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

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 20 July 2016 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: 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 Mrs L A Rollings (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages	Estimated Time
5	**Congenital Heart Services - East Midlands Congenital Heart Centre** *(On 8 July 2016, NHS England announced that "subject to consultation with relevant trusts and, if appropriate the wider public" it was decommissioning congenital heart disease surgery ("Level 1 services") from the East Midlands Congenital Heart Centre (formerly known as Glenfield Hospital). This report seeks the Committee's view on the next step)*	13 - 36	
6	**Proposed Merger of Peterborough and Stamford Hospitals NHS Foundation trust with Hinchingbrooke Health Care NHS Trust** *(This report provides an update to the Health Scrutiny Committee for Lincolnshire on the proposed merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust.* *This report covers the engagement phase of the proposed merger programme and also provides an update on the redevelopment work at Stamford and Rutland Hospital. Stephen Graves, Chief Executive, and Caroline Walker, Deputy Chief Executive and Finance Director, from Peterborough and Stamford Hospitals NHS Foundation Trust, will be in attendance)*	37 - 60	
7	**Lincolnshire Partnership NHS Foundation Trust - Response to the Care Quality Commission Comprehensive Inspection** *(The purpose of this report is to provide the Health Scrutiny Committee for Lincolnshire with assurance that Lincolnshire Partnership NHS Foundation Trust (LPFT) is making progress with implementation of the action plan arising from the Care Quality Commission (CQC) Comprehensive Inspection, which took place between 30 November and 4 December 2015)*	61 - 68	
	LUNCH		
8	**East Midlands Ambulance Service - Response to Care Quality Commission Comprehensive Inspection Report** *(This item will enable the Committee to consider the issues arising from the inspection of the East Midlands Ambulance Service, which was undertaken by the Care Quality Commission in November 2015)*	To Follow	
9	**Lincolnshire Recovery Programme Board** *(This item provides an update on the Lincolnshire Recovery Programme, the purpose of is to oversee the delivery of the NHS Constitutional Standards; improvements in the quality of care; and actions to address financial balance within the Lincolnshire health economy. The reports lists the outcomes from Programme over the last year.* *Jim Heys, Locality Director, Midlands and East (Central Midlands) NHS England, and Ian Hall, Senior Delivery and Development Manager, NHS Improvement, will be in attendance)*	69 - 74	

Item	Title	Pages	Estimated Time
10	**Work Programme** *(To receive a report by Simon Evans, Health Scrutiny Officer, which invites the Committee to consider its work programme for the coming months)*	75 - 80	

Tony McArdle
Chief Executive
12 July 2016

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HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
15 JUNE 2016

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

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

Lincolnshire District Councils

Councillors 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)) and Mrs R Kaberry-Brown (South Kesteven District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Simon Evans (Health Scrutiny Officer) and Tracy Pilcher (Chief Nurse, Lincolnshire East CCG)

County Councillors B W Keimach attended the meeting as observers.

1 ELECTION OF CHAIRMAN

RESOLVED

That Councillor Mrs C A Talbot be elected as Chairman of the Health Scrutiny Committee for Lincolnshire for 2016/17.

COUNCILLOR MRS C A TALBOT IN THE CHAIR

2 ELECTION OF VICE-CHAIRMAN

RESOLVED

That Councillor C J T H Brewis be elected as Vice-Chairman of the Health Scrutiny Committee for Lincolnshire for 2016/17.

3 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors Miss E L Ransome, Mrs S Ransome and Mrs L A Rollings.

Apologies were also received from Gary James, Accountable Officer – Lincolnshire East Clinical Commissioning Group.

4 DECLARATIONS OF MEMBERS' INTERESTS

The Chairman advised the Committee that, due to personal health reasons, she was now a private patient with Circle Nottingham, Nottingham NHS Treatment Centre, Nottingham.

There were no other Declarations of Members' Interests at this stage of the proceedings.

5 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed everyone to the Committee and made the following announcements:-

i) Membership

The Chairman reported that West Lindsey District Council had appointed Councillor Mrs Lesley Rollings as its representative on the Committee in place of Councillor David Bond for 2016/17. The Committee was advised that Councillor Mrs Rollings was also a County Councillor for Scotter Rural. Councillor Angela White remained the replacement member for Councillor Mrs Rollings.

Three further changes had been made to replacement members for District Councillors:-

- Councillor Jane Loffhagen for City of Lincoln Council (as previously reported);
- Councillor Stephen Woodliffe for Boston Borough Council; and
- Councillor Neil Jones for East Lindsey District Council.

The Chairman also encouraged Members to send the replacement member to a meeting if they were unable to attend themselves to ensure their district was represented. The substantive member was asked to ensure that the replacement has the papers for the meeting.

ii) Community Pharmacy in 2016/17 and Beyond

The Chairman confirmed that a letter had been written to the Secretary of State for Health on behalf of the Committee on the topic of Community Pharmacy in 2016/17 and Beyond. The letter had also been copied to the Rt Hon Alistair Burt MP, Minister of State for Community and Social Care, and all Lincolnshire Members of Parliament.

The Chairman reported that a reply had been received from Alistair Burt MP which referred to the introduction of a Pharmacy Access Scheme which would provide more NHS funds to pharmacies on the basis of health needs of the local population and the location. It was also stated within the response that the Department of Health was unable to assess which pharmacies would close as they were unaware of the financial viability of individual businesses.

At the last meeting, the Committee was advised of a petition on the Parliament website entitled *"Community Pharmacy in 2016/17 and Beyond"*. Currently, there were 64,464 signatures which meant it was unlikely that the petition would reach the threshold of 100,000 required to trigger a debate in Parliament by the deadline of 29 June 2016.

The detail of the relationship between the Department of Health and Community Pharmacists remained unclear to the Committee. The Health Scrutiny Officer suggested that the information presented to the Lincolnshire Health and Wellbeing Board at their meeting in May 2016 be circulated to the Committee as this went some way to explain that relationship.

iii) Quality Accounts Working Group

The most recent meeting of the Quality Accounts Working Group took place on 14 June 2016 to consider the Quality Account of United Lincolnshire Hospitals NHS Trust (ULHT), a statement for which would be drafted and finalised by 20 June 2016.

The Quality Accounts for Boston West Hospital and St Barnabas Hospice both required consideration before the process was complete.

At the July meeting the Committee would be considering a report which would include all the statements together with the priorities of providers for the forthcoming year. This information would be used to inform the Work Programme for the Committee.

iv) St Barnabas Hospice – Care Quality Commission Inspection

On 8 June 2016, the Care Quality Commission published its inspection report on St Barnabas Hospice's Specialist Palliative Care Unit in Lincoln. The report concluded that the unit was rated as 'good' and that people were unanimously positive about the services received from St Barnabas Hospice and, without exception, the praise of the staff for their personalised and caring approach. The CQC also found that people were the focus of, and at the heart of, the service and were central to the planning and review of their own care packages, including those people who were important to them. Support for people's spiritual, cultural and emotional needs was an integral part of their care package.

The Committee agreed that this was a great achievement and well deserved. A letter would be sent to Chris Wheway, Chief Executive of St Barnabas Hospice, giving formal congratulations on the result of the inspection.

v) Lincolnshire Recovery Programme Update / Lincolnshire Sustainability Transformation Plan – Briefing Session

The Chairman explained that an item to discuss the progress of the Lincolnshire Recovery Programme had been on the work programme for consideration at this meeting but NHS England and NHS improvement had indicated that they would be unable to attend until the meeting in September. The reason given was that they would be in a better position to provide an update once the Lincolnshire Sustainability Transformation Plan (STP) had been finalised at the end of June.

Eleven Members of the Health Scrutiny Committee for Lincolnshire had attended the briefing session on the Lincolnshire Sustainability Transformation Plan on 18 May 2016. The key message from that session was that there was a clear case for change in Lincolnshire, given that the predicted deficit across the Lincolnshire health system of £292 million by 2020, if no action taken, was not sustainable. One of the outcomes from the session was that there would be pre-consultation engagement with the Committee in advance of the publication of the Lincolnshire Health and Care (LHAC) consultation expected later in the year.

Further explanation was given that the Lincolnshire Recovery Programme had been established to focus on the primary services across Lincolnshire including finance, quality, constitutional standards and workforce. The Recovery Board was a separate process to the Sustainability Transformation Plan. It was acknowledged that Lincolnshire was in a better position to develop its STP in accordance with national guidelines and deadlines. It was suggested to the Committee that LHAC could be considered as the first year of the STP process.

The Committee expressed disappointment that the item on the Lincolnshire Recovery Programme would not be considered at this meeting and it was agreed that the Chairman would write to request a formal update, which could be circulated to the Committee. The content of the reply would then determine if an update in September was appropriate or whether an invitation to the July meeting of the Committee be issued.

vi) Adults Scrutiny Committee – Delayed Transfers of Care

The Adults Scrutiny Committee was the lead County Council overview and scrutiny committee for the Better Care Fund which supported the integration of health and social care. One of the key targets within the Better Care Fund in 2016/17 was a reduction in delayed transfers of care. Previously, the Health Scrutiny Committee for Lincolnshire had requested that the Adults Scrutiny Committee look into delayed transfers of care. The Chairman was pleased to report that an item had been provisionally planned for the Adults Scrutiny Committee's work programme for 6 September 2016, specifically on delayed transfers of care, and it was thought that this would also link with some work which Healthwatch was undertaking in relation to discharges.

6 MINUTES OF THE PREVIOUS MEETING OF THE HEALTH SCRUTINY COMMITTEE HELD ON 18 MAY 2016

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 18 May 2016 be approved and signed by the Chairman as a correct record.

7 SHORTAGE OF MEDICAL GENERAL PRACTITIONERS IN LINCOLNSHIRE

Prior to giving consideration to this item, the Chairman advised that two press articles had been published on this topic since the last meeting of the Committee:-

1. *"GPs to be offered £8,000 incentive to come and work at struggling practices in Lincolnshire"* – this article reported that under proposals from NHS England, practices who could prove that they have had difficulties with recruitment would be able to offer up to £8,000 to prospective GPs which included estate agent fees, rental costs and the cost of boarding school fees; and
2. *"NHS to fly in GPs from across the world to combat staff shortages in Lincolnshire"* – this article reported that Lincolnshire was to take part in a national pilot to recruit doctors from across the world to fill gaps in the county's health service. This would include experts from Poland, Spain and Romania.

The Chairman also reported that the Councillor Mrs S Woolley had written to the MP for Boston and Skegness in her role as Chairman of the Lincolnshire Health and Wellbeing Board. The MP was asked to consider the possibility to offer tax incentives to those GPs coming to Lincolnshire rather than offering more money, as suggested in recent press articles, as it was thought this method would not guarantee success.

A report by Dr Kieran Sharrock (Medical Director – Lincolnshire Local Medical Committee) was considered which provided information on the shortage of GPs working to serve the population of Lincolnshire.

Dr Kieran Sharrock (Medical Director – Lincolnshire Local Medical Committee) and Debra Burley (Chief Executive – Lincolnshire Local Medical Committee) were in attendance for this item of business.

There was an increasing crisis in General Practice nationally and this was predominant in Lincolnshire. 415 GPs were required to serve the population but only 340 were in post, leaving a shortfall of 75 GPs. This led to a shortage of GP appointments which then put additional pressure on other healthcare providers or, in a lot of cases, patients received no care at all.

It was reported that the workload for general practice had expanded dramatically over recent years and, in ten years patients presenting at their GPs had doubled with the average patient attending the surgery eight times per year. The increase in workload was due to:-

1. An ageing population who had more long term conditions such as diabetes, lung disease and heart disease;
2. Conditions which were traditionally managed in hospitals were now managed within general practice; and
3. Patient demand for immediate access which was often inappropriate.

Practices continued to transform ways of working by forming larger groups of practices to work collaboratively. They also employed alternative health professionals, including pharmacists, nurses, paramedics and physiotherapists, to provide care in a different way. This could only partially replace the unique role of the GP, however.

Recruitment of GPs from other parts of the UK would help but would not help the crisis overall therefore recruitment from outside the UK was thought to be the only sustainable option. In the long term, underfunding of the NHS and general practice needed to be reversed to ensure services were safe and sustainable.

It was stressed that training more doctors for the future was essential to that success and that Health Education England (HEE) and the General Medical Council (GMC) be urged to increase the number of training places within medical schools to avoid similar crises happening in the future.

The Committee received a presentation which provided the following information:-

1. What are the Shortages?;
2. Doctors per patient – average number of patients per GP (excluding Registrars, Retainers and Locums) – Headcount;
3. Ageing population of GPs – percentage of Practitioners (excluding Registrars, Retainers and Locums) aged 55 and over – Headcount;
4. Alternative Health Professionals – All Nurses;
5. Health spending – as proportion of GDP;
6. Health spending compared to other OECD countries; and
7. Funding for general practice – real term investment in general practice (figures based on 2014/15 prices).

It was confirmed that the figures used in Slide 3 of the presentation had been taken from the Lincolnshire Research Observatory (LRO) and did not include the figures for people living in Cambridgeshire, Peterborough, etc, who may be registered with a GP in the South Lincolnshire CCG area.

