Lincolnshire COUNTY COUNCIL
Working for a better future

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
21 OCTOBER 2015

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

Councillors R C Kirk, S L W Palmer, Miss E L Ransome, Mrs S Ransome, Mrs J M Renshaw, T M Trollope-Bellew and Mrs S M Wray

Lincolnshire District Councils

Councillors Dr G Gregory (Boston Borough Council), J Kirk (City of Lincoln Council), D Edginton (East Lindsey District Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)) and B Russell (South Kesteven District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Mark Brassington (Director of Performance and Improvement, United Lincolnshire Hospitals NHS Trust), John Brewin (Chief Executive (Deputy Director, Lincolnshire Partnership NHS Foundation Trust), Andrea Brown (Democratic Services Officer), Kakoli Choudhury (Consultant in Public Health), Alison Christie (Programme Manager, Health and Wellbeing), Kevin Costello (Chief Pharmacist, United Lincolnshire Hospitals NHS Trust) Simon Evans (Health Scrutiny Officer), Chris Higgins (Associate Director of Business Development, Lincolnshire Partnership NHS Foundation Trust), Dr Tony Hill (Executive Director of Community Wellbeing and Public Health), Jane Marshall (Director for Strategy, Lincolnshire Partnership NHS Foundation Trust), Lynne Moody (Director of Quality and Executive Nurse, South Lincolnshire CCG), Pauleen Pratt (Acting Chief Nurse, United Lincolnshire Hospitals NHS Trust) and Kevin Turner (Acting Chief Executive, United Lincolnshire Hospitals NHS Trust).

County Councillor B W Keimach (Executive Support Councillor for NHS Liaison and Community Engagement) attended the meeting as an observer.

44 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor D P Bond (West Lindsey District Council), Councillor Mrs P F Watson (East Lindsey District Council) and Councillor Mrs R Kaberry-Brown (South Kesteven District Council).

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor D Edginton to the Committee in place of Councillor Mrs P F Watson (East Lindsey District Council) and Councillor B Russell in place of Councillor Mrs R Kaberry-Brown (South Kesteven District Council) for this meeting only.

Apologies for absence were also received from Councillor Mrs S Woolley (Executive Councillor for NHS Liaison and Community Engagement), Chris Weston (Consultant in Public Health) and Gary James (Accountable Officer for Lincolnshire East CCG).

45 DECLARATION OF MEMBERS' INTERESTS

Councillor Dr G Gregory declared a pecuniary interest in the item on *United Lincolnshire Hospitals NHS Trust – Improvement Portfolio* as an employee of United Lincolnshire Hospitals NHS Trust and would therefore be leaving the meeting for the consideration of this item of business.

Councillor Dr G Gregory advised that, although an employee of United Lincolnshire Hospitals NHS Trust, he did not feel it necessary to declare a pecuniary interest in the item on *United Lincolnshire Hospitals Trust - Pharmacy Services* as he had no involvement with this area of the Trust.

Councillor S L W Palmer advised the Committee that he was currently involved in a complaints process with United Lincolnshire Hospitals NHS Trust, however this was not a pecuniary interest and for members' information only.

46 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed everyone to the Committee and made the following announcements.

i) Celebrating Success Awards – Lincolnshire Community Health Services NHS Trust

On 21 September 2015, the Chairman attended the Celebrating Success Awards, held by Lincolnshire Community Health Services NHS Trust, at the Show Room in Lincoln, where she presented the Emily Jane Glen Memorial Award for Volunteers. Councillor S L W Palmer also attended the Awards and his report was available within Item 9 of the Agenda Pack – *Annual General/Public Meetings and Annual Reports*.

ii) Joint Ambulance Conveyance Project

The Joint Ambulance Conveyance Project was a joint initiative between the East Midlands Ambulance Service, Lincolnshire Fire and Rescue and Lincolnshire Integrated Voluntary Emergency Service (LIVES). On 23 September 2015, the project won a prestigious Health Service Journal (HSJ) *Value in Healthcare* Award in

the Acute Service Redesign Category. The Chairman would send a letter on behalf of the Committee offering congratulations to all those involved.

iii) United Lincolnshire Hospitals NHS Trust – Financial Position

Minute 38 of the Health Scrutiny Committee for Lincolnshire meeting held on 16 September 2015, covered the financial position of United Lincolnshire Hospitals NHS Trust. The Trust Board of ULHT held their monthly meeting on 6 October 2015 where the Trust reported a deficit of £27.3m for the period 1 April to 31 August 2015. The in-month deficit for August was £5.7 million as opposed to £4.1 million in July which meant the Trust was £9.2 million worse than plan. The Chairman advised that a meeting with the Acting Chief Executive had been arranged for 27 October 2015.

