Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 February 2022**
Subject:	**Supplementary Chairman's Announcements**

1. Care Quality Commission Report on United Lincolnshire Hospitals NHS Trust

On 8 February 2022, the Care Quality Commission (CQC) published an inspection report on United Lincolnshire Hospitals NHS Trust (ULHT). The inspection report, which has been emailed to members of the Health Scrutiny Committee, focuses on urgent and emergency services; maternity services; medical care (including care for older people); and children and young people services, provided at both Pilgrim Hospital Boston, and Lincoln County Hospital.

The CQC has welcomed the widespread improvements at ULHT, following inspections during October 2021. As a result, the overall trust rating has remained 'requires improvement'. The trust ratings for being effective and well-led have improved from 'requires improvement' to 'good'.

The ratings for medical care and children's and young people's services at Lincoln County Hospital improved from 'requires improvement' to 'good'; and children's and young people's services at Pilgrim Hospital improved from 'inadequate' to 'good'. Urgent and emergency services, previously rated as 'inadequate', are now rated as 'requires improvement' and maternity services at Pilgrim Hospital went up from 'requires improvement' to 'good'.

While the CQC acknowledged widespread improvements, it still recorded some concerns regarding access and flow in the urgent and emergency department at Lincoln County Hospital. People continued to experience delays in accessing the service and receiving care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were still below national standards. The CQC's full report is available at: United Lincolnshire Hospitals NHS Trust (cqc.org.uk)

The Committee may wish to consider the inclusion of a report from ULHT on its progress with its action plan in response to the CQC at a forthcoming meeting.

2. Covid-19 Update

A report is attached at Appendix A, which is based on the weekly briefing prepared by Lincolnshire County Council Public Health.

Also included in this report are the main points from a stakeholder toolkit issued by the NHS following the advice from the Joint Committee on Vaccination and Immunisation that five to eleven year olds, either in a clinical risk group or in a household of someone of any age who is immunosuppressed should be offered two 10 microgram doses of the Covid-19 vaccine.

3. Joining up Care for People, Places and Populations, the Government's Proposals for Health and Care Integration

On 9 February 2022, the Government published its 'integration' white paper under the title: *Joining up Care for People, Places and Populations, the Government's Proposals for Health and Care Integration*. The white paper's executive summary is attached as Appendix B.

4. Intermediate Minor Oral Surgery – Response from NHS England (Midlands)

Consultation by NHS England Midlands

On 15 December 2021, I was authorised by the Committee to respond to the consultation, which was being undertaken by NHS England and NHS Improvement (Midlands) on the future arrangements for Intermediate Minor Oral Surgery.

Intermediate Minor Oral Surgery is currently provided at five locations in Lincolnshire (Lincoln, Boston, Gainsborough, Grantham and Skegness). Given the rural nature of the county, I outlined the Committee's view that the service should at the very least continue in these five locations, and consideration should be given by NHS England and NHS Improvement to extending the provision to other locations in Lincolnshire.

I thus opposed the NHS's plans for reducing the number of locations in Lincolnshire from five to three (Lincoln, Skegness and Spalding), on the basis that this would represent a loss of this service for Boston, Gainsborough and Grantham, but would create a perception that there is no commitment to NHS dental services in Lincolnshire, at a time when access to an NHS dentist for general treatment in part of the county is difficult.

I also challenged some of the accessibility arguments put forward in the consultation document, which relied on the three proposed locations having a 'main' railway station. Whilst this would apply to Lincoln, it would not be satisfactory for Skegness and Spalding, where rail services are less frequent. This meant that the proposals were not in line with NHS England's own objective of reducing 'inequalities in access' and concluded that the stated benefit of improved accessibility by car, train or bus would be a benefit at all.

Response from NHS England (Midlands)

On 10 February 2022, I received a response from NHS England and NHS Improvement – Midlands, which is set out at Appendix C to these notes.