Members were given the opportunity to ask questions, during which the following points were noted:-

- Recruitment from Europe was being actively pursued as currently approval of visas for applicants from Commonwealth countries was not guaranteed as the Home Office did not recognise GPs as being a shortage;
- Concern was increased as a number of practices on the east coast of the county, as well as in Gainsborough and Lincoln, had indicated that their practices were not sustainable and ultimately these practices would not be able to fulfil their contracted obligations;

- Currently a package of care for overseas doctors was being considered. Included in that would be an English language test at the end of the training package and this would include reading, writing, comprehension and language. Payment would not be made unless the test was passed;
- Although Spain had a surplus of doctors, the cultural difference between the two areas was such that a great number returned to Spain after a short period of time. As part of the Sustainability Transformation Plan (STP), work was ongoing with the Trusts to produce an Attraction Strategy which included GPs and Nurse Practitioners as well as the wider health community. Work with the Chamber of Commerce was also underway which was looking to improve recruitment within all sectors within Greater Lincolnshire, and on the east coast in particular;
- There were lots of avenues to encourage people in to nursing and to ensure that they were offered the right level of training. This included Lincoln University, a talent academy set up by United Lincolnshire Hospitals NHS Trust (ULHT) and an NHS Careers College for Bands 1-7;
- Figures used were based on LRO population for the CCGs in Lincolnshire and did not include temporary residents so the figures given would be higher;
- The LMC were commended for proactively working on these issues to relieve the pressures faced;
- It was suggested that the GP shortage was not a new problem and one often faced when government changed the number of places in medical schools;
- It was noted that the vocational scheme had improved since the three year financial incentive had been given. It was hoped that the cohort currently in that scheme would assist in filling the gap;
- A new website was being developed in an attempt to improve the reputation outside of Lincolnshire was included a marketing campaign with a video about Lincolnshire General Practice. GP Registrars appeared on that video which could be found at www.lincolnshiregeneralpractice.co.uk ;
- When asked why the majority of GPs retired at the age of 55, it was explained that this was generally the age where the pension contributions would stop. Retired GPs often chose to return to practice on a part-time basis but it had been found that this was reducing dramatically due to the workload involved;
- GP training was different to that provided for hospital doctors and it was thought that this should be more inclusive, with previous roles being considered as part of the training before extensive, possible duplication, training was undertaken;
- It was stressed that patients had been going to their GPs to ask them to pursue follow-up hospital appointments which was inappropriate. The GP practices had found themselves assisting with this to the point it had become best practice although this should not be the case.

At 12.00pm, Councillor B W Keimach left the meeting and did not return.

The Chairman thanked the Lincolnshire LMC for the work undertaken to establish a better understanding in regard to the GP shortage.

RESOLVED

1. That the report and comments be noted in relation to the crisis facing general practice;
2. That the endeavours of GPs, practices and Clinical Commissioning Groups to make GP services sustainable be supported;
3. That further action, for example by lobbying MPs on overall NHS funding and the decline in the proportion of funding which goes to provide GP service, be supported;
4. That increased recruitment from countries outside the UK where there was a surplus of doctors, be supported; and
5. That the efforts to increase medical school places in the UK and in Lincolnshire specifically, be supported.

8 WORK PROGRAMME

The Committee considered its work programme for forthcoming meetings.

At 12.15pm, Councillor T M Trollope-Bellew and Dr B Wookey left the meeting and did not return.

During the meeting it had been suggested to add the Lincolnshire Recovery Programme Update to the agenda for the meeting of the Committee scheduled for 20 July 2016. It was explained that, as regulators, it was not within the Committee's powers to require attendance from NHS Improvement (formerly Monitor and the Trust Development Authority) but that a request for their attendance would be made for the July meeting.

In relation to the item relating to Community Pharmacies it was agreed that the Chairman would write to the Minister of State, making reference to the issue of whether these proposals were a substantial variation.

RESOLVED

That the contents of the work programme be approved, with the following addition for July 2016:-

1. Lincolnshire Recovery Programme Update

The meeting closed at 12.30 pm

Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
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Open Report on behalf of Richard Wills the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 July 2016**
Subject:	**Congenital Heart Services – East Midlands Congenital Heart Centre**

Summary

On 8 July 2016, NHS England announced that "subject to consultation with relevant trusts and, if appropriate the wider public" it was decommissioning congenital heart disease surgery ("Level 1 services") from the East Midlands Congenital Heart Centre (formerly known as Glenfield Hospital).

Actions Required:

(1) The Committee is requested to consider the report; and

(2) To authorise the Chairman to seek further information on whether NHS England intends to consult on the decommissioning of Level 1 Congenital Heart Services from the East Midlands Congenital Heart Centre in Leicester.

1. Background

The first section of this report sets out the history of the planned developments to congenital heart services, which have been subject to two full public consultations in the last five years.

Historical Background – Part 1 - *Safe and Sustainable*

In 2001, the Kennedy Report on Bristol Royal Infirmary concluded the need for children to have heart surgery in fewer specialist surgery centres. In 2003, the

Paediatric and Congenital Services Review Group published recommendations for fewer and larger children's heart surgery centres. In 2007, the Royal College of Surgeons supported this view.

In 2008, a full and detailed review of service provision was begun under the title *Safe and Sustainable*. In March 2011, the Joint Committee of Primary Care Trusts, comprising local commissioners representing each region, launched the *Safe and Sustainable* consultation. *Safe and Sustainable* contained details on the eleven regional centres, undertaking children's congenital heart surgery, and concluded that clinical expertise was spread too thin across these eleven centres. *Safe and Sustainable* put forward six options, which were in effect permutations of between six and seven surgical centres from the eleven centres. The Health Scrutiny Committee for Lincolnshire responded to the *Safe and Sustainable* consultation, supporting Option A, which would have seen the retention of Glenfield Hospital in Leicester, now known as the East Midlands Congenital Heart Centre. Glenfield Hospital is based in Leicester and is part of the University Hospitals of Leicester NHS Trust.

On 4 July 2012, the Joint Committee of Primary Care Trusts decided to approve Option B in the original consultation document, having considered all the consultation responses on the original six options in the consultation document (as well as a further six options, identified as a result of the consultation). Option B did not see the continuation of surgical services at Glenfield Hospital in Leicester.

The decision of the Joint Committee of Primary Care Trusts was referred to the Secretary of State for Health by the Health Scrutiny Committee for Lincolnshire on 27 July 2012. In addition, there were two further referrals to the Secretary of State on *Safe and Sustainable*: firstly by the Leicester, Leicestershire and Rutland Health Overview and Scrutiny Committee on 7 September 2012; and secondly by the Yorkshire and the Humber Joint Health Overview and Scrutiny Committee on 27 November 2012. All three referrals were passed to Independent Reconfiguration Panel for a full review. Independent Reconfiguration Panel is a national organisation, used by the Secretary of State to provide advice on referrals, so that an informed decision can be made.

In a separate development a judicial review of the *Safe and Sustainable* consultation by Save Our Surgery Ltd, a Leeds-based charity, resulted in a Court of Appeal decision on 24 April 2013 to quash the decision made by the Joint Committee of Primary Care Trusts on 4 July 2012 to close children's heart surgery centres.

The Independent Reconfiguration Panel published its full review of the *Safe and Sustainable* process on behalf of the Secretary of State and made a total of 15 recommendations. This was published on 12 June 2013.

Historical Background – Part 2 – New Review of Congenital Heart Services

In June 2013, the NHS England Board resolved to start with a fresh review of congenital heart services for both children and adults and on 15 September 2014 launched a national consultation on the *Proposed Congenital Heart Disease Standards and Service Specifications*. The key difference between this

consultation and the earlier *Safe and Sustainable* consultation, is that the consultation was based on service standards, which would be used by NHS England to commission congenital heart services. The consultation document did not make any reference to any particular reconfiguration of surgical centres.

The New Review had the following aims:

- Securing the best outcomes for all patients – not just lowest mortality but reduced disability and an improved opportunity for survivors to lead better lives;
- Tackling variation – ensuring that services across the country consistently meet national standards, and are able to offer resilient 24/7 care, and;
- Improving patient experience – including how information is provided to patients and their families, and consideration of access and support for families when they have to be away from home.

The review referred to three levels of service:

Level 1 – Specialist Surgical Centres. These centres would manage all patients with highly complex congenital heart disease. All congenital heart surgery and catheter interventions would be undertaken at these centres.

Level 2 – Specialist Cardiology Centres. These centres would provide the same quality standards as the specialist surgical centres, but focusing on diagnosis and the ongoing management of patients. There would be no surgery or catheter interventions.

Level 3 – Local Cardiology Centres – These centres would often be involved in the diagnosis of congenital heart disease and would be part of congenital heart network.

On 14 December 2014, the Health Scrutiny Committee for Lincolnshire approved its response to the consultation, which is attached at Appendix A to this report. There were three particular issues:

- the number of surgeons at each centre – whether a one-in-three or a one-in-four was appropriate;
- the minimum number of operations undertaken by each surgeon each year, with 125 operations proposed in the consultation averaged over a three year period; and
- the co-location of congenital heart services with other paediatric services, which would mean Glenfield Hospital having to move its heart surgery services from Glenfield Hospital to Leicester Royal Infirmary.

On 23 July 2015 the NHS England Board received the review's report and around two hundred new standards and service specifications were approved, which providers of CHD services would be expected to meet from April 2016, with a five-year trajectory to full compliance.

Announcement by NHS England - 8 July 2016

On 8 July 2016, NHS England issued an announcement, which included the following:

> *"Subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England will also work with* ***University Hospitals of Leicester NHS Trust*** *and Royal Brompton & Harefield NHS Foundation Trust to safely transfer CHD surgical and interventional cardiology services to appropriate alternative hospitals. Neither* ***University Hospitals Leicester*** *or the Royal Brompton Trusts meet the standards and are extremely unlikely to be able to do so. Specialist medical services may be retained in Leicester."*

The full NHS England statement is enclosed at Appendix B.

Prior to the release of this statement, on 30 June 2016 NHS England had written to the Chief Executive of University Hospitals of Leicester NHS Trust, advising him that the East Midlands Congenital Heart Centre does not meet all the April 2016 requirements and is unlikely to do so. As a result NHS England was minded to cease commissioning Level 1 services (congenital heart disease surgery) from the Trust. This letter is attached as Appendix C.

The Trust replied on 5 July 2016, indicating that it had made excellent progress over the last 18 months and setting out the progress made. The response of the Trust is attached at Appendix D.

Issues for the Committee

The Committee's powers are set out in Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Under Regulation 23, where an NHS commissioner, such as NHS England, has under consideration any proposal for a substantial development of the health service or for a substantial variation in the provision of such service, they must consult with the relevant local authority health scrutiny function.

In this instance, it is not absolutely clear whether NHS England is proposing to undertake any consultation, or whether it considers that the consultation undertaken in 2014 is sufficient and that it can decommission a service against its agreed standards. In the first instance, it might be best to establish the intentions of NHS England in this area.

2. Conclusion

The Committee is requested to consider the report; and to authorise the Chairman to seek further information on whether NHS England intends to consult on the decommissioning of Level 1 Congenital Heart Services from the East Midlands Congenital Heart Centre in Leicester.

3. Consultation

The issue of consultation is pertinent to this report, as it needs to be ascertained whether NHS England is proposing to consult on the decommissioning of Level 1 Congenital Heart Services from the East Midlands Congenital Heart Centre in Leicester.

4. Appendices

These are set out below: -

Appendix A	Response of the Health Scrutiny Committee for Lincolnshire to the Proposed Congenital Heart Disease Standards and Specifications (December 2014)
Appendix B	NHS England Media Announcement – 8 July 2016
Appendix C	Letter, dated 30 June 2016, from Will Huxter, Regional Director of Specialised Commissioning (London Region), NHS England to John Adler, Chief Executive of University Hospitals of Leicester NHS Trust.
Appendix D	Letter, dated 5 July 2016, John Adler, Chief Executive of University Hospitals of Leicester NHS Trust to Will Huxter, Regional Director of Specialised Commissioning (London Region), NHS England

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, Health Scrutiny Officer, Lincolnshire County Council, 01522 553607 Simon.Evans@lincolnshire.gov.uk

Lincolnshire COUNTY COUNCIL *Working for a better future*		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
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PROPOSED CONGENITAL HEART DISEASE STANDARDS AND SPECIFICATIONS

Response of the Health Scrutiny Committee to the Consultation

(including a representative of Lincolnshire Healthwatch)

(1) Will the draft standards and service specifications meet the aims of the Congenital Heart Disease review?

Response of the Health Scrutiny Committee for Lincolnshire

In relation to the first aim (Securing the Best Outcomes for All Patients – page 9 of the consultation document) the Health Scrutiny Committee for Lincolnshire would like to stress the importance of low mortality figures. The Committee is sure that NHS England is aware that differences in mortality, highlighted in the Bristol Royal Infirmary Report in 2001, led to the need to review the provision of congenital heart surgery services.

Most importantly, the second aim of the New CHD Review (Tackling Variations) is not reflected in the standards and specification for the following two reasons. Firstly the standards and specification does not adequately address the issue of travel and accessibility (as emphasised by the Independent Reconfiguration Panel's report of 2013)[1]. We would like to see the standards and specifications recognise the importance of enabling patients and their families to be treated at their nearest centre. This is most important for Lincolnshire, which has a population of 724,500, in 307,000 households spread over 2,350 square miles. Lincolnshire has poor road links and an equally challenging public transport network. This impacts most particularly in the East of Lincolnshire, in towns such as Boston, Louth, Mablethorpe and Skegness, where travel times to large cities such as Birmingham and Leeds are considerable. There is also an issue in terms of travel costs, which are higher the further an individual has to travel. This is compounded by the fact that salary levels in Lincolnshire are below the national and regional average.

[1] Advice of the Independent Reconfiguration Panel on *Safe and Sustainable* Proposals for Children's Congenital Heart Services – Submitted to the Secretary of State for Health on 30 April 2013 and published on 12 June 2013.

Secondly, we are not convinced that the second aim of the New CHD Review (Tackling Variations) will be addressed by the standards and specification. This is explained in more detail in the response to question 2 and relates to the proposal that some parts of the country will operate with Level 1 and Level 3 centres, while other parts of the country will have Level 1, Level 2 and Level 3 centres.

(2) What do you think of the model of care that we are proposing?

