified this will save 110 strokes per year. This work is being undertaken by Dr Howarth and Dr Akram.

Mr Diamond referred to the QIA and advised that this has continued to be developed since its development for the Pre-Consultation Business Case.

Mr Burnett sought the views of members in terms of the proposals:-

Criteria	Outcome	
Quality	Met	No comments.
Clear Clinical Evidence Base	Met	No comments.
Access	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 good patient outcomes 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

Mr Burnett thanked members for attending and their engagement and that this reaches the critical step in the proposals being taken forward.

Dr Hindocha reiterated the thanks and support from members and that the debate has been extremely helpful over the last two sessions and that this is the reason why Clinical Directorates were formed.

Appendix L

Statements of support from providers

Statement of Support**: Orthopaedics**

Clinical lead(s):	Mr Kulandaivel Sakthivel	Consultant Orthopaedic Surgeon
Operational leads(s):	Mr Mark Lacey	Divisional Managing Director - Surgery

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust 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.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality Orthopaedic services are delivered in Lincolnshire in a sustainable way for the future:

- At the end of February 2020 the evaluation of the orthopaedics pilot showed very positive results. The experience of the pilot has reaffirmed the preferred option for the future provision of orthopaedic services identified through the ASR options appraisal (to consolidated elective orthopaedic services at Grantham Hospital) and allowed it to be refined.

- Achieve a balance between access and ensuring the long term sustainability of services.

- This reconfiguration of services is highly likely to repatriate services back into our County which in turn helps both the patients and the healthcare staff.

- As an example we highlight one of the metrics for quality of care - Reduction in the average length of stay for elective orthopaedics at Grantham 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.

- For further details on the improvement of quality of care please refer to the PCBC.

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.

- For further details on the improvement of quality of care please refer to PCBC.

Deliverability – achievable workforce requirement

The proposed future model of a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery supports a more sustainable and resilient workforce:

- A reduction in a heavy reliance on locum and agency staff.
- Increases the chances of recruiting to substantive roles.
- The pilot workforce model has successfully removed all agency doctor usage within orthopaedics ULHT wide. 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.
- For further details on the improvement of quality of care please refer to the PCBC.

Risks

Patient's willingness to travel to Grantham for surgery, although throughout the pilot this has not proved to be an issue.

A risk in the recruitment and retention of staff, has in fact already improved since the commencement of the orthopaedic pilot, which 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.

During the pilot there was more pressure on the emergency orthopaedic theatre lists at Lincoln and Boston. However, this was offset and more theatre time freed up by the elective orthopaedic care going to Grantham and Louth. As such the Lincoln and Boston sites have been able to absorb the increase in non-elective demand.

Conclusion

The Division and Clinical Lead support the service change model proposed.

Statement of Support: UEC

Clinical lead(s):	Dr Flynn	Consultant A&E
Operational leads(s):	Carl Ratcliff	Managing Director Medicine
	Cheryl Thomson	General Manager Urgent & Emergency Care

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust 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 Hospital and Pilgrim Hospital.

The benefits we believe these changes will result in are set out below.

Quality of care

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.

- 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 Hospital and Pilgrim Hospital 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

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).

- 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

	24/7 A&E (as was)	**24/7 UTC**
Opening hours	• 24hrs a day 7 days a week Av. 80 attendances per day (24hrs) • Av. 11 attendances between 23.00-07.00	• 24hrs a day 7 days a week
Acuity	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E

	• Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals	• Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals. • Refinement of exclusion criteria to allow a larger proportion of frail and elderly patients from the geographic locality to receive inpatient care at Grantham and a small volume of higher acuity cases currently managed at Grantham to receive specialised treatment elsewhere
Workforce	• Consultants: 80hrs/week plus on-call evenings & weekends • Middle Grades: 24/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours	• Consultants: 40hrs/week no on-call evenings & weekends • Middle Grades: 16/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours Planning assumptions: All subject to review and change once service is fully operational
Diagnostic	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7

- In addition, through workshops with stakeholders proposals have been developed to improve support to patients with regards to travel in the broadest sense across Lincolnshire (i.e. not just relating to proposed service changes under the acute services review). These include:
  - Ensuring a seamless process for advice, eligibility assessment and booking
  - Improved coordinated way of ensuring the appropriate transport is arranged for discharges from hospital:
  - The default should be Non-Emergency Patient Transport Services (NEPTS) unless there is a 'medical need'
  - Better planning and coordination with the family/patient early in a patients stay as an integral part of discharge planning
  - Coordination of NEPTS with potential other options through a single system approach to discharge planning
- Booking of clinics:
  - More proactive choices regarding clinic bookings should include a discussion on 'how are you intending to travel'
  - Real time information to support administrators in understanding public transport should be easily accessible on their IT systems so that 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
- Integration of systems to allow funded, non-funded and concessionary fares/bus passes to use multiple types of transport.
- Access to treatment would further improve for children because the UTC team would broaden to include community and primary care staff (eg. GPs) who are more experienced and familiar with treating children than a traditional, non-paediatric A&E team.
- 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 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.

Deliverability – achievable workforce requirement

The proposed model supports a more sustainable and resilient workforce by:

- The Consultant workforce will be ULHT employed and will undertake sessions at Grantham UTC 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 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.

Estimated future Grantham UTC attendance analysis

Attendees at the proposed Grantham Urgent Treatment Centre				
	15/16	**19/20**	**23/24 Scenario 1**	**23/24 Scenario 2**
Grantham 24/7 A&E attendances Assuming 24/7 operation in 19/20	29,297	33,900	-	-
Grantham OOH service	15,675	7,600	7,800	11,600
Grantham 24/7 UTC attendances	-	-	34,900	39,000
Total	44,972	41,500	42,700	50,600
Adjusted for displaced patients	-	-	42,000	49,900
Sensitivity analysis – reduction in 10% of attendances through ICC				
Grantham 24/7 UTC attendances	-	-	37,800	44,910

The table below sets out the proposed workforce (funded establishment) of the Grantham Hospital A&E when it operated 24/7 together with the Out of Hours workforce, what the workforce currently is (19/20 baseline 'pre-covid') and the workforce for the proposed 24/7 Urgent Treatment Centre developed for planning purposes.

