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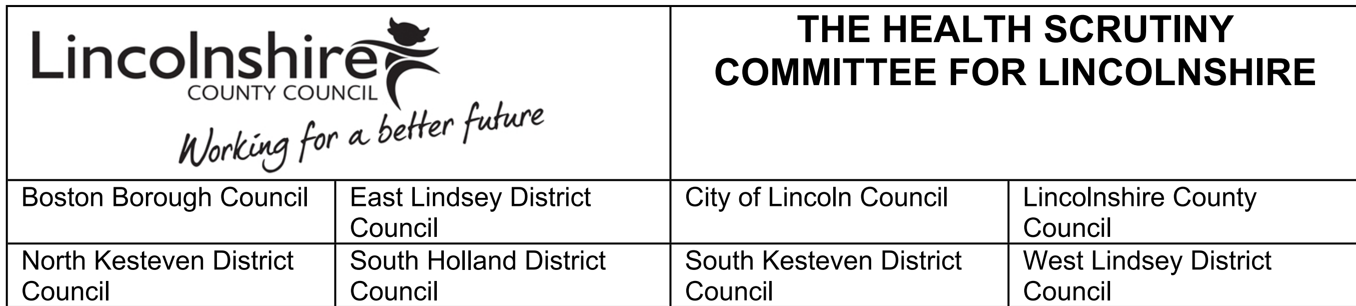

THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

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

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Democratic Services
Lincolnshire County Council
County Offices
Newland
Lincoln LN1 1YL

A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 18 November 2015 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: Mrs C A Talbot (Chairman), 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

District Councillors: Dr G Gregory (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), J Kirk (City of Lincoln Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and D P Bond (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interests**	
3	**Chairman's Announcements**	
4	**Minutes of the meeting of the Committee held on 21 October 2015**	3 - 22
5	**Update on Delegated Commissioning Arrangements for GP Services - Lincolnshire West Clinical Commissioning Group** *(To receive a report from Dr Sunil Hindocha (Chief Clinical Officer – Lincolnshire West Clinical Commissioning Group) and Sarah Newton (Chief Operating Officer – Lincolnshire West Clinical Commissioning Group), which describes the new responsibility Lincolnshire West Clinical Commissioning Group has for commissioning GP services and the governance arrangements in place to mitigate potential conflicts of interest)*	23 - 32

Item	Title	Pages
6	**South West Lincolnshire Clinical Commissioning Group - General Update** *(To receive a report from Allan Kitt (Chief Officer – South West Lincolnshire Clinical Commissioning Group), which provides an update on the activities within South West Lincolnshire Clinical Commissioning Group, covering urgent care, planned care, primary care and commissioning support in addition to information on mental health and learning disabilities for which South West Lincolnshire CCG is the lead commissioner)*	33 - 36
7	**Urgent Care - Constitutional Standards Recovery and Winter Resilience** *(To receive a report from Gary James (Accountable Officer – Lincolnshire East Clinical Commissioning Group) and Sarah Furley (Urgent Care Programme Director – Lincolnshire East Clinical Commissioning Group), which provides information on the Constitutional Standards recover plan for urgent care and the winter plans)*	37 - 44
8	**Work Programme** *(To receive a report by Simon Evan (Health Scrutiny Officer), which invites the Committee to consider its' work programme for the coming months)*	45 - 50

Tony McArdle
Chief Executive
10 November 2015

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:-

County Councillors

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.

District Councillors

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);

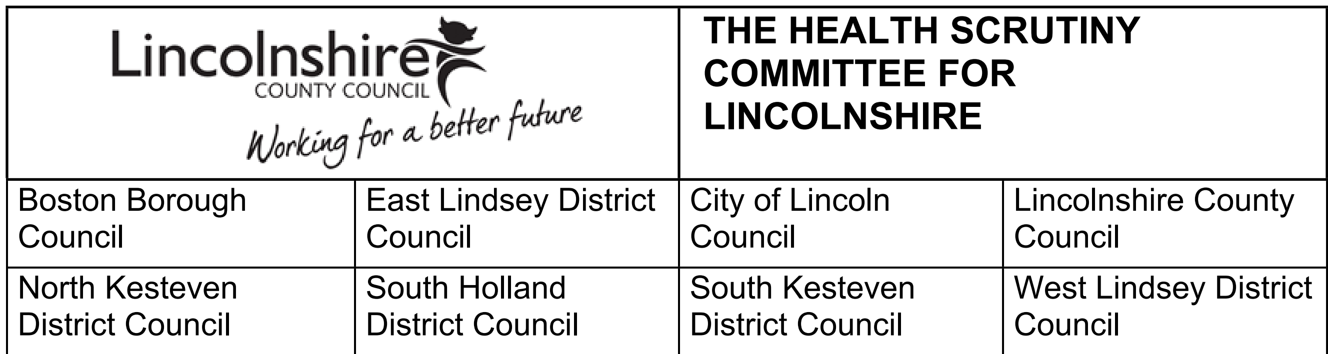
In relation to the work programme, members requested the following items be scheduled for a future meeting:-

- 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



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

Open Report on behalf of Lincolnshire West Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 November 2015**
Subject:	**Update on Delegated Commissioning Arrangements for GP Services – Lincolnshire West Clinical Commissioning Group**

Summary:

The paper describes the new responsibility Lincolnshire West Clinical Commissioning Group has for commissioning GP services and the governance arrangements in place to mitigate potential conflicts of interest.

Actions Required:

To consider and comment as necessary on the content of the report.

1. Background

When the Health and Social Care Act 2012 was initially implemented in April 2013, the responsibility for the commissioning of primary care services was undertaken by the Leicestershire and Lincolnshire Area Team of NHS England.

In May 2014, NHS England invited clinical commissioning groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities.

Lincolnshire West CCG, (along with colleague Lincolnshire CCGs), made a successful application to take on delegated responsibility for GP commissioning. Since 1 April 2015 the CCG has been responsible for carrying out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, except those relating to individual GP performance management, which have been reserved to NHS England.

This includes the following activities:

- General Medical Service (GMS), Primary Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract); but not the alteration of the Terms and Conditions of any national contract.

- Designing, developing, introducing and monitoring new newly enhanced services ("Local Enhanced Services" and "Directed Enhanced Services"), and modifying or stopping existing schemes.

- Designing and managing of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF).

- Determining whether to establish new GP practices in an area.

- Approving practice mergers.

- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

Governance

All CCGs taking on responsibility for GP commissioning were required to establish an independent Primary Care Commissioning Committee to exercise and oversee the delegated Primary Care commissioning functions. Such committees are required to have a lay chair and a majority on non GP members.

