OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

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Open Correspondence

12 June 2020

Dear Gareth and Caroline

Proposed New Temporary Measures at Grantham and District Hospital

Thank you for your letter dated 9th June 2020 regarding the above matter.

Firstly, can I thank you both for your time on Monday 8th June when we had the brief opportunity to discuss ULHT's response to COVID as we move further into the restore phase and, in the near future, the recovery phase. This was a 'heads up' discussion that I arranged to advise you of the imminent publication of our Board paper about temporary changes to our services. The Board accepted the temporary service changes in the paper, at a meeting held in public via MS teams, on Thursday 11th June.

As we know, COVID is expected to remain within our population for some considerable time, with a second wave of cases possible in the future. The plan we have shared with you addresses both this and our need to increase the level of essential non-COVID services. As a result, it affects all of our hospital sites, meaning that staff, patients and the public will need to adapt to a new way of working or accessing services.

As an organisation, we must now act to balance our ability to manage COVID patients and non-COVID patients, including some of the most vulnerable patients such as cancer and clinically urgent patients. Due to our need to adhere to strict infection prevention and control requirements, including patient segregation, hand and surface hygiene, PPE and social distancing, our hospital sites have become more complex and complicated to manage. Associated with this, we have a fluctuating workforce due to normal sickness but also for additional COVID-related reasons. We therefore have a mix of reduced capacity and reduced workforce, with a growing list of elective care patients who have been waiting unacceptable periods of time for their treatment. This excessive waiting is driven partly by our reduced capacity but also by patients being apprehensive about accessing care due to the perceived risk of contracting COVID in hospitals. This waiting is having a detrimental impact on some patient outcomes and/or an individual's health and wellbeing. A recent survey by Healthwatch Lincolnshire demonstrates that the population of Lincolnshire are nervous about accessing healthcare. Just continuing as we are is not therefore an option.

Through our deliberations, we have reviewed, with our senior clinical colleagues, all available options as outlined within the Trust Board paper. This paper is available on our website. The options appraisal identified a 'green' site approach as the preferred way forward, and Grantham as the only possible location for such a site, using the criteria that we had set. These criteria were based around national guidance. Taking this approach and organising ourselves in a different way would enable us to treat a significant number of Lincolnshire patients, 17,000 more, than if we did nothing. On top of that, circa. 15 additional cancer patients and 35 elective patients are added to our waiting list without a plan to provide treatment each week. Unfortunately we are not in a position to expand our green pathways at Lincoln and Pilgrim to deliver this level of required activity due to the aforementioned constraints.

In order to achieve the green site status, we would need to know the COVID status of our staff and patients who work or attend this site. Unfortunately, the nature of emergency care means that we do not know the COVID status of the patients that we are seeing, and therefore admitting emergency patients to the hospital would compromise the green site status. Hence the requirement to cease medical admissions and make the move to temporarily change the A&E to an Urgent Treatment Centre (UTC) with no admissions. In addition, we do not have the level of diagnostics at Grantham to support separate blue and green diagnostic pathways or have them situated in such a way as to enable segregation of the different patient and staff groups. As a result we would not be able to support an A&E service with medical admissions.

The level of available diagnostics which can be ring fenced within the current A&E footprint would be able to support an Urgent Treatment Centre, which would provide the widest possible clinical intervention possible without it being deemed an A&E. The Board paper provides details of the level of clinical intervention that would be available within an Urgent Treatment Centre, which does include the conveyance of ambulance patients within an agreed set of clinical criteria. In order to support as many patients locally within this model, there will also be a continuation of a consultant-delivered same day emergency care service. This will reduce the number of patients who would need to attend alternative sites. These services will be provided from a self-contained unit that can be isolated from the remainder of the hospital site. Under this model, non-elective admissions would be transferred to the next most local hospital to a patient, which depending on where they live could be Lincoln, Pilgrim, Peterborough or Nottingham.

As mentioned previously, it would not be possible to run a hybrid site at Grantham with blue and green pathways in a way which would enable us to deliver the level of required access for Lincolnshire patients. There is not a physical way to re-introduce increased outpatient, diagnostic, daycase and elective operating in a safe and segregated way on the Grantham site, if there were also unplanned medical admissions. Nor would continuing with four sites with blue and green pathways address the public's obvious concerns about safely accessing healthcare. Not taking the action we have proposed, would result in continued increases in the number of patients waiting for cancer and clinically urgent elective care, resulting in growing waiting lists and waiting times. We must also remind ourselves that protecting our patients when reintroducing more operating is paramount, because the evidence indicates a significantly higher mortality rate if patients' contract COVID post-operatively.