Grantham UTC model workforce compared to A&E & Out of Hours model (funded establishment)

	A&E 24/7 & Out of Hours (WTE) 2015/16	**A&E (08.00-18.30) & Out of Hours (WTE) 2019/20**	**UTC 24/7 (WTE)*****
Medical			
• Consultants	2.0*	2.0	1.2
• Middle/Trust Grade	6.0**	5.0	5.0
• Foundation/Trainee	7.0	6.0	6.0****
• Admin	0.6	0.6	0.6
• GPs	10 sessions/week	10 sessions/week	10 sessions/week + OOH
ACP			
• Nurse ACPs	4.5	4.0	4.0
Nursing			
• Registered	24.5	19.0	25.5
• Nursing Associate	2.5	1.0	1.0
• Non Registered	10.0	7.5	14.0

• Receptionist	4.0	2.5	2.5
Out of Hours • GP • Registered • Non Registered/ Clerk	 2.0 6.5 7.0	 2.0 6.5 6.5	 Out of Hours will be integrated with UTC

** Consultants provided on-call cover overnight and at weekends*
*** Middle grades covered the whole out of hour's rota between them – 'rule of thumb' guidance suggests should be 12.0*
**** Planning assumptions: All subject to review and change once service is fully operational*
***** Junior training posts will be retained, proposed model will offer a valuable and interesting environment. Ongoing engagement of HEE to ensure they remain supportive and posts will need to be considered in the context of the overall requirement/ need for these posts across the whole of ULHT*

The service change proposal improves the services ability to attract and retain talented and substantive staff through building a strong and successful service that offers opportunities to work in a centre of excellence.
Recruitment and retention of urgent and emergency staff has been a long-standing concern for Lincolnshire, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals.
The proposed model of an Urgent Treatment Centre at Grantham Hospital is seen to provide and achieve the optimum balance of patient volumes, acuity, outcomes and resource. Medical middle grades would 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.

Risks

A key risk will be the in ability to recruit staff, however stability and certainty, along with general improvements in nursing / medical will mitigate the risk.

There is the risk of 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 on the changes could be a risk, 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.

Conclusion
The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Statement of Support: Acute Med

Clinical lead(s): Kate Scheele Consultant Respiratory - Medicine

Operational leads(s): Carl Ratcliff Managing Director - Medicine

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to provide an innovative integrated model of integrated community/acute beds at Grantham Hospital to work closely with the neighbourhood team.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality services are delivered in Lincolnshire in a sustainable way for the long term, by:

- 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.

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

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

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

The table below shows: Estimated future acute medicine bed requirement.

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

<u>Deliverability – achievable workforce requirement</u>

The proposed future model of services supports a more sustainable and resilient 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.

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

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

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

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

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

Risks

There is a risk that the lower acuity ward cannot be staffed / opened – however a plan will be put in place to recruit workforce and having certainty for the site will support this new community bed function.

There is a risk that 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. However the Trust was able to deliver the SDEC model at Grantham during the work for the Green site and the success of SDEC's across all sites. Frailty also have been successfully able to deliver their units so Grantham's risk needs to be seen in the context of these successes as a Trust.

There is a risk that staff leave Grantham as a result of all changes made as part of ASR. However the 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.

Conclusion

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to provide an innovative integrated model of integrated community/acute beds at Grantham Hospital.

Statement of support: Stroke

Clinical lead(s):	Dr Abdul Elmarimi	Consultant Stroke Medicine
Operational leads(s):	Carl Ratcliff	Managing Director Medicine

Statement of support

The United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services Trusts 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.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality hyper-acute and acute stroke services are delivered in Lincolnshire in a sustainable way for the long term, by:

- 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.
- Our 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.

Deliverability – achievable workforce requirement

- 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 covered by agency staff. Currently, there is only one substantive accredited consultant in stroke medicine in ULHT.

- 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 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 Pilgrim 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.

The table below sets out the current hospital based stroke service workforce model (funded establishment) together with the workforce model under the proposed preferred option.
The current workforce and future requirements for acute stroke services are outlined in the tables below:

Staff Group	**Current configuration**		**Preferred Option**	
	Lincoln Hospital	**Pilgrim Hospital**	**Lincoln Hospital**	**Pilgrim Hospital**
Medical				.
Consultants	3.0	3.0	6.0	-
Associate Spec.	1.0	1.0	2.0	-
F2 (Trust)	-	1.0	1.0	-
F2 (Deanery)	1.0	-	1.0	
F1 (Trust)	-	1.0	1.0	
F1 (Deanery)	1.0	1.0	2.0	
GPVTS (Deanery)	1.0	-	1.0	
Core Trainee (Deanery)	-	1.0	1.0	
Administration	2.0	2.66	4.66	
ACP Nurse ACPs			5.8	
Nursing				
Registered	26.90	23.24	51.08	-
Nursing Associate	2.00	4.0	-	-
Non Registered	15.32	11.26	21.04	
Ward Clerk	1.0	2.0	1.4	
AHP Physio/OT/SALT	39.36 (Across the trust)		33.67	

NOTE: TABLE IS TAKEN FROM PCBC. CURRENT CONFIGURATION THEREFORE REFERS TO 19/20 BASELINE

As there will no longer be a stroke service at Pilgrim Hospital, staff will be offered the opportunity to transfer to Lincoln Hospital, or to be re-deployed within another department at the Pilgrim Hospital.

The enhanced community stroke rehabilitation service will link 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.

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.

Risks

A key risk will be in the ability to recruit staff, however stability and certainty, along with general improvements in nursing / medical will mitigate the risk.

Another risk will be securing of funding for the required extension of the stroke ward at Lincoln hospital. However this has been discussed at system level and assurance given that funding will be made available.

There is a risk that the patient activity rises above the levels set out in the business case and analysis. However all activities will be monitored and mitigations considered as with any service.

Conclusion

The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix M

CCG statement on choice and bed closures

NHS Lincolnshire CCG

Statement of consistency with current and prospective need for choice

Statement of bed closures

Introduction

The NHS Lincolnshire CCG launched a public consultation on the 30 September 2021 for four NHS services. It ran for 12 weeks until 23 December 2021.

The four change proposals are outlined in the table below.

Change Proposal	Description
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.
Urgent and Emergency Care	• Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre (UTC).
Acute Medicine	• Develop integrated community/acute medical beds at Grantham & District Hospital, in place of the current acute medical beds.
Stroke Services	• Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation team.

Statement of consistency with current and prospective need for choice

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.

The NHS constitution enshrined the right to informed choice for patients. The constitution gave patients the right to:

- choose their GP practice (unless there were reasonable grounds for refusal)
- express a preference for using a particular doctor within a GP practice
- make choices about NHS care and access information to support those choices.

Building on the NHS Constitution, the Department of Health & Social Care published guidance on 'The NHS Choice Framework: what choices are available to me in the NHS?' (updated 14 January 2020).

This framework sets out six areas where there is a legal right to choice, however there are some situations and circumstances where choice is not available:

- People can choose which GP practice they register with and ask to see a particular doctor or nurse at the GP practice.
- People can decide which NHS organisation they would like to receive care from as an outpatient, and choose the clinical team which will be in charge of their care
- People can ask to be referred to a different hospital if they have to wait more than 18 weeks before starting treatment for a physical or mental health condition, or have to wait more than 2 weeks before seeing a specialist for suspected cancer
- If a healthcare professional decides a specialist test is required, people may choose to have this carried out by an organisation that provides NHS services.
- People may be able to choose to have a personal health budget which can be used to access some NHS services.
- People have the right to choose, subject to certain conditions, to receive treatment which is normally available on the NHS in other countries within the European Economic Area (EEA) – subject to Brexit negotiations

Exceptions include:

- Where speed of access to diagnosis and treatment is particularly important, for example in an emergency

Within the Pre Consultation Business Case consideration was given to whether the proposed changes are consistent to current and prospective choice, and concluded they are. An overview of this assessment is set out below.