The Chairman was scheduled to meet Jan Sobieraj, Chief Executive designate, on 4 November 2015 and his official start date was 7 December 2015.

iv) NHS Provider Trusts – Overall Financial Position

On 9 October 2015 both the Trust Development Authority and Monitor released figures which showed that, for the first quarter of 2015/16, NHS provider trusts were running a total deficit of £930 million between them, with an overall deficit of £2 billion anticipated by the end of the year.

v) East Midlands Congenital Heart Centre – Stakeholder Meetings

A programme of stakeholder meeting dates of the East Midlands Congenital Heart Centre had been advised, the first of which was to take place in January 2016. It was hoped that all local authorities in the East Midlands would participate in these meetings.

vi) Meeting with Lincolnshire West Clinical Commissioning Group

On 13 October 2015, a meeting was held with senior management from Lincolnshire West Clinical Commissioning Group, including Richard Childs (Chairman), Dr Sunil Hindocha (Chief Clinical Officer) and Sarah Newton (Operating Officer). It was agreed that the Health Scrutiny Committee for Lincolnshire would consider an item on co-commissioning at the November meeting.

vii) Emergency Planning – Exercise Black Swan

On 15 October 2015, the Chairman together with Councillors C J T H Brewis, R Kaberry-Brown, J Kirk and Mrs S Ransome, attended Exercise Black Swan, an emergency planning exercise. The scenario of a flu pandemic formed the basis for the exercise and different members of various organisations were involved, making it appear very real. The outcomes of the exercise would be reported to a future meeting of the Committee. The Chairman felt that all County Councillors would benefit from a Councillor Development Training Day on this topic.

viii) Briefing from East Midlands Ambulance Service

A meeting was held on 16 October 2015 with Andy Hill (Lincolnshire Divisional Manager of the East Midlands Ambulance Service (EMAS)) who reported several operational issues on the deployment of ambulances in Lincolnshire. This included the impact of turnaround times at hospitals on the numbers of ambulances which could be available to respond to 999 emergencies. The Chairman advised that these issues would be pursued further.

ix) Lincolnshire Community Health Services NHS Trust – Foundation Trust Application

As reported in July, Lincolnshire Community Health Services NHS Trust's application for Foundation Trust status was now being considered by Monitor. A telephone interview with the Chairman and County Council's Executive Director for Community Wellbeing and Public Health had taken place with Monitor on 20 October 2015 as part of that application process.

x) Joint Strategic Needs Assessment Working Group

A meeting of the Joint Strategic Needs Assessment Working Group would take place on Wednesday 11 November 2015 at County Offices. The Chairman gave thanks to Councillors C J T H Brewis, J Kirk and S L W Palmer for volunteering to join the working group.

xi) Health Scrutiny Committee Training

Members were reminded that a training session was to be held on Wednesday 18 November 2015 at 2.00pm. It was anticipated this would last approximately two hours and Members were asked to consider what they would like to be included as part of the training. This would be agreed during consideration of the Work Programme.

47 MINUTES OF THE MEETING OF THE COMMITTEE HELD ON 16 SEPTEMBER 2015

RESOLVED

That the minutes of the meeting held on 16 September 2015 be approved and signed by the Chairman as a correct record.

The Chairman also confirmed that Replacement Members would also be invited to participate in the training also.

NOTE: In line with his declarations of interest, Councillor Dr G Gregory left the meeting room for the following item of business (Minute 48).

48 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST (ULHT) - IMPROVEMENT PORTFOLIO

A report by Kevin Turner (Acting Chief Executive – United Lincolnshire Hospitals NHS Trust) was considered which provided an update on progress following the establishment of an Improvement Portfolio covering the four key recovery work streams – Quality Improvement, Workforce and Organisational Development, Constitutional Standards and Financial Recovery.

Kevin Turner (Acting Chief Executive – United Lincolnshire Hospitals NHS Trust), Pauleen Pratt (Acting Chief Nurse – United Lincolnshire Hospitals NHS Trust) and Mark Brassington (Director of Performance and Improvement – United Lincolnshire Hospitals NHS Trust) were all in attendance for this item of business.

Members were given a brief overview of the complex plans which focussed on the four main themes. The Board had agreed the Trust's priorities for 2015/16 alongside a programme management approach to managing the recovery of performance. A coordinated programme approach had been established with full executive support to address the key recovery streams identified.

The core themes had been broken down in to key project areas which had been Red Amber Green (RAG) Rated to indicate the progress made. Most projects had a rating of Amber which acknowledged that there were significant issues which required attention but that these issues were resolvable and successful delivery of the project remained feasible.

Members agreed to take the report in sections to allow introduction and the opportunity to ask questions on those particular sections:-

Section 1
Quality Improvement Programme (Rating – Amber/Green)
Senior Responsible Owner – Pauleen Pratt, Acting Chief Nurse

This programme would embed and sustain the changes delivered in response to the CQC Inspections whilst moving into the third phase of the Trust's continuous quality improvement journey. A monthly progress report was submitted to the Quality Governance Committee with CQC Compliance Notice issues also being reported directly to the CQC. The main achievements for this programme were:-

Louth – The Governance arrangements in Louth had been improved and there was now a Medical and Nursing Lead responsible for leading the newly established Governance Meeting for Louth Hospital with a focus on learning issues;
Pharmacy – Recruitment to Pharmacy posts had been successful including a new Consultant Antimicrobial Pharmacist;
Outpatient Department – The environment had improved in Lincoln Out-Patient Department with new "self-check-in" and a new central reception desk had opened with all staff wearing a uniform. The booking system for follow-up patients to Out-Patients had also been improved;

See It My Way – If patients or carers would like to raise concern about services, response times had improved by doing so through the new PALS Teams.