Response of the Health Scrutiny Committee for Lincolnshire

There is an inconsistent approach to the proposed model of care. The second aim of the review (as set out on page 9 of the consultation) states: -

- "tackling variations so that services across the country consistently meet demanding performance standards and are able to offer resilient 24/7 care"

The proposal that some parts of the country will operate with Level 1 and Level 3 centres, while other parts of the country will have Level 1, Level 2 and Level 3 centres appears to be inconsistent with the aim of tackling variations across the country. **We recommend that NHS England should be clear on its preferred model of care: it should either opt for networks comprising Level 1 and Level 3 centres; or networks comprising Level 1, Level 2 and Level 3 centres.** We believe that this is the only way of tackling variations across the country, and ensuring consistency of provision.

Furthermore, it is important that certain regions such as the East Midlands are not disadvantaged with a network of care that does not provide for patients receiving surgical interventions at their nearest centre. This is most important for Lincolnshire, which has a population of 724,500, in 307,000 households spread over 2,350 square miles. Lincolnshire has poor road links and an equally challenging public transport network. This impacts most particularly in the East of Lincolnshire, in towns such as Boston, Louth, Mablethorpe and Skegness, where travel times to large cities such as Birmingham and Leeds are considerable. There is also an issue in terms of travel costs, which are higher the further an individual has to travel. This is compounded by the fact that salary levels in Lincolnshire are below the national and regional average.

(3) What do you think about our proposals for Level 2 Specialist Cardiology Centres?

Response of the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire believes that the continuity of care is important for all patients and their families. Patients and their families like to have the reassurance of staff, with whom they are familiar. The Committee is not convinced that this can be provided by a network containing Level 2 Specialist Cardiology Centres. Patients and their families using Level 2 centres will become familiar with staff at these centres, but patients and families may lose this confidence when a surgical intervention is required at a Level 1 centre, as the established trust and familiarity will not be present.

Page 15 of the consultation document states: *"We heard concerns that Specialist Children's Cardiology centres may not be sustainable in the longer term, especially if it is not possible to attract high quality staff to work there."* Whilst the consultation continues with a statement indicating that these centres may play a vital role, it does not address the fundamental issue of being able to attract high quality staff.

If NHS England adopts a three level model of care, **the Committee recommends that NHS England give further consideration to the sustainability of Level 2 centres in the longer term and in particular brings forward detailed proposals on how Level 2 Centres can be sustainable in terms of their staffing.** Without this sustainability, the proposed model of care is likely to become Level 1 and Level 3 centres, but more by accident than by design.

(4) What do you think of our proposals for the development of networks?

Response of the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire would like to reiterate recommendation 10 of the Independent Reconfiguration Panel[2]:

"More detailed and accurate models of how patients will use services under options for change are required to inform a robust assessment of accessibility and the health impact of options so that potential mitigation can be properly considered."

Recommendation 10 of the Independent Reconfiguration Panel refers to the issue of accessibility, which is a matter of great concern for the residents of Lincolnshire. We cannot find any reference in the consultation document to enabling equity of access across the country to surgical centres.

[2] Advice of the Independent Reconfiguration Panel on *Safe and Sustainable* Proposals for Children's Congenital Heart Services – Submitted to the Secretary of State for Health on 30 April 2013 and published on 12 June 2013.

The consultation document contains the following statement on page 20:

> *"The precise shape of each congenital heart network will be determined by local need and local circumstances, including geography and transport, but would welcome further views. There is an opportunity later on in the review to do more work on how networks are set up."*

We recommend that NHS England provide information on "*the opportunity later on in the review to do more work on how networks will be set up*". We would like to know whether this statement means that NHS England will be conducting further consultation on the configuration of the networks to comply with Recommendation 10 of the Independent Reconfiguration Panel.

To meet with the findings of the Independent Reconfiguration Panel, we also recommend that NHS England develop networks that give patients access to their nearest Level 1 centre. This means that some of the existing patient flows will need to be adjusted in certain regions, where referrals seem to be directed to London for historic reasons. Without this approach, it could mean that some regional Level 1 centres would not be able to reach the required standards in relation to the number of procedures.

The development of a sustainable network in the East Midlands is of paramount importance for Lincolnshire, which has a population of 724,500, in 307,000 households spread over 2,350 square miles. Lincolnshire has poor road links and an equally challenging public transport network. This impacts most particularly in the East of Lincolnshire, in towns such as Boston, Louth, Mablethorpe and Skegness, where travel times to large cities such as Birmingham and Leeds are considerable. There is also an issue in terms of travel costs, which are higher the further an individual has to travel. This is compounded by the fact that salary levels in Lincolnshire are below the national and regional average.

(5) What do you think of our proposals for staffing Congenital Heart Disease Services?

Response of the Health Scrutiny Committee for Lincolnshire

We note that the consultation document summarises a number of the standards that are detailed in the standards and specifications document. We see no reason to disagree with most of these standards, with the exception of the standards B9 and B10 for both Specialist Children's Surgical Centres and Specialist Adult Congenital Heart Disease Surgical Centres (in so far as they relate to four surgeons in a one in four rota). **There is more detail on this in our response to Question 6.** Page 5

(6) What do you think of our proposal that surgeons work in teams of at least four, each of whom undertakes at least 125 operations per year? Please explain your answer.

Response of the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire supports the proposal that each surgeon should undertake a minimum of 125 operations per year, averaged over a three year period.

The Health Scrutiny Committee for Lincolnshire believes that teams of three surgeons can provide a safe and sustainable service, in terms of providing adequate on call facilities. Page 24 of the consultation refers to "*mixed views from the surgeons themselves*" on this topic and many surgeons consider that teams of three are acceptable and safe, provided all the other service standards are met. The document states:

> *"A number of the centres currently have teams of three surgeons, and their results are good."*

For these reasons the Committee disagrees with Standards B9 and B10 for both Specialist Children's Surgical Centres and Specialist Adult Congenital Heart Disease Surgical Centres, in so far as these standards relate to four surgeons in a one in four rota.

The Health Scrutiny Committee for Lincolnshire understands that "within three years" means Quarter 4 of 2018/2019, effectively by 31 March 2019. If the B9 and B10 standards are adopted, we recommend that NHS England consider fully the implications of implementing all these standards by 31 March 2019, in terms of securing fully developed networks serving all the regions of England, including Lincolnshire and the rest of the East Midlands region**. In effect, we recommend that providers need a clear timetable to consolidate and plan their services in order to meet these standards.**

(7) What do you think about our proposed approach to sub-specialisation?

Response of the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire supports NHS England's views on sub-specialisation: all congenital heart surgeons and consultant interventional cardiologists must only undertake procedures for which they have appropriate competence. We also note NHS England's statement that surgical teams will have to recognise their competences and not conduct operations where their competence may be lacking. **We recommend that the issue of collaboration and the difficulty of enabling surgeons to work in other hospital trusts be resolved.**

(8) What do you think of the proposed standards for service interdependencies and co-location?

Response of the Health Scrutiny Committee for Lincolnshire

The detailed standards and specifications document states that the co-location standards will be achieved "within three years". The Health Scrutiny Committee for Lincolnshire understands that "within three years" means Quarter 4 of 2018/2019, effectively by 31 March 2019.

The Committee recognises the drive for all standards to be met within three years, effectively by 31 March 2019, but recommends that NHS England gives further consideration to this proposed implementation period. This is because some providers cannot meet the co-location standards without additional building or refurbishment work, requiring capital expenditure. There is a risk that this would not be achieved by the intended date. This would destabilise the proposed networks. **We further recommend that NHS England clarify the exact timing of the implementation of the co-location standards, so that providers can be given a clear indication of the timeline to comply with all these standards.**

(9) What do you think of the proposed service specifications?

Response of the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire in particular welcomes the standards relating to Communication with Parents and Patients; Transition; and Palliative Care and Bereavement and welcomes the approach whereby NHS England has developed these standards after engagement with patients and their families.

The Committee also welcomes the inclusion of standards C1 and C2 for both Specialist Children's Surgical Centres and Specialist Adult Congenital Heart Disease Surgical Centres, as these standards provide convenient and accessible accommodation free of charge for up to two family members, which is an essential part of supporting families during a very stressful time in their lives.

The Committee also recognises the importance of foetal diagnosis and strongly recommends that NHS England improve the rates of foetal diagnosis from the existing level of 35%. The Committee recognises that as the identification of a congenital foetal defect is relatively rare many sonographers would need additional training so that foetal diagnosis rates can improve. Page 7

(10) To ensure that we work within the available resources, difficult decisions may need to be made. What parts of our proposals matter most to you?

Response of the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire would like to stress the importance of ensuring that the residents of Lincolnshire have high quality and accessible children's and adults CHD services, including the services provided by Level 1 surgical centres.

There is a risk that services will be destabilised by the commissioning process, leaving parts of the country without accessible services. For example, if several of the current providers of Level 1 services fail to meet all the standards, these providers could be decommissioned or reclassified as Level 2 centres. This approach could mean the piecemeal decommissioning of Level 1 Centres, without any co-ordination or planning. It would not provide networks to serve the whole of England, and in turn could leave Lincolnshire, as well as the rest of the East Midlands, without access to a Level 1 centre.

Accessibility is most important for Lincolnshire, which has a population of 724,500, in 307,000 households spread over 2,350 square miles. Lincolnshire has poor road links and an equally challenging public transport network. This impacts most particularly in the East of Lincolnshire, in towns such as Boston, Louth, Mablethorpe and Skegness, where travel times to large cities, such as Birmingham and Leeds, are considerable. There is also an issue in terms of travel costs, which are higher the further an individual has to travel. This is compounded by the fact that salary levels in Lincolnshire are below the national and regional average.

(11) Do you have any comments on the range of approaches proposed to ensure that the standards are being met by every hospital providing Congenital Heart Disease care?

Response of the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire understands that NHS England will be approving a set of standards and the specifications in 2015 and following this it "will work with clinical commissioners to complete the commissioning of the agreed service specification during 2015/16".

The Committee would like to highlight that this commissioning approach puts at risk the need for a network of Level 1 centres, serving the whole country. For example, if none of the centres that are readily accessible to the residents of Lincolnshire meet the standards, there is a risk that these Level 1 centres would be de-commissioned, leaving the residents of Lincolnshire to longer and more difficult journey times than currently. **We recommend that NHS England take responsibility for commissioning a national network of providers, which in turn provides accessible services in each region, rather than relying on the system of chance, on which the current commissioning arrangements are based.**

Taking this argument one step further, the Committee would like to emphasise the importance of patient choice as outlined in the NHS Constitution. It is important that patients in Lincolnshire are offered a genuine choice of locally accessible Level 1 centres, rather than these patient choices being made by a commissioning process relying on historic referral pathways.

(12) Is there anything else that you want to tell us or ask us to consider? If your comments relate to a particular standard or section please specify which you are referring to.

Response of the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire acknowledges the challenge of reflecting the proposed standards, which exceed 1,100 in total, in a single consultation document. **However, the Committee believes that the document lacks some of the necessary detail, which can only be found in the detailed draft standard and specifications documentation.**

The Health Scrutiny Committee for Lincolnshire believes that if congenital heart surgery were to cease at any of the centres where it is currently undertaken it would constitute a substantial development of the health service and a substantial variation in the provision of the health service (as defined in Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Such an outcome is possible as a result of the approach whereby NHS England determines whether providers would meet the standards and service specifications. This could mean the piecemeal decommissioning of Level 1 Centres, without any co-ordination or planning, in terms of providing networks to serve the whole of England.

NHS England's approach to the commissioning process could lead to serious impacts for Lincolnshire patients and their families, as they would have to travel further to access Level 1 centres for both Specialist Children's Surgical Centres and Specialist Adult Congenital Heart Disease Surgical Centres. Furthermore NHS England's approach to the development of networks does not meet Recommendation 10 of the Independent Reconfiguration Panel[3], as stated in our response to Recommendation 4. There is a risk that NHS England's approach could lead to patients in Lincolnshire, as well as the rest of the East Midlands, not having access to an accessible Level 1 centre within the region.

On the theme of accessibility, the Health Scrutiny Committee for Lincolnshire would like to reiterate the issue of accessibility. This is most important for Lincolnshire, which has a population of 724,500, in 307,000 households spread over 2,350 square miles. Lincolnshire has poor road links and an equally challenging public transport network. This impacts most particularly in the East of Lincolnshire, in towns such as Boston, Louth, Mablethorpe and Skegness and, where travel times to large cities such as Birmingham and Leeds are considerable. There is also an issue in terms of travel costs, which are higher the further an

[3] Advice of the Independent Reconfiguration Panel on *Safe and Sustainable* Proposals for Children's Congenital Heart Services – Submitted to the Secretary of State for Health on 30 April 2013 and published on 12 June 2013.

individual has to travel. This is compounded by the fact that salary levels in Lincolnshire are below the national and regional average.

The Health Scrutiny Committee for Lincolnshire has been established by Lincolnshire County Council to discharge the health overview and scrutiny functions set out in Sections 244-246 of the National Health Service Act 2006 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. In accordance with regulation 31 of these Regulations, one representative of each of the district councils in Lincolnshire has been co-opted as a member of the Health Scrutiny Committee. Lincolnshire Healthwatch is also represented as a member of the Committee.

ANNOUNCEMENT BY NHS ENGLAND – 8 JULY 2016

The full announcement by NHS England on 8 July 2016 is set out below:

"Patients with complex, sometimes life-threatening congenital heart disease will benefit from action to ensure core standards of quality and sustainability apply across all specialist services announced today (Friday 8th July) by NHS England. Congenital heart disease (CHD) services have been the subject of a number of reviews since the public inquiry at Bristol Royal Infirmary in 2001, with the outcome of a further review of a number of children's heart surgery cases at Bristol published last week.

In 2015, NHS England published new commissioning standards for CHD services following extensive consultation with patients and their families, clinicians and other experts. Since then, hospital trusts providing CHD services have been asked to assess themselves against the standards, which came into effect from April 2016, and report back on their plans to meet them within the set time frames.

As a result of these assessments, and following further verification with providers, NHS England intends – subject to necessary engagement and service change process in relation to this assessment – to take the following actions to ensure all providers comply with the set standards.