4. NHS Support for Victims of Sexual Assault

As part of a national campaign, NHS England and NHS Improvement (Midlands) has highlighted the specialist support available at sexual assault referral centres. These centres offer confidential specialist, practical, medical and emotional support to anyone who has been raped, sexually assaulted, or abused - regardless of when the incident happened. Lincolnshire's centre is located at Spring Lodge, Lincoln.

This campaign has followed a survey which found that two in five people are not sure or do not know where to get help after being sexually assaulted, with 72% unaware there are specialist sexual assault services who can offer confidential support. More than half of people who have experienced sexual assault also say they did not seek help afterwards.

NHS England has announced a £20million of additional national funding for sexual assault and domestic violence services over the next three years, including enhanced support services for victims and survivors of sexual assault and abuse who have complex, trauma-related mental health needs.

APPENDIX A

COVID-19 BRIEFING – 14 FEBRUARY 2022

1. LATEST DATA

Tests (updated: 13 February 2022)

	Total Tests Carried Out	Total Positive Tests	% Positive Tests	Positive Cases	Rate of Positive Cases per 100,000 Population	Positive Cases (last update)	Rate of Positive Cases per 100,000 Population (last update)
Lincolnshire	**98,386**	**6,805**	**6.9%**	**4,296**	**560.6**	**6,904**	**900.9**
Boston	7,628	699	9.2%	461	650.8	617	871.0
East Lindsey	17,256	983	5.7%	635	447.1	1060	746.3
Lincoln	11,076	769	6.9%	476	475.8	863	862.6
North Kesteven	17,437	1,098	6.3%	670	567.1	1030	871.8
South Holland	12,073	1,057	8.8%	664	692.7	1009	1052.6
South Kesteven	20,722	1,423	6.9%	877	612.3	1527	1066.2
West Lindsey	12,194	776	6.4%	513	533.3	798	829.6

The data in the table above are a rolling seven day summary of Pillar 1 and Pillar 2 Tests. Data have been extracted from Public Health England daily line lists, which provide data on laboratory confirmed cases and tests captured through their Second Generation Surveillance System (SGSS). The rates shown are crude rates per 100,000 resident population.

Cases (updated: 13 February 2022)

	Cases in the Last Seven Days (5 Feb - 11 Feb)	Cases to Date
Lincolnshire	**4,296**	**186,580**
Boston	461	17,554
East Lindsey	635	30,223
Lincoln	476	27,874
North Kesteven	670	28,508
South Holland	664	22,549
South Kesteven	877	36,348
West Lindsey	513	23,524

Data on cases are sourced from Second Generation Surveillance System (SGSS). This is PHE's surveillance system for laboratory confirmed cases. Lab confirmed positive cases of COVID-19 confirmed in the last 24 hours are reported daily by NHS and PHE diagnostic laboratories. This is the most accurate and up to date version of data and as such it will not align with the data that is published nationally due to delays in reporting.

Deaths (updated: 13 February 2022)

Area	Total deaths reported On 12 Feb 2022	Total deaths in the last 7 days (6 Feb 2022 – 12 Feb 2022)
Lincolnshire	**1,987**	**10**
Boston	215	2
East Lindsey	481	5
Lincoln	239	1
North Kesteven	260	0
South Holland	245	2
South Kesteven	319	0
West Lindsey	228	0

Total number of deaths since the start of the pandemic of people who have had a positive test result for Covid-19 and died within 28 days of the first positive test. The actual cause of death may not be Covid-19 in all cases. People who died from Covid-19 but had not tested positive are not included and people who died from Covid-19 more than 28 days after their first positive test are not included. Data on Covid-19 associated deaths in England are produced by Public Health England from multiple sources linked to confirmed case data. Deaths newly reported each day cover the 24 hours up to 5pm on the previous day. As of 31 August 2020, the methodology for counting Covid-19 deaths was amended and, as such, the total number of Covid-19 related deaths was reduced.