Change Proposal	Consistency with patient choice
Orthopaedics	• Once fully implemented will reduce number of sites from which certain procedures are provided (the number of providers is not reducing under the change proposals). • However, cancellations and waiting lists should reduce and outcomes and patient satisfaction increase (as demonstrated through the pilot). • More patients should be able to choose to have their operation /procedure in Lincolnshire rather than go out of county.
Urgent and Emergency Care	• Once implemented will reduce number of hospital sites in Lincolnshire with a service called an 'Accident and Emergency Department' from three to two (the number of providers is not reducing under the change proposals). • However, in terms of services provided and available to patients from each of the three hospital sites there will be minimal change due to the exclusion criteria that has been in place at Grantham Hospital since 2007/08. • It is estimated refinement of the exclusion criteria under this proposal will impact c.2.5-3% (c.600 patients per annum) of current total activity, these being higher acuity cases that clinically should receive specialist treatment elsewhere.

Acute Medicine	• Implementing the preferred option for acute medicine will not reduce the number of hospital sites from which acute medicine is provided from (the number of providers is not reducing under the change proposals). • However, for a small number of patients (c.385 patients per year) with higher acuity needs they will receive care specialist treatment elsewhere. • It should also be noted that the under this proposed model Grantham Hospital will be able to see a larger proportion of frail and elderly patients from the geographic area to receive inpatient care at Grantham.
Stroke Services	• The number of sites from which acute stroke services will be provided will be reduced, however there is a compelling case to reconfigure and centralise these services to improve quality, safety and sustainability of services and make best use of resources (the number of providers is not reducing under the change proposals). • Key drivers are current performance in national stroke audit, having two acute stroke units one slightly above recommended yearly activity levels and one slightly below and significant doctor and nurse shortages • Consolidation of acute stroke services onto one hospital site would be supported by an enhanced community stroke rehabilitation service to enable people to discharge sooner from hospital and return to their home/communities earlier.

Having assessed the change proposals in light of the feedback received through the public consultation and additional work completed and actions identified, it is considered that patients will continue to be able to exercise choice in line with the NHS Constitution.

Statement of bed closures

Another one of the national tests for service reconfiguration is the consideration of bed closures. None of the changes described in the public consultation and following a review and assessment of the public feedback will require hospital bed closures.

Decision Making Business Case – Supporting documents

Lincolnshire Integrated Care System
Acute Services Review:

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

One: United Lincolnshire Hospitals NHS Trust supporting documents

Two: Lincolnshire Community Health Services NHS Trust supporting documents

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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17 May 2022

Dear Gerry and John

Re: Supporting Documents for consideration of Acute Service Review Decision Making Business Case

The appendices to this letter contain a number of supporting documents in respect of the Acute Services Review Decision Making Business Case which the CCG Board is due to consider at the end of this month:

Appendix 1 – Orthopaedic Statement of Support

Appendix 2 – Stroke Services Statement of Support

Appendix 3 – Acute Medical Services Statement of Support

Appendix 4 – Urgent and Emergency Care Statement of Support

Appendix 5 – Benefits Plan Orthopaedic

Appendix 6 – Benefits Plan Stroke Services

Appendix 7 – Benefits Plan Acute Medical Services

Appendix 8 – Benefits Plan Urgent and Emergency Care

Appendix 9 - Outline Implementation Timeline Orthopaedic

Appendix 10 - Outline Implementation Timeline Stroke

Appendix 11 - Outline Implementation Timeline Medical Services

Appendix 12 - Outline Implementation Timeline Urgent and Emergency Care

These documents were reviewed:

- By the ULHT Executive Leadership Team on 12th May; and
- By the ULHT Trust Board (virtually) on 13th May 2022.

Based on those discussions, the Trust is able to provide these documents to the CCG Board. ULHT recognises that the documents are advisory only in nature and makes no presumption that it will be the provider of any of the services referenced within them in future.

Please do not hesitate to contact us if you have any queries.

Yours sincerely



Elaine Baylis
Chair



Andrew Morgan
Chief Executive

Cc. Maz Fosh, Chief Executive, LCHS

Appendix 1
Statement of Support:

Clinical lead(s): Mr Kulandaive Sakthivel
Operational leads(s): Mark Lacey, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust 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.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality Orthopaedic services are delivered in Lincolnshire in a sustainable way for the future:

- At the end of February 2020 the evaluation of the orthopaedics pilot showed very positive results. The experience of the pilot has reaffirmed the preferred option for the future provision of orthopaedic services identified through the ASR options appraisal (to consolidated elective orthopaedic services at Grantham Hospital) and allowed it to be refined.

- Achieve a balance between access and ensuring the long term sustainability of services.

- This reconfiguration of services is highly likely to repatriate services back into our County which in turn helps both the patients and the healthcare staff.

- As an example we highlight one of the metrics for quality of care - Reduction in the average length of stay for elective orthopaedics at Grantham 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.

- For further details on the improvement of quality of care please refer to the PCBC.

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

- For further details on the improvement of quality of care please refer to PCBC

Deliverability – achievable workforce requirement

The proposed future model of a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery supports a more sustainable and resilient workforce:

- A reduction in a heavy reliance on locum and agency staff.
- Increases the chances of recruiting to substantive roles.
- The pilot workforce model has successfully removed all agency doctor usage within orthopaedics ULHT wide. 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.
- For further details on the improvement of quality of care please refer to the PCBC.

Conclusion

The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 2
Statement of Support:

Clinical lead(s): Dr Abdul Elmarimi

Operational leads(s): Carl Ratcliff, Sarah Southall, Angela Shimada

Statement of support

The United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services Trusts 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.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality hyper-acute and acute stroke services are delivered in Lincolnshire in a sustainable way for the long term, by:

- 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.
- Our 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

Deliverability – achievable workforce requirement

- 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 covered by agency staff. Currently, there is only one substantive accredited consultant in stroke medicine in ULHT.

- 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 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 Pilgrim 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.

The table below sets out the current hospital based stroke service workforce model (funded establishment) together with the workforce model under the proposed preferred option.
The current workforce and future requirements for acute stroke services are outlined in the tables below:

Staff Group	**Current configuration**		**Preferred Option**	
	Lincoln Hospital	**Pilgrim Hospital**	**Lincoln Hospital**	**Pilgrim Hospital**
Medical				.
Consultants	3.0	3.0	6.0	-
Associate Spec.	1.0	1.0	2.0	-
F2 (Trust)	-	1.0	1.0	-
F2 (Deanery)	1.0	-	1.0	
F1 (Trust)	-	1.0	1.0	
F1 (Deanery)	1.0	1.0	2.0	
GPVTS (Deanery)	1.0	-	1.0	
Core Trainee (Deanery)	-	1.0	1.0	
Administration	2.0	2.66	4.66	

ACP Nurse ACPs			5.8	
Nursing Registered Nursing Associate Non Registered Ward Clerk	26.90 2.00 15.32 1.0	23.24 4.0 11.26 2.0	51.08 - 21.04 1.4	- -
AHP Physio/OT/SALT	39.36 (Across the trust)		33.67	

NOTE: TABLE IS TAKEN FROM PCBC. CURRENT CONFIGURATION THEREFORE REFERS TO 19/20 BASELINE

As there will no longer be a stroke service at Pilgrim Hospital, staff will be offered the opportunity to transfer to Lincoln Hospital, or to be re-deployed within another department at the Pilgrim Hospital.

