Appendix 3: workshops summary feedback report and FAQs

Healthy Conversation 2019 workshops summary feedback report

Grantham 19th June 2019 / 9th October 2019
Boston 27th June 2019 / 10th October 2019

1. Purpose

Lincolnshire's NHS held workshops, open to all, in Grantham on 19th June and Boston on 27th June. Two further workshops were held on 9th and 10th October in Grantham and Boston.

In the June workshops clinicians and staff were involved in discussions with attendees about the key themes relating to the ongoing Acute Services Review in the county which had emerged from previous engagement. This focused on the proposed changes to services for women's and children's, stroke services and Grantham A&E and also travel and transport for each of the services.

This document provides a summary of the main points and issues raised during conversations and our subsequent response to those Frequently Asked Questions (FAQs) and scenarios which emerged during the workshops.

At the follow-up workshops in October, attendees were provided with the feedback from the June workshops and along with staff and clinicians were asked to:

1. Check the feedback makes sense and make any amendments required following their review
2. Gather their suggestions for how we can communicate these messages and scenarios more widely with the public
3. Ask if they have any more outstanding concerns

This document now includes any supplementary questions which resulted from the workshops held on 9th and 10th October and any amendments to the previous FAQs or additional responses are highlighted in bold/blue.

2. Summary of feedback from June and October workshops Discussions were held around the following main themes and specific questions and answers are presented in the subsequent section of the report.

<u>Main themes raised at Grantham workshops:</u>

- Service and staffing provision within the proposed Urgent Treatment Centre (UTC) and how this may impact other hospitals
- How any proposed changes might affect other wards and services at Grantham Hospital
- Healthy Conversation 2019 engagement process prior to consultation and involvement of those with protected characteristics

- NHS 111 service provision and performance
- NHS support offered to disadvantaged patients, especially for travel and transport
- Access to services and inadequate public transport provision in areas
- East Midlands Ambulance Service (EMAS) service provision, performance and the 'golden hour'

Main themes raised at Boston workshops:

- Travel times and ambulance transfers to Lincoln Hospital
- Treatment times for patients suffering a stroke
- East Midlands Ambulance Service (EMAS) performance and targets
- Advertising of engagement events and provision for those not able to attend
- Additional travel needs of friends and families if paediatric patients moved to other hospitals
- Options being consulted on for women's and children's services
- Recruitment, retention and availability of staff to deliver services in Boston Hospital
- Rural funding for Lincolnshire

2. FAQs

2.1 Grantham service change FAQs

What is the current service at Grantham A&E?
Grantham Hospital has not had a full A&E department for a number of years. It provides a restricted range of services.

Grantham A&E is open from 8am – 6.30pm, seven days a week.

After 6.30pm, there are services in place such as the NHS111 Services, the Lincolnshire Clinical Assessment Service (CAS), East Midlands Ambulance Service (EMAS) and the out of hours service to maximise the number of patients who can still be treated at Grantham Hospital. This means that some patients may still be brought by ambulance to Grantham overnight.

Our emerging option envisages the vast majority of patients who are treated at Grantham Hospital today, will be able to receive the same care in the Grantham Urgent Treatment Centre (UTC). In fact, there is very little difference in the service which has been available in the Grantham A&E department in recent years to that of a UTC.

A fully functioning A&E department requires a comprehensive range of back up services and facilities, such as specialist critical care and specialist medicine, emergency surgery, paediatric assessment and maternity services. Grantham Hospital does not currently have these services.

If someone is critically ill or injured, it is crucial that they get to the right hospital with the right facilities, first time, in order to ensure the best chance of a positive outcome.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Are we aware of the impact on other hospitals following the closure of A&E?
Do we have statistics showing how many people are being sent elsewhere?
Do we have statistics to show the number of patients pre and post closure?
Since the overnight closure of Grantham A&E, we have seen a small increase in the number of patients from Grantham being seen at our A&Es in Lincoln and Pilgrim – an average of just over two people each day. The growth in patients to Peterborough, which has been widely reported in the media, equates to three patients a week. This reflects the overall increase in A& E attendances both locally and nationally over the last few years. We consider these figures with the commissioners and remain aware of the activity at the other hospitals for both planned and emergency care.

Why are staff being moved from Grantham to cover Lincoln?
There is no evidence that ULHT is instructing staff to do this or that it is happening locally either. On occasion, however, all staff working in any of our three acute hospitals (Lincoln, Boston and Grantham) may be asked to volunteer to cover additional shifts in other hospitals.

If Grantham A&E becomes an Urgent Treatment Centre, what services will be provided?

UTCs, which are slowly being introduced into Lincolnshire, having just launched in Louth and Skegness, provide urgent care for people whose conditions are not life threatening. Services provided by UTCs means Emergency Departments (A&E) services are protected for those who need specialist emergency care. UTCs are GP-led, staffed by multi-disciplinary teams of doctors, nurses, therapists and other professionals, who are trained in life support for adults and children. At Grantham specifically, there will be a higher level of staffing than the national specification – including staff with skills equivalent to middle grade A&E doctors; GPs and nurse practitioners - to ensure the vast majority of patients who are treated at Grantham Hospital today, will be able to receive care in the UTC.

Examples of conditions which may be treated at a UTC include:

- Sprains and strains
- Suspected broken limbs
- Minor head injuries
- Cuts and grazes
- Bites and stings
- Minor scalds and burns
- Ear and throat infections
- Skin infections and rashes
- Eye problems
- Coughs and colds
- Feverish illness in adults
- Feverish illness in children
- Abdominal pain
- Vomiting and diarrhoea
- Emergency contraception

There will be minimal changes to services currently provided at Grantham A&E. Patients who are likely to require critical care services will be cared for at Lincoln, Boston, Nottingham or Peterborough hospitals, where they will receive the specialist care they require to enable the best outcome possible. These patients are likely to have been assessed by a GP or paramedic and taken directly to the most appropriate place for treatment. Those patients with critical care / specialist needs who do arrive at Grantham in the first instance will be stabilised and then transferred. This works out at approximately 200 patients a year who currently attend Grantham Hospital but are very ill and require specialist treatment at a more specialist hospital.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Will patients with long term conditions still be seen and treated at Grantham?

Yes. The appropriate place for treatment depends on the level of severity of the patient's symptoms.

What will happen to the cardio ward at Grantham?

Grantham does not now have a cardiology ward.

Would Grantham Urgent Treatment Centre be open 24/7?
The national specification is that UTCs are required to be open for at least 12 hours a day, seven days a week, including bank holidays. People can walk into UTCs during the opening hours, while others may be referred by NHS111 or by a GP.
Our emerging preferred option is to have 24/7 access to urgent care through the introduction of a UTC at Grantham Hospital.

The emerging option suggests that in the 'out of hours' period, access would be through NHS 111 for the reasons of patient safety. We will be listening to a wide range of feedback in order to inform our thinking, including people's views on how the service could best be accessed.

The NHS 111 service is able to book the patient into the right urgent care service first time so they have an appointment which is convenient for the patient and reduces their waiting time. The NHS 111 and Clinical Assessment Service (CAS) has a Directory of Services informing, for example, where and when an x-ray service is available. They are able to advise the patient where to go to receive such a service meaning the patient goes to the right place first time. It will improve the speed of treatment and stop patients having to move between services. Crucially it will advise when an A&E attendance is necessary, preventing the patient wasting potentially vital time going to the UTC first.

Patients with booked appointments will take precedence over walk in patients – unless there is a clinical priority and will therefore not have to wait as long.

A final decision on UTCs will not be made until after the formal consultation.

What if national funding is reduced? Would this mean Grantham UTC would be reduced to the national minimum specification of 12 hours per day?
While we cannot predict what might happen in the future, our current commitment is to offer Grantham residents a quality service which is sustainable and deliverable, e.g. we can attract the right staff, and one which instils confidence throughout the community. There will be a formal consultation on the proposed option of an UTC and the outcome will inform future decisions on the UTC such as opening times etc.

Who will staff work for in a UTC? Will they be able to stabilise patients?
All staff working in the UTC will be able to provide emergency care. It is anticipated that the majority of staff in the UTC will be employed by Lincolnshire Community Health Services NHS Trust (LCHS). It is also proposed that staff on the Grantham Hospital site will work in an integrated way so clinicians on the site (employed by other organisations) will be available to provide advice. Today, consultants on other hospital sites already provide advice when needed for example, consultants are available via telemedicine or to review scans sent to them.