With regard to providers of specialist surgical (Level 1) services:

- *Subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England will also work with Alder Hey Children's Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital NHS Foundation Trust to safely transfer CHD surgery from Central Manchester University Hospitals NHS Foundation Trust. Specialist medical services may be retained at Central Manchester.*

- *Subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England will also work with* ***University Hospitals of Leicester NHS Trust*** *and Royal Brompton & Harefield NHS Foundation Trust to safely transfer CHD surgical and interventional cardiology services to appropriate alternative hospitals. Neither* ***University Hospitals Leicester*** *or the Royal Brompton Trusts meet the standards and are extremely unlikely to be able to do so. Specialist medical services may be retained in Leicester.*

- *NHS England will work with Newcastle Hospitals NHS Foundation Trust to ensure progress is made towards meeting the standards and the strategic importance of the link of CHD surgery to the paediatric heart transplant centre is sustainable and resilient.*

- *NHS England will support and monitor progress at University Hospitals Bristol NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, University Hospitals Birmingham NHS Foundation Trust, Barts Health NHS*

Trust, Guy's and St Thomas' NHS Foundation Trust, and University Hospital Southampton NHS Foundation Trust to assist them in their plans to fully meet the standards. In the case of Bristol this will also include addressing specific recommendations set out in the independent report published last week.

- *Birmingham Children's Hospital NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust will continue to be commissioned, with ongoing monitoring, as they currently meet all or most of the standards.*

NHS England remains concerned as to the level of occasional and isolated practice in specialist medical (Level 2) services, and intends to take the following actions:

- *NHS England will work with Blackpool Teaching Hospitals NHS Foundation Trust, University Hospital of South Manchester NHS Foundation Trust, Papworth Hospital NHS Foundation Trust, Nottingham University Hospitals NHS Trust and Imperial College Healthcare NHS Trust to cease occasional and isolated specialist medical practices. Plans will be put in place to transfer services to other appropriate providers.*

- *NHS England will support and monitor progress at Liverpool Heart and Chest hospital to develop Level 2 and Level 1 services in line with standards and Oxford to assist them in their plans to fully meet the standards.*

- *Norfolk & Norwich University Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust will receive ongoing monitoring of their progress towards meeting the standards.*

In addition, a small number of hospital trusts not recognised as a specialist centre, but which responded to the self-assessment that they undertook occasional practice/interventions, have been instructed to make arrangements for such patients to be cared for at a specialist centre in future. This process has now all-but eliminated occasional practice, with follow-up action to be taken against providers if they continue.

Dr Jonathan Fielden, NHS England Director of Specialised Commissioning and Deputy National Medical Director, said: *"Patients, families and staff need to be assured of sustainable, high quality services now, and into the future. There has been a great deal of uncertainty over the future of congenital heart disease services over the past fifteen years. We owe it to patients, families and staff to end that uncertainty, and to provide clear direction for the safety and quality of this specialist area of medicine going forward. A great deal of work has gone into achieving consensus across the board on the standards that providers should meet. We are determined to take all actions necessary to ensure that those standards are met, so that patients get the high quality and safe services that they expect and deserve. This is further proof that NHS England as the national commissioner of specialised care is stepping up decisively on behalf of patients now and to sustain quality care for the future."*

Professor Sir Ian Kennedy, who was the chair of the public inquiry at Bristol Royal Infirmary, said: "*These are vital services and we have waited 15 years to arrive at a solution which delivers quality and consistency for current and future generations. It is good news for patients that there is finally a clear consensus on the standards that need to be met, and that we are now seeing decisive action to make those standards a reality for every patient in every part of the country."*

Miss Clare Marx, President of the Royal College of Surgeons, said: *"Improvements to care for children undergoing heart surgery continue to be needed in spite of improvements since the Bristol Royal Infirmary public inquiry report in 2001. The Royal College of Surgeons strongly supports today's plans and we hope these changes will now finally happen for the ultimate good of patients. Units need to be the right size to enable surgical teams to be familiar and skilled in all conditions, treating these patients on a regular basis to maintain their experience and expertise. It's absolutely critical that teams are sufficiently staffed to provide secure on-call rotas, disseminate new techniques, and train the next generation of specialists. The proposals set out today represent a consensus view of what consistent, high quality care should look like across the country. As a profession we are confident these standards will help reduce variation in care and improve outcomes. Any further delay or obstruction by local parties will prolong uncertainty for the very ill patients who need this surgery."*

Congenital heart disease (CHD) affects up to 9 in every 1,000 babies born in the UK, with differing types of CHD and levels of severity. Some of the more common CHDs include:

- *septal defects, commonly referred to as a "hole in the heart";*
- *coarctation (or narrowing) of the aorta,*
- *pulmonary valve stenosis, where the valve controlling blood flow to the lungs is narrower than normal, and;*
- *transposition of the great arteries, where the pulmonary and aortic valves and the arteries they're connected to have swapped positions.*

Services and surgery – the provision of which is clustered in a small number of specialist centres across England – have progressed significantly over the last few decades, and around 80% of those born with a CHD now survive into adulthood. However, there has been uncertainty over their future configuration. In an effort to address this uncertainty, in July 2013, after discussions with key stakeholders, NHS England established the New Congenital Heart Disease Review.

In order to establish which providers do or can meet the standards in the set time frame, all providers were asked to complete a self-assessment process, the results of which have now been processed and form the basis of the actions set out today. In 2014/15, the last year for which reliable data exists, the number of operations performed by CHD services was 4,354, and the number of interventional procedures was 3,793. While some patients will have to travel further to access specialist services as a result of these changes, emergency admissions are rare, and ongoing work aims to ensure that more of a patient's long-term care can be delivered closer to home, meaning fewer trips to specialist centres. Where the transfer of services goes ahead, NHS England will work with the hospital trusts to ensure that staff are supported.

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John Alder
Chief Executive
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30 June 2016

Dear John,

You will be aware that NHS England has been assessing CHD services against the new standards approved by our board in July 2015 and which came into effect in April this year.

We are grateful for all the hard work of your staff in helping us to complete that assessment. Details of the process are shown in appendix 1.

We have now completed our assessment and I am writing to you to report our assessment of your organisation's compliance with the standards and the action that we are minded to take as a result.

Following our assessment we consider that your organisation does not meet all the April 2016 requirements and is unlikely to be able to do so.

As a result of this assessment we are minded to cease commissioning level 1 CHD services from your organisation.

I am enclosing a copy of our assessment for your review and comment. You will have until close of play 5 July to respond with any comments you may have on the factual accuracy of our assessment. We will then consider your response and confirm our final assessment with you, at which time we will set out our proposed next steps. Our regional team will contact you shortly to confirm these arrangements.

In the event that our assessment remains that your organisation does not meet all the April 2016 requirements and is unlikely to be able to do so we expect to initiate a service change process. There will be appropriate further local engagement before that service change process reaches a final decision on the future of services at your hospital.

We are taking these steps because we believe that they are in the best interests of patients with congenital heart disease and their families, including those yet to be diagnosed who will need these services in future. We believe that by ensuring that all patients across the country are able to benefit from services that meet agreed national standards, the quality of care they receive will be improved. We hope that you will support us in these aims and that you will work with us in the interests of patients and their families to ensure that sound decisions are taken, and once taken that they are implemented effectively and efficiently.

The uncertainty about the future of CHD services has been unsettling for staff and for patients and their families for many years. While this process is designed to bring that uncertainty to an end, it is inevitable that during the coming weeks and months fresh concerns will emerge and we hope and expect that you will work with us to reassure patients and their families and your staff who are potentially affected by any changes if they are decided on.

Yours sincerely,

Will Huxter

Regional Director of Specialised Commissioning (London Region)

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5th July 2016

Dear Will,

Re: Outcome of NHS England assessment of CHD services against the new standards.

The East Midlands Congenital Heart Centre (EMCHC) has made excellent progress over the last 18 months through the leadership of our clinicians, the energy and efforts of the whole CHD team, the support of our charities and the closer integration of our partner organisations. We have expanded bed numbers, improved outcomes, invested in staffing, created a new adolescent unit and have briefed architects to create a new single site children's hospital which will both meet your co-location standard and provide a wonderful new environment for the care of all our younger patients.

This progress has all been achieved against a backdrop of many years of uncertainty following the "flawed" decision four years ago to stop Level 1 CHD services in Leicester. It does make me wonder what this service could achieve if NHS England backed these clinicians.

I trust it will therefore come as no surprise when I say that I cannot agree that your decision to "cease commissioning" children's heart surgery in the East Midlands is in any way "in the best interests of patients with congenital heart disease and their families".

I have discussed your assessment in detail with our clinical leadership team and I have set out our response below.

1. We provide a high quality service.

Our most recent clinical outcomes, when compared with current published data, place us alongside the best performing surgical centres in England. Further, we can predict that upon publication of the NICOR data in October 2016 that the clinical outcomes for our patients will be amongst the best in the country. Despite seeing and treating more children than ever before there have been no deaths at the EMCHC within 30 days of surgery in the last year.

Recognising that quality is about more than outcomes (as the latest Bristol Review identified), our same-day cancellation rates and un-planned re-operation rates within 30 days are significantly better than the national average and our patient and family satisfaction rates have increased to 99% over the last year.
All of this is supported by the Care Quality Commission who, in their initial feedback letter following their inspection in June 2016, reported: "*We noted the excellent clinical outcomes for children following cardiac surgery at Glenfield Hospital."*

Our first rebuttal to your assessment of our service is therefore that you want to close a centre beloved of its patients and families despite quality indicators that ought to alert you to the fact that this is a grave mistake.

2. We are on target to meet the number of surgical procedures.

In 2014/15 we carried out 280 surgical cases. In 2015/16 we increased this to 332 cases. Based on current projections of activity we expect to meet the standard of an average of 375 cases per year, with three surgeons over the next three years. To accommodate this additional work this year we expanded our bed-base by 31% (17 beds total) including the provision of an adolescent unit, and a short stay bay at a cost of just under £1million.

All that aside we would remind you again that the evidence for 125 cases being the 'magic number' is selective. As you know, following a worldwide review of literature on behalf of NHS England, the School for Health and Related Research in Sheffield found "that, whilst a relationship between volume and outcome exists, this is unlikely to be a simple, independent and directly causal relationship." In other words, no cut-off relating to surgical volume and better outcomes was identified.

Our second point of rebuttal is that NHS England is therefore proposing to close a top quality service despite the fact that the clinicians working in the service are confident of their ability to perform the required number of procedures. This is compounded by the fact that the premise for the decision is based on an arbitrary number of cases for which there is no scientific evidence. We would encourage you therefore to look at our outcomes, our zero mortality and our actual results.

3. A compromised Paediatric Intensive Care Service.
The East Midlands Congenital Heart Centre supports 12 Paediatric Intensive Care Unit, (PICU) beds at Glenfield Hospital which will obviously be lost if NHS England ceases to commission surgical services. Of equal importance is that as a consequence of losing these beds, the viability of the PICU at the Leicester Royal Infirmary will be compromised. As you are no doubt aware, paediatric intensivists in Leicester work across both units and in common with other units are attracted by the diverse caseload that this offers. The loss of a specialist PICU at the EMCHC, which more than halves the total PICU beds in Leicester, will mean that the children's intensive care will cease to be as attractive a place for our clinical teams to work; we will lose existing staff and find it harder to attract new staff.

Taken together, the two Leicester units provide 30% of the PICU capacity across Birmingham, Leicester and Nottingham; close one and destabilise the other, and even assuming a bed in the region can be found, more children and their families will have to travel further to support one another in a time of crisis.

Our third rebuttal is simply that given the national crisis in PICU capacity highlighted by last week's report into the Bristol service, the decision to remove beds from the system and destabilise the remaining Leicester PICU seems at best misguided and at worst, reckless.

4. The worst possible domino effect.

If NHS England closes the EMCHC service the PICU at the Glenfield is lost and the Royal's is compromised. Without a suitably sustainable children's intensive care service there will be an inevitable domino effect on other specialist paediatric services which require intensive care capacity to function safely. These include include: children's general surgery, ear nose and throat surgery, metabolic medicine, fetal and respiratory medicine (for long term ventilated children), children's cancer and finally our neonatal units. In addition, those neighbouring hospitals currently supported by the specialist teams in Leicester will no longer be able to look for support for their more complex patients from their nearest specialist trust. These these include hospitals in Burton, Coventry, Kettering, Northampton and Peterborough.

Our fourth rebuttal is that if NHS England closes the children's heart service in Leicester you should be aware that you are essentially undermining the vast majority of other specialist services for children in the East Midlands.

5. Extra Corporeal Membrane Oxygenation (ECMO) Service.

Leicester's paediatric respiratory ECMO service is the largest in the country accounting for 50% of all capacity nationally. As NHS England is aware, Leicester pioneered ECMO in the UK and as a consequence there are many children and adults alive today who have our clinicians to thank for a second chance of life. (In fact, survival following respiratory ECMO treatment in Leicester last year was 15% higher than for patients treated elsewhere). The EMCHC ECMO unit is also the only unit providing a national transport service which stabilises patients at their local hospital before transporting them to a specialist centre. Obviously the decision to close the Leicester surgical service would also result in the closure of the ECMO service, as the doctors working in one also work in the other. This would mean that decades of experience, knowledge and innovation would be lost.

Our fifth rebuttal is that when assessing our surgical service NHS England stressed the importance of achieving a certain critical mass of patients. It therefore strikes us as either peculiar or convenient for those making the decisions on our future that this same principle does not apply when considering ECMO*.*

In summary the East Midlands Congenital Heart Centre is not a service which has stood still for the last four years, since the time of the last discredited review. We are confident that our clinical outcomes are now amongst the best in the country. We have invested in our people and our infrastructure and we have a vision to take the service to the next level within a new children's hospital.

With that in mind we are frankly incensed by the fact that NHS England can say in their press statement, following the latest critical review into children's cardiac services elsewhere that "We will be working closely with Bristol and other centres to support their plans to meet these standards in full." On the same day that we receive a letter saying that our service will close, with no sign of equivalent support.