Vaccinations in Lincolnshire – Period Covered 8 December 2020 – 6 February 2022
(Published: 10 February 2022)

Total number of vaccines given in Lincolnshire up to 6 February was 1,667,211

Age Group	First Dose	Second Dose	Booster or Third Dose	% who have had at least one dose	% who have had two doses	% who have had a booster or third dose
12 - 15	22,719	9,220	1,271	68.7%	27.9%	
16 -17	12,663	9,570		82.0%	61.9%	
18 - 24	49,596	45,971	27,159	83.0%	76.9%	45.5%
25 - 29	35,184	32,701	20,237	84.4%	78.4%	48.5%
30 - 34	38,151	35,850	23,926	88.0%	82.7%	55.2%
35 – 39	37,792	36,207	26,677	88.7%	85.0%	62.6%
40 – 44	37,781	36,602	29,156	93.4%	90.5%	72.1%
45 – 49	42,027	41,096	35,015	88.8%	86.8%	74.0%
50 – 54	52,285	51,466	46,142	97.1%	95.6%	85.7%
55 – 59	55,526	54,895	50,551	97.5%	96.4%	88.8%
60 – 64	50,484	50,001	46,969	99.4%	98.5%	92.5%
65 – 69	45,351	45,016	43,398	95.2%	94.5%	91.1%
70 – 74	48,112	47,836	46,628	94.7%	94.1%	91.7%
75 – 79	37,442	37,284	36,512	100%*	100%*	99.8%
Over 80	44,748	44,561	43,478	94.8%	94.4%	92.1%

The number of people who have been vaccinated for Covid-19 split by age group published by NHS England and NHS Improvement. All figures are presented by date of vaccination as recorded on the National Immunisation Management Service (NIMS) database. *100% signifies that the number who have received their first dose exceeds the latest official estimates of the population from the ONS for this group.

2. DEVELOPMENTS OVER THE PAST WEEK

- In the last 7 days, 95.4% of cases in Lincolnshire that were genome sequenced were the omicron variant, 1.8% were the VUI-22JAN-01 variant and 2.7% were undetermined.

- As of 7:00 am, 14 February 2022, the United Lincolnshire Hospital Trust had 53 PCR confirmed cases of Covid-19. In the last 7 days, there has been a daily average of 4 unvaccinated patients, 2 patients who had received one vaccine, 12 patients who had received two vaccines and 34 patients who had received three or more vaccines.

- Eligible, fully vaccinated individuals travelling to the UK are now not required to undertake any tests upon arrival and only a simplified passenger locater form is needed. Arrivals who do not qualify as fully vaccinated must take a pre-departure test and a PCR test on or before day 2 of arriving in the UK.

- Young people aged 12 to 15 in England can now display vaccination status or proof of prior infection for outbound travel with the NHS Covid pass.

- The UK has uploaded more than 2 million SARS-CoV-2 genome sequences to the Global Initiative on Sharing Avian Influenza Data (GISAID) database. This database facilitates rapid sharing of sequenced data to inform the global pandemic response.

3. DEVELOPMENTS EXPECTED IN THE COMING WEEK(S)

- Restrictions in England are due to expire on 24 March but may be abolished sooner if current data trends continue.

- The government's strategy for living with Covid is expected to be released following parliamentary recess later this month.

February 2022

Covid-19 Vaccination for at Risk 5 to 11-year-olds – Stakeholder Toolkit

---

Background

The Joint Committee on Vaccination and Immunisation (JCVI) has advised that 5 to 11-year-olds who are either in a clinical risk group or are a household contact of someone of any age who is immunosuppressed should be offered two 10 micrograms doses of the Covid-19 vaccine, with a minimum interval of eight weeks between doses. This means around half a million children will soon be invited to take up their vaccination.