The enhanced community stroke rehabilitation service will link 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.

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.

Conclusion

The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 3
Statement of Support:

Clinical lead(s): Kate Scheele

Operational leads(s): Carl Ratcliff, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to provide an innovative integrated model of integrated community/acute beds at Grantham Hospital to work closely with the neighbourhood team.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality services are delivered in Lincolnshire in a sustainable way for the long term, by:

- 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

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

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

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

Figure 154 – Estimated future acute medicine bed requirement analysis

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

Deliverability – achievable workforce requirement

The proposed future model of services supports a more sustainable and resilient 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.
- 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 Hospital has not had as many issues as Lincoln and Pilgrim Hospitals. At Grantham Hospital the majority of consultant posts are held by permanent Trust employees offering a consistency of service and training provision. Though there has been an increase in agency cover for some specialties more recently.

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

**Planning assumptions: All subject to review and change once service is fully operational – optimal nursing skill-mix will be refined over time once service is fully operational to ensure alignment with patient need*

*** In line with the innovative acute/community model consideration will be given to one of the consultants being a non-medical consultant.*

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

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

<u>Conclusion</u>

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to provide an innovative integrated model of integrated community/acute beds at Grantham Hospital as part of the neighbourhood team

Appendix 4
Statement of Support:

Clinical lead(s): Dr Flynn

Operational leads(s): Carl Ratcliff, Cheryl Thomson, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust 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 Hospital and Pilgrim Hospital.

The benefits we believe these changes will result in are set out below.

Quality of care
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.

- 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 Hospital and Pilgrim Hospital 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
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).

- 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

	24/7 A&E (as was)	24/7 UTC
Opening hours	• 24hrs a day 7 days a week Av. 80 attendances per day (24hrs) • Av. 11 attendances between 23.00-07.00	• 24hrs a day 7 days a week
Acuity	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals. • Refinement of exclusion criteria to allow a larger proportion of frail and elderly patients from the geographic locality to receive inpatient care at Grantham and a small volume of higher acuity cases currently managed at Grantham to receive specialised treatment elsewhere
Workforce	• Consultants: 80hrs/week plus on-call evenings & weekends • Middle Grades: 24/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours	• Consultants: 40hrs/week no on-call evenings & weekends • Middle Grades: 16/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours Planning assumptions: All subject to review and change once service is fully operational
Diagnostic	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7

- In addition, through workshops with stakeholders proposals have been developed to improve support to patients with regards to travel in the broadest sense across Lincolnshire (i.e. not just relating to proposed service changes under the acute services review). These include:
  - Ensuring a seamless process for advice, eligibility assessment and booking
  - Improved coordinated way of ensuring the appropriate transport is arranged for discharges from hospital:
  - The default should be Non-Emergency Patient Transport Services (NEPTS) unless there is a 'medical need'
  - Better planning and coordination with the family/patient early in a patients stay as an integral part of discharge planning
  - Coordination of NEPTS with potential other options through a single system approach to discharge planning

- Booking of clinics:
  - More proactive choices regarding clinic bookings should include a discussion on 'how are you intending to travel'
  - Real time information to support administrators in understanding public transport should be easily accessible on their IT systems so that 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
- Integration of systems to allow funded, non-funded and concessionary fares/bus passes to use multiple types of transport.
- Access to treatment would further improve for children because the UTC team would broaden to include community and primary care staff (eg. GPs) who are more experienced and familiar with treating children than a traditional, non-paediatric A&E team.
- 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 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.

Deliverability – achievable workforce requirement

The proposed model supports a more sustainable and resilient workforce by:

- The Consultant workforce will be ULHT employed and will undertake sessions at Grantham UTC 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 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.

Estimated future Grantham UTC attendance analysis

Attendees at the proposed Grantham Urgent Treatment Centre				
15/16		**19/20**	**23/24 Scenario 1**	**23/24 Scenario 2**
Grantham 24/7 A&E attendances Assuming 24/7 operation in 19/20	29,297	33,900	-	-
Grantham OOH service	15,675	7,600	7,800	11,600
Grantham 24/7 UTC attendances	-	-	34,900	39,000
Total	44,972	41,500	42,700	50,600
Adjusted for displaced patients	-	-	42,000	49,900
Sensitivity analysis – reduction in 10% of attendances through ICC				
Grantham 24/7 UTC attendances	-	-	37,800	44,910

The table below sets out the proposed workforce (funded establishment) of the Grantham Hospital A&E when it operated 24/7 together with the Out of Hours workforce, what the workforce currently is (19/20 baseline 'pre-covid') and the workforce for the proposed 24/7 Urgent Treatment Centre developed for planning purposes.

Grantham UTC model workforce compared to A&E & Out of Hours model (funded establishment)

	A&E 24/7 & Out of Hours (WTE) 2015/16	**A&E (08.00-18.30) & Out of Hours (WTE) 2019/20**	**UTC 24/7 (WTE)*** **
Medical • Consultants • Middle/Trust Grade • Foundation/Trainee • Admin • GPs	 2.0* 6.0** 7.0 0.6 10 sessions/week	 2.0 5.0 6.0 0.6 10 sessions/week	 1.2 5.0 6.0**** 0.6 10 sessions/week + OOH
ACP • Nurse ACPs	 4.5	 4.0	 4.0
Nursing • Registered • Nursing Associate • Non Registered • Receptionist	 24.5 2.5 10.0 4.0	 19.0 1.0 7.5 2.5	 25.5 1.0 14.0 2.5
Out of Hours • GP • Registered • Non Registered/ Clerk	 2.0 6.5 7.0	 2.0 6.5 6.5	 Out of Hours will be integrated with UTC

** Consultants provided on-call cover overnight and at weekends*
*** Middle grades covered the whole out of hour's rota between them – 'rule of thumb' guidance suggests should be 12.0*
**** Planning assumptions: All subject to review and change once service is fully operational*
***** Junior training posts will be retained, proposed model will offer a valuable and interesting environment. Ongoing engagement of HEE to ensure they remain supportive and posts will need to be considered in the context of the overall requirement/ need for these posts across the whole of ULHT*

The service change proposal improves the services ability to attract and retain talented and substantive staff through building a strong and successful service that offers opportunities to work in a centre of excellence.
Recruitment and retention of urgent and emergency staff has been a long-standing concern for Lincolnshire, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals.
The proposed model of an Urgent Treatment Centre at Grantham Hospital is seen to provide and achieve the optimum balance of patient volumes, acuity, outcomes and resource. Medical middle grades would 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.