If this proposed UTC is implemented following the formal consultation, transfer of staff from the current A&E to the UTC (with additional staff to deliver the model if needed) will be looked into in more detail. We will consult with staff and follow HR guidance. This does not mean a downgrade in services or skills and we will support our staff to have the right skills if there are changes to any roles. Our staff are our greatest asset.

What will happen to ambulance admissions into Grantham Hospital overnight if there is a UTC?
If an ambulance is dispatched, the paramedic will decide if the patient's needs can be met in the UTC or whether the patient has more specialist needs that require a specialist hospital. The paramedic is able to take advice by phone, talking with clinicians either in the CAS or a consultant in an A&E, to assist making this decision. This happens now.

The paramedic will take the patient to the right service that will be able to meet the patient's needs and ensure the best possible outcome.

One of the options for care will be taking low acuity patients to Grantham Hospital at night and directly admitting the patient (with prior agreement with night teams). Treating patients locally and within the Grantham community is important, as is keeping people out of hospital whenever that is possible.

What do we mean when we refer to the "right place, right time"?
We know that the best outcome for critically ill patients comes from being in the right place, where the right service can be provided as quickly as possible.

While this may mean they are not treated at the hospital closest to them, it means they will be taken directly to a hospital which can give them the immediate treatment they require, therefore giving them the best possible chance of a positive outcome.
Arriving at a hospital which is not equipped to treat them (and their specific condition) can waste critical time. The extra travel time getting to the right place far outweighs the risk of delayed treatment.

Patients who do arrive at a hospital that cannot treat their specific condition will still be cared for and the model being discussed does include a contingency for this scenario. Appropriate processes will be in place and staff will be able to stabilise those patients until they are transported safely to the most appropriate place.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

Who decides where a patient goes if an ambulance is called?
Ambulances go to Grantham hospital where this is appropriate. If an ambulance is dispatched, the ambulance crew will decide if the patient's clinical needs can be met or whether the patient has more specialist needs that require a specialist hospital. The paramedic is able to take advice by phone, talking with clinicians either in the CAS or a consultant in A&E, to assist making this decision. Our senior clinicians recommend that our patients go to the right hospital first time, rather than going to the closest NHS location, as this will not necessarily be able to provide the right care. Patients, carers or families should always phone 999 for an emergency ambulance if they believe that there is a life threatening health situation. Our senior clinicians are reviewing the current exclusion protocol (restriction criteria) to ensure that critically injured and ill patients will be cared for at the right service; treated safely and quickly by staff who have the right training and experience to give the best outcome.

If a patient is given a diagnosis at Grantham's A&E or proposed Urgent Treatment Centre but then transferred to another hospital, would they need to be triaged twice?
Triage is a process carried out on all patients attending A&E. Triage ensures people with the most serious conditions are seen first. Triage should not be required twice; however it is right that when the patient with a serious condition arrives on a new hospital site that they are assessed again so the specialist clinicians can make a clinical decision on further treatment.

Who will run medical beds in Grantham Hospital? What exactly are they?
Our preferred option is to maintain medical services at Grantham Hospital by joining up the hospital services with local primary and community services and be managed as part of the local enhanced neighbourhood team. This new model would be led by Lincolnshire Community Health Services NHS Trust (LCHS) which means that medical staff would in future be able to provide care in people's homes and local community settings, as part of a local integrated service, as well as to patients in the hospital. However, they will be working closely with the hospital trust and other health care providers so staff can support patients who, for example, deteriorate and need additional care. This model aims to keep patients out of hospital where appropriate but also to get them back home as soon as possible if they are admitted. This model of care in Grantham will be the first in the county.

The medical beds will be for patients with, for example, pneumonia, diabetes, chest infections, asthma, other respiratory diseases, i.e illnesses not requiring surgery – those who have a range of chronic ailments who can manage perfectly well most of the time but sometimes have a crises and need to go to the right place to be stabilised.

How have the views of the people who signed the petition to keep the A&E been taken in to account? How are the rallies we had in the town with 4000 or 5000 people to save A&E going to be taken in to account? How have all the views so far been taken into account?
We have listened carefully to the voices of the public and councilors and will continue to do so. We have also received a copy of the petition. Sometimes it is not possible to make the changes that are suggested to us because of factors such as patient safety or staffing. Through Healthy Conversation 2019, we have been open with the public about what is and is not possible for us to deliver, and the clinical and service reasons for that. It is right that any NHS service must be safe and sustainable. We have to be realistic as we do not have the staff to run three full A&E departments and it is highly unlikely that will change with a national shortage of A&E Consultants. We have 19 A&E consultant posts in Lincolnshire but only four of these have substantive consultants in posts.

Our emerging preferred option of a 24/7 UTC would enable more patients to receive services in Grantham than is currently the case.

Whilst the Healthy Conversation 2019 has taken place, how have you reached hard to reach and protected characteristic groups?
The workshops are publicised extensively through the following media channels: local newspapers/magazines, local radio, social media, websites, e-shots to stakeholder groups and through relevant third parties. As this event was open to all and was not invite only, we could not guarantee that people with protected characteristics would attend but ensured a wide reach with our communications so the opportunity was there.

In addition, these workshops are only one part of the much bigger programme of engagement we are undertaking and understand that events like this are not the best way

for some people to engage with us. Therefore, we offer a variety of ways for people to tell us their views if they don't want to or are unable to come along to a workshop, for example our paper and online surveys which are also available in different languages, paper and online feedback forms, meeting us when we're out and about in town centres and supermarkets, and people can phone, email or write to us. Consultation opportunities will continue as we move into the formal public consultation.

The purpose of these specific workshops was a 'deep dive' into the particular themes which emerged from the wave 1 engagement events and therefore smaller, more detailed group discussions was an appropriate way to achieve this. We are also mindful that our clinical staff's time is extremely valuable and we are grateful that they were able to sit around tables and have a conversation with our patients and the public, something which would not have been possible with larger scale events.

Further details of our proactive engagement with groups with protected characteristics will be made publically available on completion and we will share this with you. As reported in the Health Scrutiny Committee, we are working with The People's Partnership, an independent partner to ensure proactive engagement with people with protected characteristics.

The People's Partnership is made up of a Leadership Team who represent major areas of disability and some areas of the protected characteristics. In addition to the Leadership Team, they have individual members, members of groups and communities, and members who support the hidden and hard to reach communities.

The current members of the Leadership Team are:

- Age UK Lincoln & South Lincolnshire
- CarersFIRST
- Children's Links
- Every-One (contributes and facilitates the organisation of the People's Partnership)
- Linkage Community Trust
- Links Lighthouse
- South Lincolnshire Blind Society

As part of the engagement, The People's Partnership has engaged with a number of hidden and hard to reach communities which included 56 respondents who identified as having sight loss.

Will a formal consultation exercise be undertaken on the Grantham UTC?
Yes. The Healthy Conversation 2019 engagement exercise is providing invaluable feedback and will help to shape any emerging options on our proposed service changes. We will go out to formal consultation to gather further views and no final decision will be made until after this has concluded.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

When will the public consultation around Grantham take place? Why is taking so long?
Before we can start public consultation, capital funding must be secured so that we can be confident we can implement any proposals. As soon as there is any progress, the consultation will be widely publicised and we will inform the public of our next steps.

NHS 111

Is Grantham Hospital given as an option when you call NHS111 for minor conditions?
If you call NHS111 for a minor condition, Grantham Hospital is currently offered to patients as an option if it is the most appropriate place for their treatment.
The Directory of Services profile for the Grantham Minor Injury Unit is a nurse-led profile in operation 7 days a week 18:30 – 23:30. Patients ringing NHS111 within these timeframes with clinically appropriate symptoms for this unit will be directed there.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Is Grantham Hospital available as NHS111 option?

Yes. The Out of Hours service at Grantham Hospital operates between 18.30 to 08:00 Monday to Thursday and from 18:30 on Friday through to 08:00 on Monday. Access is via NHS111 and the Clinical Assessment Service. The service offers telephone advice, face to face consultations (15 minute appointments) or home visits if required. Appointments can be made during the night if necessary although most activity is before 23:00.