If NHS England was genuinely seeking to support other centres we would expect, for example, that you would broker conversations that meant that children were treated in their nearest specialist hospital and in doing so, put an end to the ridiculous state of affairs where children in *North*amptonshire are referred to a centre in *South*ampton for no better reason than it was ever thus. If active commissioning of this kind took place then the 500 cases in 5 years' time standard would be achievable in Leicester. If intelligent commissioning of this kind is not within the remit of NHS England, we fail to see what value you add other than to arbitrarily ratify standards irrespective of the consequences.

I recognise that you will find this letter unwelcome but I must caution you against thinking that we are being parochial. If I thought for a moment that my medical and nursing colleagues were motivated simply by a desire to maintain the status quo, the conversation would be different. They are not and as such my Board and I will not sit by whilst NHS England destroys a fabulous service. **For the avoidance of doubt, we reject your stated intention to cease commissioning level 1 CHD services from us and we will use all the means at our disposal to reverse this intention.**

As requested, we have undertaken a factual accuracy check of your assessment of our compliance against the standards and our response to this is attached, together with an evidence file.

When we spoke on the telephone on 3rd July, we noted that the communication process around these decisions had thus far been less than satisfactory and you apologised for this. You also undertook to inform providers in advance of any further announcements so that we can brief our staff and local stakeholders. I understand from Paul Watson, Regional Director – Midlands and East for NHS England, that there is a plan in place to make announcements on Friday, with an embargoed release to a wide range of stakeholders (including providers) at 10am on Thursday. If that plan goes ahead, you will need to ensure that providers are notified **in advance of the wider release** so that we can brief our staff. The reason is that, given the profile of the issue, there is no chance of the embargo holding. This will apply whenever you actually make any announcements. I would of course encourage you not to move with such haste but that is ultimately your decision.

Finally, you say in your letter that "uncertainty about the future has been unsettling for staff and for patients and their families". Of course it has and we have been managing that uncertainty for years and yet still produce wonderful results for our children and families. If you truly want to put that "uncertainty to an end", it is in your gift but it will require you to listen to us and support us as active commissioners.

Yours sincerely

John Adler
Chief Executive

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 Stephen Graves, Chief Executive, Peterborough and Stamford Hospitals NHS Foundation Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 July 2016**
Subject:	**Proposed Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust**

Summary:

This report provides an update to the Health Scrutiny Committee for Lincolnshire on the proposed merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust.

This report covers the engagement phase of the proposed merger programme and also provides an update on the redevelopment work at Stamford and Rutland Hospital.

Actions Required:

(1) The Health Scrutiny Committee for Lincolnshire is requested to consider this report, in particular focusing on the following points:

- any impact of the merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust on services to patients from Lincolnshire; and
- the latest position with regard to developments at Stamford and Rutland Hospital.

(2) The Health Scrutiny Committee for Lincolnshire is requested to consider if it wishes to respond formally to the merger proposals, either at this stage or subsequently at the Full Business Case stage.

1. Background

Development of the Case for Merger

In October 2015 Monitor developed a strategic outline case, which suggested savings of approximately £10 million might arise from closer collaboration between Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust. In November 2015 Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust boards agreed to explore four levels of collaboration:

Option 1	Do nothing for now
Option 2	Shared back office function - leading an integrated back office
Option 3	As per option 2, plus two boards, one executive team and one operational organisation
Option 4	Merger into one organisation

A project management board was established and there was engagement between the two trust boards, leading to the development of an Outline Business Case.

Decision to Proceed with Merger

In May 2016, the boards of Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust considered an Outline Business Case that recommended the merger of the two Trusts. The Outline Business Case is available at the following link:

https://www.peterboroughandstamford.nhs.uk/about-us/working-with-hinchingbrooke/

The Executive Summary of the Outline Business Case is attached at Appendix A to this report. The presentation given to the two Boards in May 2016 is attached at Appendix B.

The boards agreed to the recommendations made in the Outline Business Case that in order to sustain and improve clinical services for patients and value for money for the taxpayer in Huntingdonshire, Greater Peterborough and South Lincolnshire, both Trusts would benefit from working as one organisation in the future.

Development of Full Business Case for Merger

The two Trusts have agreed to work together on a Full Business Case in readiness for a merger on 1 April 2017. This work commenced in June 2016 and the boards will consider the Full Business Case in September 2016, with final approval planned for November 2016.

Both hospital trusts are passionate about providing quality services that are better, safer and local and that can be easily accessible to the local population. However there are real challenges. Hinchingbrooke Health Care Trust is not sustainable in its current form either clinically or financially. Peterborough and Stamford Hospitals NHS Foundation Trust was

declared clinically and operationally sustainable but not financially sustainable by Monitor in 2013.

Having considered a range of options including doing nothing and joint working, merging the two organisations into one came out clearly as the preferred option to deliver clinically sustainable services and also reduce costs to the taxpayer.

While there will be a cost to merging, we have identified at least £9 million of savings to be made per annum, primarily in back office services, which will help improve the deficit position of both organisations in the future.

Engagement with Staff and Members of the Public on Outline Business Case

Both Trusts are fully committed to engaging with staff and members of the public, having started this process in board meetings which were held in public in May.

This engagement will continue through July, August and September as part of a dedicated engagement plan which will be used to help inform the Full Business Case. Residents, GPs, commissioners and service providers in South Lincolnshire fulfil a key stakeholder position in our engagement plan. The importance of retaining local views in a wider merged organisation is recognised, and one of the early considerations is the need to develop constituencies and governors that will separately represent, and therefore provide views from the three areas surrounding Stamford, Peterborough and Hinchingbrooke hospitals. This contrasts with the current approach at Peterborough and Stamford Hospitals NHS Foundation Trust, where there is a single public constituency. This development will be included in the engagement plan.

Further Period of Engagement After Approval of Full Business Case

There will be a further period of engagement following a review of the Full Business Case by both Trust boards in September, before the final approval in November 2016.

Both trusts are working with doctors and clinicians across the local health and social care economy, as part of the Cambridgeshire and Peterborough Sustainability and Transformation Plan, to provide sustainable and responsive urgent and emergency care and maternity/paediatric services. These areas are not under review as part of our merger plans, but they are being looked at by the wider health economy transformation programme.

Key Facts About the Two Trusts

The Outline Business Case includes the following key facts about the two Trusts:

	Hinchingbrooke Healthcare NHS Trust	**Peterborough and Stamford Hospitals NHS Foundation Trust**
Populations served	193,000	507,000
Main commissioners	Cambridgeshire and Peterborough Clinical Commissioning Group	Cambridgeshire and Peterborough Clinical Commissioning Group: 57% South Lincolnshire Clinical Commissioning Group: 22% NHS England: 10%

	Hinchingbrooke Healthcare NHS Trust	Peterborough and Stamford Hospitals NHS Foundation Trust
		Others: 11%
Forecast Turnover FY16	£112.6m	£260.8m
Forecast surplus/deficit FY16	£17.1m	£37.1m
Surplus as % of turnover	-15.1%	-14.2%
Number of sites	1	2
Number of beds	235 + 21 day case in Treatment Centre	611 + 22 intermediate care at Stamford
Staff (Whole Time Equivalent)	1,553	4,019
CQC overall rating	Requires Improvement	Good
National performance standards (Year to Date)	Failing ED 4 hour wait	Failing ED 4 hour wait

Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust provide services to a combined population of around 700,000 people living predominantly in Cambridgeshire, Peterborough and South Lincolnshire. Their FY16 combined income was £372 million with a combined forecast deficit of £54.8 million. Between them, they employ 5,572 whole time equivalent employees.

The main commissioner of services for both trusts is Cambridgeshire and Peterborough Clinical Commissioning Group although nearly a quarter of the Peterborough and Stamford Hospitals NHS Foundation Trust activity is commissioned by South Lincolnshire Clinical Commissioning Group.

Care Quality Commission Ratings

As detailed in the Outline Business Case, the two trusts have different Care Quality Commission (CQC) ratings. As overall headline scores, Hinchingbrooke Health Care NHS Trust is rated as 'Requires improvement' and is currently in special measures, whereas Peterborough and Stamford Hospitals NHS Foundation Trust has been rated 'Good'.

Peterborough and Stamford Hospitals NHS Foundation Trust had a CQC revisit in May 2015 to review identified areas following the main trust inspection in May 2014. The final report was received and published in July 2015 giving the trust an overall rating of 'Good'. A summary of their findings based on the initial inspection in 2014, with the updated scores for the areas they re-inspected in 2015 is shown in the table below.

There were areas of exemplary practice that the trust was commended for and some areas that were recommended for improvement particularly with regard to medical care in medical specialties. Stamford hospital was rated overall as 'Good' with all inspection domains rated 'Green'.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Hinchingbrooke Health Care NHS Trust was revisited by the CQC in October 2015, following its earlier inspection in September 2014. On re-inspection, the overall rating was 'Requires Improvement'. Urgent and emergency care services are rated 'Inadequate'. The summary report is shown in the table below.

The CQC identified material improvements since their last inspection and reported that the leadership team was well placed to continue the improvements made recently. They recommended that the trust should remain in special measures, with a re-inspection undertaken in May 2016. The outcome of this re-inspection is not yet known.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Clinical Benefits of Merger

The Outline Business Case details the clinical benefits of the merger, and includes the following summary:

> "With larger combined clinical teams, there are greater opportunities to sustain services across both sites. For example, with the additional five ED [*Emergency Department]* consultants recruited at Peterborough and Stamford Hospitals NHS Foundation Trust there will be more opportunities to sustain urgent care services at Hinchingbrooke Health Care NHS Trust. The additional radiology capacity recruited at Peterborough and Stamford Hospitals NHS Foundation Trust will make sustainable services, and seven day reporting more sustainable across the new enlarged organisation.
>
> Activity forecasts show that activity demand will continue to rise (even after QIPP *[Quality, Innovation, Productivity and Prevention]*) over the coming years. Of the four options being considered, option 4 *[merger]* reduces or eliminates the most barriers to flexible management of elective capacity and therefore best supports delivery of the Sustainability and Transformation Plan.
>
> As with other options, the strategy to provide a specialist 'frail medical specialist centre' by collocating acute medical care with primary care, therapy, step-down/intermediate care capacity, pharmacy and older peoples mental health is focussed on providing care for the growing elderly population. This strategy would be better supported by larger clinical teams offering recruitment and retention opportunities for community and acute geriatricians, a critical mass to support some sub-specialist clinical roles and varied training opportunities for all staff groups.

Financial Benefits and Costs of Merger

The Outline Business Case details the costs and benefits of the merger, summarising them as follows:

> "The estimated savings under this option are £9m associated with reductions in Board costs and corporate pay and total elimination of the agency spend in back office areas.
>
> The transition costs of £8m for this option are roughly equal to one full year of the anticipated level of savings. Costs include development of the full business case including legal, due diligence, CMA engagement costs of £4m, and redundancy costs of £2.5m plus £800k for project management and implementation costs."

The costs of transition are also set out in the following table, which formed part of the presentation to the Trust Boards in May 2016 (included as Appendix B to this report):

Category	Costs / £million				
	Year 1	Year 2	Year 3	Total	
				One-Off	Recurrent
Redundancy	(0.3)	(1.4)	(1.1)	(2.8)	
Project Transition Costs	(1.0)	(0.9)	0.0	(1.9)	
Legal and Due Diligence Costs	(1.8)	(1.5)	0.0	(3.3)	
IT Integration Costs	(1.0)	(1.5)	(1.5)	(4.0)	
CEO	0.0	1.9	0.0		1.9
Finance	0.3	0.3	0.3		1.0

Category	Costs / £million				
	Year 1	Year 2	Year 3	Total	
				One-Off	Recurrent
HR	0.0	0.5	0.5		0.9
Nursing	0.0	0.1	0.0		0.1
Facilities	0.5	0.5	0.0		1.0
IT/IS	0.0	0.0	0.8		0.8
Ops	0.0	0.5	0.0		0.5
Clinical Support	0.0	0.3	0.0		0.3
CEO site leadership	0.0	0.0	0.0		0.0
Additional 4%	0.0	0.0	0.8		0.8
Non-pay	0.0	0.0	1.8		1.8
TOTAL	**(3.3)**	**(1.3)**	**1.6**	**(12.0)**	**9.1**

Private Finance Initiative

The Health Scrutiny Committee for Lincolnshire has specifically requested information on the current position of the Private Finance Initiative (PFI) and its impact on finances. The Outline Business Case includes the following statement, which provides context for the PFI:

> "Since the move to the new Peterborough City hospital site in FY11, Peterborough and Stamford Hospitals NHS Foundation Trust has been operating at a financial deficit of around £40 million. This is due to reliance on locum and agency staff, below tariff payments, penalties associated with the rise in emergency activity, and the national tariff not covering the premium cost of PFI buildings. Achievement of above average cost improvement has failed to deliver a surplus position over the past four years.
>
> Peterborough and Stamford Hospitals NHS Foundation Trust is anticipating a reduction in its deficit largely through delivery of above average CIP [Cost Improvement Programme], and sustainability and transformation funding. This will reduce the forecast deficit to £17.2 million by FY21. Previous reports including the National Audit Office (2012) have identified that Peterborough and Stamford Hospitals NHS Foundation Trust also require an additional £15 million Depatment of Health permanent subsidy to meet the recognised gap between the tariff and the cost of the PFI. The benefit of this additional funding is not included in the financial plan. Including it would bring the deficit to £2 million. The benefits of merger would move the trust into a financial surplus position."