<u>Conclusion</u>
The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 5
Benefits Plan**:Orthopaedics**

Clinical lead(s): Mr Kulandaivel Sakthivel Consultant Orthopaedic Surgeon
Operational leads(s): Mr Mark Lacey Divisional Managing Director - Surgery

ASR Proposal - Benefits Management Framework (Orthopaedics)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the ASR can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Orthopaedics	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
	Orthopaedics	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
	Orthopaedics	Reduced chance of post-op infection, extended use of	Length of Stay and current recorded	Provider	PAS Data / Provider Datix /	Monthly

		enhanced recovery.	incidents and patient quality indicators		Complaints System	
	Orthopaedics	Reduced cancellations for elective patients, as following this reconfiguration as hot and cold activity are split.	Monitor current recorded cancellations	Provider	PAS Data	Monthly
	Orthopaedics	Reduced waiting times for surgery.	Monitor performance of the reduction	Provider	PAS Data	Monthly
	Orthopaedics	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
	Orthopaedics	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

Appendix 6
ASR Proposal - Benefits Management Framework (Stroke Services)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Stroke Services	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
	Stroke Services	This proposed changes should improve patient safety.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
	Stroke Services	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
	Stroke Services	This program should improve overall performance against constitutional standards.	National Standards	Provider	PAS Data	Monthly

	Stroke Services	By creating a specialist centre for Stroke Services, this should attract candidates from further afield	Vacancy rate	Provider	Workforce Data / ESR	Monthly
	Stroke Services	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
	Stroke Services	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

Appendix 7
ASR Proposal - Benefits Management Framework (Acute Med)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Acute Med	This proposed changes should improve patient safety.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
	Acute Med	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
	Acute Med	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

	Acute Med	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
	Acute Med	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
	Acute Med	Greater integration with the Integrated Neighbourhood Team should support earlier discharge from the integrated community/acute beds	Length of Stay	Provider	PAS Data	Monthly
	Acute Med	This program should improve overall performance against constitutional standards.	National Standards	Provider	PAS Data	Monthly
	Acute Med	Positive Impact - 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

Appendix 8
ASR Proposal - Benefits Management Framework (UEC)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	UEC	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
	UEC	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
	UEC	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
	UEC	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

Appendix 9

<u>Outline Implementation Plan</u>: Orthopaedics

Clinical lead(s): Mr Kulandaivel Sakthivel Consultant Orthopaedic Surgeon
Operational leads(s): Mr Mark Lacey Divisional Managing Director - Surgery

Formal governance arrangements are required to steer and govern the process of service change and deliver the changes to Orthopaedics.
It is proposed that a dedicated implementation group will be established to ensure that the proposed changes to orthopaedics that is currently being piloted can be delivered as a permanent change to the service. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues and manage risks.
- Involve members of the ICS such as Acute/Community Trusts, local GP's and the ICS function.
- Appoint an SRO.
- Agree and monitor performance metrics to track and manage progress against key metrics.
- Align any other key programmes in place as required such as other ASR projects.

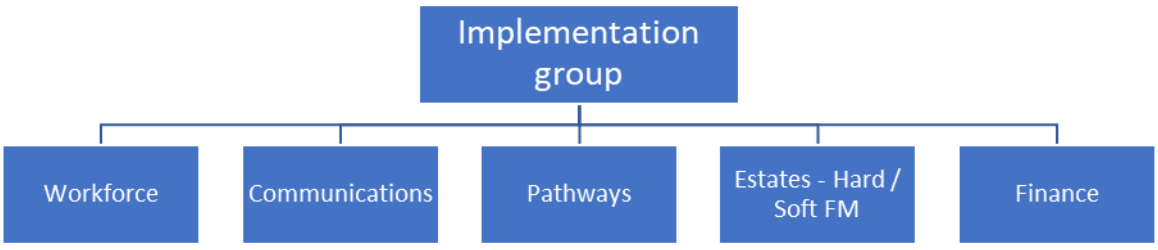
A number of workstreams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.
A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

The proposed changes to the service have been in place, as part of a national pilot, since August 2018.

Therefore if the proposed change was approved provisions would need to be made for this pilot to become a permanent change. Key aspects of this would be the need to review internal governance around the programme and any necessary HR facets, such as staff consultation.

The proposed change shouldn't see a protracted timeframe, given the current circumstances.

Governance Structure:



Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients.
- Ensure function of other aspects of ASR fit into the model, other system Health/Social care provision.
- How service changes will be made/when will services start.

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training.
- Estates.
- Equipment.
- Communications and stakeholder management.
- Finance.

Appendix 10

Outline Implementation Plan: Stroke

Clinical lead(s): Dr Abdul Elmarimi Consultant Stroke Medicine
Operational leads(s): Carl Ratcliff Managing Director Medicine

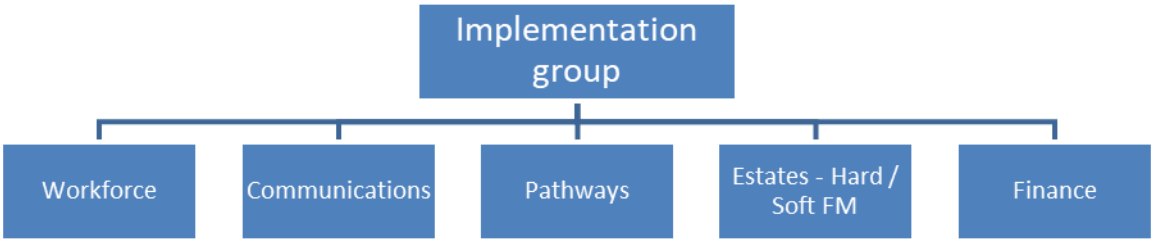
Formal governance arrangements are required to steer and govern the process of service change and deliver the changes in the stroke pathway. It is proposed that a dedicated implementation group will be established to ensure the project is delivered and embedded. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues an manage risks
- Involve members of the ICS such as Acute/ Community Trusts, local GP's and ICS function.
- Appoint a SRO for the project
- Agree and monitor performance metrics to track and manage progress against key metrics
- Align any other key programmes in place as required such as other ASR projects.

A number of work streams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

Governance Structure:



Prior to the implementation of the proposed single site model, there would need to be a business case development process which we envisage to take circa.18 months to increase the footprint of the current Lincoln stroke unit.

	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.

Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients.
- Ensure 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.
- How service changes will be made, for example will there be double running / when will services start.
- Management structures, workforce issues, governance including policies and protocols.
- Management of the deteriorating patient.