Are we going to see any improvements with NHS111?
NHS111 is receiving an increasing number of calls, particularly just for advice or guidance, with CAS fielding 10.5k calls per month across Lincolnshire.

How is NHS111 currently monitored?
We receive monthly reports on the activity, performance and quality in the 111 service and attend formal monthly meetings with our NHS111 provider that are led by the lead commissioner. In addition, ad hoc issues are raised to the lead commissioner and provider as they arise.

How do foreign nationals access NHS111?
In the same way.

How does our CAS performance compare to other regions?
We cannot make direct comparisons between our CAS and other CASs in the country because they operate differently. It is also pertinent to note that all cases reaching CAS have been assessed as being safe to wait for at least 30 minutes, although 22% were still called back within ten minutes.

Around 70% of calls from NHS111 got to CAS and, of those, approximately 70% of those calls have their needs met and treatment provided by CAS.

What is NHS111 and who will answer my call?
The NHS111 service is available 24 hours a day, every day of the year and is intended for urgent but not life-threatening health issues. Depending on the situation the caller will be advised what local service can help; be connected to a nurse, emergency dentist, pharmacist or GP; get a face-to-face appointment booked if required; be told how to get any medicine that may be needed; and get self-care advice. NHS111 can also send an ambulance if needed.

A Health Advisor takes the calls and asks the caller a series of questions to determine what the best service is for their needs. Health Advisors undergo 12 weeks of intensive training to enable them to answer NHS111 calls. Health Advisors are not clinicians and do not make clinical decisions. They follow a nationally agreed and signed off algorithms (NHS Pathways) that determine the clinical need of the patient. In addition to this, the Health Advisors are supported by a range of clinical staff to provide any advice required.

If a patient needs to speak to a local clinician the health advisor will arrange this, or arrange for a clinician to call the patient back in a time frame suitable to the clinical urgency. The Lincolnshire Clinical Assessment Service (CAS) picks up these clinical calls. The Clinical Assessment Service is staffed by Lincolnshire clinicians; GPs, nurses, paramedics, pharmacists. This clinician is able to discuss the patient's health needs, recommend and arrange treatment and/or refer the patient onwards to the most appropriate service within the county. Around 70 per cent of calls from NHS111 go to CAS and, of those, approximately 70 per cent of callers have their needs met and treatment provided by CAS.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

Do NHS111 call handlers know the local area?
The NHS111 call handler is able to see information relating to the caller's location and while they may not be *familiar* with the local area, services pertinent to the caller's condition/query will be visible to the call handler on the Directory of Services (DoS), such as service opening times, appropriateness for the caller's needs and distance from the caller's location. Call handlers are supported by local clinicians via CAS.

What are the waiting times since Clinical Assessment Service (CAS) has been introduced?
The introduction of CAS means that if NHS111 decides the patient needs to talk to a clinician, a Lincolnshire clinician will take that call. The clinician is able to discuss the patient's health needs, recommend and arrange treatment and/or refer the patient onwards to the most appropriate service within the county. CAS exists to get to the right solution quickly – this means no unnecessary travel and waiting time for the patient and no unnecessary use of acute services.

The introduction of CAS has, so far, saved 35,000 visits for patients, therefore saving time and reducing the need to travel. We are still awaiting final statistics but its initial six months has resulted in a saving of over £600,000 for Lincolnshire NHS.

What is being done to encourage the public to call NHS111 to book appointments at an Urgent Treatment Centre day or night, rather than just turning up?
The national winter NHS England / Improvement communications campaign is designed to do exactly that and it is where the majority of the investment for winter is being made this year.

UTCs in Louth and Skegness are being introduced into Lincolnshire in October so not currently 'live' to NHS111 and promoting these services has already started. The main message is to access an UTC, patients should ideally contact NHS111 although there may be the ability to walk in. Patients who are booked in using the NHS111 service will be seen before patients who have walked in, as will patients who may present with more serious conditions. Only clinically appropriate patients will be booked into UTCs. If a patient's situation is very serious, then that patient will be referred or transported to the most appropriate place for treatment.

Calling 111 will ensure patients are directed to the right place for treatment in the first instance, rather than walking in to an UTC and then being transferred elsewhere for the right treatment.

If you are concerned about your health but it is not an emergency, call NHS111 or walk in to the Urgent Treatment Centre. If you are concerned because you are clearly very ill, call 999 and an ambulance will be sent and your condition will be assessed, so that you are taken to the most appropriate place for treatment.

WHAT WOULD HAPPEN IN THE FOLLOWING SCENARIOS IF GRANTHAM BECAME AN URGENT TREATMENT CENTRE?

Suspected heart attack or stroke
If the patient rang NHS 111 and described the symptoms of a potential heart attack or stroke, then an ambulance would be dispatched. The paramedic would assess the symptoms and start treatment in the ambulance, depending on the condition. If the paramedic's assessment indicated a heart attack or a stroke, he / she would liaise with The Lincolnshire Heart Centre/ stroke unit and transport the patient direct to the Heart Centre / stroke unit at Lincoln Hospital to ensure the patient receives the specialist treatment needed. If the paramedic's assessment was that the patient did not require these specialist services e.g. chest pain NOT suggestive of a heart attack- they could be taken to Grantham hospital – see scenario below.

If the 111 call handler was unsure about the patient's symptoms, they can call CAS to talk to a clinician, who will advise about whether the patient needs an ambulance, or should attend the UTC.

If a patient arrived at an Urgent Treatment Centre with a suspected heart attack they would not be turned away. They would immediately be assessed and triaged as a priority while initial stages of treatment – such as blood tests and ECG – took place. If it's evident they were having a heart attack, then the most appropriate care would be to transport them in a blue light ambulance to Lincoln Hospital's Heart Centre where the patient would have the best and most appropriate care, and therefore the best possible outcome. There would be liaison between the UTC, ambulance service and The Heart Centre pre and during transfer of the patient.

Patients arriving with other suspected serious conditions, such as suspected stroke, will be treated in the same way. Staff will be on hand to start treatment until the patient is transported, via blue light ambulance, to the most appropriate place for care e.g the stroke unit at Lincoln County hospital.

Someone collapses and needs resuscitating
If the patient collapses in an UTC, resuscitation and treatment would take place.

If someone in a surrounding village / in the community collapses, the ambulance paramedics would resuscitate and treat them, then take them to the hospital which can provide the best specialist care.

Compound Fractures with compartment syndrome (needing immediate treatment or risk limb amputations)
A compound fracture – where a broken bone has pierced the skin – is a medical emergency and a 999 call would result in patients being transported to Boston or Lincoln hospitals. If someone presented to an UTC with a compound fracture they would be assessed, stabilised then transported to the right place for treatment.

Non-specified chest pain
The appropriate place for treatment depends on the level of severity of the chest pain. A patient who is in low level / moderate pain who presents at the UTC would be assessed / treated accordingly. So, for example, the chest pain is muscular or indigestion, it would be treated in the UTC.

If a patient is in severe pain and has called 999, paramedics would assess if it was felt to be a heart problem and would stabilise and transport the patient if needed to the The Lincolnshire Heart Centre. Similarly, if someone presented to an UTC with severe chest pain they would be assessed, stabilised and where this was felt to require specialist treatment they would then be transported to the right place for treatment.

Breathlessness
The appropriate place for treatment depends on the level of severity of the breathlessness. If the patient is in acute respiratory distress with oxygen saturation <91% on room air 'unless' the patient has significant frailty or known significant chronic lung disease they would be taken to another hospital with more specialist services. We would not expect a patient or their family to make these assessments.

If a patient attends an UTC, staff will be able to treat their symptoms (for example with an inhaler or nebulizer, oxygen).

If a patient's breathing is highly compromised at home, they should dial 999; the paramedics will stabilise and transport to the most suitable place for treatment. Similarly, if someone presented to an UTC with severe breathing problems they would be stabilised then where necessary transported to the right place for treatment.

Acute exacerbation of inflammatory bowel diseases
The appropriate place for treatment depends on the level of severity of the patient's symptoms and whether the patient knows that they have inflammatory bowel disease and is confident to manage their illness.

A patient who has low level / moderate symptoms could ring their GP and / or 111 and talk with a clinician for advice. If advised, they could be booked into an appointment at the UTC for further assessment / treatment. Those who present at the UTC would be assessed / treated accordingly.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

Anaphylaxis

An anaphylactic reaction is a severe and potentially life-threatening reaction to a trigger such as an allergy or bee sting.