The JCVI has set out criteria for determining who should be offered vaccination within this group and clinicians will be responsible for identifying children in their care who are eligible. Parents will need to give consent for their child to be vaccinated. Information on eligibility can be found in the Green Book, chapter 14a, which is published by the UK Health Security Agency (UKHSA). See the section on children aged 5-11 years and tables 3 and 4.

How will I know if my child is eligible?

GPs and hospital specialists have been asked to identify 5 to 11-year-olds who are eligible for Covid-19 vaccination. For children eligible as a household contact, the person who is immunosuppressed will be written to directly. Parents and guardians will be notified if their child should get the vaccine and told how they can book an appointment. The NHS will be in touch with parents in the coming weeks if their child is eligible, so please wait to hear and do not contact your GP practice.

Where will children be given their vaccine?

Vaccination services have been asked to make preparations to vaccinate this cohort and consider necessary reasonable adjustments to accommodate their needs on an individual basis, to ensure children and their families have a positive experience. It is expected that most children will be vaccinated at a site run by local GPs, a hospital or a specialist children's centre. In cases where this isn't possible, local arrangements will be in place with community pharmacies, vaccination centres, hospital hubs, housebound teams and in some cases at special schools.

Parents or guardians will also be able to take their child to a walk-in appointment, however it's important to be aware that not every site will be able to offer vaccination for this group, so please use our online walk-in site finder (www.nhs.uk/vaccine-walk-in) to make sure you choose the right site. If this is the preferred option, when attending the appointment, you will need to remember to take the letter from your child's GP or hospital consultant confirming their eligibility for the vaccine.

Parents cannot currently book their child's vaccination appointment by calling 119 or on the NHS website.

Q&A

What are the eligibility criteria for the clinical risk group for 5 to 11-year-olds?

A clinician will determine whether or not a child within this age group should be offered Covid-19 vaccination. Children considered at higher risk of severe Covid-19 include those who have:

- chronic respiratory disease
- chronic heart conditions
- chronic conditions of the kidney, liver or digestive system
- chronic neurological disease
- severe, profound or multiple learning disabilities, Down's syndrome or are on the learning disability register
- endocrine disorders
- a weakened immune system due to a treatment (such as steroid medicine, biological therapy, chemotherapy or radiotherapy)
- asplenia or dysfunction of the spleen
- serious genetic irregularities that affect a number of systems, including mitochondrial disease and chromosomal abnormalities

A full list of the eligibility criteria is available in table 4 of the Green Book, chapter 14a.

What are the eligibility criteria for 5 to 11-year-olds classed as a household contact of someone who is immunosuppressed?
Children aged 5 to 11 years who are expected to share living accommodation on most days with individuals of any age who are immunosuppressed will be entitled to Covid-19 vaccination.

Will vaccination staff be offered special training?
All staff involved in vaccinating 5 to 11-year-olds will have appropriate training specific to communicating with and vaccinating this age group. For staff vaccinating children with special educational needs and disabilities, all clinical staff are required to have the skill and competences to care for this group of patients.

Will vaccination appointments be available at flexible times to fit around families' work and school commitments?
Vaccination sites should ensure a range of times are available which are convenient to parents and children.

Can vaccination be provided with a nasal spray like with flu?
No, the Covid-19 vaccine is currently only available as an injection.

What happens if my local GP has opted out of giving vaccines to this age group?
GPs who aren't providing vaccinations to this age group have been asked to identify all eligible patients on their lists and ensure they receive an invitation for vaccination at another local site.

APPENDIX B

JOINING UP CARE FOR PEOPLE, PLACES AND POPULATIONS
THE GOVERNMENT'S PROPOSALS FOR HEALTH AND CARE INTEGRATION

EXECUTIVE SUMMARY FROM THE WHITE PAPER

The NHS and local government have delivered remarkable things for the public, in the most challenging circumstances, over the last 18 months. From the extraordinary success of the vaccine programme, to meeting the needs of people previously identified as Clinically Extremely Vulnerable and many other examples of reshaping services to continue to deliver care safely. There is a lot for local government and the NHS to be proud of and to learn from as we move into recovery from Covid-19. Through multi-agency community hubs, integrated neighbourhood teams, and other locally developed arrangements, local partners developed a shared understanding of local needs and made flexible use of resources across services to ensure that people got the support they needed. A vast range of other activity has been jointly delivered by various organisations thanks to a combined commitment to go beyond normal organisational boundaries and do whatever has been required to support their local residents. The resilience, commitment to finding a way through for citizens, and the willingness to innovate will all be just as important as we tackle the challenges ahead.