Stamford and Rutland Hospital

Peterborough and Stamford Hospitals NHS Foundation Trust remains committed to delivering services from our Stamford site in line with the strategy for the site as last updated to the Health Scrutiny Committee for Lincolnshire in February/March 2015. The Trist also maintains dialogue and engagement with the South Kesteven District Council and Stamford Town Council. Work began in June 2016 to improve the electrical infrastructure on the Stamford Hospital site and an application for planning

permission for a new, permanent, MRI scanner is due to be submitted mid-July. The business case to purchase the scanner and incorporate it on site is with NHS Improvement for approval. The work to refurbish the 'east' end of the site, which includes services such as outpatients, is awaiting the release of capital which is an issue across the whole of the NHS.

The Trust also continues to liaise with the Lakeside Healthcare, which runs the three GP practices in Stamford as well as practices in other areas, regarding their plans and developments with the aim to ensure coherent services for patients in South Lincolnshire, and will engage in the Lincolnshire Health and Care team following the release of their Case for Change Document on 29 June 2016.

Next Steps for the Merger

The next steps are outlined in the Executive Summary, attached at Appendix A. The key dates are as follows:

- September 2016 – Completion of a Full Business Case for decision by both Boards
- September – November 2016 (six weeks) - Further public engagement on Full Business
- November 2016 - If all the necessary approvals are received, implementation will commence
- 1 April 2017 - Subject to all necessary approvals being received, the merger would formally take place.

2. Conclusion

As part of this engagement plan, the Health Committee Scrutiny Committee for Lincolnshire can be assured that it will be kept up to date with developments on this proposal between now and November 2016. The Trust is also happy to gather members' views to inform the Full Business Case.

3. Consultation

The Health Scrutiny Committee for Lincolnshire is requested to consider whether it wishes to pass on any comments to Peterborough and Stamford Hospitals NHS Foundation Trust on the merger arrangements, set out in the Outline Business Case. Alternatively, the Committee may wish to respond to the engagement between September and November 2016 on the Full Business Case.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Outline Business case: Merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust – Executive Summary
Appendix B	Public Board Presentation of Outline Business Case

5. Background Papers

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

Outline Business Case: Merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust.

This report was written by Mandy Ward, Head of Communication at Peterborough and Stamford Hospitals NHS Foundation Trust, who can be contacted on 01733 678024 or Communications@pbh-tr.nhs.uk with assistance from the Health Scrutiny Officer

Merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust

Outline Business Case - Executive Summary

1. Executive summary

Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) and Hinchingbrooke Health Care NHS Trust (HHCT) both face significant sustainability challenges.

Sustainability challenge for PSHFT

In their assessment of PSHFT in 2013, the Contingency Planning Team appointed by Monitor found that while clinically and operationally sustainable, Peterborough and Stamford Hospitals NHS Foundation Trust is not financially sustainable in its current form.

PSHFT's financial position on 31 March 2016, i.e. the end of financial year FY16, is a deficit of £37.1m. Despite achieving above average cost improvements for the last few years, PSHFT will not be able to deliver a balanced budget for the foreseeable future without joint working with partners in the wider health economy.

The PSHFT recovery plan is based on three pillars: delivery of above average cost improvement; savings through collaboration with Hinchingbrooke; and agreement with the Department of Health that the £15m additional cost of the PFI not met by tariff should be separately funded.

The trust has a track record of delivering above average cost improvement for each of the past four years. External reviews have identified further savings, including Lord Carter which identified further opportunities to reduce bank and agency costs.

The Department of Health will need to commit to giving the trust long-term financial support at a level that provides stability for the trust. The National Audit Office (2012), the Contingency Planning Team (2013) and PriceWaterhouseCooper (2015) all identified the need for £25m additional ongoing tariff subsidy to meet the additional costs of the PFI. The trust currently receives £10m support in the form of a subsidy, and an additional £15m is required in future.

Monitor (2015) identified £10m potential joint savings from PSHFT working collaboratively with Hinchingbrooke through reducing back office and corporate costs.

A combination of all three will return the trust back to a position of financial surplus.

There are also clinical sustainability challenges for some services which could be mitigated through collaboration with Hinchingbrooke. Examples include gastroenterology and diagnostic imaging.

Sustainability challenge for HHCT

Hinchingbrooke Health Care NHS Trust (HHCT) is not sustainable in its current form, clinically or financially.

Despite the passion, commitment and hard work of the hospital staff, there are services that HHCT is currently struggling to provide sustainably for its local population. Amongst those most affected are clinical haematology (blood disorders), the Emergency Department (ED) and stroke services, primarily because it has not been possible to recruit to all of the permanent consultant posts for these services.

As a result of Hinchingbrooke's size and case mix, it is likely to face further clinical service sustainability issues in the near future. HHCT's emergency department is the third smallest in the country and relies significantly on locum doctors to provide a safe service. This is not a sustainable option in the long term.

Other services such as orthogeriatrics, neurology, cardiology and end of life care services are also significantly challenged due to the size of the teams delivering the services.

In the current configuration, HHCT is too small for the continued future provision of high quality sustainable modern healthcare to its local population. The HHCT Board recognises that alternative solutions are required to ensure that all the existing services continue to be provided locally on the Hinchingbrooke site in the future.

The financial challenge at HHCT is also significant.

- At 15.2%, it has one of the largest financial deficits as a proportion of turnover in the country; a FY16 deficit of £17.1m on £112m turnover
- The recent national financial efficiency work led by Lord Carter, identified HHCT as being the second most financially inefficient hospital in the country.
- HHCT annual reference costs are 14% greater than the average costs across the country of providing the same volume and case mix of activity.

There is a financial plan to recover this deficit over the next five years which relies on ambitious cost reduction, significant additional revenue from a proposed Health Campus, and collaboration with other organisations to reduce back office costs. However, even if fully delivered, the clinical sustainability issues remain.

The Local Health Economy

The Cambridgeshire and Peterborough CCG total population is forecast to grow by 10% between 2016 and 2021, with Peterborough growing by 11% and Huntingdon over 65 age group growing by 17%. As people age, they are progressively more likely to live with multiple illnesses, disability and frailty, and therefore we can expect increased pressure and demand for services and care at HHCT and PSHFT in the future.

The latest projections across Cambridgeshire and Peterborough show that the financial deficit across the NHS providers and commissioners is likely to be £250m by FY21 if things continue as they have done in the recent past. The system has incurred a collective deficit of £150m in FY16, which is one of the highest per person in the country.

Meeting the future demands on services, while maintaining and improving clinical sustainability for patients within the tight financial envelope, means there is a growing need for providers to work together and differently in the NHS.

Sustainability and transformation plan

Across the country, local commissioners are leading their health and social care organisations in working together to identify how these clinical and financial challenges can be met by developing Sustainability and Transformation Plans (STP) by June 2016.

Lincolnshire Clinical Commissioning Groups are doing this to cover the south Lincolnshire patients although it mainly focusses on the acute providers within Lincolnshire. PSHFT and HHCT are directly involved with the STP that is being led by Cambridgeshire and Peterborough Clinical Commissioning Group and focusses upon:

1. End to end pathway redesign including primary and secondary care
    - Sustainable General Practice
    - Proactive care and prevention
    - Urgent and Emergency Care (CPCCG is a national Vanguard site)
    - Elective care design
    - Maternity and neonatal services
    - Children and Young People
2. Greater collaboration between HHCT and PSHFT
3. Financial incentives alignment
4. Utilisation of estate across Cambridgeshire and Peterborough
5. Increasing the effective use of staff skills and experience

Collaboration between HHCT and PSHFT

The STP work includes collaborative working between HHCT and PSHFT.

Material changes to how these services are designed and delivered may happen as a result of other commissioner led work streams, but this is **not** an area which will be decided by the outcome of this Outline Business Case, or Full Business case approval decisions. If as part of the wider STP work, significant changes to these pathways are proposed by the CCG, they would be subject to public consultation before implementation.

Maintaining core acute services at Hinchingbrooke Hospital

Both trusts are passionate about providing services which are better, safer and local. They are committed to providing high quality care that is easily accessible to the local population. There may be future changes, particularly as a result of the STP, but **there is a joint commitment from both trusts to ensure the ongoing provision of safe, sustainable core acute services from Hinchingbrooke Hospital.**

Key findings of the Outline Business Case (OBC)

This document describes the drivers, options and potential benefits of greater collaboration between Hinchingbrooke Health Care NHS Trust (HHCT) and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT).

This business case shows that merger of HHCT and PSHFT will:

1. Support the ongoing provision of fragile clinical services locally on the HHCT site
2. Improve sustainability of some clinical services in PSHFT
3. Enable financial benefits of more than £9m to be achieved through the integration of back office functions
4. Improve staff experience with more realistic rotas, increased training and educational opportunities, and in so doing, improve retention and recruitment.
5. Offer more robust infrastructure for example through the single procurement and running of IT; greater flexibility of major equipment and more robust business continuity
6. Provide real engagement with the local community through the development of a membership strategy and body in Huntingdonshire. PSHFT has over 9,000 members with public and staff representation on the Council of Governors and the ability to appoint the Non-Executive Directors and hold the Board to account. This would be expanded to Huntingdonshire as a part of a merger.

Next steps

If the OBC recommendations are approved, a Full Business Case (FBC) for the merger of HHCT and PSHFT will be produced. Timelines agreed by both boards and the regulator for the next steps are:

Engagement with the public will start from the OBC decision, and formally after the European referendum at the end of June
by September 2016, complete a Full Business Case for decision by both Boards
Further public engagement post FBC decision for six weeks
from November 2016, if the FBC is approved by both Boards and the regulator, commence implementation
Subject to all necessary approvals, the formal merger would take place on 1 April 2017.

The FBC will be the document upon which the final decision by the Boards will be made on the collaboration between the organisations. The FBC will then be sent to regulators for review and approval. This will include the main conclusions contained in the body of the OBC and a more detailed review of both organisations, the case for change and the opportunities and risks associated with any future transaction.

During the interim period, both trusts will work together to provide safe sustainable services, particularly in those areas already identified as being unsustainable.

To ensure these plans are considered and commented on both internally and externally, public engagement will be undertaken over a four month period.

These benefits, and others to be explored as a full business case is prepared, will be delivered through a merged organisation. This will be achieved by April 2017 with some benefits being realised from autumn 2016 and the full benefits being delivered over a four year timetable, i.e. autumn 2020.

Recommendation from Stephen Graves, CEO PSHFT and Lance McCarthy CEO HHCT

The Boards at both trusts are asked to approve this Outline Business Case which shows the clear clinical and financial benefits for both organisations.

In doing so the Boards agree to work together to deliver a Full Business Case (FBC) by the end of September 2016. The FBC will confirm the date (subject to approval) of a merged organisation. This is currently planned to be 1st April 2017.

PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST
HINCHINGBROOKE HEALTH CARE NHS TRUST

POWERPOINT PRESENTATION GIVEN TO PUBLIC BOARD MEETGINS
MAY 2016

Hinchingbrooke Health Care NHS
NHS Trust

Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

PSHFT and Hinchingbrooke merger

Hinchingbrooke Health Care NHS
NHS Trust

Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

THE JOURNEY SO FAR

Reminder: Our 'challenged' health system

'Cambridgeshire and Peterborough area is one of 11 challenged health economies in England'
- NHS England, Monitor and the Trust Development Authority

- The System-wide Sustainability and Transformation Programme, led by Cambs and Pboro CCG, began in 2014 to look at all NHS-funded, hospital-based, GP and community healthcare services – with the aim of developing services that are clinically, operationally and financially sustainable for the future
- Under this banner, in January 2016, Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS FT announced they were working collaboratively to reduce duplication and costs, and support the future delivery of sustainable services for the benefit of patients, staff and taxpayers

Background

HHCT

- 1983 hospital opened
- 2005 new treatment centre opened
- 2005- Trust in financial deficit and clinically unsustainable
- 2005 SHA review of services
- 2009 EoE SHA announces HHCT franchise tender
- 2010 PSHFT joint bid with Serco to operate Hinchingbrooke hospital
- 2012 Circle awarded franchise and begin managing Hinchingbrooke
- 2015 CQC rates HHCT inadequate with lack of clinical sustainability
- 2015 Circle withdraw early from the contract citing unsustainable losses

PSHFT

- 2004 first wave Foundation Trust
- 2002-2008 In financial surplus
- 2010 move to PFI building, Trust reports a £45m deficit in 2010/11
- 2010 PSHFT joint bid with Serco to operate Hinchingbrooke hospital as a franchise
- 2012 Monitor appointed CPT finds PSHFT clinically and operationally sustainable but financially unsustainable
- 2012 NAO and CPT identify approximately £20-25m shortfall between PFI cost and tariff
- 2013 Project Orange to franchise PSHFT (Project Orange)
- 2015 CPCCG challenged health economy and Project Orange paused

- 2015 Strategic outline case recommends closer collaboration between HHCT and PSHFT
- 2016 HHCT and PSHFT commence business case

- **Summary**
- PSHFT is clinically and operationally sustainable, but with specific challenges BUT is not financially sustainable;
- HHCT is neither clinically or financially sustainable in its current form;
- Cambridgeshire and Peterborough is one of the most financially challenged systems in the Country.