If the patient has a reduced conscious level, an ambulance should be called and the paramedic can make a decision about treatment / next steps. If someone already knows that they have an allergy and carries an epipen (medication used in emergencies to treat very serious allergic reactions to insect stings/bites, foods, drugs, or other substances) whose reaction is not improving despite self-medicating, should seek urgent clinical advice via GP, 111, at an UTC or A&E depending on the severity of their condition. In this circumstance, if the patient experiences any reduced conscious level, an ambulance should be called and the paramedic can make a decision about treatment / next steps.

Sepsis

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. A diagnosis can be made in the UTC and a first treatment may be administered. The most appropriate next steps for treatment will be decided by the UTC clinical staff depending on the severity of the illness.

If the patient has a reduced conscious level (not alert) at home, an ambulance should be called and the paramedic can make a decision about treatment / next steps. The paramedic will assess the patient and if the paramedic decides that the symptoms could be severe sepsis they will usually not be taken to an UTC.

Diabetic emergencies

If someone's condition is life threatening then it is crucial that the person gets to the right place at the right time. As with any life threatening situation, a call should be made to 999. If someone presents at an UTC with a diabetic emergency then the clinical team will assess that person and start treatment.

Complications of cancer

The appropriate place for treatment depends on the level of severity of the patient's symptoms and the type of cancer diagnosis that the patient has received.

Some potential complications of cancer and cancer treatment, e.g. chemotherapy, can be anticipated and the patient will already know the plan of care should such symptoms occur, such as directly ringing the cancer ward at Lincoln Hospital and getting clinical advice. Other complications / symptoms will not be anticipated and should be treated as an unexpected illness and depends on the severity of the symptom.

Kidney failure

Acute kidney injury (AKI) is when your kidneys suddenly stop working properly. It can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness. This type of kidney damage is usually seen in older people who are unwell with other conditions and the kidneys are also affected.

The appropriate place for treatment depends on the level of severity of the patient's symptoms.

A patient who has low level / moderate symptoms could ring their GP and / or 111 and talk with a clinician for advice. If advised, they could be booked into an appointment at the UTC for further assessment / treatment. Those who present at the UTC would be assessed / treated accordingly.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

Seizures

If someone's condition is life threatening then it is crucial that the person gets to the right place at the right time. As with any life threatening situation, a call should be made to 999. If someone presents at an UTC with a seizure then the clinical team will assess that person, start treatment and decide whether the person needs to be transported to a more specialist site.

Mental health emergencies

If a patient arrives at an UTC with a mental health emergency, the appropriate place for treatment depends on the level of severity of the patient's symptoms. The UTC staff will liaise with the mental health crisis team and agree a plan of care.

Overdose

The appropriate place for treatment depends on the level of severity of the patient's symptoms.

A patient who has low level / moderate symptoms could go to the UTC for further assessment / treatment. The UTC staff will liaise with A&E consultants on another site for advice if required. They will refer the patient to Mental Health services.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

If the patient has a reduced conscious level (not alert) at home, an ambulance should be called and the paramedic can make a decision about treatment / next steps.

Suicide attempt

An example was given of a young male who cut a vein in his arm and lost a lot of blood. An ambulance was called, his arm was dressed and then transported to Grantham A&E where he received four units of blood. He was then transferred to Boston Hospital for an operation to repair the vein. We were asked in this scenario, what would happen with an UTC?

If Grantham A&E becomes an UTC, the young male would still be attended by paramedics following the 999 call. They would start treatment, e.g. by giving him intravenous fluids and dressing his wound and care for him while they transport him directly to Boston or Lincoln Hospital where he would receive blood and surgical care.

3.2 Grantham travel and transport FAQs

Some people may not be able to afford to travel to other A&Es outside of Grantham – what support can you offer them?
Our preference is to reduce the need for patients to be transported to another hospital by providing care locally when appropriate. We will only ask patients to travel further if they have complex, specialised needs and/or their outcome(s) will be improved by additional travel. We have heard from Lincolnshire's public that they agree with this approach and receiving the right care, first time is their priority, even if that means further travel.

It could be that some need for transport becomes reduced, for example by increasing numbers of virtual consultations such as telephone calls, Skype or online services. We understand that some members of the public want virtual consultations and others prefer face to face, this will be accommodated. For other people, the need for transport can be reduced if we help them to manage their long term conditions better through local community-based care.

If someone's condition is life threatening then it is crucial that the person gets to the right place as fast as possible. As with any life threatening situation, a call should be made to 999. We have worked with EMAS throughout the process to date and continue to do so.

If someone's condition means that they need assistance to travel for health reasons, this is provided through non-emergency patient transport services and will be provided to and between services.

If someone's condition means that they need to travel for health care but they do not have any health reasons for transport, they will not receive non-emergency patient transport. It is then that affordability, convenience and other forms of (non health) transport need to be considered.

Lincolnshire County Council (LCC) has responsibility for statuary Home to School, Adult and Children's Social Care transport and for Public Transport services. The NHS has responsibility for transport if there is a health reason; this does not include affordability and convenience.

Both the NHS and LCC understand how crucial transport is so that patients can access NHS services, therefore we are working closely together on a joint transport strategy to improve public transport and look at other viable options to supplement non-emergency patient travel.

At the Grantham Healthy Conversation workshop on 19 June, the public suggested some ideas to resolve the affordability and convenience issues. This proved a very useful starting point and the following list is a summary of the ideas on which we are now actively working with the LCC;

- Co-ordination of transport budgets, infrastructure and existing transport provision to maximise the value of what's already there
- Digital mechanisms to reward providers of lift-shares (UBER style) - digital payment infrastructure that tracks per mile travelled in a registered car share. Automated payments on a cost-share basis. Rates set by the scheme to avoid profiteering. Scheme provides safeguarding and vetting of participants.
- Vehicle loan schemes e.g. wheels to work. Broaden the scope, capitalise on the added value of these schemes.

- Tackling “The last mile”: Create transport hubs/interchanges; make waiting more social, comfortable or usable time. Integrate transport information and potentially other rural information hubs.
- Goods delivery: identify opportunities for village retailers to provide distinctive offers: align rural services with delivery hubs, e.g. delivery of medicines.
- There are already a variety of local and voluntary transport services which could be utilised, such as Call Connect and Grantham Community Transport, for example. Maximise the opportunities these services offer.
- A bus service that travels between hospital sites for staff, patients and carers.

These are ideas and final ideas will be finalised in the joint transport strategy.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

What is being done / what support is being provided for patients with transport difficulties?

The NHS is responsible for delivering medical and health care services and only has responsibility for transport if there is a health reason; this does not include affordability and convenience. Lincolnshire County Council is responsible for public transport, statutory Home to School, Adult and Children’s Social Care transport. However, while we must spend our funds on health provision, we fully appreciate how crucial transport is so that patients can access NHS services, therefore we are working closely with Lincolnshire County Council on a joint transport strategy to improve public transport and look at other viable options to supplement patient travel. If someone’s condition is life threatening then it is crucial that the person gets to the right place as fast as possible. As with any life threatening situation a call should be made to 999. We have worked with EMAS throughout the process to date and continue to do so.

If someone needs assistance to travel for health reasons, this is provided through non-emergency patient transport services and will be provided to and between services. If someone needs to travel for health care but they do not have any health reasons for transport, they will not receive non-emergency patient transport. It is then that affordability, convenience and other forms of (non-health) transport need to be considered.

Call Connect is a public bus service that operates in response to pre-booked requests. Registration is free but you must be a member to book a journey. You can then use the service for any reason and as frequently as required. The fully accessible minibuses operate from 7am – 7pm, Monday to Friday, and from 7.30am – 6.30pm on Saturdays, with some local variations. In most cases. Call Connect will pick up and set down at designated locations in each village or town. Passengers with a disability or those living in more isolated locations can be picked up and returned to their home address, if it is safe and practical to do so.

You can use Call Connect to travel anywhere within each service’s operating area. You can also use it to connect with the main Interconnect bus service or other bus and train services. Concessionary bus passes are valid on all services.

We are working to a principle of the most regular care requirements remaining close to home, such as routine screens in cancer care for example. It is when care needs become more complex and specialised that further travel is required; we have heard from Lincolnshire’s public that the right care, first time is the priority, even if that means further to travel.