Among the lessons of the pandemic is the need to do more to bring the resources and skills of both the NHS and local government together to better serve the public. So, as well as record investment, NHS and local government reform will be needed to recover from the pandemic and deliver on the government's priorities, including on its central mission to level up every part of the UK. Our health and care system needs to take this agenda forward with real urgency if the challenges the sectors face - both in the short and long term - are to be met; and this will need to be done with the full involvement of local leaders and the public.

Successful integration is the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time.

We want to go further and faster in building integrated health and care services. People should experience joined up care which makes the best use of public resources and services. While a more integrated approach clearly will not address all of the challenges facing staff, joining up services around users can also improve job satisfaction for the staff delivering them - removing some of the barriers that stop staff delivering care as they would like. This requires change that builds on improvements made across the health and care sectors in recent years.

While progress has been made, our system remains fragmented and too often fails to deliver joined up services that meet people's needs. The goals of different parts of the system are not always sufficiently aligned to prioritise prevention, early intervention and population health improvement to the extent that is required. That needs to be our focus if we are to continue building better health, tackling unjustifiable disparities in outcomes, and ensuring the sustainability of the NHS and other public services. People too often feel like they have to force services to work together, rather than experiencing joined-up health, public health, social care and other public services.

This paper is part of a wider set of mutually reinforcing reforms: our Adult Social Care Reform white paper, People at the Heart of Care; the Health and Care Bill and reforms to the public health system. It sets out our plans to make integrated health and social care a reality for everyone across England and to level up access, experience and outcomes across the country. Specifically, this paper:

- sets out our approach to designing shared outcomes which will place person-centred care, improving population health and reducing health disparities at the centre of our plans for reform, and ensuring that accompanying oversight arrangements and regulatory structures have a clear focus on the planning and delivery of these outcomes
- sets out proposals to strengthen the health and care services in places that feel familiar to the people living in them. While strategic, at-scale planning is carried out at the Integrated Care System[1] (ICS) level, places will be the engine for delivery and reform
- introduces an expectation for a single person, of accountable at place level, across health and social care, accountable for delivering shared outcomes and strong, effective leadership
- sets out how we will make progress on the key enablers of integration (workforce, digital and data and financial pooling and alignment) required to further join up services around people and populations
- reinforces the role of robust regulatory mechanisms to support the delivery of integrated care at place level

Joined up Care: Better for People and Better for Staff

As people who use health and care services require ever-more joined up care to meet their needs, achieving this will make all the difference both to the quality of care and to the sense of satisfaction for staff. Without a decisive shift to consistently joined up care, we will continue to see fragmentation for people and frustration for staff. For example, closer working between primary and secondary care will improve access to specialist support and advice and enable care to be delivered closer to home, managing risk more effectively and keeping people healthy and independent. And closer working between mental health and social care services can reduce crisis admissions and improve the quality of life for those living with mental illness.

[1] In this document we refer to 'Integrated Care Systems' or ICSs - an ICS is made up of both the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP) that are set out in the Health and Care Bill. The term 'ICS' is also used to refer to the geographical area covered by the system.

Unlocking the power of data across local authorities and the NHS will provide place-based leaders with the information to put in place new and innovative services to tackle the problems facing their communities. A more joined up approach will bring public health and NHS services much closer together to maximise the chances for health gain at every opportunity.