Main areas of concern where significant issues existed were:-

Safeguarding (Amber rating) – Additional safeguarding training had been established and there was sufficient capacity to deliver training to all relevant staff. The project was behind trajectory primarily due to DNA (did not attend) rates at training events. A new HR process had been introduced for managers to apply when staff did not attend booked training sessions.

Hospital at Night (Amber rating) – A new Hospital at Night model had been introduced to improve care to deteriorating patients overnight and, following staff consultation, recruitment was now complete. The project was rated "amber" due to the requirement for newly recruited staff to complete the necessary training and there was also a management focus on implementing recommendations from a review by Health Education for East Midlands (HEEM). A further visit during October 2015 to review progress was expected.

Control of Infections (Amber rating) – Significant improvements had been made in delivering control of infection requirements and the team had been restructured. ULHT had now recruited to a new position of Consultant Nurse for Control of Infection and the appointed candidate would take up post in October 2015. In order to improve cleanliness standards a housekeeping review specification had been completed but, due to the Trust's financial recovery plan, the identified funding was no longer available to support this. Discussions were taking place with the Trust Development Authority (TDA) regarding next steps and potential alternative funding arrangements. Due to a decline in compliance, there was particular focus on hand hygiene.

Training and Appraisal (Amber/Green rating) – Compliance was slightly behind trajectory for core learning (79% against an overall target of 95%) however appraisal rates continued to improve.

Out-Patients (Amber/Green rating) – Environmental work was moving forward with a new reception desk in place and clinic room standards being introduced. Patients waiting for a follow-up appointment to Out-Patients were now managed through a system known as "Partial Booking". Improvements had also been made to this system and its effectiveness was routinely audited. Focus was now on providing adequate capacity to ensure patients received timely appointments.

Members were given the opportunity to ask questions on this section of the report during which the following points were noted:-

- High DNA rates for staff training on safeguarding were due to departments being unable to release staff from busy ward areas to enable them to attend training. The Trust had no empty beds and had opened up 66 escalation beds which was the priority. The Committee suggested amending the acronym DNA (Did Not Attend) as this gave the impression that it was the choice of

staff not to attend training rather than them being unable to attend due to work pressures;

- The infection control team as a whole had been reconfigured therefore the skill mix had changed and the leadership had become much stronger. The RAG rating remained at Amber as it was not without risk but it was believed that improvements were being made. Additionally, CPID was under trajectory for the year and outcomes remained stable;
- Staff were not required to use the hand gel at the point of ward entry but at the point of care although it was acknowledged that public perception and confidence may have been affected due to not being aware of this requirement;
- Significant improvements in infection control had been made although significant issues did remain which required resolution. A plan was in place to do so but improvements to-date had included containers at the end of each bed and hand gel at entry and exit points;
- There would be no reason why nursing staff members were unable to work at night only, or days only, should that be their preference. However, the experience and issues subjected to during the night would be different to those during the day. To ensure that relevant training and experience was maintained, staff would have to work at least one week per year on the opposite shift to remain up to date with regular training;
- It would be difficult to monitor all visitors and their use of the hand gel, however, it was suggested that communal areas, i.e. lift buttons, etc, be wiped on a more regular basis to further reduce risk of infection;
- The decline in compliance had been for staff to be bare below the elbows. The Medical Director had been very clear about staff use of the hand gel and sanctions had been implemented to ensure that this was now strictly adhered to;
- Safeguarding training was a slightly different issue to Hospital at Night training. At night, practitioners were required to undergo a six month training programme to enable them to prescribe. Safeguarding was for all staff;
- The process of Partial Booking was explained to the Committee. If a patient attended a hospital appointment and it was deemed that a time critical follow-up appointment was required, the system would allow departments to book that appointment before the patient left the hospital. Should the appointment not be time critical, the patient would be added to a list and contacted by letter with the next appointment. It was hoped that this would alleviate the problem of appointments being cancelled or moved without patient knowledge;
- All milestones had been identified, including those for Lincolnshire Wide Frailty Service, which would continue to be monitored.

Section 2
Workforce and Organisational Development (Amber/Red)
Senior Responsible Owner – Ian Warren, Director of Human Resources and Organisational Development

The programme scope outlined the development and implementation of projects to deliver the required improvements in workforce and staffing. The scope and

milestone plan was agreed and an implementation team was established at the beginning of July 2015 and would report progress directly to the Portfolio Improvement Board. The main achievements for the programme were:-

International Recruitment – a business case had been approved by the Trust Board to recruit up to 140 additional nurses and this recruitment had already commenced. Return visits to Poland and Romania were planned to recruit nurses as this had previously proved successful;
Student Nurse – 90 students had been recruited and employed by ULHT. They would start to work in ward areas during October 2015.