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training
- Estates (including Business case
- Equipment
- Communications and stakeholder management
- Finance

Appendix 11

Outline Implementation Timescales: Acute Med

Clinical lead(s): Kate Scheele Consultant Respiratory - Medicine
Operational leads(s): Carl Ratcliff Managing Director - Medicine

Implementation

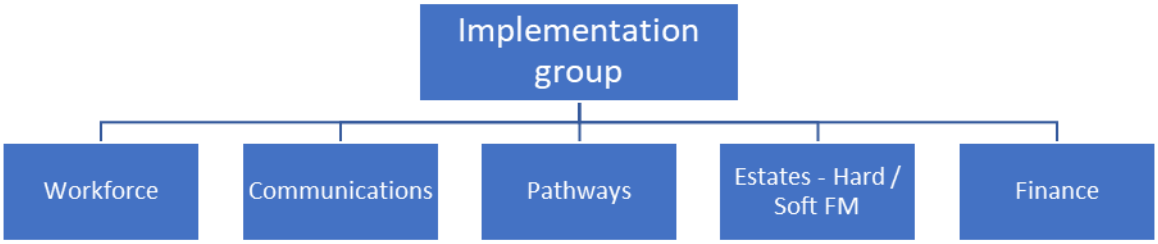
Formal governance arrangements are required to steer and govern the process of service change and deliver the changes in the medical beds. It is proposed that a dedicated implementation group will be established to ensure the project is delivered and embedded. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues and manage risks.
- Involve members of the ICS such as Acute/Community Trusts, local GP's and ICS function.
- Appoint a SRO for the project.
- Agree and monitor performance metrics to track and manage progress against key metrics.
- Align any other key programmes in place as required such as other ASR projects.

A number of work streams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

Governance Structure:



	Month													
Acute Medicine	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Evaluation of Procurement for new provider														
Organisational Review														
Provider Collaborative Agreed														
Establishment of Operational & Governance Structures / Working Groups														
Staff Consultation														
Implementation														
Evaluation														

Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients.
- Ensure 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.
- How service changes will be made, for example will there be double running / when will services start.
- Management structures, workforce issues, governance including policies and protocols.
- Management of the deteriorating patient.

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training.
- Estates.
- Equipment.
- Communications and stakeholder management.
- Finance.

Appendix 12

<u>Outline Implementation Plans</u>: UEC

Clinical lead(s): Dr Flynn Consultant A&E

Operational leads(s): Carl Ratcliff Managing Director Medicine
Cheryl Thomson General Manager Urgent & Emergency Care

Formal governance arrangements are required to steer and govern the process of service change and deliver the changes in the Emergency care pathway. It is proposed that a dedicated implementation group will be established to ensure the project is delivered and embedded. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues and manage risks.
- Involve members of the ICS such as Acute/Community Trusts, local GP's and ICS function.
- Appoint a SRO for the project.
- Agree and monitor performance metrics to track and manage progress against key metrics.
- Align any other key programmes in place as required such as other ASR projects.

A number of work streams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

Governance Structure:

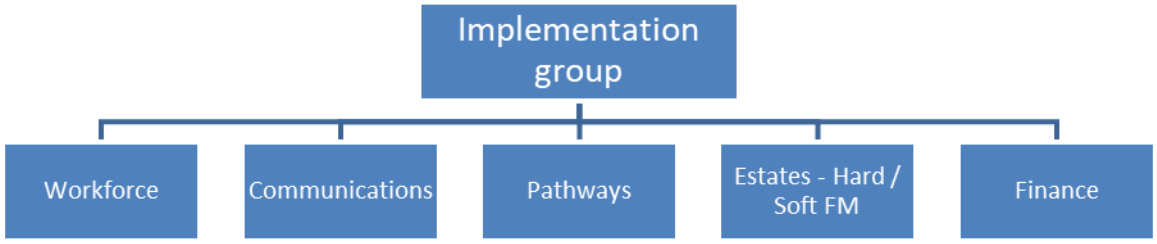


Figure 1: UEC Implementation Proposed Timeline

	Month																	
UEC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Evaluation of Procurement for new provider																		
Organisational Review																		
Provider Collaborative Agreed																		
Establishment of Operational & Governance Structures / Working Groups																		
Staff Consultation																		
Implementation																		
Evaluation																		

Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients.
- Ensure 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.
- How service changes will be made, for example will there be double running / when will services start.
- Management structures, workforce issues, governance including policies and protocols.
- Management of the deteriorating patient.

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training.
- Estates.
- Equipment.
- Communications and stakeholder management.
- Finance.

Lincolnshire Community Health Services
NHS Trust

Beech House
Witham Park, Waterside South
Lincoln, LN5 7JH

Date: 17th May 2022

Dr Gerry McSorley, Acting Chair
John Turner, CEO
NHS Lincolnshire CCG
Bridge House
The Point
Lions Way
Sleaford
NG34 8GG

Calls via typetalk are welcome
Website: www.lincolnshirecommunityhealthservices.nhs.uk

cc: Andrew Morgan, CEO
United Lincolnshire Hospitals NHS Trust

Supporting Documents for consideration of Acute Service Review Decision Making Business Case

Dear Gerry and John,

The appendices to this letter contain a number of supporting documents in respect of the Acute Services Review Decision Making Business Case which the CCG Board is due to consider at the end of this month:

Appendix 1 – Orthopaedic Statement of Support

Appendix 2 – Stroke Services Statement of Support

Appendix 3 – Acute Medical Services Statement of Support

Appendix 4 – Urgent and Emergency Care Statement of Support

Appendix 5 – Benefits Plan Orthopaedic

Appendix 6 – Benefits Plan Stroke Services

Appendix 7 – Benefits Plan Acute Medical Services

Appendix 8 – Benefits Plan Urgent and Emergency Care

Appendix 9 - Outline Implementation Timeline

These documents were reviewed:

- By the LCHS Trust Leadership Team on 3rd May 2022; and
- By the LCHS Trust Board (meeting in private session) on 10th May 2022.

Based on those discussions, the Trust is able to provide these documents to the CCG Board. LCHS recognises that the documents are advisory only in nature and makes no presumption that it will be the provider of any of the services referenced within them in future.

Please do not hesitate to contact us if you have any queries.

Yours sincerely,



Elaine Baylis
Chair
Lincolnshire Community Health Services NHS Trust



Maz Fosh
Chief Executive
Lincolnshire Community Health Services NHS Trust

Appendix 1
Statement of Support:

Clinical lead(s): Mr Kulandaive Sakthivel
Operational leads(s): Mark Lacey, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust 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.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality Orthopaedic services are delivered in Lincolnshire in a sustainable way for the future:

- At the end of February 2020 the evaluation of the orthopaedics pilot showed very positive results. The experience of the pilot has reaffirmed the preferred option for the future provision of orthopaedic services identified through the ASR options appraisal (to consolidated elective orthopaedic services at Grantham Hospital) and allowed it to be refined.

- Achieve a balance between access and ensuring the long term sustainability of services.

- This reconfiguration of services is highly likely to repatriate services back into our County which in turn helps both the patients and the healthcare staff.

- As an example we highlight one of the metrics for quality of care - Reduction in the average length of stay for elective orthopaedics at Grantham 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.

- For further details on the improvement of quality of care please refer to the PCBC.

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

- For further details on the improvement of quality of care please refer to PCBC

Deliverability – achievable workforce requirement

The proposed future model of a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery supports a more sustainable and resilient workforce:

- A reduction in a heavy reliance on locum and agency staff.
- Increases the chances of recruiting to substantive roles.
- The pilot workforce model has successfully removed all agency doctor usage within orthopaedics ULHT wide. 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.
- For further details on the improvement of quality of care please refer to the PCBC.