Shared Outcomes which Prioritise People and Populations

Shared outcomes are a powerful means of bringing organisations together to deliver on a common purpose for the people they serve. We have set out the case for a new approach for designing and measuring progress against these. We will work with stakeholders to develop and introduce a framework with a focused set of national priorities, and an approach for prioritising shared outcomes at a local level, focused on individual and population health and wellbeing. We will set out a framework which makes space for local leaders to agree shared outcomes that meet the particular needs of their communities, whilst also supporting national priorities. Places will be able to choose health and care priorities that matter most to their citizens, alongside national commitments. Implementation of shared outcomes will begin from April 2023. There will be robust arrangements in place to assure both the planning and delivery of both national and local outcomes.

Ensuring Strong Leadership and Accountability

Effective leadership, accountability and oversight are key to delivering integration. Local leaders - including in local government and the NHS, in partnership with their citizens - have a unique understanding of, and relationships with, their populations. We will make changes that bring together these leaders to deliver on shared outcomes in an accountable and transparent manner, through formal place-based arrangements which provide clarity over the responsibility for health and care services in each area. Several places such as Tameside have already successfully adopted arrangements of this kind.

We will set out criteria for place-level governance and accountability for the delivery of shared outcomes. We have suggested a model which meets those criteria and expect places to adopt either this specific governance model, or an equivalent, by Spring 2023.

The key characteristics needed in any model will be for it to develop a clear, shared plan and, crucially, to be able to demonstrate a track record of delivery against agreed shared outcomes over time, underpinned by pooled and aligned resources.

Local NHS and local authority leaders will be empowered to deliver against the agreed outcomes and will be accountable for delivery and performance against them. Any governance model should also provide clarity of decision-making, covering contentious issues, practical arrangements for managing risk and resolving disagreements between partners, and agreeing shared outcomes. There should be a single person, accountable for shared outcomes in each place or local area, working with local partners (e.g. an individual with a dual role across health and care or an individual who leads a place-based governance arrangement). This person will be agreed by the relevant local authority or authorities and Integrated Care Board (ICB). We would expect place-based arrangements to align with existing ICS boundaries as far as possible. We recognise that in some geographies this can be challenging, and we expect NHS and local

authority partners to work together (drawing, where needed, on the flexibilities that the legislation will provide, subject to Parliament) to ensure that all citizens are able to benefit from effective arrangements wherever they live. These proposals will not change the current local democratic accountability or formal Accountable Officer duties within local authorities or those of the ICB and its Chief Executive.

Places will be supported by central government, NHS England, ICBs and others to develop arrangements which deliver the best outcomes for their populations.

Finance and Integration

Financial frameworks and incentives can play a key role in enabling the integration of services and supporting service innovation.

Local leaders should have the flexibility to deploy resources to meet the health and care needs of their population, as necessary. NHS and local government organisations will be supported and encouraged to do more to align and pool budgets, both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.

Working within the principles set out in this paper, we will work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling. We will also review existing pooling arrangements (e.g. section 75, NHS Act 2006), with a view to simplifying the regulations for commissioners and providers across the NHS and local government to pool their budgets to achieve shared outcomes. This will continue to be subject to both NHS and local authority partners agreeing what constitutes a fair and appropriate contribution.

Digital and Data: Maximising Transparency and Personal Choice

A core level of digital capability everywhere will be critical to delivering integrated health and care and enabling transformed models of care. When several organisations are involved in meeting the needs of one person, the data and information required to support them should be available in one place, enabling safe and proactive decision-making and a seamless experience for people.

Digital tools will empower people to look after their health and take greater control of their own care, offering flexibility and support - through the NHS App and NHS.uk, remote monitoring and digital health apps. We will aim to have shared care records for all citizens by 2024 that provide a single, functional health and care record which citizens, caregivers and care teams can all safely access.

We will support digital transformation by formally recognising the Digital Data and Technology profession within the NHS Agenda for Change and including basic digital, data and technology skills in the training of all health and care staff. We will support all health and care staff to be confident when recommending digital interventions to patients and individuals using services, based on what we know works and what people want to access.