The programme's focus was on six main work streams:-

Improving Time to Care (Amber/Green rating) – this was a new nurse roster system which had been introduced in order to support safe staffing levels. Some areas on non-compliance with the roster policy had been identified and meetings were being held between relevant managers to address those issues. Monthly dashboards had also been developed to support discussions and enable budget holders to access information regarding rota compliance.

Recruitment (Amber/Red rating) – Recruitment to Pilgrim Hospital had been identified as a risk due to the level of recruitment required for nursing staff. A Business Case for International Recruitment to secure 140 additional nurses, and 11 staff had accepted posts in the first week of recruitment in Romania. Local recruitment events would also be attended to further promote the organisation.

Retention (Amber/Green rating) – a revised interview process had been introduced to enable managers to understand why staff were leaving the organisation. Staff benefits were also being actively promoted.

Medical and Nursing Agency Usage (Amber/Red rating) – Medical and Nursing spend was being monitored closely and the Trust were actively recruiting permanent members of staff to further reduce this expenditure. Wherever possible, the same agency staff were booked to ensure consistency.

Electronic Staff Record (ESR) – Manager Self Service (Amber rating) – Electronic Staff Records were to be introduced by HR. Employees would have access to their own records as would line managers who were able to monitor issues such as core learning compliance, appraisal, annual leave and sickness absence.

Bank (Amber rating) – Part of the Financial Recovery Plan was to develop centralised control through a single office for booking of medical and nursing bank/agency staff which would be more efficient and avoid duplication.

Members were given the opportunity to ask questions on this section of the report during which the following points were noted:-

- Of the 90 nurses who had recently qualified at Lincoln University, 18 were employed at Pilgrim Hospital, although it was noted that some did come from both Sheffield and Nottingham Universities;
- Whilst at university, student nurses had a degree of choice, they were required to cover all placements. Work was ongoing with the university to come to an agreement which would enable students to do all placements at Pilgrim Hospital to give them the full experience of one particular hospital;
- Options were being considered to ensure staffing levels at the Pilgrim site could be maintained whilst balancing the ability to treat patients and maintain safety, rather than having to close beds;
- When asked about overseas recruitment and the English language, it was explained that non-EU staff were required to pass an English standard test but recruiters were careful, when selecting candidates through the interview process, that they had good skills in communication. Also, it was acknowledged that regional dialect in parts of Lincolnshire was a consideration;
- A suggestion had been made by the Lincolnshire Local Medical Committee (LMC) that a joint letter be sent to Jeremy Hunt, Secretary of State for Health, about the need to establish a medical school in Lincolnshire. The Chairman of the Committee had been asked to be one of the signatories and it had been agreed that the letter should include the current work ongoing at Lincoln University for medical training and the increased links made with schools and the NHS to improve the situation;
- Dr B Wookey advised that he had been pleased to take part in a Radio 5 Live programme which followed the course of the Trust's recruiters in Poland, confirming that the press had been supportive of the process.
- It was hoped that those recruited from overseas would stay in Lincolnshire but it was accepted that this may not be the case for some. UK nursing places had also increased and national discussions were ongoing in regard to training;
- Staff were now offered a combination of shift lengths which allowed them to work more flexibly. However, enabling that flexibility had resulted in some gaps where there was not enough staff to support patients, for example, school runs, etc. The responsibility to cover the ward safely had been passed to Ward Sisters;
- A rewards system was also implemented to retain staff but young nurses, and recently qualified nurses, often want to gain experience in other hospitals/areas, and professionally this was acknowledged as a good thing to do;
- Overseas recruitment had some contractual clauses included so that staff who left the organisation within a certain time were obligated to pay back some of the incentives received on appointment. This may include the flight to the UK, accommodation and some training;
- All Hospital Trusts had been given a maximum cap on how many agency staff they were able to employ. Agency nursing staff was set at 10.3% at ULHT but this currently stood at 11.5%. It was reported that this level would remain for some time given the current situation, this position would have to be explained to the Trust Development Authority. This was due to having more beds open

than the Trust would normally support and were depending wholly on agency staff to safely maintain those beds;

- A recommendation had been made nationally that the amount of money paid to an agency and the amount the nurse receives should move closer to the substantive grade for those posts. It was hoped that this would, in turn, encourage nurses to apply for substantive roles;
- The ratio of registered to unregistered nursing staff on wards was 65% registered and 35% non-registered. Within the registered cohort there would be those newly qualified up to sister level but it would be apportioned due to the patient need;
- A Lincolnshire-wide piece of work about careers in health, across the board, was ongoing with all schools. There was a good number of applicants for nursing, four applicants for every place available at Lincoln University so work was also being done on how to develop their own registered workforce;
- Offices for booking medical and nursing bank/agency staff were across the Trust but the main office was based at Lincoln County Hospital. After implementing this single office process, the Trust have started to see some improved control and progress although acknowledged further work was required;
- Following a query regarding a university in Lancashire offering places only to medical students from overseas, it was clarified that the University of Central Lancashire was only able to offer placements to overseas students, at a cost of over £135k, and not to UK students. This was due to limited government places and not a decision made by the university themselves.