'As the Accountable Officer I have a duty to look at the options to improve this Trust's and the whole health systems position, balancing the needs of patients, staff, the public and the taxpayer'

In doing so Lance and I have made the following statement:

'Both trusts are passionate about providing services which are better, safer and local. They are committed to providing high quality care that is easily accessible to the local population. There may be future changes, particularly as a result of the STP, but there is a commitment from both trusts to ensure the ongoing provision of safe sustainable core acute services from Hinchingbrooke Hospital

5

Outline business case

- October 2015 Monitor led strategic outline case suggests £10m savings from closer collaboration
- November 2015 HHCT and PSHFT boards agree to explore four levels of collaboration:
  - Option 1 - Do nothing for now
  - Option 2 - Shared back office function - leading an integrated back office
  - Option 3 - As per option 2, plus two boards, one executive team and one operational organisation
  - Option 4 - One organisation
- Project Management Board established
- Engagement between two Trust Boards
- OBC developed
- Option appraisal- option 4 preferred choice

6

Outline business case

- October 2015 Monitor led strategic outline case suggests £10m savings from closer collaboration
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  - Option 4 - One organisation
- Project Management Board established
- Engagement between two Trust Boards
- OBC developed
- Option appraisal- option 4 preferred choice
- **Recommendation: The Boards at both trusts are asked to approve this Outline Business Case which shows clear clinical and financial benefits for both organisations.**
- **The Boards agree to work together to deliver a Full Business Case by end September 2016. The FBC will confirm the date (subject to approval) of a merged organisation. This is currently planned to be 1st April 2017**

7

Hinchingbrooke Health Care NHS NHS Trust

Peterborough and Stamford Hospitals NHS NHS Foundation Trust

CLINICAL SERVICES - SUSTAINABILITY

8

Clinical Case for Change

- Some services in both organisations are clinically fragile now, with further services at risk in the medium-term
- Contributory factors:
  - Smaller teams compared to teaching trusts and larger DGH's can make recruitment difficult
  - Agency spending caps
  - 7-day working
  - Junior Doctors contract and provision of compensatory rest
- Meeting future challenges requires looking outside traditional organisational boundaries
- For both organisations, integrated collaboration largely resolves the clinical sustainability issues

Clinical Case for Change

Merger joins all clinical teams under a single operational management structure:

- larger teams
- medical staff working equitably across locations
- shared workload, rotas and out of hours cover.

Merger maximises opportunities for:

- Single governance arrangements, clinical policies, management arrangements and operational procedures
- Greater flexibility for staffing and service provision across sites
- Greater opportunities for training and sub-specialism
- Support staff recruitment and retention
- Reduce agency
- Senior decision-makers at key points in the patient pathway
- Clinical consistency with shared best practice protocols

Our Joint Vision

Delivering excellence in care in the most efficient way in hospitals where it is great to work

Our Joint Strategy

Clinical Excellence
Doing the very best for our patients

Financial Sustainability
Getting value for money for taxpayers for our services

Operational Sustainability
Making the most of our hospitals for the future

Underpinned by Our Values

Across the populations of South Lincolnshire, Peterborough and Huntingdonshire we will…

Provide safe and timely care for our patients

Ensure that our staff feel valued and have opportunities for development

Design our services to meet the changing needs of our patients

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Clinical sustainability

Clinical Sustainability is defined as:

Provision of resilient, high quality, best value care locally both now and into the future in accordance with all relevant requirements

Clinical unsustainability is defined as one or more of

- Inability to recruit competent substantive staff
- Inability to match provision to demand
- Inability to meet required service and quality standards

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Clinical sustainability

Services are under significant pressure in both Trusts, but HHCT services are particularly challenged:

- No specialist consultant cover for some services
- High staff vacancies in a number of wards / areas
- High use of agency / locum staff at premium cost – ability to provide cover now compounded by agency caps
- Senior Nurse leadership capacity is challenged

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Clinically unsustainable services at HHCT

- **A&E** unable to recruit medical staff
  - 40% vacancy rate for middle-grade doctors
  - 66% vacancy rate for consultants
  - Nursing recruitment and retention
- **Haematology** – no haematology consultants; service covered by locum haematologists and two substantive haematology specialist nurse.
- **Stroke rehabilitation** – No specialist stroke physicians, and insufficient therapy support

'Fragile':

- **Back Pain** – discontinuation of spinal orthopaedic service and wider impact on system chronic pain services

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Services at risk of becoming unsustainable at HHCT & PSHFT

Future challenges associated with

- Agency spending cap
- 7-day working
- Junior Doctors contract – compensatory rest

Services identified in the OBC:

HHCT	PSHFT
Acute Medicine	Diagnostic Imaging
Cardiology	Interventional radiology
Diagnostic Imaging	Gastroenterology - 7 day bleed service
Interventional Radiology	Stroke
Nephrology	Ortho-Gerontology
Neurology	
Ortho-Gerontology	
Palliative care	

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Conclusion

Compelling case for clinical collaboration to address service vulnerability, particularly for the population of Huntingdon who are currently disproportionately disadvantaged

Clinical collaboration will strengthen the provision of a number of services across both sites to ensure long term, sustainable, high quality health services for the populations of both Peterborough and Huntingdon

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FINANCIAL REVIEW

17

PSHFT five year break even plan

- PSHFT forecast deficit for FY17 of £21.7m
- Deficit reduced by:
  - above average CIP for two years
  - NAO and PwC estimate additional £15m PFI subsidy on top of the existing £10m required from DH
  - £5m saving from collaboration with HHCT

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OBC savings from merger

Departments	units	New baseline	Merger
CEO	£'m	3.7	1.8
Finance	£'m	5.9	4.9
HR	£'m	4.6	3.6
Nursing	£'m	4.8	4.7
Facilities	£'m	34.7	33.7
Ops	£'m	2.1	1.6
IT/IS	£'m	6.5	5.7
Clinical Support	£'m	63.8	63.5
CEO Challenge site leadership reductions	£'m	0.0	(0.02)
Additional 4% CIP reduction on pay in yr 2	£'m	0.0	(0.8)
Non-pay	£'m	0.0	(1.8)
TOTAL COSTS	**£'m**	**126.0**	**117.0**
Saving against baseline	£'m	0.0	**9.1**
WTE reduction	wte		-70

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Process to agree savings and costs of al 4 options

- Overseen by collaboration PMB
- PMB updated on savings calculation and process at each meeting
- PMB approved key assumptions on certain category of potential savings
- Executive to Executive agreement by department
- CEO review and challenge
- CEO overall year 2 extra efficiency challenge and some grade reduction
- Option appraisal process considered impact of any variation of estimated savings on scoring and decision for option 4
- External consultancy have reviewed the calculations

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OBC costs of transition

Category	Cost/£m				
	Yr1	Yr2	Yr3	Total One-off	Total Recurrent
Redundancy	(0.3)	(1.4)	(1.1)	(2.8)	
Project Transition Costs	(1.0)	(0.9)	0.0	(1.9)	
Legal and due diligence costs	(1.8)	(1.5)	0.0	(3.3)	
IT Integration Costs	(1.0)	(1.5)	(1.5)	(4.0)	
CEO	0.0	1.9	0.0		1.9
Finance	0.3	0.3	0.3		1.0
HR	0.0	0.5	0.5		0.9
Nursing	0.0	0.1	0.0		0.1
Facilities	0.5	0.5	0.0		1.0
IT/IS	0.0	0.0	0.8		0.8
Ops	0.0	0.5	0.0		0.5
Clinical Support	0.0	0.3	0.0		0.3
CEO site leadership	0.0	0.0	0.0		0.0
Additional 4%	0.0	0.0	0.8		0.8
Non-pay	0.0	0.0	1.8		1.8
Total	(3.3)	(1.3)	1.6	(12.0)	9.1

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What happens next

- If boards agree to explore merger, commence a Full Business Case
- Prepared over the summer and presented in September 2016
- Engage with staff and the public
  - During FBC development (June to Sept)
  - After FBC presented to Boards (Sept to Nov)
- Build Governor and Membership base in Huntingdon
- Regulator approval from December 2016 to February 2017
- Work with fragile clinical services (June to Dec)
- Build clinical case and early collaboration commences(June to Dec)
- Commence organisational development programme
- Merge April 2017
- Implementation and benefits 2017-2020

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 Partnership NHS Foundation Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**29 July 2016**
Subject:	**Lincolnshire Partnership NHS Foundation Trust – Response to the Care Quality Commission Comprehensive Inspection**

Summary:

The purpose of this report is to provide the Health Scrutiny Committee for Lincolnshire with assurance that Lincolnshire Partnership NHS Foundation Trust (LPFT) is making progress with implementation of the action plan arising from the Care Quality Commission (CQC) Comprehensive Inspection, which took place between 30 November and 4 December 2015.

Actions Required:

(1) The Committee is asked to note progress on implementing the action plan arising from the Care Quality Commission's comprehensive inspection and the process by which the plan is monitored.

(2) To comment as necessary on the content of the report.

1. Background

The Care Quality Commission (CQC) inspected eleven service areas of Lincolnshire Partnership NHS Foundation Trust (LPFT) and on 23 April 2016 published a detailed report for each along with an overall provider report. Copies of the CQC reports are available on the Trust website and the ratings given to services by the CQC are displayed across the

service areas so that patients, carers and visitors can see the results. A summary of the outcomes is attached at Appendix A.

Overall the organisation was rated "Requires Improvement" with a "Good" rating for caring in all services inspected and an "Outstanding" rating for community based Child and Adolescent Mental Health Services. The rating for "safe" was "Inadequate", due to concerns from the CQC about Mixed Sex Accommodation and Points of Ligature.

Action Plan

Following publication of the CQC Report on 23 April 2016, LPFT was required to submit an action plan covering the five CQC domains and to address the issues raised in the reports. This plan was submitted to the CQC in early June 2016 in line with the CQC deadline.

This is a key plan for the organisation as it moves forward with learning from the inspection. A copy of the action plan was considered by the Board of Directors of LPFT on 30 June 2016, in public session, and is available at the website address: www.lpft.nhs.uk.

In terms of the development of the action plan, immediately following the inspection, a plan was in place to address the initial feedback given by the CQC during the inspection visit. This included Mixed Sex Accommodation breaches and Points of Ligature where action was taken to make immediate changes to both. This secured patient safety immediately. An example of this was putting up a safety fence at the Ash Villa Unit given the outside space was one where there were trees and other possible points of ligature.

The action plan was then updated following the publication of the CQC reports and the latest version of the action plan includes all of the immediate “must do” and “should do” actions identified as a result of the inspection provider report as well as individual service area actions required in the provider reports. The action plan also includes progress on the well led domain.

In total there are approximately 100 actions in the action plan – each has an accountable person along with the evidence of progress being made and the key milestones for each action.

The CQC Action Plan forms a part of the overall Quality Improvement Plan, which is in place for the organisation and includes the wider transformational activities that the services are taking forward through initiatives to improve care for patients, staff satisfaction and wider Lincolnshire developments.

Monitoring the Plan

The action plan describes the accountable and responsible officers along with the actions to be taken and timescales. Assurance and evidence columns are populated with hyperlinks through to documentation (which will be stored on the LPFT intranet site for staff and audit access).

A review and reporting process is in place and further reports on progress will be available monthly. Where evidence is photographic, for example a stair rail, a dated image will be stored as the evidence.

A diagram describing how the action plan will be monitored internally to LPFT is attached as Appendix B.

Internal monitoring of the plan is led by the LPFT Director of Operations, who is the executive sponsor, liaising on a regular basis with Clinical Division leaders and through the internal Operations Governance meetings.

The pulling together of factual evidence of progress is through the Compliance Team, who will produce reports to the Quality Committee for scrutiny at each meeting.

The Chief Executive has further oversight of progress through regular updates to the Executive Team and assurance is given to the Trust Board of Directors via the scrutiny of the action plan performed by the Quality Committee.

A quarterly meeting is being established with NHS Improvement and NHS England/Clinical Commissioning Group colleagues to ensure that there is one process for advising stakeholders on progress with the action plan.

Quality Summit and feedback on the action plan

Following feedback from the Quality Summit and in addition from NHS Improvement on the action plan, the following work is being undertaken to strengthen it further: -

- Incorporation of the CQC well led key line of enquiry into the action plan (complete);
- Completion of the Assurance and Evidence columns (will be complete end of July 2016);
- Description of the monitoring process (complete); and
- Consideration, by the Board of Directors, of the Well Led Domain.

Risks

Identification of risks to delivery will be included in the Clinical Divisional Risk Registers and escalated to the Operational Risk Register according to the established system of recording and reporting risk and mitigation. Risks to delivery are described and monitored as part of the Trust Board Assurance Framework on a monthly basis.

Assurance and oversight

Assurance on progress is overseen by the Health Scrutiny Committee for Lincolnshire, NHS Improvement, NHS England, South West Lincolnshire Clinical Commissioning Group through regular contact and quarterly meetings.

LPFT teams have made good progress including on addressing the areas of concern relating to the SAFE domain of the CQC inspection.

The main areas of concern about SAFE related to patients on wards in mixed gender areas (mixed sex accommodation breaches at Ash Villa, Sleaford (inpatient child and adolescent unit) and Peter Hodgkinson Centre, Lincoln (inpatient acute mental health wards) and on points of ligature that may be used by patients to harm themselves (either removed or the risk associated with them assessed and managed).

The point of ligature concerns related to some points of ligature inside some of the LPFT patient building areas (inpatient and rehabilitation services) and possible points of ligature in outside/external areas in the immediate surrounding areas of buildings that patients have access to.

The latest report on progress to the Trust Board (30 June 2016) confirmed, for the "must do" areas of the CQC report that relate to the organisation as a whole (and that relate to mixed sex accommodation and points of ligature specifically) are ON TRACK with areas of concern about progress clearly highlighted and action being taken, through named individuals, to address them.

On Mixed Sex Accommodation and Points of Ligature, the Director of Nursing and Quality and the Director of Operations respectively lead task and finish groups to review safety, privacy and dignity along with best practice relating to these important patient issues.

The Trust implemented a smoke free policy on 28 June 2016, which will also allow existing outside spaces that were used for patients to smoke to be improved and upgraded.

2. Conclusion

As a learning organisation, LPFT welcomes the feedback given by the CQC as part of the inspection and is making progress on the areas identified in the CQC inspection. The Board of Directors has a clear line of sight, through the action plan, on continued progress and will update the Health Scrutiny Committee on a regular basis as required.