The Lincolnshire West CCG committee has a total of 11 members and is chaired by a lay member. To further support good governance an additional lay member was recruited with a specific remit for primary care commissioning. Details of the membership are given below:

- Lay Chair of the CCG* (or lay vice chair if the chair is a General Practitioner)
- Chief Operating Officer or nominated deputy*
- Chief Nurse or nominated deputy *
- Chief Finance Officer or nominated deputy*
- Lay member for Public & Patient Involvement*
- Lay member for primary Care*
- Secondary Care Clinician Governing Body member*
- NHS England Representation
- The Clinical Accountable Officer
- GP Clinical Advisor

- The four CCG Localities chairs

Voting rights are indicated by *. No GPs have voting rights. In addition to members listed above, representatives from Lincolnshire Healthwatch and the Lincolnshire Health and Wellbeing Board are invited to attend the meeting as observers, and attend regularly. Meetings are open to the public and are normally held on third Wednesday in the month.

Conflicts of Interest Policy

To mitigate potential conflicts of interest the CCG revised its Conflicts of Interest policy in accordance with new national guidance. The revised policy was reviewed and approved as part of the CCG's application to take on delegated primary care commissioning.

Funding for Commissioning GP Services

The revenue budget for commissioning GP primary care services has been delegated to the CCG. The CCG also holds the budget for GP IT. Funding for infrastructure such as development of primary care premises has been retained centrally, although this may change in future. Some NHSE staff have been assigned to the four Lincolnshire CCGs to support administration, but the CCG's nationally set management allowance was not increased as a result of taking on these additional responsibilities, in fact the CCG's management allowance was cut by 10% in 2015/16.

Quarterly Declaration

CCGs who have taken on responsibility for delegated primary care commissioning are required as part of the new assurance process, to submit a quarterly declaration regarding these duties. A copy of the quarter 1 declaration is attached as Appendix 1

Key Issues

The Primary Care Commissioning Committee has met monthly since April 2015 and has discussed a number of issues including:

1. Concordat for the Sharing of information and the Management of Concerns relating to the Professional and Contractual Performance of Primary Medical Practitioners.
2. Estates issues.
3. Quality Assurance for Primary Care
4. QOF *[Quality and Outcomes Framework]* 2013/14 Heart Failure Indicator Performance by Practice.
5. Practice/Locality Profiles.
6. Prescribing and Physiotherapy.
7. Policy for Practices in Crisis (including failing practices).
8. Individual Practice Issues.
9. Care Quality Commission Reports.

2. Conclusion

The CCG believes that by taking on delegated commissioning responsibilities for GP Primary Care Services, along with its existing responsibilities, enables it to commission

services in a more integrated way which will benefit the population of Lincolnshire West CCG.

3. Consultation

This is not a direct consultation item

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Quarter 1 Declaration

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Sarah Newton, who can be contacted on
Sarah.newton@lincolnshirewestccg.nhs.uk

Annex A

CCG Assurance Framework 2015/16
Delegated Functions - Self-certification

CCG Name or joint committee of CCGs	
Lincolnshire West CCG	
Quarter/year to which certification applies	**Q1 2015-16**

1. Assurance Level

To support ongoing dialogue, CCGs are asked to provide a self-assessment of their level of assurance for each Delegated Function (as appropriate).		
	Assurance Level	**Change since last period**
Delegated commissioning	Assured as good	Not applicable
OOH commissioning	Assured as good	Not applicable

N.B All OOH are commissioned through Lincolnshire Community Health Services NHS Trust, none are commissioned through CCG member practices.

2. Outcomes

Briefly describe progress in last quarter towards the objectives and benefits the CCG set out in taking on delegated functions, in particular the benefits for all groups of patients
<maximum 200 words>

Delegated Functions:
Focus during the first quarter has been on getting appropriate systems and processes in place to facilitate desired improvements**.** A primary care Quality subcommittee has been established and a Dashboard of key quality indicators agreed and produced, which benchmarks our practices against national, CCG and locality groups. Support has been provided to practices in relation to CQC visits and any required remedial action.
Delegation has supported improved engagement with practices and work has begun to look at better alignment of QOF to the key CCG objectives. The CCG has taken measures to improve the recruitment of GPs including a recruitment incentive scheme, and an integrated recruitment drive with the LMC.
The CCG has been proactive in supporting continuity of primary care in Gainsborough (an area of high deprivation), identify integrated ways to support one practice to remain open despite the loss of more than 50% of its GPs.

OOH commissioning: OOH is commissioned from Lincolnshire Community Health Services NHS Trust and does not incorporate CCG practices as providers. The last CQC inspection of OOH assured the services as ‘Good’.

Excerpt from CCG assurance: delegated functions self-certification 2015/16. Publications Gateway reference: 03808

3. Governance and the management of potential conflicts of interest in relation to primary care co-commissioning (this section should be completed by those CCGs which undertake joint commissioning with NHS England as well as those that have delegated commissioning arrangements)

	Co-commissioning	OOH commissioning
Have any conflicts or potential conflicts of interest arisen during the last quarter?	Yes	No
If so has the published register been updated?	Yes	No
Is there a record in each case of how the conflict of interest has or is planned to be managed?	Yes	Not applicable

Please provide brief details below and include details of any exceptions during the last quarter where conflicts of interest have not been appropriately managed
<maximum 200 words>

Delegated Functions:
There have not been any instances where conflicts of interest have not been appropriately managed. At the beginning of every meeting members are asked to declare any conflicts of interest. This used to happen as a standing item after the minutes but it now occurs straight after apologies, as conflicts may arise in consideration of issues arising from the minutes.

The following extract from the PCCC minutes provides a good example of how conflicts of interest have been handled

Minutes of the Primary Care Commissioning Committee Meeting
Held on Wednesday 20th May 2015
The Showroom, Tritton Road, Lincoln, LN6 7QY

15/048 DECLARATIONS OF INTEREST

Dr Hindocha, Dr Whitlow, Dr Qureshi, Dr Vessey all declared an interest in agenda items: **6** – Cardiovascular Intelligence Packs, 7 – Making a Difference to Primary Care, **8** – Concordat for the Sharing of Information and the Management of Concerns relating to the Professional and Contractual Performance of Primary Medical Practitioners and agenda item **9** – 2015/16 Locally Enhanced Services.

15/053 2015/16 LOCALLY ENHANCED SERVICES

Ms Newton referred to the Lincolnshire West CCG Pricing Principles paper and advised that CCG's will need to develop their own pricing policy as no national mechanism had been set. It was further noted that there will be pricing variances across the CCG's, particularly in light of affordability.

Mrs Patrick circulated a copy of the current LES's/DES's for the CCG.