To support place-based organisations, Integrated Care Systems (ICSs) will develop digital investment plans for bringing all organisations to the same level of digital maturity. These plans will outline how ICSs will ensure data flows seamlessly across all care settings and use tech to transform care so that it is person-centred and proactive at place level.
The digital and data transformations outlined in this document provide an opportunity for greater transparency. We will look to introduce mandatory reporting of outcomes for local places, putting citizens at the heart of what we do.

Delivering Integration through Our Workforce and Carers

The health and care workforce are our biggest asset, and they are at the heart of wrapping care and support around individuals. We want to ensure that staff feel confident, motivated and valued in their roles and that they can work together in a person's interests regardless of who they are employed by. Staff numbers and skills across teams should be planned to meet the needs of their local populations and places. They should also be able to progress their careers across the health and social care family, supporting the skills agenda in their local economy. Our proposals in this paper build on our proposals to support the social care workforce, as outlined in our Adult Social Care Reform white paper, People at the Heart of Care.

To achieve this, ICS will support joint health and care workforce planning at place level, working with both national and local organisations. We will improve initial training and ongoing learning and development opportunities for staff, create opportunities for joint continuous development and joint roles across health and social care and increase the number of clinical practice placements in adult social care for health undergraduates.

What this Means for People and Communities

Taken together, these reforms will support a better joined up health and care system, with people's wishes and wellbeing at its heart. Citizens with access to more information will be more empowered to make decisions about their care and have more choices about where and how they access care. Working with local places and ICSs, we will remove unnecessary barriers so places will be empowered to do what is best for their citizens. They will be supported to be transparent and accountable for the delivery on the outcomes which matter to communities, and variations in performance between areas will be addressed. The financial frameworks and incentives which support this will be reformed over time so that the way funding is allocated and accounted for does not prevent places and ICSs doing the right thing for the people they serve.
These reforms will help us develop a world-leading health and care system which works for every person, and where people work together to deliver continuous improvement in the delivery of health and care services. This is possible and necessary, and we will start making it a reality now.

APPENDIX C

NHS England and NHS Improvement – Midlands
Trish Thompson Director of Primary Care and Public Health Commissioning
Anglesey House
Towers Business Park
Wheelhouse Road
Rugeley
Staffordshire WS15 1UL

Private and Confidential
Councillor Carl Macey
Chairman of the Health Scrutiny Committee for Lincolnshire

Sent via email c/o Simon Evans
Health Scrutiny Officer
Simon.Evans@lincolnshire.gov.uk

10th February 2022

Dear Councillor Macey,

Re: Health Scrutiny Committee Response to Lincolnshire Intermediate Minor Oral Surgery Consultation

I am writing to you regarding your letter dated 21st December 2021 to provide a response to the Lincolnshire Intermediate Minor Oral Surgery Consultation.

Firstly, we would like to thank the Health Scrutiny Committee for taking the opportunity to review the consultation proposals for Intermediate Minor Oral Surgery (IMOS) Services.

We are sorry to learn of the Committee's disappointment in the consultation proposals and note that you have concerns regarding the proposed locations, perceived reduction in access to NHS dental services and would like NHS England and NHS Improvement to reconsider proposals to expand locations.

As you will be aware from the consultation document, the Intermediate Minor Oral Surgery (IMOS) is a referral service for patients aged over 16 years and is provided within a primary care dental setting. The service provides specialist treatment e.g. complex dental extractions by a clinician with enhanced skills and experience that is either on the oral surgery specialist list or accredited in line with national guidance. Treatment for minor oral surgery procedures may be provided under local anaesthetic , supported behavioural management techniques, or provided under conscious sedation where appropriate. Once the one-off course of treatment has been completed, the patient will return to their regular dentist.