Section 3
Constitutional Standards (Amber)
Senior Responsible Owner – Michelle Rhodes, Director of Operations

The programme scope outlined the development and implementation of projects to deliver the required performance improvement against the constitutional standards as set out in the regional escalation system recovery letter and was consistent with the Lincolnshire wide recovery plan. This was a newly developed programme and the implementation team commenced meetings in August 2015, reporting directly to the Portfolio Improvement Board and SRG on risks and issues. The main achievements for this programme include:-

Urgent Care – Pilgrim has successfully recruited a dedicated Head of Nursing for the Emergency Department at Pilgrim;
Frailty – Frailty services (including dementia) now have an increased focus and additional staff had been recruited for a "front door" frailty service;
Breast Services – additional capacity was now available for urgent two week wait breast services with an additional 60 appointments routinely available every month.

The programme had three major work streams and had an overall "Amber" RAG rating:-

Urgent Care (Amber rating) – The Trust were developing a business case to expand medical capacity in the A&E department at Pilgrim for further discussion with commissioners. The Pilgrim site had made significant progress in September but there was still concern about the site delivering 95% of patients being discharged, admitted or transferred within 4 hours. The Director of Operations had taken additional steps to make improvements including additional workforce support. A full time Emergency Department Head of Nursing dedicated to Pilgrim A&E was in place and additional support had been provided from Lincoln Consultants, Grantham Consultants and the Lincoln A&E Sister. Additional medical shifts had been added to the rota and a dedicated Site Duty Manager had been piloted out of hours during September.

Length of Stay (Amber rating) – this was a large complex project and was rated "amber" as it required significant attention. TDA funding had been identified for expert support and discussions were taking place with Stakeholders to have support in place during October.

Planned Care (Amber rating) – All projects were progressing well and on track to deliver.

Members were given the opportunity to ask questions on this section of the report during which the following points were noted:-

- The programme of work within A&E was working with the ambulance service to ensure that they work together;
- Although new breast cancer referrals patients were not seen at Grantham Hospital, a breast clinic continued there for follow-up appointments. It was reported that the breast Radiologist from Pilgrim Hospital would be retiring from the NHS which would also create a service delivery issue. Work was ongoing with out of county providers to engage with breast Radiologists to provide sessions in the short term;
- Although an additional Breast Service Mammographer had been appointed, the service remained under pressure therefore discussions with the Clinical Commissioning Groups (CCGs) were ongoing;
- The targets for the "suspect cancer process" were still being met but the targets for "breast symptomatic patients" and the 14 day standard was not being consistently met;
- When asked how members of the public would be educated in utilising the correct service for their particular need, i.e. attending GP surgery rather than presenting at A&E, it was explained that urgent care was not just A&E but the whole system. Discussions were in process with Resilience Groups where it was agreed that Neighbourhood Teams were critical. Part of the national strategy was to make the whole process simpler but it was acknowledged that this would be a timely process;
- The Site Duty Manager was to coordinate the site and ensure all services knitted together. The pilot had worked well and consideration was being given to extending it into the winter plan;
- Within Planned Care, Elective Services had achieved a second month of meeting targets although some work was still to be done and was ongoing.

- NHS England, the TDA and the Strategic Cancer Network were developing the Cancer Network;
- Each of the programmes being undertaken had a Clinical Lead and Improvement Lead who worked alongside a Management Lead. They had taken ownership of the programmes and were improving the design of the services required for patients. Lower GI, Urology and Lung Cancer were the three priority pathways being focussed on for the 62 day pathway.

Section 4
Financial Recover (Amber/Red rating)
Senior Responsible Owner – Allan Coffey, Interim Turnaround Director

This programme was pulling together all financial recovery plans across all programmes and business as usual. A financial recovery plan had been submitted to the Trust Development Authority (TDA) and Allan Coffey had been appointed as Interim Turnaround Director to provide some additional capacity and pace to drive forward financial recovery. Work was progressing with all Project Initiation Documents (PIDs) now being developed for identified savings schemes, along with Quality Impact Assessments. On review of the detail, it was clear that further schemes needed to be identified to deliver a deficit of £40.3 million. Weekly meetings were in place with ULHT and TDA to jointly review progress.

Members were given the opportunity to ask questions on this section of the report during which the following points were noted:-

- The meetings with the TDA were progressing well and, despite struggling financially, the position for September had not yet been finalised;
- Costs in September were higher than the previous month but that was due to the new cohort of nurses who were currently going through their preceptorship. Additionally, lower levels of income had been received which cast further doubt on achieving the £40.3 million deficit;
- It was clarified that the total number of nurse recruitment to-date was 19 and the aim was 120.

The Chairman thanked officers for their comprehensive report and honest answers.

RESOLVED

That the report and comments made be noted.