Mr Childs stated that as GP's are beneficiaries to this, they would be required to input in the debate, however, when a decision is finalised, it would be inappropriate for the clinician colleagues to remain in attendance and would therefore leave the meeting at this point. Dr Vessey, Dr Whitlow, Dr Hindocha and Dr Qureshi left the meeting.

4. Procurement and expiry of contracts

Briefly describe any completed procurement or contract expiry activity during the last quarter in relation the Delegated Functions and how the CCG used these to improve services for patients (and if and how patients were engaged).
<maximum 250 words per Delegated Function>

Delegated Functions: None

OOH Commissioning: None

Local Incentive Schemes	
Is the CCG offering any Local Incentive Schemes to GP practices?	No
Was the Local Medical Committee consulted on each new scheme?	No
If any of those schemes could be described as novel or contentious did the CCG seek input from any other commissioner, including NHS England, before introducing?	No
Do the offered Local Incentives Schemes include alternatives to national QOF or DES?	No
If yes, are participating GP practices still providing national data sets?	No

What evidence could be submitted (if requested) to demonstrate how each scheme offered will improve outcomes, reduce inequalities and provide value for money?
<maximum 250 words for each Delegated Function>

Delegated Functions: Not applicable

OOH commissioning: No local incentive schemes to GP Practices were associated with OOHs as this service is provided by LCHS

5. Availability of services

Briefly describe any issues raised during the last quarter impacting on availability of services to patients (include if and how patients were engaged).
<maximum 250 words for each Delegated Function>

Delegated Functions:
There have been two issues relating to resilience of primary care services, both in Gainsborough. The first related to a practice which had a shortfall of 2 GPs and was unable to recruit, with 2 further part time partners giving notice, leaving potentially just one partner for 9,000 registered list. Intensive support was provided to this practice by the CCG and its members, including facilitating discussions with other practices in the area, the LMC and community provider, in order to explore new ways

of working. This practice has now been stabilised and continues to provide comprehensive primary care services. The second practice applied for a temporary closure to its list, as it was unable to recruit and its list size had increased, whereas others in the area had remained static or declined. After consultation with other practices in the area, HealthWatch, PPGs and other interested groups, permission to close the list for 4 months was granted. The list size has reduced and new patients will be accepted again from the end of September.

OOH commissioning: No issues with availability of GP OOH services.

	Delegated commissioning	OOH commissioning
How many providers are currently identified by the CCG for review for contractual underperformance?	[0]	[0]
And of those providers, how many have been reviewed and there is action being taken to address underperformance?	[0]	[0]
During the last quarter were any providers placed into special measures following CQC assessment?	No	No

If yes, please provide brief details of each case and how the CCG is supporting remediation of providers in special measures
<maximum 50 words per case>

Delegated Functions: Not applicable

OOH commissioning: Not applicable

In the last 12 months has the CCG published benchmarked results of providers OOH performance (including Patient experience)	Yes

If yes, please provide link to published results:
http://www.lincolnshirewestccg.nhs.uk/documents
then look at GP Patient Survey Results 2013-14 and 2014-15

6. Internal audit recommendations

	Co-commissioning	OOH commissioning
Has internal audit reviewed your processes for completing this self-certification since the last return?	No	No

If so, what was their conclusion and recommendations for improvement?
<maximum 200 words for each Delegated Function>

This is the first self-certification and the CCG will request a review of self-certification processes by internal audit during Q2. A review of Delegated Commissioning arrangements is also part of the 2015/16 Audit plan.

Use this space to detail any other issues or highlight any exemplar practice supporting assurance as outstanding
Not applicable

7. CCG declaration

I hereby confirm that the CCG has completed this self-certification accurately using the most up to date information available and the CCG has not knowingly withheld any information or misreported any content that would otherwise be relevant to NHS England assurance of the Delegated Functions undertaken by the CCG.

I confirm that the primary medical services commissioning committee remains constituted in line with statutory guidance.

I additionally confirm that the CCG has in place robust conflicts of interest processes which comply with the CCG's statutory duties set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012), and the NHS England statutory guidance on managing conflicts of interest.

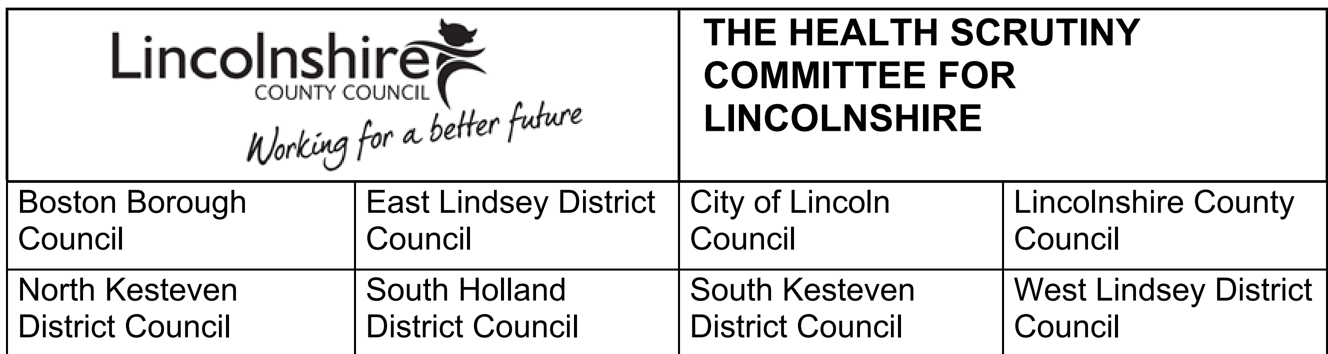
Signed by Sunil Hindocha CCG Accountable Officer

Name: Sunil Hindocha
Position: Accountable Officer
Date: 25/9/2015

Name: Roger Buttery
Position: Chair of Audit Committee & Lay Member of LWCCG
Date: 25/9/2015

Please submit this self-certification to your local NHS England team and copy to england.primarycareops@nhs.net using the email subject ‘Delegated functions self-certification.’

Excerpt from CCG assurance: delegated functions self-certification 2015/16. Publications Gateway reference: 03808



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

Open Report on behalf of South West Lincolnshire Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 November 2015**
Subject:	**South West Lincolnshire Clinical Commissioning Group – General Update**

Summary:

This report provides the Committee with an update on the activities of South West Lincolnshire Clinical Commissioning Group. It covers urgent care; planned care, primary care and commissioning support. There is also information on mental health and learning disabilities, where South West Lincolnshire CCG is the lead commissioner, on behalf of the other three CCGs in Lincolnshire.

Actions Required:

The Health Scrutiny Committee is asked to consider the content of the report and comment as necessary.