In terms of how the Grantham site would be used through the restore and later the recovery phase, we are suggesting that it completes all cancer and clinically urgent operating for the whole of Lincolnshire. When possible, we will also look to re-introduce more routine work. Our modelling suggests that this would utilise up to 48 beds in the restore phase and up to 67 in the recovery phase. Further work to understand this in more detail is underway. As part of the plans we are also looking to establish a green site 15 bedded rehabilitation model, whereby we would move inpatients back to Grantham if their COVID status is negative, they require ongoing rehabilitation and it is closer to their home. Of the baseline 96 General and Acute beds we had

available at Grantham pre-COVID, this would in total utilise c.82 beds. This means that the bed occupancy at Grantham would be at pre-COVID levels, albeit with a different patient cohort.

As part of our plans we will, as we have throughout our response to this pandemic, support our staff in terms of the implications for them of what is proposed. There will be no job losses as a consequence of these proposals. Moreover we have committed to ensuring they are not financially disadvantaged, that all staff have the required skills to care for our patients in whatever new role they are asked to undertake, and we are offering enhanced support to those within a clinical setting. For staff who are asked to work across different sites, we will discuss any impacts that this may have on their work-life balance. We already have many staff redeployed to alternative sites and we have adapted their working hours, provided transport and met any additional travel costs. We are committed to doing the same for any Grantham staff who are temporarily redeployed.

Based on the best available guidance at the time of writing, we understand the restore and then recovery phase will last until the 31st March 2021. We are also aware of the assumption that COVID will remain within our communities for some time. Therefore, to give some indication of the duration of our current plan, we have suggested that these measures will remain in place until 31st March 2021. We will of course review this should national guidance or circumstances change, and we would amend the date accordingly. This may mean ending these temporary service changes earlier than we anticipated. This plan will remain under review through daily and weekly internal review processes, reporting formally through our committee and Board structures. The Board will want a monthly update on the progress with the changes and the impact they are having. This will be done in the Board meetings held in public session.

I note that you make reference to the write-off of our historic debt, which was very welcome. However, this is not new money that is available to spend and it does not relate to our response to COVID. The write-off means that we do not have to pay interest on loans, but we are liable to pay public dividend capital charges. We benefit to the tune of circa £2m to £3m per annum overall. We have been able to access additional national funds to support our response to COVID. However, our temporary service changes are not based on financial considerations, as our Board paper outlines.

We believe our temporary service changes represent the best available option to enable us to both restore public confidence in being able to safely access NHS services, and in helping us to tackle the growing waiting lists. Both aims are part of national policy. Indeed, I have been involved in a number of discussions with my NHSE/I colleagues in the Midlands during which they have quite rightly been seeking assurances about the percentage of essential services that we will have back up and running by the 15th June. As a result of our plans, which affect all of our hospital sites, 17,000 patients will receive more timely care across Lincolnshire.

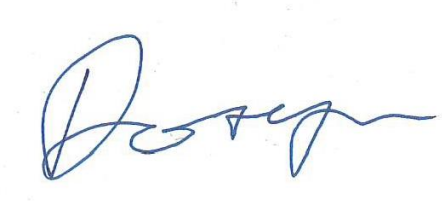
I hope I have been able to provide the additional information that you have requested and that this helps explain our rationale for the actions we are taking.

On a related point, I note Caroline that you have expressed concerns on your public Facebook page about our alleged lack of briefing of our staff on this matter. I cannot agree with your comments. Ahead of the public announcement on Monday, we carried out face to face staff briefings at Grantham Hospital as well as sending out messaging to all staff using all of our internal communications channels. I was at the hospital on that day, so I saw the briefings taking place and I heard staff talking about the messages they had received. I know that some staff posted messages on social media both during and immediately after their own briefing, despite knowing that other staff were still being briefed. This is very unhelpful and inappropriate. I know that many staff were very unhappy at their colleagues' behaviour, as they raised it with me later that day when we did one of our regular online Executive Leadership Team Live sessions with staff.

As I mentioned on Monday, I would be happy to have a follow-up MS Teams discussion with you both. I would be accompanied by senior clinical and operational colleagues in order to aid the discussion. Please let me know if you would like such a discussion.

Kind regards

Yours sincerely



Andrew Morgan
Chief Executive