NOTE: In line with his declarations of interest, Councillor Dr G Gregory returned for the remainder of the meeting.

49 PHARMACY SERVICES AT UNITED LINCOLNSHIRE HOSPITALS NHS TRUST

A report by Colin Costello (Chief Pharmacist – ULHT) was considered which provided details of the processes in place for the delivery of Specialist Hospital Pharmacy Services to provide services in accordance with nationally defined Department of Health and NHS England commissioner requirements.

Kevin Turner (Acting Chief Executive – ULHT) was also in attendance for this item.

Members were advised that this was part of a wider programme within the Trust for discharge, and despite some delays in this area, they were now being addressed. Issues in regard to enabling patients to leave hospital with their medication was also being addressed as part of the redesign of the discharge management process, which formed part of the wider Constitutional Standards process.

The process was to be trialled at Pilgrim Hospital but this was a paper based system which also added to the delay in discharge. That information needed to be transcribed by Junior Doctors from the patient chart on to the system which also had to be accurate.

Members were given the opportunity to ask questions on this section of the report during which the following points were noted:-

- Confirmation was provided that the inpatient chart was accurate at all times. Errors occurred when a manual, handwritten, transcription was done. In order to prevent those delays, four discharge processes were being implemented so that the majority of medication for patients was ready and correct, to remove or minimise the delay;
- It was aimed to rollout the pilot programme at Pilgrim Hospital at the start of the next financial year;
- The idea was to utilise the inpatient chart as the prescription itself. Pharmacists would then be able to respond more quickly and any information could be transcribed on to a summary of care. The process would mirror what would eventually become an electronic prescribing system;
- Patients would also be able to utilise the Discharge Lounge which would free the bed. Lockers next to the bed would also give patients access to their own medication thus empowering them to have the ability to self-medicate in hospital, wherever it was safe to do so;
- The same people currently completing the manual charts would complete the electronic system once they were in place. The computer system would be made up of specifically written algorithms which would highlight issues with drug treatment, ensuring that medical staff were aware of any potential discrepancies with combined prescriptions. The system also builds in further checks and balances;
- Although not directly related, the Johnson Ward at Lincoln County Hospital was piloting an electronic monitoring system where the observation statistics of patients were input which then reminded nurses when the next set of

observations were due. It was hoped this would be widely rolled out in the New Year;

- It was hoped to have medication processed and ready for patients to be discharged the following day. To ensure that the pharmacy were prepared they would need to be advised of patients discharge dates, it was acknowledged that better communication and organisation was required;
- The Lloyds Pharmacy contract was for dispensing to patients attending outpatient clinics. This gave a better service and also took advantage of VAT payments back to the Trust. The Trust also receive 0% VAT through the contract with Lloyds Pharmacy but would have to pay the VAT if this service was provided in-house;
- Lloyds Pharmacy were based in each hospital and staffed by their own staff. They opened at weekends, but an out-of-hours service was not being provided. In such instances, doctors would issue hospital prescriptions which could be dispensed at community pharmacies but this did come at a considerable cost. This was funded by the CCGs in winter and a five month service would commence in November to open on a Saturday and Sunday. This service would reduce the requirement of using the FP10(HP) Prescription (hospital prescription) and the costs involved;
- Grantham and Louth hospital pharmacies were supported by staff who travelled from Lincoln and Boston as they now had the flexibility within the workforce to be able to do that;
- Although few formal complaints were received about discharge and the availability of medication, all that were received were processed through the formal channel as any other complaint would be. There was some degree of truth that people expected a considerable delay in discharge so rarely made a formal complaint. The number of formal complaints was an approximation of whether the service was improving or worsening. The Trust did appreciate that the British public were very patient, especially with the NHS;
- Prescriptions were based on what the patient needed during their stay but there was sometimes a delay in that information reaching the GP system which often resulted in the patient being prescribed too much medication. This was due to the different electronic interfaces used but merging of the systems in the future could resolve those issues.

RESOLVED

(1) That the report and comments be noted;
(2) That an update on the pilot be added to the Work Programme of the Committee for February/March 2016.

50 JOINT HEALTH AND WELLBEING STRATEGY OVERVIEW

Consideration was given to a report by Alison Christie, Programme Manager Health and Wellbeing) which provided an overview of the strategy, including details of the Mid Term Review agreed by the Health and Wellbeing Board in June 2015 in addition to the assurance arrangements in place to assess the progress being made to deliver improving health and wellbeing outcomes.

Dr Tony Hill (Executive Director of Community Wellbeing and Public Health) and Alison Christie (Programme Manager, Health and Wellbeing) were both in attendance. Dr Hill explained that the Joint Health and Wellbeing Strategy was owned and approved by the Health and Wellbeing Board and was recently reviewed halfway through the strategy period. The strategy provided some of the detail about that review and the outcomes.