1. Background

The aim of the report is to update the Health Scrutiny Committee on developments within South West Lincolnshire Clinical Commissioning Group (CCG). The CCG covers a population of approximately 130,000 centred around the market towns of Grantham and Sleaford. The CCG has only one practice area where deprivation is above the national average. However, the prevalence of disease is significantly higher than the national average, including cardiovascular disease, diabetes and respiratory disease. Cancer mortality overall is improving, with mortality for breast, lung and gastrointestinal being better than the national average, however, overall

cancer survival rates are worse than national average, but improving steadily. The CCG's Strategic Plan has been underpinned by the work consulted on and shared with the Scrutiny Committee and of the Shaping Health for Mid Kesteven Programme.

The CCG's work has focussed on the following key areas:

Urgent Care

The Hospice in Hospital, the joint venture between local GPs, St Barnabas Hospice, United Lincolnshire Hospital NHS Trust (ULHT) and the CCG is now fully operational at Grantham and District Hospital and for the first time providing local inpatient palliative care for the population.

Fifteen new intermediate care beds have been commissioned by the CCG in partnership with Lincolnshire County Council, Lincolnshire Community Health Services and local GPs to provide an alternative to hospital admission and a means to avoid unnecessary hospital stays. The CCG is planning to expand these bed numbers in order to manage the inevitable winter pressures.

The CCG has worked closely with ULHT and Lincolnshire Community Health Services to open a single integrated reception area at A&E where Out of Hours, the GP in A&E and the Emergency Assessment Unit (EAU) team now all work together.

The ambulatory emergency care centre at Grantham Hospital is now complete and is currently being made operational for the winter. This will enable a robust alternative to admission and ensure that more patients receive a diagnosis and urgent treatment without unnecessary hospital stays.

Overall, non elective admissions for the South West Lincolnshire across all of its providers, which include ULHT, Nottingham University Hospitals NHS Trust, Sherwood Forest NHS Foundation Trust, fell in 2014/15 by 7%. The CCG's non-elective admissions have fallen by between 6% and 7% each year for the past three years. We do not expect that in the light of our aging population and high disease burden it is likely to fall much further.

Emergency admission rates for South West Lincolnshire CCG are significantly lower than the national average. However, it is only fair to say that admission rates for all Lincolnshire CCGs are lower than the national average.

Planned Care

Focus on delivering the referral to treatment standards for our patients. In 2014/15 our patients experienced significant problems as a result of difficult access at ULHT. The CCG is now achieving a 92% incomplete pathway standard. This means that 92% of our patients are scheduled to be treated on time and not subject to the build-up of a backlog.

We have been focussing on improving cancer access with the loss of breast services at Grantham due to staff shortages. Whilst we do not consider the current standard of service and access to be good enough, this has been showing steady

improvement, largely as a result of us using services outside Lincolnshire in Nottingham and in Peterborough.

We have developed new relationships with other providers and are increasingly accessing the independent sector and other NHS trusts outside Lincolnshire in order to secure steady access. South West Lincolnshire is well placed to access alternative providers when there is not capacity at either Grantham, Lincoln or Boston. We have recently launched a pilot scheme for a new hearing loss service with Specsavers in Grantham in order to provide a real alternative to the current hospital service which is unable to meet demand. The service will enable hospital services to concentrate on more serious cases and give speedy local access. We will be evaluating the pilot in twelve months' time and if successful, we will formally procure the service.

Mental Health and Learning Disabilities

As the lead CCG for this area we have been leading the work on the deployment of £2m of recurrent investment from the Lincolnshire CCGs on the Parity of Esteem programme. This is largely focussed on the delivery of a robust 24 hour 7 day liaison service and response to A&E and working with urgent services and ensuring that the 24 hour and 7 day CAMHS services work coherently with our adult mental health services.

We have been working closely with Lincolnshire Partnership NHS Foundation Trust (LPFT) in managing the impacts for hopefully the closure of Long Leys Court Assessment and Treatment Unit and working closely with them to ensure that high quality safe placement alternatives were found for the remaining service users in the unit. We are working closely with LPFT to develop a community based model as an alternative which will be fully compliant with the requirements of new national policy and will put Lincolnshire at the leading edge of modern learning disability services.

We have worked closely with LPFT's leadership team and clinical team on the development of a single quality plan which has been reviewed by the Health Scrutiny Committee and are continuing to work on delivering those improvements.

Primary Care

We have been working with South West Lincolnshire CCG practices around premises developments with three successful bids going into the Primary Care Infrastructure Fund providing additional consulting space and team working space at three practices. This building work is currently being rolled out.

We have been working closely with practices to develop the quality infrastructure including quality dashboards and a process based on practice visits by the CCG to ensure that practices are making not only best use of resources but ensuring that they are delivering high quality services. The CCG is also working with practices which have improvement requirements following CQC inspection, as South West Lincolnshire CCG practices are currently being inspected. Where there is a significant need for improvement the CCG is providing significant levels of support to ensure that that improvement takes place rapidly.

We have invested in practices in care co-ordination at a local level to ensure that our practices are able to provide co-ordinated joined up care and have provided additional non GP resources to enable practices to have more time to manage the care of those with the most complex needs.

The CCG has delivered all of its financial obligations for the second year in a row and in 2015 was awarded by the Health Service Journal and Nursing Times the award as 'Best CCG to Work In' and therefore one of the five best NHS organisations to work in across the country, which is clearly a significant achievement for the team.

For the future, the CCG will be continuing to work closely with partners on the development of the Lincolnshire Health and Care Strategic Outline Case and playing an important role in the development of the collective vision for the future.

Commissioning Support

Working in partnership with South Lincolnshire CCG we have become the first CCG in the country to successfully access the new national Lead Provider Framework for commissioning support. This framework offers CCGs a choice of accredited providers for "back office functions" ranging from payroll to IT support. Following a rigorous selection process Optum, a private company, have been selected as the new provider and a transition will take place from the existing provider, Arden Greater East Midlands Commissioning Support Unit, beginning in January 2016.

2. Conclusion

The Health Scrutiny Committee is request to consider and comment on the content of the report.