We are also working to a principle of trying to reduce the need for transport, for example by increasing the numbers of virtual consultations such as telephone calls, Skype or online services. We understand that some members of the public want virtual consultations and others prefer face to face, this will be accommodated. For other people, the need for transport can be reduced if we help them to manage their long term conditions better through local community-based care.

Can we share the data collated by HealthWatch Lincolnshire around non-emergency transport? These are worrying figures as the number of people denied access has increased.

Healthwatch received 15 items of patient feedback in relation to all non-emergency transport over the last six months. These are included in Healthwatch monthly reports which are in the public domain and can be accessed via the Healthwatch website: **https://www.healthwatchlincolnshire.co.uk/**

The population is increasing and the public consider that public transport is inadequate. What is being done to improve the access to Lincoln if everything is going there?
We have taken into account the expected growth in population in Grantham town and feel that our emerging option of an UTC would meet this demand.

We are part of the 'One Public Estate' initiative with many partners involved in the development planning around Grantham, and are therefore fully aware of the future potential growth in housing, which has been incorporated into our planning work.

The NHS and Lincolnshire County Council are working together on the single travel and transport strategy, so that we start to address the issues that the public are describing. See above FAQ.

What happens if a patient is taken to an alternative hospital by ambulance and ambulances are queueing outside?
There is a lot of work being undertaken to improve this. Critically ill patients are handed over immediately to the hospital and do not have to sit and wait, as the ambulance is able to contact the hospital so hospital staff are waiting for the patient on arrival.

Patients whose needs are less urgent who are not able to be handed over to the hospital straightaway are constantly monitored and looked after by the ambulance crew while they wait. The most clinically unwell patients are seen first.

Patients taken to hospital by ambulance will not necessarily get priority treatment over someone who has transported themselves to hospital. If a patient is clinically well enough they will be transferred from the ambulance to the waiting room with everyone else.

What is the 'golden hour' and is it achievable?
The golden hour is 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. Some have come to use the term to refer to the core principle of rapid intervention in trauma cases, rather than the narrow meaning of a critical one-hour time period.

The golden hour for stroke services
The golden hour 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 this treatment as it depends on the type of stroke. 15% of all stroke patients can receive this treatment. Out of this 15% of stroke patients that receive thrombolysis, one third will benefit from the treatment (5%). Our clinicians believe their recommendations for stroke services will improve care and outcomes for the overwhelming majority of patients (95%).

There is a 4.5 hour time limit in the national clinical stroke guidance which refers to the time within which we can administer the thrombolysis treatment within the current licence. It 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.

People are concerned about Lincoln Hospital A&E not being able to cope with demand and, as a result, do not want to want to go there instead of Grantham Hospital.
There is no evidence to suggest that Lincoln hospital is unable to cope with the increased number of patients from the Grantham area. Lincoln hospital A&E sees an average of two additional patients per day from Grantham since the overnight closure of Grantham's A&E, against an average of 200 attendances per day - an increase of only one per cent.

Why are we not using the Kingfisher Ward?
We are using the Kingfisher Ward – it is our children's clinic at Grantham hospital, which is used for general paediatric and community paediatric clinics throughout the week. Currently, between 750 and 900 children are seen there per month.

Will Grantham be a Centre of Excellence?
As outlined in the Healthy Conversation 2019, our NHS preferred emerging option is to consolidate most elective care and make Grantham Hospital a 'centre of excellence' for elective short stay and day case orthopaedic and general surgery. The benefits of this emerging option could include:

The benefits of this emerging option could include:

- Far fewer cancelled operations for all in the county
- Better clinical results for patients, lower rates of re-admission, reduced length of hospital stay and reduced risk of infections and injuries
- Improved job satisfaction, morale and productivity for our staff

3.3 Boston stroke services FAQs

Attendees of the workshops in June (and this was raised again at the October workshop)felt that travel times to Lincoln Hospital, especially for those living on the coast, are a concern.

Our clinicians tell us that the best outcome for critically ill patients comes from being in the right place first time, where the right service can be provided as quickly as possible.

While this may mean patients are not treated at the hospital closest to them, it means they will be taken directly to a hospital which can give them the immediate treatment they require; therefore giving them the best possible chance of a positive outcome. Arriving at a hospital which is not equipped to treat them can waste critical time. The extra travel time getting to the right place far outweighs the risk of delayed treatment.

Historically, patients would be taken to the nearest hospital but we now know that getting to specialist care results in better outcomes. An example of this is major trauma - we don't have specialist major trauma centres in Lincolnshire and patients have had better outcomes by traveling to Nottingham, where their care is delivered by a specialist trauma team who look after larger numbers of patients and have the expertise and skills to deliver this care. This is the same for hyper acute stroke care.

The preferred option for stroke services - a fully staffed single multi-disciplinary team on the Lincoln site - will improve the outcomes of all patients who are cared for in the stroke unit. Even if patients have to travel further, outcomes and recovery will be greatly improved.

It's about getting to the right place as quickly as possible - even if that means going past a more local hospital to get to specialist care.

When will the joint conveyances start to happen?

In terms of JACP (Joint Ambulance Conveyance Project), EMAS has a partnership with Lincolnshire Fire Service and LIVES, and Lincolnshire Fire provide a co-responder response to emergency calls in a fire ambulance, staffed by LIVES trained fire responders. If the EMAS response to that incident is a car and not an ambulance, it gives the option of transport without waiting for an EMAS ambulance with the paramedic travelling in the fire ambulance. They do not transport patients without EMAS presence.

ADDITIONAL QUESTIONS FROM 10th OCTOBER WORKSHOP

Why not centralise stroke services in Boston? If the heart centre is also moved to Boston, the heart, stroke and vascular services would all be together

The over-riding, influential factor is staffing – it is easier to recruit to Lincoln, than it is to Boston, therefore the current and the future stability of the service will be protected if we specialize in Lincoln. We also know it is very difficult to recruit doctors to Boston for stroke services.

Co-location of services is very important, but we already have an established and highly successful heart centre in Lincoln. The cost of transferring estates is high and potentially unachievable and very risky, as is the cost and likelihood of successfully transferring all staff of this service.

More patients would be displaced if the centre was moved from Lincoln. There has been lots of analysis undertaken – there would be greater displacement across the county if located in Boston than in Lincoln. Lincoln is a better solution for more of Lincolnshire's population.

Can clarification be given as to when treatment starts, as the time taken for patients to begin receiving treatment after a stroke is critical?
There is a 4.5 hour time limit in the national stroke clinical guidance which refers to the time within which we can administer the thrombolysis treatment within the current drug licence. It 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.

Sometimes the 'golden hour' is talked about in relationship to stroke services. This 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 this treatment as it depends on the type of stroke. 15% of all stroke patients can receive this treatment. Out of this 15% of stroke patients that receive thrombolysis, one third will benefit from the treatment (5%). Our clinicians believe their recommendations (preferred option) for stroke services will improve care and outcomes for the overwhelming majority of patients (95%).

Obesity, hypertension or cardiovascular disease, for example, all need to be addressed as part of the STPs approach to stroke and stroke care, what is being done about prevention services?

Lincolnshire County Council has protected and invested in primary preventative services when other areas have been reducing them. The Lincolnshire system is taking a life-course approach, supporting children to have the best start in life and providing parenting support to families in the early years, and focusing on diet, physical activity and mental health support for school age children.
In addition, we have recently commissioned a new integrated lifestyle service, 'One You Lincolnshire', which comprises smoking, alcohol and a tier 2 weight management service. This is targeted at the population with chronic disease, such as hypertension and/or type 2 diabetes.

Attendees of the workshops had concerns about staffing.
There are currently only two substantive consultants in post across Lincoln and Pilgrim Hospitals compared to national guidelines which recommend eight full time posts.

Staffing issues are not about money; in fact more is being spent at the moment through the need to have locums and agency staff. It is recognised that nationally more consultants are needed, as there are more vacancies than staff. Our preferred option is to treat more patients in a single site which means concentrating our skilled workforce in one place to provide improved care, treating a greater number of patients and more opportunity to develop specialist skills.

Another challenge is that some consultants have retired and a number of staff are getting near retirement age too.