Conclusion

The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 2
Statement of Support:

Clinical lead(s): Dr Abdul Elmarimi

Operational leads(s): Carl Ratcliff, Sarah Southall, Angela Shimada

Statement of support

The United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services Trusts 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.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality hyper-acute and acute stroke services are delivered in Lincolnshire in a sustainable way for the long term, by:

- 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.
- Our 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

Deliverability – achievable workforce requirement

- 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 covered by agency staff. Currently, there is only one substantive accredited consultant in stroke medicine in ULHT.

- 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 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 Pilgrim 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.

The table below sets out the current hospital based stroke service workforce model (funded establishment) together with the workforce model under the proposed preferred option.
The current workforce and future requirements for acute stroke services are outlined in the tables below:

Staff Group	**Current configuration**		**Preferred Option**	
	Lincoln Hospital	**Pilgrim Hospital**	**Lincoln Hospital**	**Pilgrim Hospital**
Medical				.
Consultants	3.0	3.0	6.0	-
Associate Spec.	1.0	1.0	2.0	-
F2 (Trust)	-	1.0	1.0	-
F2 (Deanery)	1.0	-	1.0	
F1 (Trust)	-	1.0	1.0	
F1 (Deanery)	1.0	1.0	2.0	
GPVTS (Deanery)	1.0	-	1.0	
Core Trainee (Deanery)	-	1.0	1.0	
Administration	2.0	2.66	4.66	
ACP Nurse ACPs				5.8
Nursing				
Registered	26.90	23.24	51.08	-
Nursing Associate	2.00	4.0	-	-
Non Registered	15.32	11.26	21.04	
Ward Clerk	1.0	2.0	1.4	
AHP Physio/OT/SALT	39.36 (Across the trust)		33.67	

NOTE: TABLE IS TAKEN FROM PCBC. CURRENT CONFIGURATION THEREFORE REFERS TO 19/20 BASELINE

As there will no longer be a stroke service at Pilgrim Hospital, staff will be offered the opportunity to transfer to Lincoln Hospital, or to be re-deployed within another department at the Pilgrim Hospital.

The enhanced community stroke rehabilitation service will link 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.

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.

Conclusion

The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 3
Statement of Support:

Clinical lead(s): Kate Scheele

Operational leads(s): Carl Ratcliff, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to provide an innovative integrated model of integrated community/acute beds at Grantham Hospital to work closely with the neighbourhood team.

The benefits we believe these changes will result in are set out below.

Quality of care

High quality services are delivered in Lincolnshire in a sustainable way for the long term, by:

- 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

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

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

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

Figure 154 – Estimated future acute medicine bed requirement analysis

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

Deliverability – achievable workforce requirement

The proposed future model of services supports a more sustainable and resilient 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.
- 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 Hospital has not had as many issues as Lincoln and Pilgrim Hospitals. At Grantham Hospital the majority of consultant posts are held by permanent Trust employees offering a consistency of service and training provision. Though there has been an increase in agency cover for some specialties more recently.

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

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

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

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

Conclusion

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust supports the change proposal to provide an innovative integrated model of integrated community/acute beds at Grantham Hospital as part of the neighbourhood team

Appendix 4
Statement of Support:

Clinical lead(s): Dr Flynn

Operational leads(s): Carl Ratcliff, Cheryl Thomson, Sarah Southall, Angela Shimada

Statement of support

The United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust 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 Hospital and Pilgrim Hospital.

The benefits we believe these changes will result in are set out below.

Quality of care
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.

- 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 Hospital and Pilgrim Hospital 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
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).

- 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

	24/7 A&E (as was)	**24/7 UTC**
Opening hours	• 24hrs a day 7 days a week Av. 80 attendances per day (24hrs) • Av. 11 attendances between 23.00-07.00	• 24hrs a day 7 days a week

Acuity	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals. • Refinement of exclusion criteria to allow a larger proportion of frail and elderly patients from the geographic locality to receive inpatient care at Grantham and a small volume of higher acuity cases currently managed at Grantham to receive specialised treatment elsewhere
Workforce	• Consultants: 80hrs/week plus on-call evenings & weekends • Middle Grades: 24/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours	• Consultants: 40hrs/week no on-call evenings & weekends • Middle Grades: 16/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours Planning assumptions: All subject to review and change once service is fully operational
Diagnostic	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7

- In addition, through workshops with stakeholders proposals have been developed to improve support to patients with regards to travel in the broadest sense across Lincolnshire (i.e. not just relating to proposed service changes under the acute services review). These include:
  - Ensuring a seamless process for advice, eligibility assessment and booking
  - Improved coordinated way of ensuring the appropriate transport is arranged for discharges from hospital:
  - The default should be Non-Emergency Patient Transport Services (NEPTS) unless there is a 'medical need'
  - Better planning and coordination with the family/patient early in a patients stay as an integral part of discharge planning
  - Coordination of NEPTS with potential other options through a single system approach to discharge planning
- Booking of clinics:
  - More proactive choices regarding clinic bookings should include a discussion on 'how are you intending to travel'
  - Real time information to support administrators in understanding public transport should be easily accessible on their IT systems so that 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

- Integration of systems to allow funded, non-funded and concessionary fares/bus passes to use multiple types of transport.
- Access to treatment would further improve for children because the UTC team would broaden to include community and primary care staff (eg. GPs) who are more experienced and familiar with treating children than a traditional, non-paediatric A&E team.
- 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 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.

Deliverability – achievable workforce requirement

The proposed model supports a more sustainable and resilient workforce by:

- The Consultant workforce will be ULHT employed and will undertake sessions at Grantham UTC 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 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.

Estimated future Grantham UTC attendance analysis

Attendees at the proposed Grantham Urgent Treatment Centre				
15/16		**19/20**	**23/24 Scenario 1**	**23/24 Scenario 2**
Grantham 24/7 A&E attendances Assuming 24/7 operation in 19/20	29,297	33,900	-	-
Grantham OOH service	15,675	7,600	7,800	11,600
Grantham 24/7 UTC attendances	-	-	34,900	39,000
Total	44,972	41,500	42,700	50,600
Adjusted for displaced patients	-	-	42,000	49,900
Sensitivity analysis – reduction in 10% of attendances through ICC				
Grantham 24/7 UTC attendances	-	-	37,800	44,910

The table below sets out the proposed workforce (funded establishment) of the Grantham Hospital A&E when it operated 24/7 together with the Out of Hours workforce, what the workforce currently is (19/20 baseline 'pre-covid') and the workforce for the proposed 24/7 Urgent Treatment Centre developed for planning purposes.