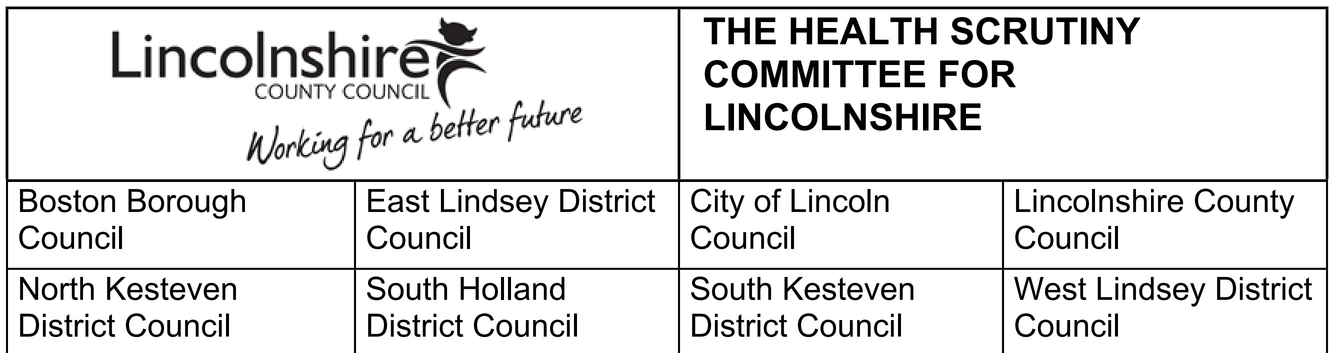
3. Consultation

This is not a direct consultation item.

4. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Allan Kitt, who can be contacted on 01476 406578 or
Allan.Kitt@southwestlincolnshireccg.nhs.uk



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

Open Report on behalf of Lincolnshire East Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 November 2015**
Subject:	**Urgent Care – Constitutional Standards Recovery and Winter Resilience**

Summary:

The purpose of this item is to provide the Health Scrutiny Committee for Lincolnshire with information on the Constitutional Standards recovery plan for urgent care and the winter plans.

Actions Required:

(1) To consider and comment on the Constitutional Standards recovery plan for urgent care.

(2) To note the winter plans.

(3) In the light of any impact on patients, to determine whether the Committee would wish to receive further reports on the delivery of the A&E four hour standards during the course of the year.

1. Background

The NHS constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours (the four hour A&E standard).

However patient experience is the most important driver for the need for improvements. Recent evidence describes that there is an increased risk of harm to patients if the four hour A&E standard is below 90%.

Also, a study by Richardson* found a 43% increase in mortality at 10 days after admission through a crowded A&E.

**Richardson DB (2006) Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust2006:184:213-6*

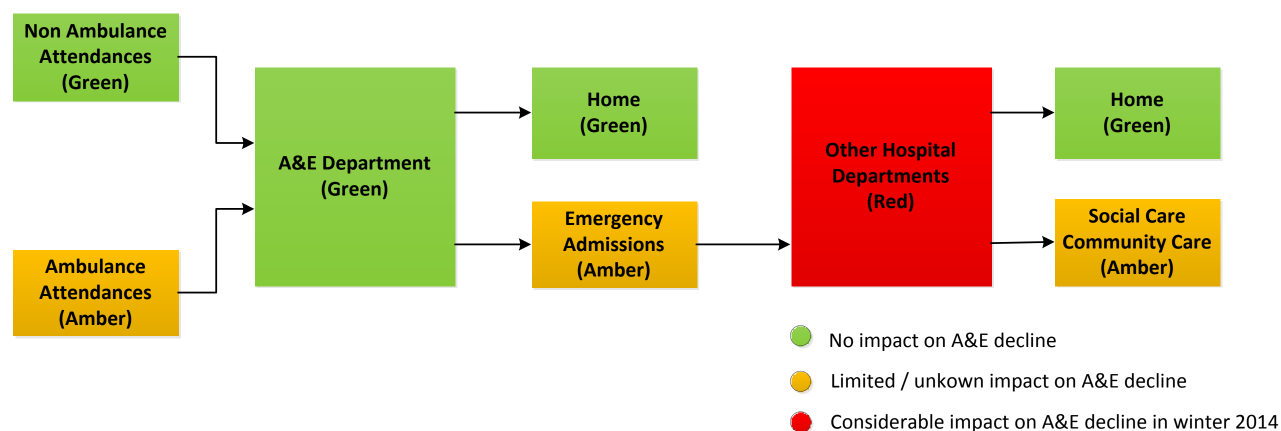
1.1 National Context

During Q3 2014/15 (winter 2014) the four hour A&E standard declined lower than at the end of the same period the previous year, to its lowest level for more than 10 years. This sharp decline was seen nationally. Since winter 2014 work has taken place to identify the factors driving the sudden decline in A&E performance in order to take action and stop it from happening again this winter.

Monitor published a report in September 2015 called *A&E delays: Why did patients wait longer last winter?* that analysed national data, the response to acute trust information request, interviews with experts and observations from acute trust visits.

Their analysis indicates that half of the decline in A&E performance against the four hour target in winter 2014 could be explained by national systemic challenges. The most important national cause was hospitals' inability to accommodate the increase in admissions from A&E departments generated by the increase in A&E attendances. This inability was a result of hospitals running at very high occupancy rates of 90% or above. Other factors such as blockages at other stages in the patient pathway had either a minor or an unquantifiable impact on A&E delays (See Figure 1). Their findings advocate that measures taken by hospitals and urgent care systems to improve patient flow through hospital departments other than A&E and back into the community may be highly effective in avoiding another sharp decline in A&E performance against the four-hour target this winter.

Figure 1: Drivers of the decline in A&E performance against the four-hour target in Q3 2014/15



Monitor found that the other half of the decline is likely to be explained by local drivers of A&E performance, which analysis at the national level were unable to capture, and potentially other drivers for which data is not yet available, in particular expenditure on social care.

1.2 Local Context

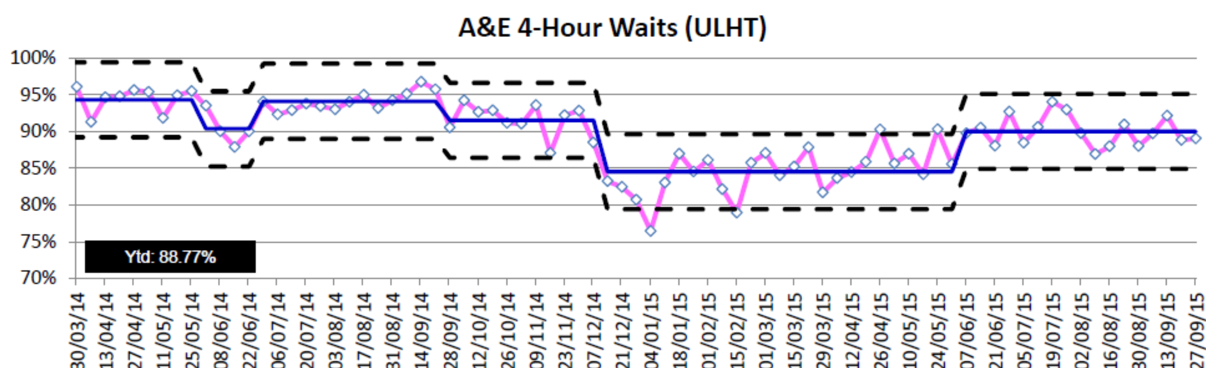
Whereas nationally there has been an improvement in the four hour A&E standard since winter 2014, Lincolnshire has not recovered to the same extent.