We now have the new medical school at Lincoln University and are hoping that trainee doctors stay in Lincolnshire when they qualify. This is not a quick solution and will have an impact in the coming years. We're working with Visit Lincolnshire and looking at what other organisations, such as Siemens, have done to attract staff; all of the NHS partner organisations are working together to resolve our recruitment issues.

Will EMAS be able to cope with the transfer of stroke patients to Lincoln Hospital?
We recognise that Lincolnshire is a large geographic county and travel times vary across the county, particularly coming to and from the coast. We also know that the best outcome for critically ill patients comes from being in the right place where the right services can be provided and, at times, this means driving past a more local hospital to get to specialist care.

EMAS take on average 60 calls a day in Lincolnshire for category one patients with life threatening conditions and the ambulance aims to get to the patient within seven minutes. EMAS constantly reviews where their ambulances are needed and moves them around the county if needed. EMAS has a range of quick response cars and four wheel drive cars for inclement weather.

We have been working jointly with EMAS on the stroke service options and EMAS can transport the patients.

ADDITIONAL QUESTIONS FROM 10 OCTOBER WORKSHOP

When will EMAS achieve its targets?
EMAS has plans to meet key performance targets in April 2020. Current performance is not meeting the trajectory and it is unlikely that EMAS will be able to meet the April 2020 position. There are a number of reasons for the lower than planned performance including increased demand for ambulance services, hand over delays at hospitals and resources within EMAS. We are continuing to work with EMAS to achieve targets as soon as possible.

EMAS should be held to task for not meeting targets for cat 1 and 2
The trajectory is to hit targets by April 2020 due to an increase in staff completing the correct training. By April next year, EMAS will have enough people with the right skills to help achieve its targets. EMAS has additional cars and responders who can help stroke patients. Additionally, representatives regularly attend the Health Scrutiny Committee.

EMAS funding is inadequate and Simon Stevens should be challenged. There has been millions spent on the TV campaign FAST yet patients are not reached in time as there are not enough ambulances. The £1.25 million received 4 years ago for ambulances is not adequate. Fundamental aspects for stroke need to be in place before looking at changes and conveyances is one of them.
Patients calling EMAS with stroke symptoms are prioritised.

In Lincolnshire we do not have any 4x4 ambulance, this is not acceptable on Lincolnshire roads especially in the winter; there could be a three hour ride due to the weather conditions.
EMAS has a range of quick response cars and four wheel drive cars for inclement weather. We recognise that Lincolnshire is a large geographic county and travel times vary across the county, particularly coming to and from the coast. We also know that the best outcome for critically ill patients comes from being in the right place where the right services can be provided and, at times, this means driving past a more local hospital to get to specialist care. EMAS take on average 60 calls a day in Lincolnshire for category one patients with life threatening conditions and the ambulance aims to get to the patient within seven minutes. EMAS constantly reviews where their ambulances are needed and moves them around the county if needed. We have been working jointly with EMAS on the stroke service options and EMAS can transport the patients.

What about the air ambulance for moving patients?
Although there are some conditions for which this isn't appropriate, the air ambulance can and is regularly used to transfer patients. There is one aircraft available in Lincolnshire but we also get support from neighbouring counties and coast guard search and rescue if necessary under exceptional circumstances. The air ambulance is a 24 hour service but there are limitations to this service due to night time flying regulations.

How are events advertised for people with visual impairment and how are all organisations implementing the Accessible Information Standard?
Since the workshop in June, meetings have been held with several community groups to ensure messages reach all communities in Lincolnshire. These included South Lincolnshire Blind Society and Lincolnshire Sensory Services, to improve our communications with deaf, blind and deaf / blind members of the public. We are now able to utilise existing newsletters and bulletins sent out by both organisations plus Lincolnshire Blind Society has offered to hold focused workshops with blind and visually impaired people to hear their views and opinions. We have also met with Carers First to improve our communications and opportunities for engagement with carers in Lincolnshire. Over the next few months, it is our intention to meet with further organisations to strengthen communications with members of their communities such as groups who support people with disabilities, Black Minority Ethnic groups, travellers, eastern European groups, faith groups and LGBT+ communities etc.

The Clinical Commissioning Groups (CCGs) across Lincolnshire are working with their GP practices to reiterate their responsibilities around the Accessible Information Standard. Information can be found on the CCGs websites. Additionally, all systems at Lincolnshire Partnership Foundation Trust (LPFT) are now AIS compliant. United Lincolnshire Hospitals Trust (ULHT) has, since the AIS was published, been working on a structured approach to implement the standard and continues to undertake further promotion with service users. ULHT will also be undertaking a gap analysis of its own systems to ensure best delivery of the AIS.

Lincolnshire Community Health Service NHS Trust (LCHS) has raised awareness of how to record patients' access needs, and sign-ups in clinics encourage patients to declare any access needs.

3.4 Boston women's and children's services FAQs

There are concerns that paediatric patients are being moved to Lincoln, Peterborough, Kings Lynn and Grimsby Hospitals rather than Boston, resulting in additional travel for families.
The NHS is responsible for delivering medical and health care services and local councils are responsible for public transport. However, we fully appreciate how crucial transport is so that patients can access NHS services and family can visit their loved one. Therefore we are working closely with Lincolnshire County Council on a joint transport strategy to improve public transport and look at other viable options to supplement patient travel. We have worked to a principle of the most regular care requirements remaining close to home, such as routine outpatient appointments for example. It is when care needs become more complex and specialised that we introduce further travel; we have heard from Lincolnshire's public that the right care, first time is the priority, even if that means further travel.

For carers– if there's a transfer from Boston to Lincoln - travel may be an issue. There is support for carers - personal budget that pays for that transport.

At the Grantham Healthy Conversation 2019 workshop on 19 June, the public suggested some ideas to resolve the affordability and convenience issues for travel across Lincolnshire. This proved a very useful starting point and the following list is a summary of the ideas on which we are now actively working with LCC;

- Co-ordination of transport budgets, infrastructure and existing transport provision to maximise the value of what's already there
- Digital mechanisms to reward providers of lift-shares (UBER style) - digital payment infrastructure that tracks per mile travelled in a registered car share. Automated payments on a cost-share basis. Rates set by the scheme to avoid profiteering. Scheme provides safeguarding and vetting of participants.
- Tackling "The last mile": Create transport hubs/interchanges; make waiting more social, comfortable or usable time. Integrate transport information and potentially other rural information hubs.
- There are already a variety of local and voluntary transport services which could be utilised, such as Call Connect and Grantham Community Transport, for example. Maximise the opportunities these services offer.
- A bus service that travels between hospital sites for staff, patients and carers.

These are ideas at this stage and their feasibility is being explored; final options will be incorporated into the joint travel strategy.

ADDITIONAL QUESTIONS FROM 10 OCTOBER WORKSHOP

Why do we have two options if one option is not viable and the NHS preference is for one only?
National guidance suggests that it is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions, if only one option for change is viable this one option can be consulted on. The Healthy Conversation 2019 is about engaging and hearing people's views about both options for women's and children's services. All of the work that has been done since August 2018 is striving to avoid a single site option and the NHS' preferred option is to continue with these services at Pilgrim Hospital.

There is a lack of trust in survey questions – we will only get the answers to the questions we ask – if you ask if people are prepared to travel a bit further for the specialist services, then most people will say yes but if you asked would they prefer having the specialist services in their local hospital then most people would prefer this.
We will not give an option if this isn't viable, for example, if there are not enough specialist staff to provide a local service. We want to be open and honest with the public even when messages are difficult. We always allow a section for people to share their own concerns or comment in order to ensure people do not feel there are any restrictions upon what they want to say.

Back in 2015 – Alan Kitt and Dr Tony Hill stated in the LHAC document that "nothing is going to change until there has been a full consultation" however things are changing under the banner of safety concerns. Changes are being made by stealth.
This statement remains true. We will engage and consult with the public on any significant changes to services. However, it is also our duty to ensure our services are safe and on

occasion urgent changes are needed to maintain the safety of patients / services. Any changes made on this basis are temporary and a full consultation will follow.

How have you taken into account population increases when determining the preferred emerging option?
Yes, we use predicted population growth identified by the County Council.