Members were given a detailed presentation, covering the following areas:-

- Introduction
- Promoting healthier lifestyles – Outcome: People lead healthier lives (Priorities)
- Promoting healthier lifestyles – What are our plans?
- Improve the health and wellbeing of older people – Outcome: Older people are able to live life to the full and free part of their community (Priorities)
- Improve the health and wellbeing of older people –What are our plans?
- Delivering high quality systematic care for major causes of ill health and disability – Outcome: People are prevented from developing long term health conditions, have them identified early if they do develop them and are supported effectively to manage them (Priorities)
- Delivering high quality systematic care for major causes of ill health and disability – What are our plans?
- Improve health and social outcomes for children and reduce inequalities – Outcome: ensure all children get the best possible start in life and achieve their potential (Priorities)
- Improve health and social outcomes for children and reduce inequalities – What are our plans?
- Tackling the social determinants of health – Outcome: Peoples health and wellbeing is improved through addressing wider determining factors of health that affect the whole community (Priorities)
- Tackling the social determinants of health – What are our plans?

The detail of each slide was taken from Appendix A to the report which detailed how the improvements would be measured over the next few years. Appendix B of the report showed the Boards Assurance Framework which had been agreed in June 2015. The Health and Wellbeing Board were assured by this strategy but did have some reservations in regard to Theme 3 – *Delivering high quality systematic care for major causes of ill health and disabilities.*

The Committee would be the "lead scrutiny committee" involved for Theme 3 of the strategy, which was sponsored by Dr Peter Holmes of Lincolnshire East Clinical Commissioning Group. Due to the sizeable piece of work, the Chairman suggested a small group of the Committee meet with the Programme Manager Health and Wellbeing to ensure a clearer understanding of each area and each theme. This was agreed and volunteers were sought.

Councillors Mrs S M Wray, Mrs J M Renshaw, S L W Palmer, J Kirk, C J T H Brewis and the Chairman all volunteered to be part of the group. Although already involved with the Health and Wellbeing Board, a member of Healthwatch may also wish to join the working group.

It was suggested and agreed that there would be a benefit for the working group to discuss the current position since the strategy was implemented, before it was brought back to the Committee.

Members were provided with an opportunity to ask questions where the following point was noted:-

- It was difficult to decide a cut off point for planning of older people services as the population were all very different. The Government, in its own strategic planning, uses an age of 65 but it was suggested that an important time was when people reached the age group between 75 and 80 as this was when health services were utilised more frequently although there was an ambiguity depending on the services accessed;

RESOLVED

(1) That the report, presentation and comments made by the Committee on the purpose of the Joint Health and Wellbeing Strategy and the Lincolnshire Health and Wellbeing Board's responsibilities in respect of it be noted;
(2) That the report and comments made by the Committee on the Mid Term Review of the Joint Health and Wellbeing Strategy be noted;
(3) That the report and comments made by the Committee on the arrangements in place to assess progress and scrutinise the activities supporting the delivery of the Joint Health and Wellbeing Strategy be noted;
(4) That a working group be formed to consider both the detail of the strategy and the 2015 Annual Assurance Report.

NOTE: At this stage in the proceedings, the Committee adjourned for luncheon and, on return, the following Members and Officers were in attendance:-

<u>County Councillors</u>

Councillors Mrs C A Talbot (Chairman), R C Kirk, S L W Palmer, Miss E L Ransome, Mrs S Ransome, Mrs J Renshaw, T M Trollope-Bellew and Mrs S M Wray.

<u>District Councillors</u>

Councillors C J T H Brewis (Vice-Chairman) (South Holland District Council), T Boston (North Kesteven District Council), D Edginton (East Lindsey District Council), Dr G Gregory (Boston Borough Council) and B Russell (South Kesteven District Council)

Healthwatch Lincolnshire

Dr B Wookey.

Officers in attendance

Andrea Brown (Democratic Services Officer), John Brewin (Chief Executive (Deputy Director, Lincolnshire Partnership NHS Foundation Trust), Kakoli Choudhury (Consultant in Public Health), Simon Evans (Health Scrutiny Officer), Chris Higgins (Associate Director of Business Development, Lincolnshire Partnership NHS Foundation Trust), Jane Marshall (Director for Strategy, Lincolnshire Partnership NHS Foundation Trust), Lynne Moody (Director of Quality and Executive Nurse, South Lincolnshire CCG)

51 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST (LPFT) - DRAFT CLINICAL STRATEGY

Prior to commencement of this item, the Chairman advised that whilst the meeting was ongoing, the Care Quality Commission (CQC) had published the results of the community mental health survey based on adult mental health services across England – *CQC's response to the 2015 Community Mental Health Survey (October 2015)*.

Page 18 of the report highlighted *"Trusts achieving 'worse than expected' results"*. Table 4 referred to *"Trusts with high proportions of questions where their performance is 'worse than expected' compared with other trusts"* and included within the five trusts was Lincolnshire Partnership NHS Foundation Trust. Table 5 on page 19 also notes that the Trust was also included in Table 5 which was *"CQC inspection ratings for trusts with high proportions of 'worse' community mental health survey scores"*.