As a benchmark, the four hour standard is as follows in September 2015

- England 94.32%
- East Midlands 94.70%
- Lincolnshire 89.9%

The graph below shows current performance at United Lincolnshire NHS Hospitals Trust (ULHT). The impact of winter 2014 can be seen in declined performance from the beginning of December 2014 with some recovery of performance in June 2015.

Graph 1: ULHT A&E four hour standard



Key to graph – dashed line is confidence interval, solid line is trend, line with diamonds is actual performance

Lincolnshire recognises the findings in the Monitor report published in September 2015. Local analysis of data has identified two areas that have contributed to a decline in performance; bed occupancy and delayed transfers of care (DTOC). To give context, bed occupancy at ULHT is as follows.

Table 1: ULHT bed occupancy between June and September 2015

Beds	14-Jun	21-Jun	28-Jun	05-Jul	12-Jul	19-Jul	26-Jul	02-Aug	09-Aug	16-Aug	23-Aug	30-Aug	06-Sep	13-Sep	20-Sep	27-Sep
Grantham Hospital	84%	80%	94%	93%	89%	96%	89%	79%	70%	93%	92%	90%	88%	81%	85%	87%
Lincoln County Hospital	99%	95%	96%	95%	90%	85%	94%	92%	83%	91%	91%	89%	94%	90%	94%	93%
Louth County Hospital (Fotherby Ward)	25%	25%	25%	33%	33%	42%	17%	25%	42%	25%	25%	8%	0%	33%	17%	25%
Pilgrim Hospital	97%	97%	94%	97%	95%	95%	98%	99%	99%	97%	97%	95%	97%	97%	99%	97%
Trust Total	**93%**	**89%**	**96%**	**94%**	**92%**	**95%**	**94%**	**92%**	**96%**	**95%**	**93%**	**94%**	**93%**	**91%**	**94%**	**93%**

It should be noted that Pilgrim Hospital is running with a considerably higher bed occupancy than the other sites. And, it is well understood that medical beds have a higher bed occupancy than surgical beds. Week ending 1st November 2015 is a good example; ULHT bed occupancy for surgical beds was 85.25% and for medical beds was 95.71%. The majority of emergency admissions require a medical bed which exacerbates the delays for patients waiting in A&E to be admitted.

It should also be noted that in excess of 100 acute care beds were closed in ULHT during 2013/14 and in the first six months of 2014/15; discussed in a previous report to the Committee. These beds were closed for multiple reasons but predominantly so ULHT could achieve safe staffing levels and as system wide strategic decision to achieve a sustainable service.

DTOCs are a significant issue in the county with three main delays; completion of assessment, further non acute NHS care and care packages in own home.

Table 2: ULHT Delayed Transfers of Care

DTOC - ULHT	Aug-14		Sep-14		Oct-14		Nov-14		Dec-14		Jan-15		Feb-15		Mar-15		Apr-15		May-15		Jun-15		Jul-15	
Reason For Delay	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days
A) Completion of assessment	11	370	13	457	21	492	17	470	17	564	15	346	13	331	26	457	19	489	21	563	15	448	22	494
B) Public Funding	4	93	0	48	4	50	0	69	0	19	4	70	1	52	0	20	1	32	0	17	0	16	0	18
C) Further non acute NHS care (including intermediate care, rehabilitation etc)	10	253	9	272	8	187	6	320	26	419	21	494	24	414	12	592	20	365	16	487	20	385	16	421
Di) Awaiting Residential Care Home Placement	1	55	0	28	1	7	0	33	3	24	1	44	1	34	1	43	0	0	0	0	0	15	0	9
Dii) Awaiting Nursing Home Placement	0	0	0	0	1	5	0	5	0	0	0	0	1	9	0	2	0	0	0	0	0	0	0	3
E) Care package in own home	2	60	4	56	4	68	5	148	4	99	1	80	7	155	8	239	3	172	8	97	5	131	5	125
F) Community Equipment/adaptions	3	62	1	13	0	20	4	35	1	21	0	23	1	41	2	75	0	60	1	47	4	40	0	36
G) Patient or family choice	9	245	7	272	10	214	8	196	5	204	5	204	6	128	7	222	6	230	3	92	4	132	5	125
H) Disputes	2	64	1	53	2	65	1	38	1	37	1	31	1	28	1	31	1	49	1	31	1	51	3	41
I) Housing - patients not covered by NHS and Community Care Act	0	41	0	7	0	1	0	23	1	3	2	23	1	25	0	6	1	44	1	18	1	17	0	19
Total	**42**	**1243**	**35**	**1206**	**51**	**1109**	**41**	**1337**	**58**	**1390**	**50**	**1315**	**56**	**1217**	**57**	**1687**	**51**	**1441**	**51**	**1352**	**50**	**1235**	**51**	**1291**

To give context, July 2015 had 1291 lost beds days in ULHT due to delayed transfers of care. This is equivalent to approx. 42 beds at 95% bed occupancy; a rate of 4.1%. NHS England wanted this rate to be reduced to 2.5% by the end of September 2015 which would release 17 beds. Whilst September's data is not available, the author suggests that this target will not have been achieved in September.

1.3 Lincolnshire's Constitutional Standards Recovery Plan

In June, the Trust Development Agency (TDA) and NHS England put the Lincolnshire health system into a recovery programme. A Constitutional Standards Recovery Plan was developed which has been monitored through a new governance structure called the Lincolnshire Recovery Programme Board, chaired by NHSE and the TDA, meeting monthly. The Constitutional Standards Recovery Plan covers not only urgent care but cancer and referral to treatment (RTT) standards as well.

In addition to the Constitutional Standards Recovery Plan led through the SRG, the Lincolnshire Recovery Programme Board also has three other groups that are addressing recovery in the following areas; system finances, quality plus leadership and organisation development (OD). This paper does not address workforce issues but it would be remiss not to mention the impact of low staffing levels on Lincolnshire's ability to deliver sustainable services. The Lincolnshire workforce has contracted since last year; there are fewer staff in post and leavers continue to outweigh starters. The critical areas for vacancies are ULHT nursing and therapies and in some medical specialities (emergency care consultants) and also therapy vacancies in LCHS. In addition, LCC are reporting closures in Nursing Homes due to a lack of registered nursing staff. These workforce issues are being addressed through the LHAC Workforce and OD Board on 9 November 2015 and have been raised with the Lincolnshire Recovery Programme Board, Leadership and OD group.