The STP is supposed to not disadvantage people. In the East coast residents are extremely disadvantaged. There is a lot of deprivation. Everyone seems to be pushed towards Lincoln. Lincolnshire is so big it should have two hospitals which are equally as big. Should be equal on all levels – it must be something to do with finances?
The east coast population does have a high rate of deprivation. The options presented for service reconfigurations were assessed using four criteria, one of which was financial sustainability. However, all four criteria were equally weighted. Our ability to recruit staff to the east coast is the most significant challenge.

Are there enough staff to deliver these services?
Recruitment challenges are a national issue as well as a local one for Lincolnshire and a lot of work is being undertaken to recruit staff at all levels. We are working with many partners in the county in order to ensure Lincolnshire is presented as a thriving and appealing place to live and work.

Our Talent Academy brings together health and care organisations from across the county to help recruitment and skills development for our current and future workforce. The academy's initiatives include visiting schools, organising careers fairs, and developing our apprenticeship programme to inform and encourage careers in health care.

Alongside our colleagues across the health and care sector in the county, we have also established Lincolnshire's Attraction Strategy programme. This group focuses upon promoting the appeal of Lincolnshire as a place to live and work, as well as raising awareness of the career opportunities in the county.

Lincolnshire has developed a model for GP international recruitment that has now been adopted across England, thanks to the success we saw in the county. Central to Lincolnshire's 'grow our own' recruitment initiative, the University of Lincoln's Medical School's first students have started training in September 2019 alongside two other much needed staff groups, paediatric nurses and midwives who have also started in September 2019.

Our recruitment strategy includes increasing the number of Advanced Neonatal Nurse Practitioners in the service and their use across the Trust (there is a role for ANNPs in the SCBU at Boston). We are unlikely to attract trained ANNPs as they are in short supply across the country. The nursing team are therefore looking at getting local nurses onto training courses – final plans are currently in development.

ADDITIONAL QUESTION FROM 10 OCTOBER WORKSHOP

Is recruitment and retention improving? Are staffing vacancies still an issue?
Workforce shortages and a decrease in the number of training places have led to an increase in vacancy figures across the system especially within our acute services. We have a high number of vacancies and shortage of supply locally (and nationally) for registered nursing and midwifery staff, learning disability and other professions such as radiologists, Children's Nurses, Consultants and Middle Grade (SAS/Speciality Doctors). The geographical component is also often overlooked. Sparser and smaller populations, higher employment rates, an older population and relatively fewer younger people pose challenges for recruitment, retention and workforce development in rural areas and down the East Coast of our County especially.

Lincolnshire finds itself competing with employers on our boarders as well as those nationally from a reduced supply and labour pool and therefore success of attraction and retention very much depends upon the "total reward" package offered and the experience felt by candidates which is being addressed through our People Plan objectives particular "to become the employer of choice". Our primary focus is to reduce agency costs through substantive recruitment, attracting the best talent to Lincolnshire with a positive candidate experience and career opportunities. Our acute provider has recently contracted with a Strategic Partner in regard to International Recruitment, whilst the System as a whole implements new ways of working including different employment models, portfolio working, detailed job plans and changes to rotas, introduction of new roles and return to practice to aid the attraction and retention of our workforce. Using the positive relationship with our local University and Medical School as well as those colleges and higher education institutions further afield, we are increasing clinical placements, developing further opportunities with various apprenticeship roles and ensuring that investment supports our current workforce's future skills and competency need.

The NHS should be engaging with schoolchildren at an early age to educate them about careers in the health service. Schools are an untapped opportunity. Aspirations for young people in Lincolnshire are very low and we need to let them know everyone is needed – we need home grown talent. ParentMail is an easy system which reaches a lot of people quickly.
We are working with schools and colleges throughout the county, as well as undertaking work with the Talent Academy, and note the helpful comments around reaching children at an earlier age to 'plant the seed' of a career in the health service.

General questions

Why isn't more being done to increase funding that Lincolnshire receives?
Our executives and non-executives are in regular contact with politicians and central government about funding opportunities and promoting Lincolnshire. We have had some recent successes:

- The Prime Minister recently announced £21m fir ULHT (around one fifth of the money we have requested from NHSE)
- Mental health early implementation funding was also announced in September 2019.
- Funding has been sought, and received to support a range of initiatives from NHSE.
- A number of training initiatives have been funded by Health Education England

- Some of the Trusts have received extra funding from the Provider Sustainability Fund for their performance from NHSE
- The NHS applies for capital monies at every opportunity and has received funding to support with the development of business cases from NHSE digital

The Long Term Plan also refers to extra funding for initiatives such as digitally enabling primary care and outpatient care. We also appreciate efforts by members of the public who encourage their local MPs to lobby for more funding for Lincolnshire.

Why is the Government removing funding from rural pharmacies?
A new funding settlement has been agreed for all pharmacies contractors for the next 5 years. This should enable pharmacies to be able to plan and make any necessary changes. As part of this there is a recognition of rural pharmacies who receive Pharmacy Access Scheme payment. This gives rural pharmacies an additional level of funding.

Further information can be found here:

https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/

https://psnc.org.uk/our-news/contractor-announcement-funding-negotiations-result-in-five-year-cpcf-deal/

Is getting patients back out into the community the best approach? Is the money there to care for patients at home? Is it the best use of resources – especially with shortages of staff? Aren't patients better off in hospitals rather than sending them home?
At first glance it might seem obvious that hospital would be the best place to look after someone, but in fact there is evidence to show that this may not be the case.

Studies suggest that admitting frail older people to hospital can lead to a decline in their physical ability. For all ages, there is also a risk of getting a hospital-acquired infection, which can cause serious complications or even death. And if someone is already receiving regular care at home, sending someone into hospital can interrupt the relationship with their carer and their family. The carer bond can be hard to re-establish.

There are also financial as well as personal costs associated with hospital care. Keeping people in hospital is costly, and people over 85 account for a quarter of all bed days in the NHS. Avoiding this would be better for older people, reduce admission to residential care and keep people living at home longer, and also save money.

How successful is being stabilized by a paramedic?
Paramedics have a highly responsible role, often being the most senior ambulance service health care professional in a range of emergency and non-emergency situations. They are trained to deliver their care in the pre hospital setting and so by doing this are considered experts in their field.

They are highly skilled professionals who assess a patient's condition and make potentially lifesaving decisions. In an emergency they are trained to managed complex situations and use high tech equipment such as defibrillators and intravenous drugs. In essence they provide a mobile emergency clinic and are capable of delivering advanced life support techniques to resuscitate/stabilise

patients using sophisticated procedures, techniques, equipment and drugs. They do all of this autonomously, but do have facilities to speak with other clinicians to support their clinical decision making, for example, speaking with a doctor from a trauma centre.

Paramedics follow guidelines to support them in their role and have the facilities to consult this guidance via an electronic system which they carry with them.

Have we considered the coast in the summer and tourism? How do we factor in the extra number of visitors?
We are very adept at managing and forecasting trajectories for activity increases, for example seasonal swells such as summer or winter tourism. We are kept informed of most events taking place within the county, such as large shows, and have business continuity plans in place to ensure everything is managed well.

Alison Marriott would like to see published the options appraisal information complete with scoring from January 2017.
Options appraisal scoring from February 2018 will be published with the Pre-Consultation Business Case prior to public consultation.

END

THE FOLLOWING QUESTIONS AND ANSWERS HAVE BEEN INCLUDED UPON REQUEST BY ALISON MARRIOTT.

Why is option 2, centralising consultant-led maternity etc. to Lincoln, still in the engagement options? We have been told that it is to ensure that "there is a conversation" and so that "there isn't a done deal". Who decided that this was the case? Who decided that this unacceptable option would be included (high-risk, high-impact on patients and families) and why not a lower-risk option?

Through 2018, Clinicians considered a long list of options and reduced these to a short list of options. It is this short list that we are currently engaging on through Healthy Conversation. National guidance suggests that it is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions, if only one option for change is viable this one option can be consulted on. The Healthy Conversation is about engaging and hearing people's views about both options. All of the work that has been done since August 2018 is striving to avoid a single site option and the NHS's preferred option is to continue with these services at Pilgrim Hospital.

If it is to be a genuine conversation/consultation at the next stage, why are you not putting forward an option to have the inpatient paediatric beds and level 2 neonatal unit (LNU) at Pilgrim instead of Lincoln? As the RCPCH review report said that in some ways Pilgrim should be the site for the LNU as the population needs it. Also as

ULHT have admitted that the larger population of children with the highest needs are in this side of the county? Surely this would be a more genuine conversation if you had more than 2 options (including an option which keeps inpatient children's services at Pilgrim). Especially given that one of the current options is completely unacceptable from a risk point of view (centralisation - option 2) when considered objectively based on all the available research evidence and experience of staff. Sources of evidence can be provided on request.