Grantham UTC model workforce compared to A&E & Out of Hours model (funded establishment)

	A&E 24/7 & Out of Hours (WTE) 2015/16	**A&E (08.00-18.30) & Out of Hours (WTE) 2019/20**	**UTC 24/7 (WTE)*** **

Medical • Consultants • Middle/Trust Grade • Foundation/Trainee • Admin • GPs	 2.0* 6.0** 7.0 0.6 10 sessions/week	 2.0 5.0 6.0 0.6 10 sessions/week	 1.2 5.0 6.0**** 0.6 10 sessions/week + OOH
ACP • Nurse ACPs	 4.5	 4.0	 4.0
Nursing • Registered • Nursing Associate • Non Registered • Receptionist	 24.5 2.5 10.0 4.0	 19.0 1.0 7.5 2.5	 25.5 1.0 14.0 2.5
Out of Hours • GP • Registered • Non Registered/ Clerk	 2.0 6.5 7.0	 2.0 6.5 6.5	 Out of Hours will be integrated with UTC

** Consultants provided on-call cover overnight and at weekends*
*** Middle grades covered the whole out of hour's rota between them – 'rule of thumb' guidance suggests should be 12.0*
**** Planning assumptions: All subject to review and change once service is fully operational*
***** Junior training posts will be retained, proposed model will offer a valuable and interesting environment. Ongoing engagement of HEE to ensure they remain supportive and posts will need to be considered in the context of the overall requirement/ need for these posts across the whole of ULHT*

The service change proposal improves the services ability to attract and retain talented and substantive staff through building a strong and successful service that offers opportunities to work in a centre of excellence.
Recruitment and retention of urgent and emergency staff has been a long-standing concern for Lincolnshire, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals.
The proposed model of an Urgent Treatment Centre at Grantham Hospital is seen to provide and achieve the optimum balance of patient volumes, acuity, outcomes and resource. Medical middle grades would 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.

Conclusion
The service change proposal is considered deliverable and sustainable by the United Hospitals Lincolnshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Appendix 5
Benefits Plan**:** **Orthopaedics**

Clinical lead(s): Mr Kulandaivel Sakthivel Consultant Orthopaedic Surgeon
Operational leads(s): Mr Mark Lacey Divisional Managing Director - Surgery

ASR Proposal - Benefits Management Framework (Orthopaedics)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the ASR can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Orthopaedics	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
	Orthopaedics	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
	Orthopaedics	Reduced chance of post-op infection, extended use of enhanced recovery.	Length of Stay and current recorded incidents and patient	Provider	PAS Data / Provider Datix / Complaints	Monthly

			quality indicators		System	
	Orthopaedics	Reduced cancellations for elective patients, as following this reconfiguration as hot and cold activity are split.	Monitor current recorded cancellations	Provider	PAS Data	Monthly
	Orthopaedics	Reduced waiting times for surgery.	Monitor performance of the reduction	Provider	PAS Data	Monthly
	Orthopaedics	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
	Orthopaedics	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

Appendix 6
ASR Proposal - Benefits Management Framework (Stroke Services)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Stroke Services	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
	Stroke Services	This proposed changes should improve patient safety.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
	Stroke Services	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
	Stroke Services	This program should improve overall performance against constitutional standards.	National Standards	Provider	PAS Data	Monthly
	Stroke Services	By creating a specialist centre for Stroke Services, this should attract candidates from further afield	Vacancy rate	Provider	Workforce Data / ESR	Monthly

	Stroke Services	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
	Stroke Services	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

Appendix 7
ASR Proposal - Benefits Management Framework (Acute Med)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	Acute Med	This proposed changes should improve patient safety.	Current recorded incidents and patient quality indicators	Provider	Provider Datix / Complaints System	Monthly
	Acute Med	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
	Acute Med	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

	Acute Med	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
	Acute Med	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
	Acute Med	Greater integration with the Integrated Neighbourhood Team should support earlier discharge from the integrated community/acute beds	Length of Stay	Provider	PAS Data	Monthly
	Acute Med	This program should improve overall performance against constitutional standards.	National Standards	Provider	PAS Data	Monthly
	Acute Med	Positive Impact - 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

Appendix 8
ASR Proposal - Benefits Management Framework (UEC)

The metrics will be included in the Benefit log and then measured throughout the implementation stage of the project and post implementation to inform the Evaluation Report.

Wherever possible baseline data must be included in the table. Where baseline is not available, the team must commit to collecting the baseline data as soon as possible, to ensure any improvement attributable to the project can be measured.

Strategic Goal	Proposal	Benefit	Metric (what will be measured)	Owner *(individual responsible for realising the benefit)*	Data Source	Frequency *(e.g. quarterly, monthly etc)*
	UEC	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
	UEC	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
	UEC	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
	UEC	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

Appendix 9

ASR Outline Implementation Plan

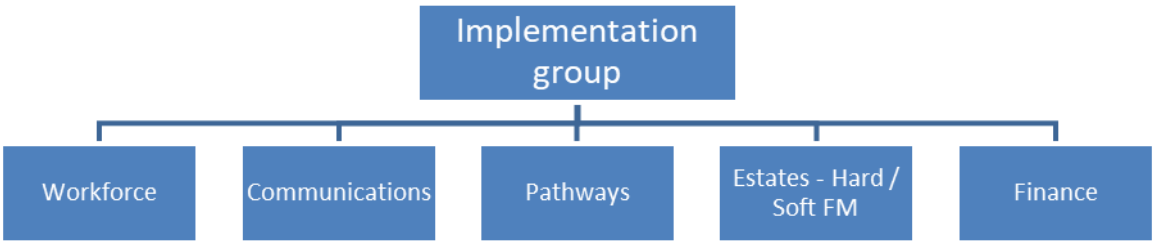
Formal governance arrangements are required to steer and govern the process of service change and deliver the changes in the ASR pathway. It is proposed that a dedicated implementation group will be established to ensure the project is delivered and embedded. This will:

- Meet often (at least monthly) to provide direction and ensure effective co-ordination, resolve issues an manage risks
- Involve members of the ICS such as Acute/ Community Trusts, local GP's and ICS function.
- Appoint an SRO for the project
- Agree and monitor performance metrics to track and manage progress against key metrics
- Align any other key programmes in place as required such as other ASR projects.

A number of work streams will be established to lead on both the planning and development required to support changes to the services, as well as the transactional process of change. The governance arrangements will report into respective organisations structures.

A robust risk management framework will be implemented to ensure that the principles of measuring, managing and reporting are maintained.

Governance Structure:



A high-level assumption around potential timeframes have been provided below, which sets out how the community provider would respond to an implementation timeline for these new proposals.

	Month															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Formal Notifcation of change to providers																
Agreement on Provider Collaborative Arrangements																
Impact Assessments (Financial and Performance)																
Establishment of Operational and Governance Structures																
Staff Consultation																
Community Beds Implementation																
Urgent Treatment Centre Implementation																
Project Evaluation																

Clinical Work streams

There are a number of clinical work streams based on the ASR and the programme will be in place to avoid silo working. Each work stream will be responsible for planning the service change and report back to the lead implementation group and they will focus on:

- Agree pathways for patients
- Ensure 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.
- How service changes will be made, for example will there be double running / when will services start.
- Management structures , workforce issues , governance including policies and protocols
- Management of the deteriorating patient

Non clinical Work streams

There will be a number of non-clinical to support clinical work streams in delivery of the proposed model including:

- Workforce – recruitment and training
- Estates
- Equipment
- Communications and stakeholder management
- Finance