John Brewin, Chief Executive of Lincolnshire Partnership NHS Foundation Trust, was invited to address the Committee in light of the report. The Trust was very disappointed with the results and being placed in the bottom five in the country although they were aware of the vast number of issues identified and steps were being taken to address them. The Trust was optimistic that the changes implemented would improve the figures. Approximately 70 inspectors from the CQC were expected w/c 30 November 2015 across a large part of the Trust and would visit all inpatient facilities, various stakeholders, commissioners, patients, carers and focus groups who would help to inform their decision.

The Chairman thanked the Mr Brewin for the update.

Item 8 – Lincolnshire Partnership NHS Foundation (LPFT) – Draft Clinical Strategy

Consideration was given to a report from Jane Marshall (Director for Strategy, Lincolnshire Partnership NHS Foundation Trust) which provided the draft clinical

strategy to the Committee for review and feedback. The Committee were also asked to consider holding a working group to refine the draft priorities.

John Brewin (Chief Executive, Lincolnshire Partnership NHS Foundation Trust), Jane Marshall (Director for Strategy, Lincolnshire Partnership NHS Foundation Trust) and Chris Higgins (Associate Director of Business Development, Lincolnshire Partnership NHS Foundation Trust) were all in attendance and provided members with a detailed presentation on the following areas:-

- Introduction
- Proud of this year…….
- Future View
- Review of our clinical strategy
- Feedback to date (1)
- Feedback to date (2)
- Lincolnshire Alignment
- Clinical priorities – short term
- Clinical priorities – long term
- Welcome view and feedback

Members were provided with an opportunity to ask questions, where the following points were noted:-

- It was suggested that it would be helpful to include the full picture within the strategy to give the context of the issues and the reason for implementing the strategy;
- It was hoped that a full working draft would be available by the end of November 2015, which the working group would have fed into. This would then form the final draft clinical strategy which would go out for consultation;
- The Lincolnshire-wide suicide prevention action plan would also be included within the strategy and it was suggested that some elements from the mental health strategy could also be incorporated;
- A good, positive, relationship had been developed during the process of writing the strategy;
- In response to a question about the knowledge gap for GP's and if any research had been done to ascertain the significance of that gap, it was confirmed that no research had been done but that reliable national data was available about the number of GP's in practices with specialist knowledge. It was reported that 90% of all mental health was dealt with in primary care with the Trust being responsible for only 10%. The issue faced was the communication and working relations between primary and secondary care within mental health. The Trust was trying to support surgeries to be more aware of the services provided;
- Success in measuring the reduction of this gap would likely be seen in high level outcomes within the strategy. It may also result in some improvements in morbidity and mortality within that group if there was good links with primary care colleagues;

- Treatments used by the Trust were fairly generic in comparison to local specialist medications. It was acknowledged that the social care environment was challenging and had a huge impact on the quality of life so it was important to also work with social care and housing;

Volunteers were sought to sit on the working group which would consider if the priorities included in the strategy were appropriate given the actions required. Further information would be sent after the meeting with a formal request for volunteers. Initial interest was noted from the Chairman, Councillors C J T H Brewis, Mrs S M Wray, Dr G Gregory, S L W Palmer, T Boston and a Healthwatch representative.

The Chairman felt it was appropriate to consider the report prior to the CQC inspection and thanked officers for attending the meeting.

RESOLVED

(1) That the report and comments made be noted; and
(2) That a working group, to refine the draft priorities, be established.

52 ANNUAL GENERAL/PUBLIC MEETINGS AND ANNUAL REPORTS

Consideration was given to a report by Simon Evans (Health Scrutiny Officer), which invited the Committee to consider information on Annual General/Public Meetings and Annual Reports.

The Health Scrutiny Officer advised the Committee that Clinical Commissioning Groups, NHS Trusts and NHS Foundation Trusts were required to prepare an annual report and accounts each year and to hold an annual meeting in public. In terms of local NHS organisations, five such meetings had taken place since the last meeting of the Committee. Where it had been possible for a member of the Committee to attend, their reports had been included within the report to the Committee.

RESOLVED

That the content of the report be noted.

The Chairman requested that the media release from Peterborough and Stamford Hospitals, introducing car parking charges as part of its development plans following complaints from patients, staff and relatives, be sent to the Committee for their information.

NOTE: At this part of the proceedings, Councillor B Russell left the meeting and did not return.

53 WORK PROGRAMME

The Committee considered its work programme for the forthcoming meetings.

The Health Scrutiny Officer advised that there were no changes to the published work programme for consideration.

Members made the following suggestions for topics on the training session scheduled for the afternoon of 18 November 2015:-

- Definition of terminology within prevention strategies;
- Remit and scope of the Health Scrutiny Committee for Lincolnshire (including the Terms of Reference and formal agreement between NHS England, Healthwatch, CCGs and Health and Wellbeing, and protocol in general);

In relation to the work programme, members requested the following items be scheduled for a future meeting:-

- Lincolnshire Dentistry
- Exercise Black Swan – Update

RESOLVED

That the contents of the work programme, subject to the above amendments being made, be approved.

The meeting closed at 3.05 pm