Through 2018, Clinicians considered a long list of options and reduced these to a short list of options. It is this short list that we are currently engaging on through Healthy Conversation. Their experience continues to be that recruiting staff to Pilgrim Hospital remains difficult. However recent recruitment campaigns have proved more successful when recruiting to paediatric posts on a rotational basis working at both Lincoln and Pilgrim Hospitals.

What sources are you basing your travel times on between Boston and Lincoln, Skegness and Lincoln? Please quote the travel times you are using along with the sources.

The travel time is dependent on the patient's condition and road conditions. We have used the following travel time thresholds for modelling purposes. These are locally agreed thresholds, there are no national travel times guidance.

The three thresholds are 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).

What impact will the national neonatal transformation programme have on Lincolnshire, and in particular Pilgrim neonatal unit? Has any member of staff in Lincolnshire (any of the NHS organisations) actually seen the draft report yet? If so how will it impact on your plans and the proposed options?

The national neonatal report has been drafted and a number of people have had sight of the draft report. Our ULHT Divisional Head of Midwifery and Nursing) is a member of the national working party, and we have ensured that the plans for Lincolnshire are aligned to this as much as possible. The neonatal work programme is an essential part of the Lincolnshire Local Maternity and Neonatal System. The latest information suggests that the national review will not be published, but there will be a focus on delivery. We are actively engaged with the East Midlands Neonatal Network to ensure that we are able to meet the national standards to sustain a full SCBU at PHB.

At the moment we have dedicated ambulances for transferring children from Pilgrim to Lincoln... if the changes are to be made permanent as in option 1, what will you be putting in place regarding transfers? Will there be a dedicated ambulance? Will EMAS be providing extra services ? Especially as moving stroke patients too are in the options...

The additional ambulance service on the Pilgrim site (started in August 2018 to support the interim model) will continue to transfer any patient that does not meet the category 1 classification (an immediate response to life threatening condition). Category 1 patients will be transferred by EMAS via 999 emergency vehicle. For neonatal babies and children being transferred to tertiary units there are specialised retrieval teams, with their own ambulance, who will attend the hospital to move patients.

6. On the SSNAP audits, Pilgrim stroke unit is mainly scored higher than Lincoln, and the figures of patients are often very similar.... so why not centralise the service Pilgrim? What is the specific and detailed rationale for choosing the Lincoln site, including specific details of any co-located dependent services, whether those services previously existed at Pilgrim, if so why were they moved, reduced or closed, what consultation process was followed, and was the potential future impact on other services made clear to the public at the time?

The stroke unit at Pilgrim does get good outcomes, but the medical staffing is fragile with temporary staffing plus one retired consultant who is returning on an annual contract. The intention is to change the stroke model so care after 7 days takes place in the community and this rehabilitation will better meet patients' needs and will reduce the overall number of beds required. The combination of a single unit will make it more attractive to staff, facilitate access to advanced treatments as they evolve, allow patients to recover in the community and make it more cost effective. The treatment that is expected to evolve over the coming years is the Mechanical Thrombectomy Service. This is currently not provided in Lincolnshire. It is anticipated that this service will be co-located with the Cardiac service in future years. The centralisation of the Cardiac Service at Lincoln Hospital has improved mortality over the last 5 years.

Where has this event been publicised? In which other languages and formats? What facilities are you providing at the venue to allow disabled people to participate equally and information in a range of formats so that everyone can understand? Please list specifically what you are doing/providing so that residents with protected characteristics can participate fully and on an informed basis.

The workshops are publicised extensively through the following media channels: local newspapers/magazines, local radio, social media, websites, e-shots to stakeholder groups and through relevant third parties. As this event was open to all and was not invite only, we could not guarantee that people with protected characteristics would attend but ensured a wide reach with our communications so the opportunity was there.

In addition, these workshops are only one part of the much bigger programme of engagement we are undertaking and understand that events like this are not the best way for some people to engage with us. Therefore, we offer a variety of ways for people to tell us their views if they don't want to or are unable to come along to a workshop, for example our paper and online surveys which are also available in different languages, paper and online feedback forms, meeting us when we're out and about in town centres and supermarkets, and people can phone, email or write to us. This is just the first part of our engagement and we will continue with many more extensive engagement and consultation opportunities as we move into the formal public consultation.

The purpose of these workshops was a 'deep dive' into the particular themes which emerged from the wave 1 engagement events and therefore smaller, more detailed group discussions was an appropriate way to achieve this. We are also mindful that our clinical staffs' time is extremely valuable and we are grateful that they were able to sit around tables and have a conversation with our patients and the public which would not have been possible with larger scale events .

Further details of our proactive engagement with groups with protected characteristics will be made publically availability on completion and we will share this with you. As reported in the Health Scrutiny Committee, we are working with People's Partnership, an independent partner to ensure proactive engagement with people with protected characteristics.

The People's Partnership is made up of a Leadership Team who represent major areas of disability and some areas of the protected characteristics. In addition to the Leadership Team, they have individual members, members of groups and communities, and members who support the hidden and hard to reach communities.

The current members of the Leadership Team are:

- *Age UK Lincoln & South Lincolnshire*
- *CarersFIRST*
- *Children's Links*
- *Every-One (contributes and facilitates the organisation of the People's Partnership)*
- *Linkage Community Trust*
- *Links Lighthouse*
- *South Lincolnshire Blind Society*

As part of the engagement, The People's Partnership have engaged with a number of hidden and hard to reach communities which included 56 respondents who identified as having sight loss.

Funding - what are you doing to ensure that Lincolnshire gets its fair share of funding and are you getting the support you need politically? For example, this report from the Nuffield foundation and NCRHC (based in Lincoln) suggests that we are underfunded. So this is not just driven by safety, is it? https://www.nuffieldtrust.org.uk/research/rural-health-care

We are aware of this report having contributed to its development and we understand that the NCRHC are taking this forward nationally. With the current national methodology on funding allocation, we are receiving our 'fair share' so any national review is welcomed.

A set of four criteria were developed for the purpose of assessing any future options and proposals, namely: 'quality of care', 'access to care, 'affordability' and 'deliverability'. Safety

is part of quality and funding is part of affordability. These four criteria are considered as equal and not weighted.

What are the exclusion protocol for ambulances and GP's, i.e not taking or sending babies, children and pregnant women to the Pilgrim at the moment? What were they before the August 2018 changes? What will they be under the proposals? (by each option). For example, will all pregnant women under 37 weeks experiencing any problem be told to go to Lincoln (or taken by ambulance) under option 2?

Today, babies born pre 29-weeks and children under five who require surgery are all treated out of county. Some of these patients will require planned care, other patients will receive initial treatment in county and be transported to tertiary services as their care needs require specialist support. This will continue in the future.

There are no exclusion protocols for ambulances and GPs taking babies, children or pregnant women to Pilgrim Hospital now nor before August 2018. There will no exclusion criteria for option 1 in the proposals.

For option 2, there would be no neonatal service or consultant obstetric service at Pilgrim Hospital. This means that if the lady is planned to have a consultant led birth, they will attend Lincoln Hospital or a hospital outside of the county for treatment / the birth. Pregnant women can still attend Pilgrim Hospital, would be treated and transferred with their baby if necessary.

We were informed by ULHT on 18th June that the reason for including Women & Children's option 2 in the Healthy Conversation engagement documents was due to advice from NHS England that these two options were necessary for valid public consultation.

We believe the event you refer to was the Paediatric Engagement Event held at Pilgrim Hospital, United Lincolnshire Hospitals Trust (ULHT) on 18th.

NHS England (NHSE) does not give instructions on the number of options to consult on. NHSE's approach is to issue guidance and promote the use of 'best practice'.

It is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions if only one option for change was viable this one option can be consulted on.

Please note there are other Acute Services Review services too where we have included a second option, which is theoretically deliverable, even though we have been clear that it is not our NHS preferred option.

Please would you provide a copy of the advice from NHS England, or from any other source if it wasn't NHS England.

We are currently engaging on our options and are using the NHSE guidance available at

https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/