The urgent care element of the Constitutional Standards Recovery Plan is split into the following critical projects;

(1) pre hospital
(2) Emergency departments
(3) Length of Stay (The Patient Flow Bundle - SAFER)
(4) Out of Hospital Care (Complex discharges and community capacity)

The details of these projects are in Appendix A.

It should be noted that the procurement of domiciliary care and reablement has, and continues to have, a significant negative impact on delayed transfers of care.

October 2015 was the agreed recovery trajectory for the four hour A&E standard. This was not achieved; the October performance was 85.47% at ULHT. Additional actions / projects are currently being finalised and will be going to the next Lincolnshire Recovery Programme Board on 20 November 2015.

In the meantime, the Emergency Care Improvement Programme (ECIP) is in Lincolnshire for the next three months. ECIP is helping 28 urgent and emergency care systems across England that are under the most pressure. It is a national clinically led programme that offers intensive practical help and support to urgent and emergency care systems that are failing to recover.

1.4 Lincolnshire's Winter Plan

Lincolnshire health and care agencies have developed a winter plan which is going to the System Resilience Group (SRG) on 10 November for ratification. This plan builds on the Recovery Plan. In addition, it is covers the following key areas;

(1) **Anticipat**e that includes Adverse Weather conditions, seasonally related illness

(2) **Assess** that identifies risks this winter

(3) **Prevent** that includes Public communication campaigns, Flu Prevention, Business Continuity and maximising the role of Neighbourhood Teams with the Voluntary and Community Sector

(4) **Prepare** which maximises capacity in services and how to maximise availability of staff through reducing sickness. This section also identifies responses in case of Industrial Action and different ways of working, e.g. integrating therapies.

(5) **Respond** - Lincolnshire's Escalation and Surge Plan has been refreshed this autumn. It details the arrangements and procedures that SRG partners in Lincolnshire will utilise in the event of surge and capacity issues, irrespective of cause, affecting one or more partner in order to sustain the provision of high quality responsive care. Within this plan, escalation trigger levels, actions and responsibilities are clearly defined and shared amongst key stakeholders.

(6) **Recover** – the Escalation and Surge Plan also sets out de-escalation levels that will support system recovery. A formal post-winter debrief session is planned in April 2016.

1.5 Fines and Penalties

Through the contractual mechanism, health commissioners have two types of fines that can be applied to non achieving organisations;

- financial penalty for not achieving an operational standard and a national quality requirement. These penalties are calculated on a monthly basis. Members of the SRG have previously agreed that all urgent care related contractual fines and penalties be aggregated and made available for application by the SRG as appropriate in-year.
- a Contract Performance Notice (CPN) that withholds 2% of income until the standard has been achieved.

If a CPN is issued, commissioners meet with the receiving provider and a Recovery Action Plan (RAP) is agreed. When this is achieved, the 2% funds that have been withheld are returned. In effect, the 2% will have already been committed by the provider as part of the totality of their annual budget so will be spent based on this pre-commitment.
If the RAP is not delivered the commissioners have choices on how to reinvest the 2%.

2. Conclusion

Urgent care is a complex adaptive system that is dynamic in terms of its interactions and relationships between professionals, services and organisations.

Put simply, increased demand is not driving the Lincolnshire urgent care system so it has to be these interactions. These interactions are non-linear meaning small changes in inputs, physical interactions or stimuli can cause large effects or very significant changes in outputs / performance.

In Lincolnshire, there is now a shared understanding that these interactions are detrimental to flow through the acute hospitals, exacerbated by a reduced number of beds and high occupancy, and high numbers of delayed transfers of care, exacerbated by reduced capacity in domiciliary care and reablement services. The Recovery Plan is focused on improving these interactions and the Winter Plan is focused on the wider system actions that will impact on system resilience.

3. Consultation

This is not a direct consultation item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	High level details of the urgent care projects within the Constitutional Standards Recovery Plan

5. Background Papers

The following background papers was used in the preparation of this report:

Report to the Health Scrutiny Committee for Lincolnshire, 17 December 2014 – Winter Pressures 2014-15.

This report was written by Sarah Furley, who can be contacted on 01522 513355 ext. 5424 or sarah.furley@lincolnshireeastccg.nhs.uk

Appendix A

The Urgent Care Element of the Constitutional Standards Recovery Plan

The following are critical projects;

(1) pre hospital – implement a Clinical Assessment Service (CAS). The Lincolnshire CAS went "live" on 1st November 2015 and aims to reduce variation in assessment and outcome for patients making sure that they receive the right care first time. It will make it simpler for patients and the general public to understand how to access urgent care services when they need medical help fast, but the situation is not life-threatening. It will reduce ambulance conveyances, A&E attendances and emergency admissions.

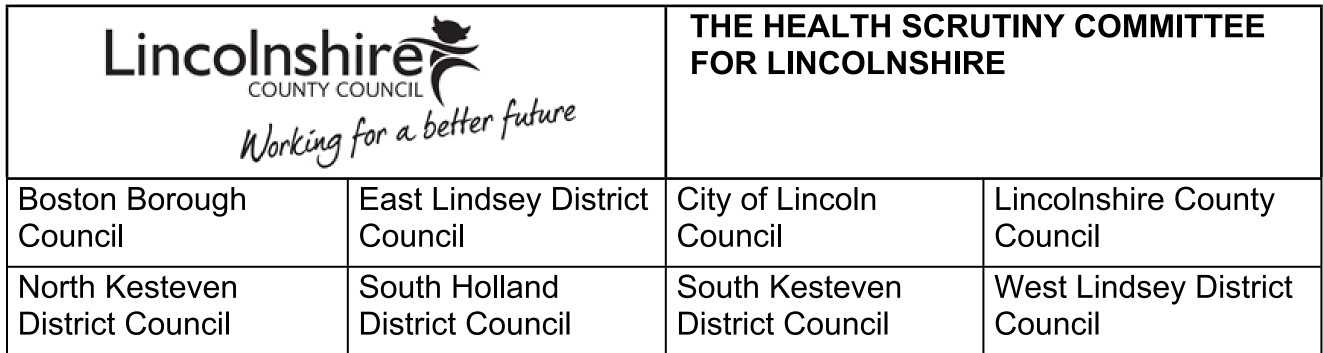
(2) Emergency departments – this project has multiple parts and includes;

   a. improving flow through the A&E departments including leadership, room utilisation, how the Rapid Assessment and intervention Team operates, how the Ambulatory Emergency Care Team operates
   b. improving the use of data to inform decision making including live data capture as well as analysis
   c. escalation processes

(3) Length of Stay (The Patient Flow Bundle - SAFER)
This project is multi-faceted and predominantly focuses on simple discharges;

   a. S - Senior Review. All patients will have a Consultant Review before midday.
   b. A - All patients will have an Expected Discharge Date (that patients are made aware of) based on the medically suitable for discharge status agreed by clinical teams.
   c. F - Flow of patients will commence at the earlier opportunity (by 10am) from assessment units to inpatient wards. Wards (that routinely have patients transferred from assessment units) are expected to 'pull' the first (and correct) patient to their ward before 10am.
   d. E – Early discharge, 33% of our patients will be discharged from base inpatient wards before midday. TTO's (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so.
   e. R – Review, a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge. This will be led by clinical leaders supported by operational managers who will help remove constraints that lead to unnecessary patient delays.