The current IMOS agreements are commissioned using a Personal Dental Services (PDS) agreement, which is time limited, and due to expire at the end of March 2023. The Lincolnshire IMOS agreements have been in place since 2008, they do not have units of dental activity (UDA) nor a financial value associated to them and payments are based on claims submitted for completed assessments and courses of IMOS treatment.

As a result, the level of activity delivered and opening hours across the existing five locations varies significantly. The current location of services was determined by the providers who met the Any Qualified Provider criteria in the procurement process in 2008.

The IMOS service was established to enable patients to access services in a primary care setting rather than a hospital setting in the county and the locations did not necessarily reflect the oral health needs of the local population across the county.

A regional Midlands IMOS service specification has been developed in line with the Oral Surgery Commissioning Guide to have a consistent IMOS model across the region which will reduce inequalities in access and provide access to treatment under conscious sedation, where clinically appropriate, and to adopt a benchmark pricing model which demonstrates better value for money. The existing contractual arrangements for Lincolnshire do differ across the providers and there is very limited access to treatment with conscious sedation.

We would like to assure the committee that we have undertaken previous engagement during May to June 2021 which included patient, public and dental professional engagement to support and develop the consultation proposals. In addition, a Prior Information Notice was advertised to the dental market regarding early notice of intentions to commission IMOS services, seek views on the Midlands service specification and contractual arrangements, this included a feedback question on possible future locations.

The above feedback and data analysis, which included a review of the dental public health data to consider oral health needs, projected population growth, deprivation, ethnicity, accessible locations across the county's geography, service levels to ensure maintenance of clinical competency requirements to deliver the specialist service, financial viability and value for money were considered in the development of the consultation proposals.

The proposed locations of Lincoln, Spalding, and Skegness were established from the above analysis, on the basis these locations would best serve the population with the greatest need and within reasonable travel distances for residents across Lincolnshire. The public transport links were considered from both a patient access and workforce perspective, and the previous engagement feedback identified that the majority of patients use private car transport to travel to access this specialist dental service in the county.

The proposals will not result in a reduction in the level of IMOS services available to residents in Lincolnshire, indeed the level of activity to be commissioned has increased to take into account projected population growth and will include the additional provision of treatment under conscious sedation.

NHS England and NHS Improvement remain committed to improving access to NHS dental services in Lincolnshire, these proposals will not impact on current access to the existing provision for general dental treatment in dental practices in the county. We continue to review and prioritise future procurement plans during the coming months to increase access to general dental services and to offer interim access initiatives in the short term.

Previous stakeholder briefings provided an overview of the East Midlands IMOS proposals to Health Scrutiny Committees and Health and Wellbeing Boards. Following communications and consultation advice, the approach to the consultation proposals

was that the local proposals should be accessible for patients and members of the public in order that they could respond at a local system area rather than an amalgamated version for the whole East Midlands, as a long consultation document containing all five systems may be perceived as a barrier to providing feedback.

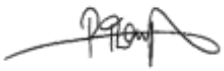
All feedback is valuable and welcomed, patients, members of the public and key stakeholders have had the opportunity to provide feedback on their local area and the wider East Midlands system areas if they wished.

The consultation responses will be analysed, and a consultation report produced for each local system area. Once finalised this will be available via our website and we are happy to share a copy of the report with the committee.

NHS England and NHS Improvement will be considering the consultation feedback to determine if the proposed locations for IMOS services need to be reconsidered and to ensure they continue to meet the oral health needs of the local population. The outcome of the consultation and any recommended changes to the proposed locations will inform the lotting approach before the procurement process commences and we will provide further stakeholder briefings on next steps as we progress through our local governance process.

I trust this has provided clarity on the consultation process and provided assurance that the proposals are to enhance and increase the level of specialist IMOS services available to best meet the oral health needs of the population in Lincolnshire.

Yours sincerely



Trish Thompson
Director of Primary Care and Public Health Commissioning NHS England and NHS Improvement - Midlands