3. Consultation

There are no issues of public consultation arising from this report.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Summary of the CQC ratings for LPFT in the Comprehensive Inspection
Appendix B	Flow chart of the internal LPFT monitoring process

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 Jane Marshall, Director of Strategy and Performance at Lincolnshire Partnership NHS Foundation Trust, who can be contacted on 01529 222244 or jane.marshall@lpft.nhs.uk

Care Quality Commission

Last rated
21 April 2016

Lincolnshire Partnership NHS Foundation Trust

Overall rating	Inadequate	Requires improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Child and adolescent mental health wards	Inadequate	Good	Good	Good	Requires improvement	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Requires improvement	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for older people	Good	Requires improvement	Good	Good	Good	Good
Forensic inpatient/secure wards	Requires improvement	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Specialist community mental health services for children and young people	Good	Outstanding ☆	Outstanding ☆	Good	Good	Outstanding ☆
Substance misuse services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

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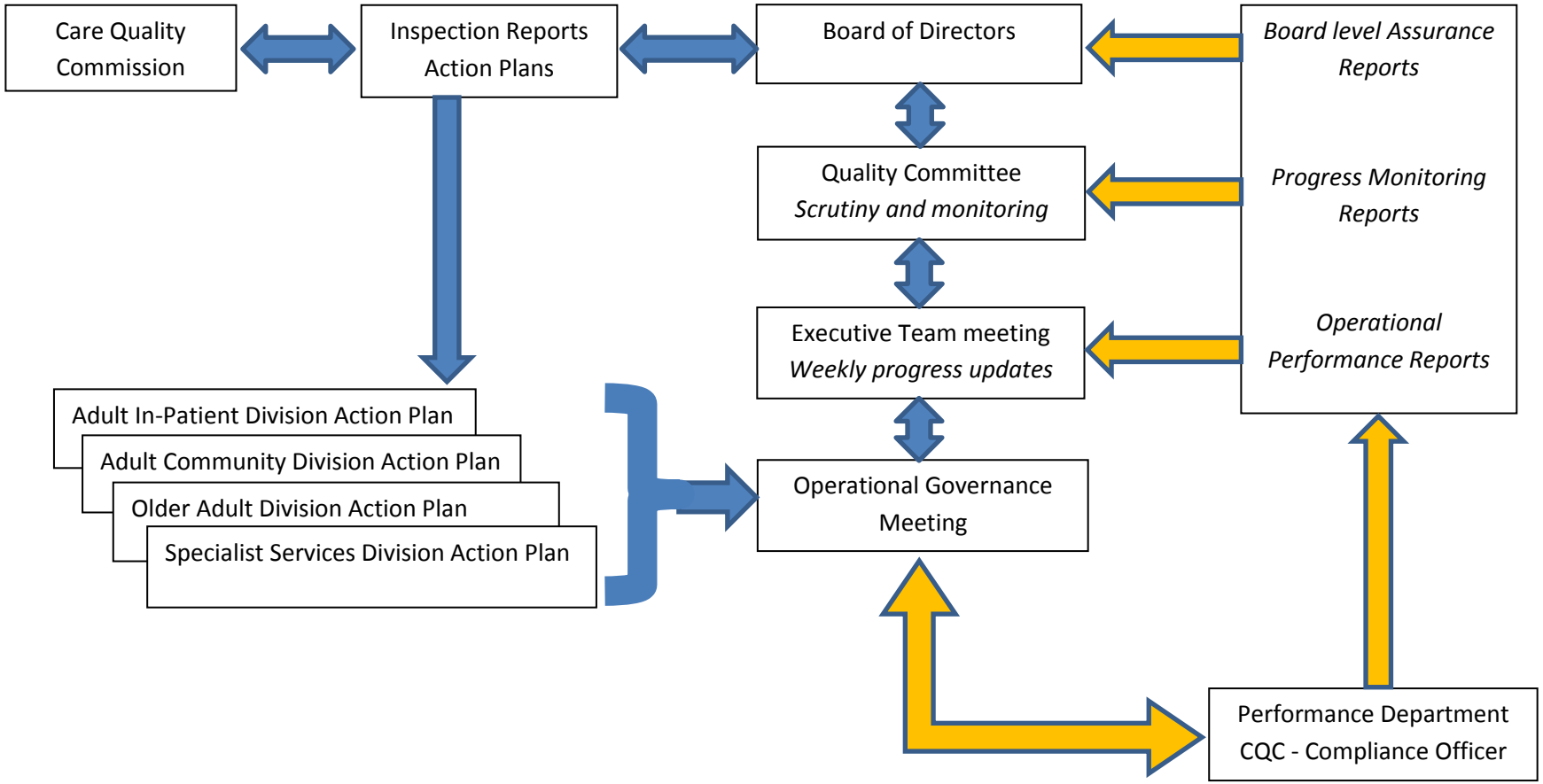
Care Quality Commission Inspection Report
Governance Arrangements



Blue arrows indicate lines of accountability: Yellow arrows indicate performance and assurance reports

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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 NHS England and NHS Improvement

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 July 2016**
Subject:	**Lincolnshire Recovery Programme**

Summary

The purpose of the Lincolnshire Recovery Programme is to oversee the delivery of the NHS Constitutional Standards; improvements in the quality of care; and actions to address financial balance within the Lincolnshire health economy. There is a monthly Programme Board, whose membership includes:

- all the Accountable / Chief Officers from the four Lincolnshire Clinical Commissioning Groups (CCGs);
- all the Chief Executives from the three main Lincolnshire providers (Lincolnshire Community Health Services NHS Trust; Lincolnshire Partnership NHS Foundation Trust; and United Lincolnshire Hospitals NHS Trust);
- senior officers from NHS England and the NHS Improvement (NHSI); and
- a senior officer from Lincolnshire County Council.

Actions Required:

To consider and comment on the content of the report, in particular focusing on the extent of the positive outcomes of the Lincolnshire Recovery Programme to date.

1. Background

The Lincolnshire Recovery Programme (LRP) has been developed to provide a senior level coordinating programme structure that supports performance improvement and the

further development of a clinically safe and financially sustainable health and care model across Lincolnshire.

The aims of the Lincolnshire Recovery Programme are to: -

- improve United Lincolnshire Hospitals NHS Trust's (ULHT's) performance against the NHS Constitutional standards so that all required targets are achieved;
- continue to improve quality within ULHT and across the health community;
- develop a financial strategy and plan to deliver improvements to the financial position across Lincolnshire; and
- design an underpinning workforce/ organisational development strategy and plan.

The Lincolnshire Recovery Programme Board is jointly chaired by NHS England and NHSI.

The Sustainability and Transformation Plan and Lincolnshire Recovery Programme

Updates on the Lincolnshire Sustainability and Transformation Plan (STP) are received at the Lincolnshire Recovery Programme Board, and discussions are held between the chief officers, NHS Improvement and NHS England on STP matters that relate to the scope of the Lincolnshire Recovery Programme.

It is anticipated that the Lincolnshire Recovery Programme will continue beyond the initial twelve months included within the terms of reference, given there are still significant issues, whilst recognising there have been improvements in both performance and in the way in which the member organisations work together. The decision on whether to extend the Programme beyond the original twelve month duration will be taken formally at the next meeting of the Lincolnshire Recovery Programme Board.

NHS England and NHS Improvement

NHS England leads the National Health Service (NHS) in England. It sets the priorities and direction of the NHS, for example in strategies such as the *Five Year Forward View.* NHS England is organised into four regional teams. Lincolnshire is in the Midlands and East Regional Team area. The Regional Teams provide support to Clinical Commissioning Groups (CCGs), in areas such as healthcare commissioning and delivery; they provide professional leadership on finance, specialised commissioning, human resources and organisational development. In addition to working with CCGs, the Regional Teams work closely with local authorities, health and wellbeing boards as well as GP practices.

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. NHS Improvement offers the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHS Improvement helps the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams.

Purpose of the Lincolnshire Recovery Programme Board

1. To oversee achievement of the programme aims for an initial period of twelve months from July 2015, after which time those responsible for health and care system delivery will be in a position to no longer require this level of intervention.

2. To agree a programme structure that holds senior leadership from all represented organisations to account and oversee high level intervention and support.

3. To ensure that the boards of each organisation represented are signed up to the LRP aims and programme structure.

4. To accept recommendations from the Operational Programme Group with regards to the scope and expected outcomes from the programme work streams.

5. To act upon exception reports and items for escalation from the Operational Programme Group, in order to ensure the programme aims are achieved.

6. To ensure that dependency issues between the LRP and the Lincolnshire Health and Care (LHAC) Programme are managed in a manner that avoids duplication between the programmes or adverse impacts on either programme.

7. To identify the need for additional support to facilitate achievement of the Programme aims and agree approaches for securing the support.

2. Conclusion

Outcomes of the programme to date include:

1. Improved working relationships between the constituent NHS organisations, and a new focus on joint action, led by a new Lincolnshire Leaders working group. Evidenced by prompt signature of the 2016/17 contract between ULHT and its lead commissioner.

   Outcome 1 relates the Lincolnshire Recovery Programme's aim of continuing to improve quality within ULHT and across the health community.

2. Consistent delivery of the Referral to Treatment (RTT) incomplete standard of 92%.

   Outcome 2 relates to the Lincolnshire Recovery Programme's aim of improving United Lincolnshire Hospitals NHS Trust's (ULHT's) performance against the NHS Constitutional standards so that all required targets are achieved.

3. Consistent delivery of the national target for diagnostic waiting times.

Outcome 3 relates to the Lincolnshire Recovery Programme's aim of improving United Lincolnshire Hospitals NHS Trust's (ULHT's) performance against the NHS Constitutional standards so that all required targets are achieved.

4. ULHT is currently off track against the Quarter 1 trajectory for the 62 day cancer standard. Improvement progress is monitored on a weekly call between NHS Improvement, NHS England, ULHT and Lincolnshire CCGs, and an improvement trajectory has been agreed.

Outcome 4 relates to the Lincolnshire Recovery Programme's aim of improving United Lincolnshire Hospitals NHS Trust's (ULHT's) performance against the NHS Constitutional standards so that all required targets are achieved.

5. The A&E standard (95% within 4 hours) varies by site and is the subject of intense support from all parties. A revised trajectory for delivery has been agreed by NHS Improvement and NHS England. Performance in April 2016 was better than the agreed monthly trajectory and performance in May and June is likely to be on or around the trajectory agreed. Current year to date delivery is 81.4% (at 17 June16).

Outcome 5 relates to the Lincolnshire Recovery Programme's aim of improving United Lincolnshire Hospitals NHS Trust's (ULHT's) performance against the NHS Constitutional standards so that all required targets are achieved.

6. ULHT delivered its revised deficit target for 2015/16, recording a year end deficit of £57 million, (original planned deficit target was £40 million). The Trust's control total for 2016/17 is a deficit of £48 million. Year to date (April and May 2016), ULHT has delivered a deficit of £8.0 million, a position that is £0.4 million better than plan. The STP includes a section on "closing the finance and efficiency gap", describing in outline the approach being developed to address the current circa £60 million system deficit and the financial gap forecast for 2020/21, if no remedial actions are taken. Further information on this and on the NHS England/ NHS Improvement review of the June STP submission can be provided at the meeting.

Outcome 6 relates to the Lincolnshire Recovery Programme's aim of developing a financial strategy and plan to deliver improvements to the financial position across Lincolnshire.

7. The Lincolnshire Health and Care (LHAC) Programme also reports on progress to the Lincolnshire Recovery Programme Board, although LHAC is subject to a separate governance and decision making structure.

Outcome 7 relates to the Lincolnshire Recovery Programme's aim of designing an underpinning workforce/ organisational development strategy and plan. Workforce modelling forms part of the LHAC programme.

3. Consultation

This is not a 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 Jim Heys, NHS England, Locality Director – Midlands and East (Central Midlands) and Ian, Senior Delivery and Development Manager, NHS Improvement who can be contacted via
Jim.Heys@nhs.net and ian.hall9@nhs.net

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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 Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 July 2016**
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

20 July 2016		
Item	**Contributor**	**Purpose**
Proposed Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust	Stephen Graves, Chief Executive, Peterborough and Stamford Hospitals NHS Foundation Trust Caroline Walker, Deputy Chief Executive and Director of Finance, Peterborough and Stamford Hospitals NHS Foundation Trust.	Update Report
Lincolnshire Partnership NHS Foundation Trust – Response to Care Quality Commission Inspection Report	Dr John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust	Update Report
East Midlands Ambulance Service NHS Trust – Response to the Care Quality Commission Report	Mike Naylor, Director of Finance, East Midlands Ambulance Service NHS Trust Steve Kennedy, Assistant Lincolnshire Divisional Manager, East Midlands Ambulance Service NHS Trust	Update Report
Lincolnshire Recovery Programme Board	Jim Heys, Locality Director NHS England – Midlands and East (Central Midlands) Ian Hall, Senior Delivery and Development Manager, NHS Improvement	Update Report

21 September 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Cancer Strategy	Sarah-Jane Mills, Director of Planned Care and Cancer Services at Lincolnshire West Clinical Commissioning Group	Update Report

21 September 2016		
Item	**Contributor**	**Purpose**
Urgent Care Update	Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group	Update Report
United Lincolnshire Hospitals NHS Trust - Pharmacy Services	Colin Costello, Director of Pharmacy and Medicines Optimisation, United Lincolnshire NHS Trust	Update Report
Quality Accounts 2015-16 – Priorities and Comments of the Health Scrutiny Committee	Simon Evans, Health Scrutiny Officer	Status Report

26 October 2016		
Item	**Contributor**	**Purpose**
Dental Services Contracts in Lincolnshire	To be confirmed	Status Report
Lincolnshire West Clinical Commissioning Group Update	To be confirmed	Status Report
Butterfly Hospice	To be confirmed	Status Report

23 November 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Health and Care – Consultation	To be confirmed	Consultation
Queen Elizabeth Hospital, King's Lynn, General Status Report	To be confirmed	Status Report

Items to be programmed

- Dementia and Neurological Services
- Lincolnshire East CCG Update

- South West Lincolnshire CCG Update
- South Lincolnshire CCG Update
- Reducing Alcohol Harm in Lincolnshire - Update on Services Report *(No earlier than October 2016)*
- St Barnabas Hospice *(Feb 2017)*

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

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