(4) Out of Hospital Care (Complex discharges and community capacity)
This project includes the implementation of Transitional Care (intermediate care), the impact of the LCC procurement for domiciliary care and reablement services. These services are completely interdependent and will improve patient experience and reduce hospital length of stay and DTOCs.



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

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 November 2015**
Subject:	**Work Programme**

Summary:

This item invites the Committee to consider and comment on its work programme.

Actions Required:

To consider and comment on the content of the work programme.

1. The Committee's Work Programme

The work programme for the Committee's meetings over the next few months is attached at Appendix A to this report, which includes a list of items to be programmed.

Set out below are the definitions used to describe the types of scrutiny, relating to the proposed items in the work programme:

Budget Scrutiny - The Committee is scrutinising the previous year's budget, the current year's budget or proposals for the future year's budget.

Pre-Decision Scrutiny - The Committee is scrutinising a proposal, prior to a decision on the proposal by the Executive, the Executive Councillor or a senior officer.

Performance Scrutiny - The Committee is scrutinising periodic performance, issue specific performance or external inspection reports.

Policy Development - The Committee is involved in the development of policy, usually at an early stage, where a range of options are being considered.

Consultation - The Committee is responding to (or making arrangements to respond to) a consultation, either formally or informally. This includes pre-consultation engagement.

Status Report - The Committee is considering a topic for the first time where a specific issue has been raised or members wish to gain a greater understanding.

Update Report - The Committee is scrutinising an item following earlier consideration.

Scrutiny Review Activity - This includes discussion on possible scrutiny review items; finalising the scoping for the review; monitoring or interim reports; approval of the final report; and the response to the report.

In considering items for inclusion in the Committee's work programme, Members of the Committee are advised that it is not the Committee's role to investigate individual complaints or each matter of local concern.

2. Conclusion

The Committee is invited to consider and comment on the content of the work programme.

3. Consultation

There is no consultation required as part of this item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health Scrutiny Committee Work Programme

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

APPENDIX A

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

Chairman: Councillor Mrs Christine Talbot
Vice Chairman: Councillor Chris Brewis

18 November 2015		
Item	**Contributor**	**Purpose**
Update on Delegated Commissioning Arrangements for GP Services – Lincolnshire West Clinical Commissioning Group	Dr Sunil Hindocha, Chief Clinical Officer, Lincolnshire West Clinical Commissioning Group Sarah Newton, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group	Status Report
South West Lincolnshire Clinical Commissioning Group Update	Allan Kitt, Chief Officer, South West Lincolnshire Clinical Commissioning Group	Update Report
Urgent Care – Constitutional Standards Recovery and Winter Resilience	Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group Sarah Furley, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group	Status Report

16 December 2015		
Item	**Contributor**	**Purpose**
Child and Adolescent Mental Health Services – Commissioning	Andrew McLean, Children's Service Manager – Commissioning, Lincolnshire County Council	Status Report
Child and Adolescent Mental Health Services – Healthwatch Perspective	Sarah Fletcher, Chief Executive, Healthwatch Lincolnshire	Status Report
Lincolnshire East Clinical Commissioning Group - Update	Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group	Update Report
Boston West Hospital	Sue Harvey, Matron, Boston West Hospital (Ramsay Healthcare)	Status Report

16 December 2015		
Item	**Contributor**	**Purpose**
Joint Strategic Needs Assessment – Finalising Response to Consultation	Simon Evans, Health Scrutiny Officer and Working Group Members	Consultation
South Lincolnshire Clinical Commissioning Group Update	To be confirmed.	Update Report

20 January 2016		
Item	**Contributor**	**Purpose**
East Midlands Ambulance Service NHS Trust	Andy Hill, General Manager – Lincolnshire, East Midlands Ambulance Service.	Status Report
Lincolnshire Integrated Voluntary Emergency Services (LIVES)	Dr Simon Topham, Clinical Director, Lincolnshire Integrated Voluntary Emergency Service Paul Martin, HQ Manager and Treasurer, Lincolnshire Integrated Voluntary Emergency Service Stephen Hyde, Marketing and Fundraising Officer, Lincolnshire Integrated Voluntary Emergency Service	Status Report
Lincolnshire Cancer Strategy	Sarah-Jane Mills, Director of Planned Care and Cancer Services at Lincolnshire West Clinical Commissioning Group	Status Report
Lincolnshire Recovery Programme Board	Jim Heys, Locality Director NHS England – Midlands and East (Central Midlands) Jeff Worrall, Portfolio Director, NHS Trust Development Authority	Status Report
Butterfly Hospice, Boston.	To be confirmed	Status Report

17 February 2016		
Item	**Contributor**	**Purpose**
United Lincolnshire Hospitals NHS Trust Portfolio Improvement Programme	To be confirmed	Update Report
United Lincolnshire Hospitals NHS Trust – Pharmacy Services	Colin Costello, Chief Pharmacist, United Lincolnshire Hospitals NHS Trust	Update Report
Universal Health – GP Provision in Lincolnshire	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust	Status Report
Adult Psychology Service – Developments in Provision	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust	Status Report
Arrangements for Consideration of Quality Accounts 2015-2016	Simon Evans, Health Scrutiny Officer.	Status Report

16 March 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Partnership NHS Foundation Trust – Outcomes from November 2015 Care Quality Inspection	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust	Status Report
Annual Report of the Director of Public Health on the Health of the People of Lincolnshire	Dr Tony Hill, Executive Director of Community Wellbeing and Public Health, Lincolnshire County Council	Status Report

Items to be Programmed

- St Barnabas Hospice
- Reducing Obesity for Adults and Children
- Dementia and Neurological Services
- Exercise Black Swan - Outcomes and Learning
- Queen Elizabeth Hospitals, King's Lynn – General Update Report
- Lincolnshire Health and Care – Strategic Outline Case
- The Prevention Agenda
- Dentistry

For more information about the work of the Health Scrutiny Committee for Lincolnshire please contact Simon Evans, Health Scrutiny Officer, on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk