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, 23 November 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
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interests**	
3	**Chairman's Announcements**	
4	**Minutes of the previous meeting of the Health Scrutiny Committee for Lincolnshire held on 26 October 2016**	3 - 14
5	**Lincolnshire Health and Wellbeing Board Annual Assurance Report** *(To receive a report from Tony McGinty (Interim Director of Public Health) which provides information on current activity to ensure the Health and Wellbeing Board is meeting its statutory duties in respect of developing the new Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS). David Stacey (Programme Manager – Strategy and Performance) and Alison Christie (Programme Manager – Health and Wellbeing) will be in attendance for this item)*	15 - 24

Item	Title	Pages
6	**Emergency Care Services at Grantham District Hospital** *(To receive a report by Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust (ULHT)) which provides the Committee with details of the decision made on 2 November 2016, by the Trust Board of United Lincolnshire Hospitals NHS Trust, for the closure of the A&E Department to continue for at least a further three months. Jan Sobieraj (Chief Executive – ULHT) and Dr Suneil Kapadia (Medical Director – ULHT) will be in attendance for this item)*	25 - 80
7	**United Lincolnshire Hospitals NHS Trust: 2021 Strategy and Change Programme** *(To receive a report by Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust (ULHT)) which provides an update on the development of United Lincolnshire Hospitals NHS Trust's* 2021 Strategy and Change Programme *to deliver the strategy. Jan Sobieraj (Chief Executive – ULHT) and Dr Suneil Kapadia (Medical Director – ULHT) will be in attendance for this item)*	81 - 86
8	**Lincolnshire East Clinical Commissioning Group Update** *(To receive a report by Gary James (Accountable Officer – Lincolnshire East Clinical Commissioning Group) which provides an update on the activities of Lincolnshire East Clinical Commissioning Group (LECCG) and includes information on the lead commissioning arrangements undertaken by LECCG. Gary James (Accountable Officer – LECCG) will be in attendance for this item)*	87 - 94
	LUNCH 1.00pm – 2.00pm	
9	**NHS Dental Services Overview for Lincolnshire** *(To receive a report by Jane Green (NHS England) which provides an overview of the NHS dental services commissioned in Lincolnshire and an update on the new Special Care Dentistry Service arrangements from 1 December 2016. Jane Green (NHS England) will be in attendance for this item)*	95 - 102
10	**Delayed Transfers of Care - The Next Steps** *(To receive a report by Simon Evans (Health Scrutiny Officer) which invites the Health Scrutiny Committee for Lincolnshire to consider the next steps for its review and scrutiny of delayed transfers of care)*	103 - 106
11	**Work Programme and Responses to Consultations** *(To receive a report by Simon Evans (Health Scrutiny Officer) which invites the Committee to consider its' work programme for the coming months. The report also sets out the Committee's final responses to two consultations)*	107 - 116

Tony McArdle
Chief Executive
15 November 2016

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
26 OCTOBER 2016

PRESENT: COUNCILLOR C J T H BREWIS IN THE CHAIR

Lincolnshire County Council

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

Lincolnshire District Councils

Councillors J Kirk (City of Lincoln Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council), Mrs A White (West Lindsey District Council) and N Jones (East Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Katrina Cope (Senior Democratic Services Officer), Ruth Cumbers (Urgent Care Programme Director, Lincolnshire East CCG), Simon Evans (Health Scrutiny Officer), Gary James (Accountable Officer, Lincolnshire East CCG), Olivia Kendall (Graduate Management Trainee), Liz Ball (Executive Nurse, South Lincolnshire CCG), Ian Jerams (Director of Operations, Lincolnshire Partnership NHS Foundation Trust) and Anne-Maria Olphert (Director of Nursing and Quality, Lincolnshire Partnership NHS Foundation Trust) and Chris Weston (Consultant in Public Health).

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

31 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors Mrs C A Talbot (Lincolnshire County Council) (LCC), Mrs S Ransome (LCC), Mrs P F Watson (East Lindsey District Council), T Boston (North Kesteven District Council) and Mrs L A Rollings (West Lindsey District Council).

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, Councillors C E D Mair (LCC), N Jones (East Lindsey District Council) and Mrs A White (West Lindsey District Council) had been appointed to replace Councillors Mrs S Ransome (LCC), Mrs P F Watson (East

Lindsey District Council), and Mrs L A Rollings (West Lindsey District Council) respectively, for this meeting only.

It was noted further that Councillor C E D Mair had submitted his apologies for the meeting.

32 DECLARATIONS OF MEMBERS' INTERESTS

Councillor S L W Palmer declared a prejudicial interest in item 7 – Lincolnshire Medicines Management Consultation due to his wife being a coeliac, and that the proposed changes would have an effect on them financially. Councillor S L W Palmer further advised that as a result, he would be leaving the meeting during consideration of the item.

33 CHAIRMAN'S ANNOUNCEMENTS

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

a) Message from the Chairman, Councillor Mrs Christine Talbot

The Vice-Chairman read out a statement from the Chairman Mrs C A Talbot which thanked those members who had sent 'Get Well' messages, and for all the support received prior to her operation. The Committee was advised that Councillor Mrs Talbot was now at home recovering from her operation.

b) Revised Agenda

That a revised agenda had been issued on Friday, to contain the report relating to the Annual General Meetings and Public Meetings, which was detailed at item 9 of the revised agenda.

Thanks were extended to Councillors T Boston, J Kirk, and S L W Palmer, who had each attended one of the annual meetings, and whose reports were contained as part of item 9.

c) Congenital Heart Disease Services – East Midlands Congenital Heart Centre

Following the last meeting and in accordance with Minute 27, the Chairman had sent a letter to Will Huxter on 29 September 2016, which had included an invitation for him to attend the Committee on 21 December 2016. It was highlighted that to date, no response had been received however, two further developments had occurred, one was that a briefing paper from NHS England dated 1 September 2016, had come to light on 10 October 2016. The Committee noted that NHS England had not sent the briefing paper directly to local authority overview and scrutiny committees, but had relied on a third party. The Committee noted further that the briefing paper contained a commitment from NHS England to undertake a full public consultation; and a copy

of the Chairman's announcements would be forwarded on to members of the Committee after the meeting.

The second development was that on 19 October 2016, there had been a thirty-minute debate in Westminster Hall concerning the Glenfield Hospital. Philip Dunne, the Minister of State at the Department of Health had responded to debate on behalf of the Government, and it had been confirmed that there was an intention for a three-month public consultation by NHS England, which would conclude in the spring of 2017.

d) Community Pharmacy 2016/17 and Beyond: Final Package

The Committee was reminded that consultation by the Government earlier in the year on 'Community Pharmacy 2016/17 and Beyond', to which the Chairman had responded on behalf of the Committee on 27 April 2016. The Government had on 20 October 2016 announced that there would be an overall funding reduction of £113 million, or 4% in the current financial year 2016/17, which would then be followed by a further reduction of 3.4% in 2017/18.

The Government had also announced that it would be removing the basic establishment payment of £23,000, paid to each pharmacy, but would be introducing a Pharmacy Access Scheme to protect pharmacies in rural areas. The scheme would apply to a pharmacy which was more than a mile away from its nearest pharmacy; and the pharmacy was not in the top 25% in terms of the number of prescriptions it dispensed. It was noted that the Government had said that support under this scheme would be on average £1,500 for each pharmacy each month. Further consideration would be required by the Health Scrutiny Committee in the coming months.

e) Proposed Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust – Full Business Care for Merger

The Committee noted that the Working Group was due to meet on Wednesday 2 November 2016, to consider the Full Business Case for the merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust. The Committee noted that Councillors T M Trollope-Bellew and Mrs S M Wray were due to attend together with local Councillors D Brailsford and R L Foulkes. It was noted further that the Trust's Chief Executive and Deputy Chief Executive were also expected to attend the Working Group.

f) Care Quality Commission – State of Health and Care Report

It was reported that on 12 October 2016, the Care Quality Commission had published 'The State of Health and Adult Social Care in England 2015/16'. The said report had received national media coverage; and had provided an overview of all inspection activity undertaken by the Care Quality Commission. The Committee was advised that copies of the report would also be circulated with the announcements from the meeting.

g) Adults Scrutiny Committee – 19 October 2016

The Committee was advised that on 19 October 2016, the County Council's Adults Scrutiny Committee had considered a report concerning Delayed Transfers of Care, which had been submitted by the County Council's Executive Director of Adult Care and Community Wellbeing. Thanks were extended to Councillors J Kirk and Mrs J M Renshaw who had attended the meeting as observers. In addition, Councillor R Kirk and Mrs S Wray had also been in attendance at the Committee as members. The Adults Scrutiny Committee had expressed a view that the Health Scrutiny Committee should continue to scrutinise this matter.

Both Councillors who attended the meeting as observers expressed their disappointment to the outcome from the Adults Scrutiny Committee.

h) South Park Branch Surgery

The Committee was advised that on 28 September 2016, the Lincolnshire West Clinical Commissioning Group announced that the Heath Surgery in Bracebridge Heath had started a consultation on a proposal to close its branch surgery at South Park in Lincoln. It was reported that the reasons for the closure was because the surgery building needed a considerable amount of investment to meet required standards, and there had also been other challenges for the surgery, which had been widely reported in the local media. It was reported further that the Heath Surgery believed that the closure would enable consistency of care with less reliance on locum staff. Patients had been asked to give their thoughts on the proposals by 28 October 2016.

i) Forty Treatments That Bring Little or No Benefits to Patients

The Academy of Medical Royal Colleges had on 24 October 2016, published a paper entitled 'Forty Treatments That Bring Little or No Benefits' as part of its Choosing Wisely initiative. It was noted that the list of treatments had been compiled with the assistance of the relevant specialists, and included the use of plaster casts for wrist fractures in children and the use of x-rays for lower back pain, where there were no other concerning factors.

j) Upgrade of Radiotherapy Equipment

The Committee noted that on 25 October 2016, NHS England had announced a £130 million investment to upgrade radiotherapy equipment across England. It was noted further that around four in ten of all NHS cancer patients were treated with radiotherapy, which typically use high-energy radiation from a machine called a linear accelerator (referred to as a 'Linac'). The Committee was advised that over the next two years, that older Linac radiotherapy equipment being used by hospitals across the country would be upgraded, or replaced.

k) Dr Tony Hill

The Committee was advised that Dr Tony Hill, the County Council's Director of Public Health had retired on 14 October 2016. The Chairman had written to Dr Tony wishing him well in his retirement. It was reported that Tony McGinty had been appointed as the interim Director of Public Health.

34 MINUTES OF THE PREVIOUS MEETING OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE HELD ON 21 SEPTEMBER 2016

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 21 September 2016 be approved and signed by the Chairman as a correct record.

35 WINTER PLANNING

The Chairman welcomed to the meeting Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group and Ruth Cumbers, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group.

The purpose of the report was to update the Committee on planning for Winter Pressures across the Health and Care Economy in Lincolnshire.

It was reported that nationally that there was recognition of an increase in demand on urgent and emergency services across the winter months. It was however highlighted that generally the system was under pressure all year round. It was noted that the whole health and social care system was running "hot" with the usual expected easing of pressures during the summer no longer being experienced. It was noted further that the acute sector escalation beds had remained largely open all year rather than as originally planned just for winter only. It was reported that the A & E performance across Lincolnshire was below the national standard with Lincoln County and Boston Pilgrim consistently underperforming against the 95% four hour treatment target.

The Committee was advised that the Lincolnshire 2016/17 Winter Plan had been produced by the Urgent Care Team with contributions from partners across the health and care community. The Plan had then been reviewed by key partner organisations to ensure its robustness. It was highlighted that there was an expectation from NHS England and the NHS Improvement that a robust system wide plan was in place for each winter. The A & E Delivery Board also had to have assurance that all commissioner and provider plans evidenced both individual organisation and system wide congruence and resilience.

In summary, the Committee was advised that the plan described how the system was aiming to manage pressures by:-

- Improvements in acute hospitals concerning bed flow processes; Emergency Department efficiency and to fully implement ambulatory emergency care and SAFER (**S**enior review: that **A**ll patients have discharge date, **F**low, **E**arly discharge; **R**eview);
- That community services and the local authority would be focussing on enhancing capacity and reablement to avoid admissions and speed up complex discharges;
- That commissioners would be focussing on driving greater throughput at treatment centres; and ensuring that demand management schemes were effective in reducing Emergency Department attendance; and
- That there would be a collective effort focused on managing complex medically fit patients within a fewer number of days; and that there would be improvement's to support, and divert greater number of the over 75 year of patients outside of the acute hospital.

The Committee noted that Delayed Transfers of Care had shown some improvement; however, there had been a slight increase in the figures for August.

It was reported that both the Surge Plan and Escalation Plan and the Winter Plan had recently been updated. It was highlighted that unlike in previous years, there had not been any additional central government funding for winter pressures, as the sums had been included in each CCG's base allocations. As a result investment in the system had been agreed through the System Resilience Group (now called the A & E Delivery Board) with funding decisions being made upon consensus and evaluation of effectiveness of previous schemes, and in setting the A & E trajectory.

The preventative measures planned as part of the winter response included:-

- Preventative measure such as flu prevention; campaigns for patients and staff. Particular reference was made to national advertisements for example the NHS 'Stay Well This Winter Campaign' aimed at patients and service users to manage themselves; and who to contact for advice and support. The Committee noted that the above said campaign had not yet commenced;
- Joint working arrangements between health and social care to help prevent admissions and speed up discharges. The Committee noted that the SAFER bundle would help support people to be discharged from hospital sooner and that their care would be planned, and supported by Adult Social Care. The system was however very dependent on early consultations and ward management. This was an area that had highlighted a variance across sites. Reference was also made to Neighbourhood Teams working in a multi-disciplinary way to provide more joined up care. This meant that people would be treated and cared for nearer to home where possible; and would only be admitted to hospital when necessary;
- Ensuring that there was operational readiness, for example bed management staffing. It was noted that patient flow was reviewed on a daily basis; and that a further ward was being opened at Lincoln County comprising of 21 step-down beds. The Committee noted further that plans were in place to operate seven day working, as Pharmacy was an area of concern. It was reported that

£1 million had been allocated to support additional nurses at ULHT; as recruitment and retention was a challenge;
- The delivery of critical and emergency care services;
- The delivery of out of hours' service;
- Ensuring joint working with the ambulance service, particular reference was made to the handover of patients from ambulance to acute care; and strengthening links with A & E and primary care; and
- Ensuring that a strong and robust communication strategy was maintained across the system.

In conclusion, it was reported that the A & E Delivery Board would do its utmost to mitigate impacts within existing resources and that operational arrangements would assist in this matter.

During discussion, the Scrutiny Committee raised the following points:-

- Clarification was sought concerning the policy regarding integration and the reduction in the number of beds. The Committee was advised that beds had previously reduced from 1005 to 950; the emphasis was to get the right staffing levels for the number of beds. It was felt that there would be enough beds, as there had been a reduction over the last two years, as a result of the NHS being able to switch the use of beds. It was highlighted that there was a focus on seeing patients once instead of multiple assessments; and this was being introduced as part of the integrated working in some wards i.e. the SAFER bundle. There was however, some inconsistency currently, as the principle had not been implemented in all wards as yet, it was therefore still work in progress. The methodology had been trialled first, once this had been reviewed and lessons learnt had been looked into, the concept would be rolled out further. The Committee was also advised that the inconsistent approach was being dealt with and that there was an action for social care and health colleagues to engage early in the process;
- One member acknowledged that changing the name of the System Resilience Group into the A & E Delivery Board had been a national requirement, but it was understandable that these changes might lead to some confusion;
- The top of page 36 listed a number of schemes to address some of the challenges within urgent care. One member enquired as to whether the schemes listed and their funding were as a result of new funding, or whether those listed were as a result of re-allocated funding. The Committee was advised that there was no additional specific funding for Winter Resilience, as the funding was now included in the overall allocation to each CCG, from which an amount was allocated for Winter Planning;
- Page 36 paragraphs 2 and 3 relating to bed reduction. The report highlighted that the United Lincolnshire Hospitals NHS Trust planned to establish a number of existing escalation beds on the Lincoln and Pilgrim sites and to increase the core bed stock. It was highlighted further that it was proposed to operate a step-up; step-down approach to mitigate need;
- Page 37 – Clinical Assessment Service – One member enquired as to whether the service was up and running to its full extent. The Committee was advised

that the system was not quite fully operational, as there had been some technical issues regarding the transference of calls, and as a result Lincolnshire was leading on this matter nationally to establish the pathway software; and licence to be used locally. One member provided the Committee with information relating to their personal experience of the 111 service; and in conclusion advised that the system needed fine tuning and that staff answering calls needed to have up to date information relating to local service provision. Others echoed this observation, and advised that some callers knew how to work the system to ensure that an ambulance arrived. The Committee was reassured that the issues raised would be passed back, to ensure that the directory of service provision was updated. It was also highlighted that the script used for the 111service was a nationally agreed script;

- The need to get GP services in front of A & E, to capture patients who did not need A & E services. The Committee noted that this was currently work in progress, however, it was highlighted that there was no capital available to help with the alterations;
- The need to recruit more staff. The Committee was advised that ULHT had had some challenges recruiting nurses; and that there had been an increased reliance on agency staff. However, there was now an increase in the number of nurses in training. The Committee noted that Lincolnshire had been successful in securing funding for a pilot scheme from the Nursing Association which was due to commence in January 2017;
- Pharmacy seven day working – It was reported that seven day working included hospital pharmacies, as this would provide a better overall experience for patients;
- Operation cancellations due to pressures – It was highlighted that on some occasions, cancellations did happen on the day of an operation; but whenever possible, this would be avoided; and
- One member enquired as to whether the ambulance service was involved in the Plan. The Committee was advised that the ambulance service was involved in arrangements and that last year the service was involved as winter navigators which had involved paramedics; and that this had worked very well. It was highlighted that a new process was to be introduced at Lincoln and Boston was to encourage patients that were able bodied to book themselves in rather than the ambulance driver, this would then free up ambulance drivers time.

The Chairman extended thanks on behalf of the Committee to officers and advised that the Scrutiny Committee would be looking forward to a further update in the New Year.

RESOLVED

That the update concerning the planning for Winter Pressures across Health and Care Economy in Lincolnshire be noted.

36 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST - CARE QUALITY COMMISSION COMPREHENSIVE INSPECTION

The Chairman welcomed two colleagues from The Lincolnshire Partnership NHS Foundation Trust, Ian Jerams, Director of Operations and Anne-Maria Olphert, Director of Nursing and Quality.

The Director of Operations advised that the purpose of the report was to provide assurance to the Committee that the Lincolnshire Partnership NHS Foundation Trust (LPFT) had continued to make good progress with the implementation of the action plan resulting from the Care Quality Commission (CQC) Comprehensive Inspection held from 30 November to 4 December 2015.

Appendix A to the report provided a summary of the CQC ratings for LPFT in the Comprehensive Inspection; and Appendix B provided the Committee with a copy of the latest version of the Action Plan for their consideration. It was reported that the CQC Action Plan was updated monthly, and was presented in a public meeting to the Board of Director each month.

The Committee noted that 74% of the 'sub-actions' were now complete; and that 46 of the sub actions were now on track to be delivered by the agreed date. Progress was also being made to complete the remaining actions and to transfer any remaining actions into a Quality Improvement Plan to support the continuous quality improvement objectives of the organisation.

Discussion ensued, from which the Committee raised the following points:-

- Chart 1.2 – page 5 of the report presented. The Committee was advised that work was now complete and a protocol was now in place; and
- Page 74 – Community Learning Disabilities and Autism – One member enquired as to whether the problem relating to data had been resolved. The Committee was advised that this had been completed; and that there was now only the historic data to be migrated. It was highlighted the system was a good news story; however, the Committee noted that varying systems were still not able talk to each other.

Overall, the Committee felt that the report was a good news story and looked forward to receiving a further update in due course.

RESOLVED

1. That the Committee record its assurance that the work being undertaken by Lincolnshire Partnership NHS Foundation Trust to meet the actions set out by the Care Quality Commission (CQC) was progressing.

2. That the Committee record its assurance that Lincolnshire Partnership NHS Partnership Trust would be focussing on continuous quality improvement once the CQC Action Plan was complete.

3. That the Committee record its assurance that the Care Quality Commission, NHS Improvement and NHS England, as well as local Clinical Commissioning Groups, were receiving progress updates.

4. That further updates be requested in relation to safe care – the requirements of single sex accommodation guidance and assessing /managing the risks of points of ligature in and around the buildings in which patients are receiving mental health services.

37 LINCOLNSHIRE MEDICINES MANAGEMENT CONSULTATION

Councillor S L W Palmer left the meeting.

Consideration was given to a report on behalf of the Lincolnshire Clinical Commissioning Groups (CCGs), which presented the Lincolnshire Medicines Management Consultation for the Committee's consideration. It was reported that the consultation was taking place between 4 October and 18 November 2016; with the results being reported back to all the four CCG Governing Bodies on 30 November to 1 December 2016.

Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group presented the report and explained to the Committee that the rationale behind the proposals was that the four CCGs had a substantial financial challenge to meet in the short term; and that currently £38m was being spent over the existing budget. As a result of this it was felt that money spent on items that were readily available over the counter might be better spent on treatments, staff and essential services to benefit patients.

The four CCGs were asking for comments from the Committee on their proposals to restrict the prescribing of over the counter/minor ailment medicines used for short-term, self-limiting conditions, the prescription of gluten-free products, baby milk (including specialist infant formula) and oral nutritional supplements. Attached at Appendix A to the report provided a copy of the Medicines Management Consultation document and survey.

Page 92 to 96 of the report provided the Committee with background information as to what was planned against each of the four areas.

During consideration of the item, the Committee raised the following issues:-

- One member enquired as to where one could obtain a copy of the consultation form. The Committee was advised that the form had been made available in GPs surgeries, pharmacies, social media, Facebook; website; engagement events, Parish Councils etc. Some members expressed concern that they were not aware of the consultation. A further member asked whether a copy of the consultation document should have been put through everyone's letter box. The Committee was advised that this would have cost at least £500,000; and evidence had suggested that leaflet drops always resulted in a poor return; except if there was an incentive for people to complete. The

Committee also noted that there had been good representation from patients groups such as the Coeliac Society;

- Some members express their support to the proposal but expressed some concern for the more vulnerable people who for instance needed large amounts of paracetamol for arthritis pain, or who were on lower incomes. The Committee was reassured that the changes would only be applied to minor conditions; and that someone requiring painkillers in large amounts would still be able to have them on prescription; and that GPs would not restrict prescriptions to vulnerable people. Some members also felt that the proposal was well overdue, and particular reference was made to coeliac disease, where it was highlighted there was now an extensive range of gluten free products available in shops and supermarkets. It was highlighted that someone on a low income who was a coeliac, or would be a risk of dietary neglect would still be able to obtain staple products as recommended by Coeliac UK. A further point raised was that gluten free products were not so widely available in budget supermarkets;
- A suggested was made that GPs needed to regularly review patient's prescriptions to see if they were working; and to make sure that patients were still taking the prescribed drugs; this would then help with wastage; and
- A question was asked on the level of charges made by pharmaceutical companies. It was noted that pharmaceutical companies would argue that the costs of research into new drugs were exceedingly high.

The Committee agreed to the setting up of a working group to formulate a formal response on behalf of the Committee. The above said group to comprise of the following Councillors J Kirk, R Kirk, Mrs R Kaberry-Brown, and C J T H Brewis.

The Healthwatch representative advised the meeting that a copy of the Healthwatch response would be forwarded onto the Health Scrutiny Officer for the working group's information.

RESOLVED

1. That the report be noted, and that the comments made at the meeting be incorporated into the formal response from the Health Scrutiny Committee for Lincolnshire.

2. That a working group be established comprising of the following Councillors J Kirk, R Kirk, Mrs R Kaberry-Brown, and C J T H Brewis to formulate a formal response to the Medicines Management Consultation to the Lincolnshire Clinical Commissioning Groups by 18 November 2016.

38 WORK PROGRAMME

Councillor S L W Palmer re-joined the meeting.

The Committee considered its work programme for forthcoming meetings.

Simon Evans, Health Scrutiny Officer confirmed that the item concerning United Lincolnshire Hospitals Trust – Pharmacy Services had been moved from the 23 November 2016 meeting to the 18 January 2017 meeting. It was also highlighted that the last two items on the agenda for the 23 November 2016 meeting were for 'information only'.

One member referred to the 'Reducing Obesity in Adults and Children' on the 'Items to be Programmed List' and requested for it to be included on a future agenda, as it was felt that this issue needed to be considered sooner, rather than later. It was also requested that when discussing such a topic, the Committee needed to be mindful of the feelings of others and discuss the item in a more sympathetic manner. It was agreed that the request for 'Reducing Obesity in Adults and Children' would be raised at the next agenda planning meeting scheduled to be held on 9 November 2016.

RESOLVED

That the contents of the work programme presented be approved, subject to the inclusion/deletion of the amendments detailed above.

39 ANNUAL PUBLIC MEETINGS OF CLINICAL COMMISSIONING GROUPS AND ANNUAL GENERAL MEETINGS NHS PROVIDER TRUSTS

The Committee gave consideration to a report, which provided the Committee with a series of reports from individual members of the Committee who had attended various Clinical Commissioning Groups, NHS Trusts and NHS Foundation Trusts Annual Meetings.

The Chairman on behalf of the Committee, expressed thanks to Councillors T Boston, J Kirk, S L W Palmer for their involvement.

RESOLVED

That the report be noted.

The meeting closed at 12.30 pm.

Lincolnshire COUNTY COUNCIL		**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 Tony McGinty, Interim Director of Public Health

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 November 2016**
Subject:	**Lincolnshire Health and Wellbeing Board Annual Assurance Report**

Summary:

Under the Health and Social Care Act 2012 Health and Wellbeing Boards (HWB) are required to publish a Joint Strategic Needs Assessment (JSNA) for the local area. The JSNA is an assessment of the current and future health and social care needs and is the overarching evidence base used by the HWB to inform the priorities in the Joint Health and Wellbeing Strategy.

The protocol agreement, signed between the Lincolnshire Health and Wellbeing Board (HWB), Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire in December 2014, sets out the working relationship and respective roles in delivering the shared ambition of improving health and wellbeing in Lincolnshire. This agreement states that the Health Scrutiny Committee will *'hold the Board to account for its work to improve health and wellbeing of the people of Lincolnshire, including its responsibilities in relation to the JSNA and JHWS.'* This report therefore provides information on current activity to ensure the HWB is meetings its statutory duties in respect of developing the new JSNA and JHWS.

Actions Required:

The Health Scrutiny Committee for Lincolnshire is asked to:

1) Consider and comment on the fundamental review of the Joint Strategic Needs Assessment.
2) Consider and comment on the Joint Health and Wellbeing Strategy Prioritisation Framework

1. Background

The Health and Wellbeing Board (HWB) is a strategic forum which brings together key leaders form the health, public health and care systems to work together to improve the health and wellbeing of the people of Lincolnshire. The Lincolnshire HWB was established as a formal committee of the county council in April 2013 as part of implementing the Health and Social Care Act 2012. Board members collaborate to understand communities' needs, agree priorities and encourage commissioners to work in a more joined up way.

The HWB has a statutory responsibility to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS). The JSNA looks at a wide range of data and evidence to identify the key issues for people living in Lincolnshire. This is then used as the basis for the planning and commissioning of services to meet these needs. The JSNA is used by the HWB to inform the priorities in the JHWS. The strategy aims to inform and influence decisions about health and social care services.

The protocol agreement, signed between the Lincolnshire Health and Wellbeing Board (HWB), Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire in December 2014, sets out the working relationship and respective roles in delivering the shared ambition of improving health and wellbeing in Lincolnshire. This agreement states the Health Scrutiny Committee will *'hold the Board to account for its work to improve health and wellbeing of the people of Lincolnshire, including its responsibilities in relation to the JSNA and JHWS.'* This report therefore provides information on current activity to ensure the HWB is meetings its statutory duties in respect of developing the new JSNA and JHWS.

Fundamental Review of the Joint Strategic Needs Assessment

The current format of the JSNA has been in place since 2011 and is constructed around 35 individual topics that consider very specific areas. In March 2015, the Board agreed a process of review for the JSNA to inform the development of the new JHWS, to be in place by April 2018. A report was presented to Health Scrutiny in September 2015 outlining the timetable for the review and giving details on the Stakeholder Engagement phase. The engagement exercise, which ran between September and December 2015 sought views on the content, processes and methodologies underpinning the JSNA. Health Scrutiny contributed to this exercise and submitted a formal response in December 2015.

The stakeholder feedback highlighted a number of weaknesses in the JSNA processes and wide variation in the levels of awareness and use of the JSNA. Stakeholders familiar with the JSNA value it as the 'go to' evidence base to inform business planning, commissioning, funding applications and service prioritisation. However, a number of respondents were either unware of the JSNA or had not used it. Buy in across partners was also inconsistent, many perceiving it as a Public Health responsibility, with little awareness of the statutory nature of the evidence base nor the requirements placed on Health and Wellbeing Board members/organisations to be involved in its development. Respondents also asked for the JSNA to be 'easier to use' and 'easier to understand'.

Based on the feedback, in March 2016 the HWB agreed the review approach based around topic expert panels. Using the current JSNA as the starting point the fundamental review began in April 2016. The topics were divided into five review cohorts with staggered started dates so not all of the topics were being reviewed simultaneously. Expert Panels, made up of appropriate representatives from the County Council, Clinical Commissioning Groups, health providers, District Councils, voluntary and community sector have been set up to support Topic Leads to refresh each of the topics. The process has been supported by a dedicated Data Analyst and the JSNA Support Officer.

A multi-agency JSNA Strategic Delivery Group (JSNA SDG) has been established by the HWB to steer the review process and approve the changes to the JSNA prior to publishing in Spring 2017. A Peer Review process has also been put in place to ensure each topic commentaries meet agreed set quality standards prior to being approved by the JSNA SDG.

Since April 2016, 33 Expert Panels have been held and approximately 400 people engaged in the process either through Expert Panels or as part of the peer review process. A full list of the JSNA topics, including a number of new topic areas, is shown in Appendix A.

Going forward (beyond March 2017), all topic areas will be reviewed on an annual basis. The JSNA Policy and Procedures also makes provision for changes to the JSNA, if there is sufficient evidence and information to do so. This change request process is managed formally as part of the work of the JSNA SDG.

Development of the next Joint Health and Wellbeing Strategy

Currently the JHWS produced by the HWB is due to end 2018 and the review of the JSNA which is being undertaken will be expected to form the basis upon which a new JHWS will be developed.

A report was presented to the HWB in June 2016 setting out some proposed principles for developing the next JHWS as well as a draft prioritisation framework which the HWB agreed should be further reviewed and tested as part of its informal session on 12th July 2016.

The HWB agreed in June that adopting a prioritisation framework will assist with the prioritisation process in a systematic way, ensuring a clear, rational approach and a defensible, transparent process for local decision making, whilst ensuring the active engagement of key stakeholders in the development of the JHWS. In order to achieve this, the following core principles for developing the next JHWS were agreed as follows:

1. Stakeholder engagement (that builds public and patient confidence in the process)
2. A clear and transparent process
3. Careful information management
4. Decisions based on clear value choices (underpinned by a sound evidence base)

5. Selection of an agreed prioritisation methodology that takes into account the ranking/scoring of a range of factors, or 'criteria'.

On the 12th July a workshop was held with members of the HWB alongside wider partners and stakeholders. The objectives of the session were to:

1. Agree the key criteria for use within the prioritisation framework for the next JHWS
2. Weight the criteria to reflect the varying importance each one has in prioritising JSNA evidence
3. Test the prioritisation framework with a JSNA topic commentary (the draft Breastfeeding topic commentary was used due it already having been completed)

These objectives formed the basis of three separate exercises in the workshop.

In total 31 people attended the workshop and were placed across five tables. Each table worked through each objective in turn. All tables at the workshop successfully reviewed the criteria and made recommendations for amendments, agreed a weighting for and assigned a score to each criterion within the framework. Following the workshop the framework has been amended along with a proposed weighting of criteria based on feedback and weighting from individual tables at the workshop. There are some limitations to the framework however with some further testing and refinement it is expected that these can be addressed.

The framework itself performed in a fairly consistent way following sensitivity analysis and so is judged to be fit for purpose from this perspective.

Following the HWB meeting on 27th September final amendments have now been made to the prioritisation framework and this is shown in Appendix B.

2. Conclusion

Lincolnshire Health and Wellbeing Board has a statutory duty to produce a JSNA and to use this to inform the priorities in the JHWS. This report updates the Health Scrutiny Committee for Lincolnshire on the JSNA review and provides information on the JHWS Prioritisation Framework agreed by the Board in September 2016 which will be used to develop the next JHWS.

3. Consultation

A range of statutory and non-statutory partners have been engaged in the ongoing development of the JSNA as part of Topic Expert Panels or through the Peer Review Process.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	2017 Lincolnshire JSNA Topics
Appendix B	Joint Health and Wellbeing Strategy Prioritisation Criteria

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 Alison Christie, Programme Manager Health and Wellbeing, who can be contacted on 01522 552322 or alison.christie@lincolnshire.gov.uk and David Stacey, Programme Manager Strategy and Performance, who can be contacted on 01522 554017 or david.stacey@lincolnshire.gov.uk

2017 Lincolnshire JSNA Topics **Appendix A**

Topic	Topic Lead	New
Alcohol (adults)	Chris Weston/Phil Garner	
Autism	Justin Hackney	Yes
Breastfeeding	Mandy Clarkson	
Cancer	Dr Kakoli Choudhury	
Carers	Jane Mason	
Coronary Heart Disease	Dr Kakoli Choudhury	
Chronic Obstructive Pulmonary Disease	Dr Kakoli Choudhury	
Dementia	Justin Hackney	Yes
Diabetes	Dr Kakoli Choudhury	
Domestic Abuse	Karen Shooter	Yes
Drug Misuse	Chris Weston/Phil Garner	
Educational Attainment (Foundation)	Heather Sandy	
Educational Attainment (Key Stage 4)	Heather Sandy	
Environment	Sean Johnson	Yes
Excess Seasonal Deaths	Dr Kakoli Choudhury	
Falls	Dr Kakoli Choudhury	
Financial Inclusion	Nicole Hilton/Lynne Faulder	Yes
Food & Nutrition	Chris Weston/Phil Garner	
Housing	Tony McGinty	
Immunisation	Shade Agboola	
Learning Disabilities	Pete Sidgwick	
Looked After Children	Janice Spencer/John Harris	
Maternal Health and Pregnancy	Mandy Clarkson	
Mental Health (adults)	Dr Kakoli Choudhury/Justin Hackney	
Mental Health (children & young people)	Sally Savage	
Obesity (all ages)	Chris Weston/Phil Garner	
Physical Activity	Chris Weston/Phil Garner	
Physical Disabilities & Sensory Impairment	Pete Sidgwick/Theo Jarratt	
Road Traffic Collisions	Steven Batchelor	
Sexual Health	Shade Agboola/ Carol Skye	
Smoking	Chris Weston/Phil Garner	
Special Educational Needs & Disabilities	Stuart Carlton/Sheridan Dodsworth	
Stroke	Dr Kakoli Choudhury	
Suicide	Dr Kakoli Choudhury	
Teenage Pregnancy	Stuart Carlton/Alison Poxon	
Young People in the Criminal Justice System	Andy Cook	

Joint Health and Wellbeing Strategy Prioritisation Framework **Appendix B**

JHWS Prioritisation Framework Criteria	Weighting of criteria (High=3, Medium=2, Low=1)	Very Low (Score = 1)	Low (Score = 2)	Mid-scale (Score = 3)	High (Score = 4)	Very High (Score = 5)
Supporting prevention Does addressing the topic area (i) improve the overall health and wellbeing of the population; (ii) reduce the escalation of health and care needs in future, e.g. through identifying individuals at risk of health conditions or events; (iii) maximise peoples independence through effective treatment and recovery of health conditions?	High	No evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery	Slight evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery	Moderate evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery	Significant evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery	Strong evidence of improvement to health, delay or prevention in the use of healthcare services and/or improvement treatment and recovery
Strategic fit: National requirement or Outcome Framework indicator (PH, NHS, ASC) or local policy priority.	Medium	Not a national requirement or indicator and no clear local policy priority	Addresses one or more national requirements or indicators but is not a local policy priority	Addresses one/two national requirements or indicators and is a local policy priority	Addresses three national requirements and/or indicators and is a local policy priority across two or more partners	Addresses four or more national requirements and/or indicators and is a policy priority across multiple partners (three plus)
Health inequalities/equity: The criteria incorporates both health inequity (an unfair or unjustifiable difference in health) and health inequality (differences in health arising from social inequalities in the conditions in which people are born, grow, live, work & age). The criteria assesses the scale of inequalities (defined as inequalities in access and outcomes) as relevant to the JSNA topic area.	High	No evidence of inequalities/inequity amongst different groups of individuals, as relates to the topic area.	Limited amount of evidence of inequalities/inequity affecting a small number/group of individuals, as relates to the topic area.	Evidence of geographic or population-based inequalities, affecting a moderate number/group of individuals	Significant evidence of geographic or population-based inequalities, affecting multiple groups of individuals	Strong documented evidence exists demonstrating the impact of persistent & widescale geographic or population-based health inequalities/inequity affecting a large section of the community.

JHWS Prioritisation Framework Criteria	Weighting of criteria (High=3, Medium=2, Low=1)	Very Low (Score = 1)	Low (Score = 2)	Mid-scale (Score = 3)	High (Score = 4)	Very High (Score = 5)
Strength of evidence: How strong is the evidence of need contained within the topic commentary? Does it include a mixture of both qualitative & quantitative data sources to provide a broader context around the topic area?	High	Evidence of need is poor	Evidence of need is limited to one type of data source	Evidence of need includes a combination of qualitative & quantitative data sources but there is no consistent 'message' regarding needs	Evidence of need includes a combination of qualitative & quantitative data with a coherent & consistent 'message' regarding needs	Evidence of need is robust containing strong and consistent evidence of need derived from multiple & diverse data sources.
Value for money: The criteria assesses the extent to which value for money considerations regarding service/activity interventions are evidenced in the JSNA topic area. Have any calculations been undertaken, e.g. Spend and Outcome (Return on Investment) Tools (SPOT)?	High	No VFM calculations available	VFM calculations available and demonstrate poor value for money	VFM calculations available showing cost effective service interventions (or the potential for them to be delivered) across a short timeframe only (1-2 years)	VFM calculations showing cost effective service interventions that deliver (or the potential to deliver) sustained value for money across a short and medium term period (3-5 years)	VFM calculations and/or good programme budgeting intelligence to support investments that deliver (or have the potential to deliver) VFM across short, medium and longer term
Magnitude of benefit: What is the benefit in terms of quality of life improvements and proportion of the population (potentially) affected? The criteria incorporates (i) the scale of improvements in health and (ii) life expectency and healthy life expectancy	High	No or negligible improvement in health or life expectancy evidenced	A small improvement in health or life expectancy evidenced	Moderate improvements in health or life expectancy evidenced	Significant improvements in health or life expectancy evidenced	Large and proven improvements in health or life expectancy evidenced

JHWS Prioritisation Framework Criteria	Weighting of criteria (High=3, Medium=2, Low=1)	Very Low (Score = 1)	Low (Score = 2)	Mid-scale (Score = 3)	High (Score = 4)	Very High (Score = 5)
Number of people benefitting: What is the scale of the benefit in terms of quality of life improvements and size of population (potentially) affected? The criteria incorporates the number of people likely to benefit/be affected.	Medium	<1% of the population (up to approximately 700-800 people) affected/benefiting	1%-3% of the population (approximately 800 to 20,000 people) affected/benefiting	3%-5% of the poulation (approximately 20,000 to 35,000 people) affected/benefiting	Between 5%-7% of the population (approximately 35,000- 50,000) people affected/benefiting	>7% of the population (approximately >50,000 people) affected/benefiting
Public Understanding & Engagement: This criteria considers the extent to which there is consistent and robust evidence regarding the local views and priorities from stakeholders inc. residents and/or service users.	Medium	No evidence of views from stakeholders, patients, residents and/or service users	Weak evidence of views from stakeholders, patients, residents and/or service users	Evidence of views from stakeholders, patients, residents and/or service users is provided but no consistent 'messages' are evident	Some evidence of strong views from stakeholders, patients, residents and/or service users	Comprehensive engagement leading to evidence of strong & informed views from stakeholders, patients, residents and/or service users.
Risk of not prioritising: This criteria considers the risk of not prioritising the topic area having considered the level of need (incorporating trend, severity of need, comparator data, etc.) evidenced in the topic commentary.	Medium	No risk	Risk is low. Available evidence suggests low risk (i.e. data demonstrates needs are stable & in-line with regional, national or comparator area data)	Risk is fairly high. Available evidence suggests fairly high risk (i.e. data demonstrates above-average prevalence/need relative to regional, national or comparator areas and/or a gradual worsening trend)	Risk is high. Available evidence suggests high risk (i.e. data demonstrates need is worse when compared to regional, national and/or comparator areas and/or a worsening trend that is predicted to continue).	Risk is very high. Available evidence suggests very high risk (i.e. data demonstrates need is significantly worse than regional, national and/or comparator areas, with a rapid worsening of need over time if not addressed.)

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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 Jan Sobieraj, Chief Executive,
United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 November 2016**
Subject:	**Emergency Care Services at Grantham and District Hospital**

Summary:

Reducing the Accident and Emergency (A&E) Department opening hours at Grantham and District Hospital to 09.00 – 18.30 has enabled the A&E Department at Lincoln County Hospital to be supported up to an additional 85 hours per week by the middle grade and consultant staff from the A&E Department at Grantham and District Hospital.

There is the potential to recruit to 21 middle grade doctors to United Lincolnshire Hospitals NHS Trust. However, it is highly unlikely that these doctors would be in employment before January or February 2017 and would need a further period to be inducted and made fully operational. Overall there have been no serious issues reported of which we are aware, but we continue to remain vigilant. On the whole the impact on United Lincolnshire Hospitals NHS Trust (ULHT) has been minimal and as expected.

The Trust Board of United Lincolnshire Hospitals has made a decision on 2 November 2016 for the overnight closure of the A&E department to continue for at least a further three months.

Actions Required:

The Health Scrutiny Committee for Lincolnshire is asked to note the contents of this report, including the views of the Clinical Management Board, staff, public and stakeholders including regulators and commissioners.

1. Background

In August 2016, a decision was made by United Lincolnshire Hospitals NHS Trust (ULHT), supported by NHS England, NHS Improvement and the local Clinical Commissioning Group to temporarily close the Grantham Accient & Emergency (A&E) Department between the hours of 18:30 and 09:00. This decision was taken in response to a series of circumstances that have led to a staffing crisis situation within our A&E departments, primarily at Lincoln County Hospital (LCH).

2. Conclusion

All options have been considered with an aim to deliver a safe service for all three Emergency Departments at ULHT. The provision of emergency services, particularly at LCH, remains fragile and requires the continued support of A&E medical staff from Grantham and District Hospital on the grounds of patient safety.

When the decision was taken in August to reduce the opening hours of the Grantham A&E Department, a threshold of a minimum of 21 wte [whole time equivalent] middle grade doctors would be required to safely staff the three A&E Departments (Lincoln, Pilgrim and Grantham).

This report has demonstrated that the recruitment drive has identified the potential to reach this threshold, but not until February 2017. It is not clear that the anticipated new medical staff will be sufficiently well versed with the NHS to be working autonomously from the outset of their employment.

The Trust Board considered four options, set out below, for the A&E Department at Grantham and District General Hospital:

1) To re-instate a 24 hour Accident & Emergency Department at Grantham and District Hospital (a) If yes, when should this commence?
2) To keep the current opening hours of 09.00 – 18.30 (a) If yes, then for how long?
3) To extend the opening hours beyond its current position (a) If yes, to what?
4) To reduce the opening hours from its current position (a) If yes, to what?

Based on the evidence provided in the report, the Trust Board concluded option 2, for a minimum of three months, was the most appropriate to implement, after 17 November 2016.

3. Consultation - This is not a direct consultation item.

4. Appendices - These are listed below and attached at the back of the report

Appendix A	United Lincolnshire Hospitals NHS Trust – Emergency Care Service October 2016

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 Dr SA Kapadia, Medical Director, who can be contacted on 01522 573850 or Suneil.kapadia@ulh.nhs.uk

EMERGENCY CARE SERVICE
CURRENT POSITION

October 2016

Executive Summary

In August 2016, a decision was made by United Lincolnshire Hospitals (ULHT), supported by NHS England, NHS Improvement and the local Clinical Commissioning Group to temporarily close the Grantham Accient & Emergency (A&E) Department between the hours of 18:30 and 09:00. This decision was taken in response to a series of circumstances that have led to a staffing crisis situation within our A&E departments, primarily at Lincoln County Hospital. This is not a situation that any health economy wants to find itself in. However, patient safety is and must always be our foremost concern and that is why a decision was made to implement this unprecedented action as approved by the Trust Board in August.

This report is set to provide a summary of the emergency department activity, performance, and capacity following the decision made by the Trust Board of ULHT, to support the temporary closure of the Grantham A&E Department between the hours of 18:30 and 09:00 with effect from 17th August 2016 until 17th November 2016. The report will also explain the actions that have been taken since then, to increase the medical staffing numbers required to support ULHT A&E departments. It will also provide details of the impact following these actions.

The report puts forward four options to be considered for the Accident & Emergency Department after the 17th November 2016. It takes into account the overall situation across all the A&E Departments and whether ULHT is now in a position to safely staff all three of them.

The objectives of the report are:

- To provide the current situation with regards to medical staffing in emergency care at Lincoln Hospital, Pilgrim Hospital and Grantham Hospital following the decision taken to close the Grantham A&E Departments between the hours of 18:30 and 09:00 from August 17th 2016.

- To evaluate the impact of this closure on each of the ULHT A&E Departments since August 17th 2016.

- To enable a decision to be made for the operational hours at Grantham Hospital following review of the staffing situation 2.5 months following the decision to temporarily close the Grantham A&E Department between the hours of 18:30 and 09:00.

1. Introduction

1.1 Context and Background

Lincoln and Pilgrim Hospitals provide a wide range of in-patient clinical services, with the following principal exclusions:

- Neurosurgery
- Cardiothoracic surgery
- Spinal surgery

Most of the emergency and specialised in-patient services provided at ULHT are either at Pilgrim Hospital Boston (PHB) or at Lincoln County Hospital (LCH), and some specialties are available at both hospital sites. A reduced range of emergency in-patient clinical services are provided at Grantham & District Hospital (GDH). These are restricted to patients with certain medical conditions and single limb orthopaedic injuries.

Elective in-patient surgical and out -patient activity is also provided at the above sites.

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health and Care Services or local GP clusters. These include:

- Louth County Hospital
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital, Spalding
- Skegness and District General Hospital

Our hospitals have approximately, the following number of beds:

- Grantham: 100 beds
- Lincoln: 540 beds
- Pilgrim 350 beds

An overview of the Emergency Department services at ULHT

ULHT currently provide three Emergency Service Departments running 24 hours per day, 7 days per week (9am to 6.30pm at Grantham since 17.8.16). The regional major trauma centre is located at Nottingham University Hospitals NHS Trust, Queens Medical Centre campus. This is where patients needing the services of a major trauma service are directed.

Lincoln Hospital

The Emergency Department (ED) at Lincoln provides unrestricted access to A&E services 24/7 with an in-patient infrastructure to support most clinical emergencies. It can receive patients by air ambulance.

Seven consultants provide on-site presence from 08:00 to 22:00 during the week and 08:00 to 20:00 at weekends. At other times they provide on call cover off site but are available to attend the hospital emergency department for emergencies. The department is funded for 11 middle grades specialising in emergency care.

Pilgrim Hospital

The ED at Pilgrim provides unrestricted access to A&E services 24/7 with an in-patient infrastructure to support a range of clinical emergencies. It can receive patients by air ambulance.

Six consultants provide on-site presence in the ED from 08:00 to 21:00 during the week and 09:00 to 16:00 at weekends. At other times they provide on call cover off site but are available to attend the hospital for emergencies. The department is funded for 11 middle grades specialising in emergency care.

Grantham & District Hospital

The ED at GDH provides unrestricted access to A&E services 24/7 (9am to 6.30pm since 17.8.16). However, because of the limited in-patient infrastructure, the ED is restricted in its ability to support a full range of emergencies that normally would be expected to be treated in an ED. It cannot receive patients by air ambulance.

The health community (East Midlands Ambulance Service and local general practitioners) are aware that patients with certain medical conditions should not be taken or sent GDH (Appendix 1).

Patients who require treatment and management beyond that available at GDH, are transferred to LCH, PHB or Nottingham University Hospital.

Two consultants provide on-site presence in the ED from 09:00 to 17:00 during the week only. At weekends and at other times they provide on call cover off site but are available to attend the hospital for emergencies. The department is funded for 6 middle grades specialising in emergency care.

Volume of patients

Table 1 below shows the summary of Emergency Department attendance data for each of the ULHT hospital sites for 2015/16. It also shows the number of patients who were admitted to the hospitals as an inpatient, following their presentation to the ED.

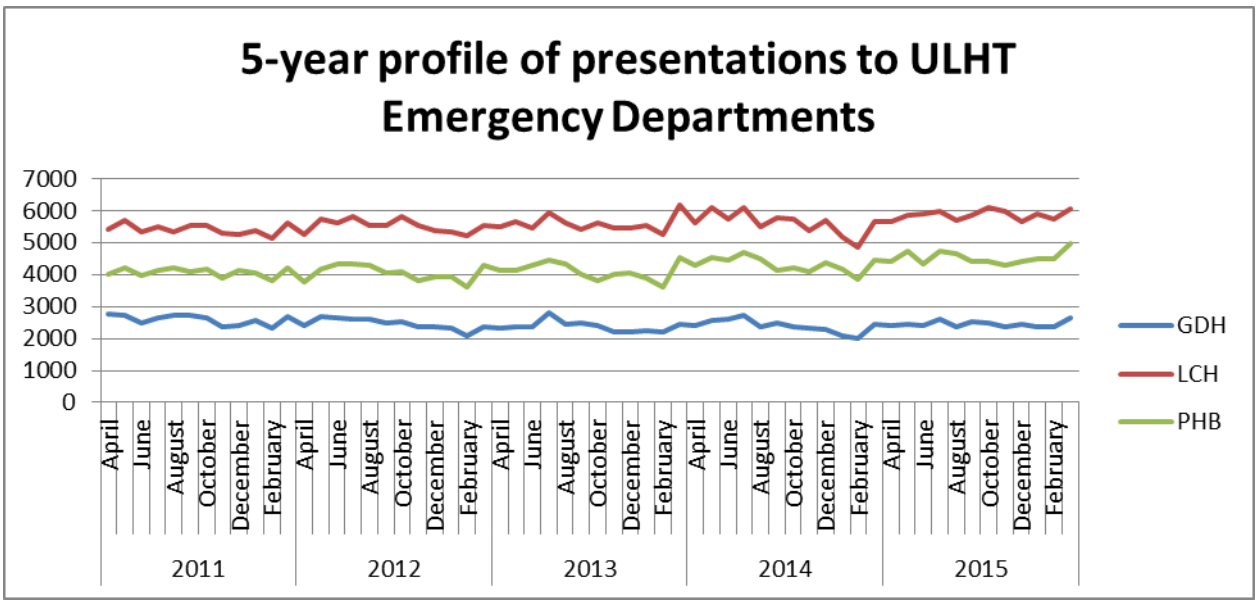
Table 1: Emergency Department attendance data for the period 2015/16 (full year)

Average numbers per day	Site	Number	%
Attendances	LCH	190	
	PHB	147	
	GDH	80	
Admissions from ED	LCH	50	26.3%
	PHB	47	32.0%
	GDH	14	17.5%

Overall ED Attendance Profile over the Last 5 Years (2011 - 2016)

Chart 1 overleaf shows the profile of presentations to the emergency departments over the last 5 years, since 2011. This demonstrates an increase in presentations to both Lincoln (13.2%) and Pilgrim (25%) Emergency Departments over the five year period. Grantham has remained relatively static.

Chart 1: Profile of patient presentations to the ULHT Emergency Departments



Summary of presentations to A&E by hour

Chart 2 below summarises the presentations to each of the A&E departments by time of presentation. It shows the average number of presentations to all three A&E departments by hour, for the period April 2015 to March 2016.

Chart 2: Presentations to the A&E departments by hour of the day

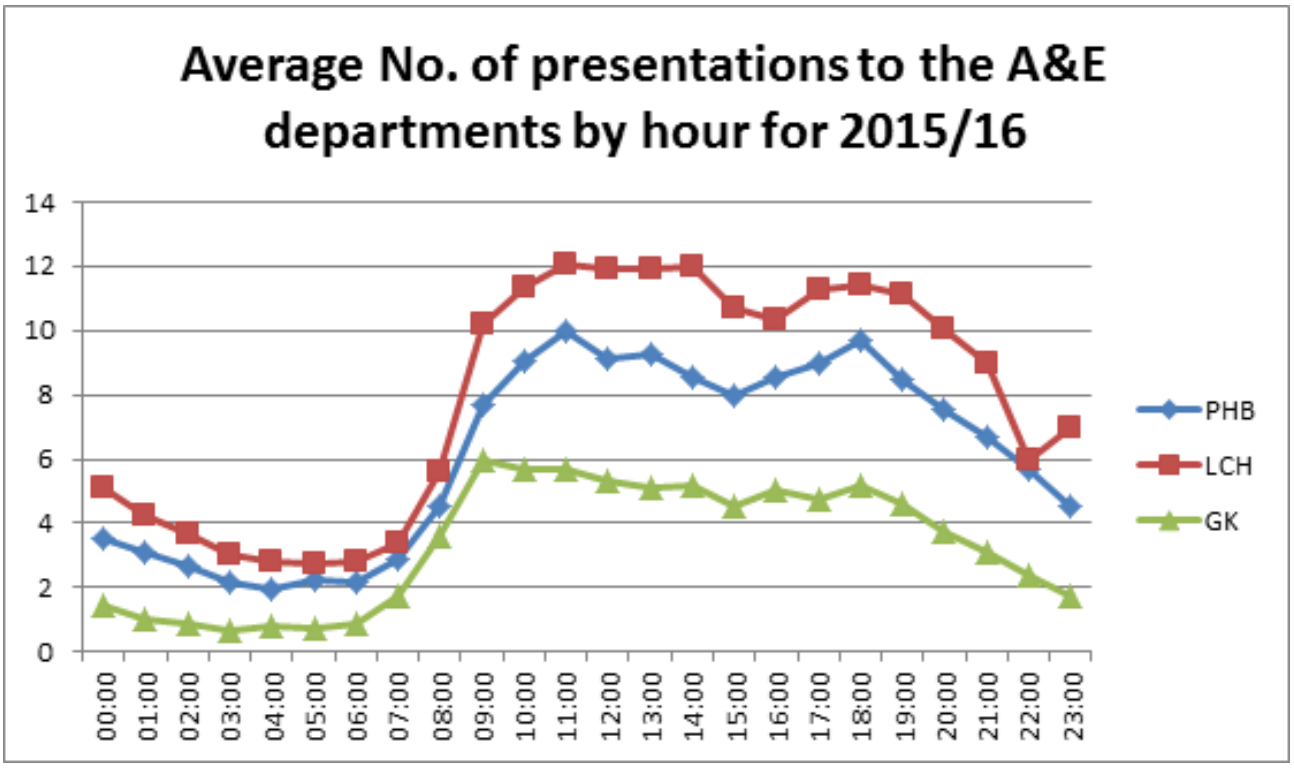


Table 2 below shows the average number of patients who present to each of the hospital emergency departments between the hours of 23:00 and 07:00

Table 2: Average number of patients presenting to A&E between 23:00 and 07:00

Site	Number of patients
LCH	34
PHB	25
GDH	11

1.2 Our current performance against national standards

The national 4-hour target has been challenging to achieve at all three hospital A&E departments. A contracted trajectory has been agreed with the commissioners and NHS Improvement.

Chart 3 below shows the performance for ULHT against the 4 hour standard for the last two years; 2014/15 and 2015/16, together with Q1 and Q2 for current year 2016/17 and finally the trajectory for the next six months. This clearly demonstrates that ULHT is significantly underperforming against the national standard and is struggling to achieve performance against the agreed trajectory.

Chart 3: ULHT performance against the A&E 4 hour standard for 2014/15, 2015/16 and Q1 and Q2 for 2016/17

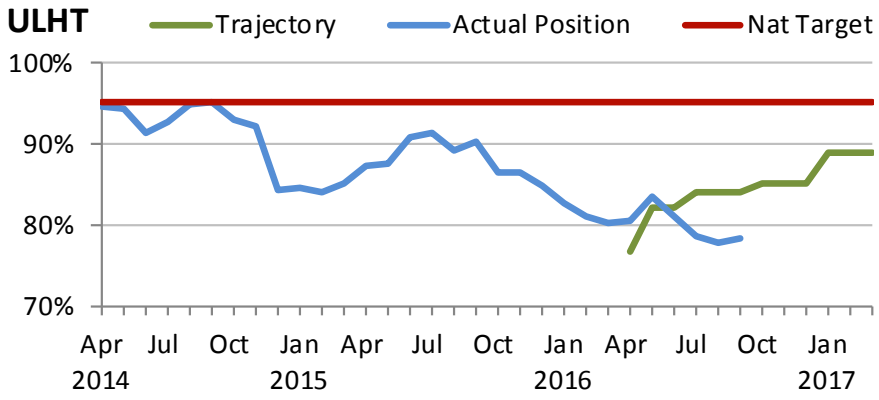
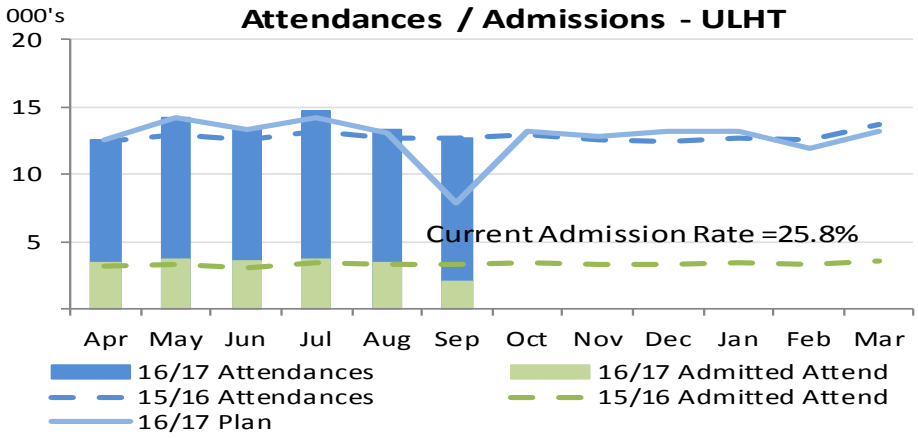


Chart 4 below shows the number of attendances to ULHT A&E departments in total, and also demonstrates that the current admission rate following presentation to A&E is running at 25%. The chart shows this detail for a full year; 2015/16 and Q1 and Q2 for the current year 2016/17. This demonstrates the number of attendances that have been planned for 2016/17.

Chart 4: Attendance and Admission details for ULHT A&E departments 2015/16 and 2016/17



1.3 What levels of staff do we need to run our A&E Departments?

The emergency departments need to be staffed to certain levels irrespective of the number of patients presenting to the department. Hospital emergency departments are staffed by a combination of consultants, middle grade doctors, doctors in training, ED nurses and emergency care practitioners

The Royal College of Emergency Medicine guidelines indicate that a 24/7 ED should provide consultant presence in the ED for 16 hours per day with appropriate support nursing and middle grade doctor support. The guidelines suggest that to run three EDs 24 hours per day, 7 days per week; we would a total of 24 - 30 consultants and a minimum of 28 middle grade doctors. Our ED medical staffing is funded for 15 consultants and 28 middle grade doctors as shown in table 3 below.

Table 3: Current funded medical posts for ULHT A&E departments

Grade	Whole time equivalents
Consultants	15.0
Middle grades	28.0

Our EDs at LCH, PHB and GDH hospitals provide a 24 hour, 7 days per week emergency department service, with weekday consultant on site presence for 14, 12 and 7 hours respectively (on call thereafter). At weekends there is a reduced site presence to 12 and 7 hours at LCH and PHB respectively. There is no consultant on site presence routinely at GDH on Saturdays and Sundays. Table 4 below summarises the medical presence for each of the ULHT Emergency Departments.

Table 4: Medical Staff presence at ULHT Emergency Departments

Site	Grade	Site presence	Days per week
Lincoln	Consultant	14 hours per day 08:00-22.00 On call off site after 22.00	Mon-Fri
	Consultant	12 hours per day 08:00-20:00 On call off site after 20:00	Sat/Sun
	Middle Grade	24 hour per day	Mon - Sun
Pilgrim	Consultant	13 hours per day 08:00-21.00 on call cover off site after 21.00	Mon-Fri
	Consultant	7 hours per day 09:00-16.00 On call cover after 16.00	Sat/Sun
	Middle Grade	24 hour per day	Mon - Sun
Grantham	Consultant	8 hours per day 09:00 – 17.00 On call off site after 17.00	Mon-Fri
	Consultant	On call off site only	Sat - Sun
	Middle Grade	24 hour per day	Mon - Sun

1.4 Gaps in medical staffing provision

Table 5 below shows the number of substantive middle grade doctors and long term locums in post at each of the hospital sites at the beginning of August 2016. The two busiest EDs with the biggest gaps in middle grade doctors were at LCH with 8.4wte and at PHB with 7.0wte. This was placing additional stress upon the existing consultants and middle grades to provide cover and to stretch shifts within the LCH and PHB EDs. Furthermore, the supervision of trainees delivering care was becoming increasingly more difficult to provide.

Prospective rotas could not be staffed with confidence and as an example for the week commencing 1st August 2016; 15-30% of the ED medical rotas at PHB and LCH were not covered.

Table 5 Gaps in provision of funded medical staff as at August 2016

	Grantham	Lincoln	Pilgrim	TOTAL	% ULHT
Consultant	0/2 ULHT 2 locums	3/7 ULHT 4 locums	1/6 ULHT 4 locums 1 gap	**4/15 ULHT** 10/15 locums 1/15 gap	**26.6%**
Middle Grade	5/6 ULHT 0 locums 1 gap	2.6/11 ULHT 0 locums 8.4 gaps	4/11 ULHT 0 locums 7 gaps	**11.6/28 ULHT** 0/28 locums **16.4/28 gaps**	**41.4%**
Junior	5/7 ULHT 2 gaps	9/9 ULHT 0 gaps	6/8 ULHT 2 gaps	**20/24 ULHT** 4 gaps	**83.3%**

Table 6 below shows the number of funded medical posts at ULHT in August 2016 against the numbers recommended by the Royal College of Emergency Medicine.

Table 6: Royal College of Emergency Medicine recommended whole time equivalent Staffing numbers, compared to funded posts at ULHT

Grade	RCEM recommended Whole time equivalents	ULHT current establishment Whole time equivalents	ULHT substantive staff in post (wte)	ULHT and long term locums in post (wte)
Consultants	**24**	15.0	**4.0**	14.0
Middle grades	**27-36**	28.0	**11.6**	11.6

The following were felt to be at increased risk of occurring:

Longer waits for initial assessment, treatment and disposition leading to:

- Increased mortality, particularly at 10 days
- Increased Length of stay (LoS) of admitted patients.
- Delayed time critical intervention
- Less frequent and less adequate pain relief
- Delayed antibiotic administration with adverse effect for treatment of sepsis
- Associated with increased risk of adverse events which doubles LoS

In addition:

- Decreased departmental function – 'under triage', inferior care in terms of standard performance measures, increased Left without Treatment rates, delays to ambulance handovers.
- Poor patient satisfaction and experience
- Staff stress and burnout and increased sickness
- Inadequate supervision for doctors in training leading to errors and patient safety issues
- Poor experience for doctors and other clinicians in training
- Risk of trainees being removed from the department, thereby exacerbating the risks
- Difficulty retaining and recruiting ED staff
- Lost opportunities for system efficiency (care isn't delivered right-first-time)
- Cost arising from high staff turnover, locums, mistakes, and performance failure
- Failure to innovate, develop practice, or invest time in basic departmental management and quality improvement
- Significant risk of not being able to respond to declared major emergencies

The Trust Board (TB) was appraised of the situation on the 2nd August, together with the potential options. There was agreement that the level of additional risk to was too great to continue without action. Approval was given to work through the possibility of a temporary service closure at Grantham for twelve weeks in order to support staffing at LCH and PHB Emergency Departments. Support to proceed with the temporary change to the opening hours at Grantham was provided by NHS Improvement on the morning of the 9th August with the change taking effect on 17th August 2016 for 12 weeks until 17th November 2016.

1.5 Threshold to re-open the ED at GDH

It was agreed with commissioners, NHS Improvement and NHS England that the ED at GDH should return to 24/7 opening hours when the required middle grade establishment had been reached and that there had been no deterioration number of consultants. The middle grade threshold was set at 21 substantives and, or long term locums, against an establishment of 28. This would enable three 24/7 rotas to be staffed consistently and prospectively but still requiring agency support to fulfil all duties within the rotas.

Model of service for the provision of emergency care at GDH with effect from 17th August 2016

- Reduced ED opening to 09.00 – 18.30 from 24/7
- Will accept ambulance conveyances in line with the current inclusions and exclusions between the hours of 09:00 and 18:30
- Medical presence was planned initially for 09.00 – 21.00 but had to be extended to 22.00 to ensure all patients could be seen in a timely manner.
- Admission to GDH for medical and orthopaedic emergencies remain unchanged
- Out of hours (OOH) service and a new minor injuries service located in the Kingfisher unit at GDH andrun by LCHS
- Single point of contact 17.00 – 09.00 for police, EMAS, LCHS and ULHT to access the crisis response team
- Direct line of access for police to the Grantham OOH services
- Dedicated telephone access outside ED for 999 and 111 only when the ED is closed.
- 2 ring fenced in-patient beds for patients needing transfer from ED to another hospital after ED closed and staff not present

1.6 Actions taken to mitigate staff shortages

In order to ensure the delivery of safe care for patients, a number of actions were taken. These included:

Utilising our current workforce

- ED consultants agreed to undertake additional shifts and acted down into middle grade slots with enhanced pay on an “as required” basis
- Stretched shifts of existing staff to cover vacant shifts
- Supported the middle grade rotas with non-middle grade staff such as junior doctors, nurse consultant and Advanced Nurse Practitioners.
- Specialities of respiratory, stroke, acute medicine, gastro, elderly and orthopaedics were asked to support the emergency department with middle grade / consultants at all sites
- Approached our system colleagues across primary and community care to help out in the ED.

Use of Agency staff

ULHT has breached the national price caps to ensure service continuation. The total number of shifts breached the price cap between 1st April 2016 and 18th July 2016 was 1,582 shifts.

Table 7 below shows the total expenditure on agency cover and additional duties from existing staff to support the A&E departments for 2015/16:

Table 7: Expenditure in 2015/16 for agency doctor cover & additional duties

	Agency spend 2015/16	Extra duty 2015/16	Total spend 2015/16
A&E Lincoln	1,888,772	140,489	2,029,261
A&E Pilgrim	1,826,510	610,000	2,436,510
A&E Grantham	287,514	215,799	503,313

Actions to recruit to establishment

Significant recruitment activity has been underway for a considerable amount of time to increase the number of middle grade staff. Additional actions have included:

- All adverts being reviewed and refreshed.
- A new agency has approached ULHT who suggest they can help to recruit consultants and middle grades to posts that have proved challenging to recruit to. This is being pursued.
- CESR (Certificate of Eligibility for Specialist Registration) posts have been re- advertised
- A&E speciality doctor posts advertised with up to 2 sessions a week, together with funding, to support the completion of an appropriate part time MSc or PhD. This ULHT funded initiative has been developed in partnership with the Community and Health Research Unit, based in the University of Lincoln and is seen as nationally innovative.
- ULHT had a recruitment stand at the Royal College of Emergency Medicine (RCEM) conference 20th-22nd of September and the BMJ Fair on 21-22nd October
- RCEM agreed to tweet all of their members with details of our vacancies to support our ED recruitment drive.
- Launch of a Master's programme for middle grades planned
- Exhibited at national recruitment conference
- Released promotional DVD to attract doctors to the trust
- Advertised through networks such as Doctors.net
- Proactive international recruitment actions including ;
    - Skype interviews undertaken to support international recruitment
    - Developed a Trust wide vacancy management strategy
    - Role substitution through nurse clinicians, physicians associates and emergency nurse practitioners

1.7 Outcome of recruitment actions since August 2016

Lincoln County Hospital

Eight applications have been received for middle grade posts in the ED. To date three have been interviewed, one still to be interviewed via Skype, one failed to attend their interview, one declined to be interviewed and for two we are still trying to contact to arrange interviews.

Offers of employment have been made to three but one has since declined, one wishes to work at PHB and one is willing to come to LCH.

It is likely that the two accepting offers will not be able to take up their post until January/February 2017.

Two general practitioners expressed an interest to work in the ED short term. One is due to start soon and the other can no longer be contacted.

Royal College of Physicians approval has been obtained for the remaining vacant consultant posts. Adverts are due to be placed shortly.

To date none of the doctors offered employment are in post.

Pilgrim Hospital
Eight applications have been received for middle grade posts. Six have been offered employment. One may be able to start in November; three are either awaiting the outcome of their International English Language Test (IELTS), visa application or GMC registration. It is likely to be January/February 2017 before they can commence employment.

Two others have accepted employment conditional on being to be able to undertake their Certificate of Eligibility for Specialist Registration (CESR) training to eventually be accredited as a consultant in ED.

Two are awaiting interviews.

Two of the current incumbent middle grade doctors will be leaving ULHT in November and December.

To date none of the doctors offered employment are in post.

Grantham and District Hospital
One application was received. The individual was interviewed via Skype, offered the post but subsequently has not responded to the offer.

Table 8 below summarises the impact of the recruitment success at each of the hospital sites, and shows the number of staff that could be in post as a result of the recruitment drive together with anticipated start dates.

Table 8: Summary of potential recruitment to medical middle grade posts

	Lincoln funded for 11.0 wte		PHB funded for 11.0 wte		GH funded for 6 .0wte		ULHT funded for 28 wte
	Substantive	**Long term locum**	**Substantive**	**Long term locum**	**Substantive**	**Long term locum**	**Total**
01.08.16	2.6	0	4.0	0	5.0	0	11.6
01.09.16	2.6	0	5.0	0	5.0	0	12.6
Current	**2.6**	**2.0**	**6.0**	**2.0**	**5.0**	**0**	**17.6**
01.11.16	2.6	2.0	5.0	2.0	5.0	*0*	16.6
01.12.16	2.6	2.0	*6.0*	2.0	5.0	*0*	*17.6*
01.01.17	*3.6*	*3.0*	*6.0*	*2.0*	5.0	*0*	*19.6*
01.02.17	*5.6*	*3.0*	*6.0*	*2.0*	5.0	*0*	*21.6*

Numbers in *italics* represent appointments subject to a number of actions beyond the control of ULHT

1.8 Impact of reduced A&E opening hours at ULHT

Medical staff (Table 8 above)
It was initially anticipated that the reduced opening hours would release up to four middle grade doctors and one or two junior doctors at FY level. Following conversations with medical staff it became clear that a maximum of three out of five available middle grades (2wte) would be able to support the ED at LCH. The initial planned support by junior medical staff had to be curtailed due to the need to ensure medical staff were present in the department until 22.00.

The GDH middle grade doctors from ED have provided up to 75 additional hours per week at LCH that were not previously available. They have helped reduced the dependency on short term locums from 65% to 50% and the number of unfilled hours from 17 to 10 hours per week.
Additionally the GDH ED consultants are now supporting LCH with 8 additional hours per week.

This is summarised in table 9 below

Table 9: Contribution by middle grade (MG) and Grantham ED consultant medical staff to the ED at LCH

	July	August	September	October	November	December
% of hours by LCH substantive MG (wte)	36 (4.0)	24 (2.6)	24 (2.6)	*24 (2.6)*	*24 (2.6)*	*24 (2.6)*
Actual hours by GH substantive MG % of hours (wte)	-	≤75hr/w (2.0)	≤75 hr/w (2.0)	≤75 hr/w (2.0)	≤75 hr/w (2.0)	75 hr/w 18 (2.0)
% of hours by long term locum MG (wte)	0	0	0	18 (2.0)	18 (2.0)	27 (3.0)
% of hours done additionally by LCH staff		6	23	?	?	
% of hours by short term locum MG (wte)	64 (7)	65 (7.1)	50 (5.5)			31 (3.4)
Unfilled hours		17 hrs/w	10 hrs/w	?	?	0 hrs/w
Actual hours by GH consultants (wte)	-	-	-	8 hrs/w (0.2)	8 hrs/w (0.2)	8 hrs/w (0.2)

The data demonstrates and confirms that the current middle grade position at Lincoln remains challenging. There is a gradually decreasing reliance on short term locums with an anticipated projection for December 2016 if support from Grantham continues

Attendances to EDs at ULHT

The attendance details to the ULHT Emergency Departments is contained in Appendix 2, but in summary:

- The average attendance over 24 hours to the ED at LCH 1st April 2016 to 16th August was 196 and since then to 23rd October was 198.
- The average attendance over 24 hours to the ED at PHB 1st April 2016 to 16th August was 161and since then to 23rd October was 157.
- The average attendance over 24 hours to the ED at GH 1st April to 16th August was 86 per day and since then to 23rd October was 58 – a reduction of 28.

For 2015/16 there has been a 4.3% growth in attendances to ULHT emergency departments [National growth 2.3% and Midlands and East 6.5%] compared with 2014/15.

Summary

There has been no significant change to the overall attendance to the EDs at LCH and PHB since the reduced opening hours at GDH.
The reduction in attendances to GDH (28) is less than predicted (30 patients) prior to the changes being implemented.

Attendance to ED at LCH and PHB from the Grantham and Sleaford area

Appendix 3 contains the detail by patient postcode of attendances to the Emergency Departments at Lincoln and Pilgrim Hospitals, for patients living in the following postcode areas: NG31, NG32, NG33, and NG34

- The average 24/7 attendance to the ED at LCH from these post codes 1st April 2016 to 16th August was 13 and since then to 9th October was 19.
- The average 24/7 attendance to the ED at PHB from these post codes 1st April 2016 to 16th August was 5 and since then to 9th October was 7.

Summary

Following the change, 6 more patients are attending Lincoln ED and 2 more at Pilgrim each day from the Grantham and Sleaford area with the above post codes

Patients conveyed to the Emergency Departments via 999

Appendix 4 contains the details of patients who were taken to the Lincoln and Pilgrim Hospital Emergency Departments via 999 calls, in summary:

- The average 24/7 attendance to the ED at LCH 1st April 2016 to 16th August was 69 and since then to 9th October was 71.
- The average 24/7 attendance to the ED at PHB 1st April 2016 to 16th August was 64 and since then to 9th October was 62.

Summary

Overall there has been no significant change to 999 conveyances to the EDs at LCH and PHB since the changes to the opening hours of the Grantham A&E Department were implemented.

Attendance to ED by 999 at LCH and PHB from the Grantham and Sleaford area

Appendix 5 shows the number of patients who were brought to the Lincoln and Pilgrim Emergency Departments via 999 calls, and who lived in the following post code areas: NG31, NG32, NG33 and NG34.

- The average 24/7 attendance to the ED at LCH from these post codes 1st April 2016 to 16th August was 8 and since then to 9th October was 10.
- The average 24/7 attendance to the ED at PHB from these post codes 1st April 2016 to 16th August was 3 and since then to 9th October was 3.

Summary

Following the changes in the opening hours of the Grantham A&E department, 2 additional people are attending Lincoln ED each day by 999 from NG31, 32, 33 and 34 post codes.
There is no change to Pilgrim ED

Total admissions to ULHT

Appendix 6 shows details of the total admissions to ULHT hospitals following patients presenting to the A&E departments.

- The average number of patient admissions to LCH 1st April 2016 to 16th August was 208 and since then to 9th October was 204.
- The average number of patient admissions to PHB 1st April 2016 to 16th August was 151 and since then to 9th October was 145.
- The average number of patient admissions to GH 1st April 2016 to 16th August was 40 and since then to 9th October was 38.

Summary

Overall there has been a slight reduction in total admissions to ULHT since the changes to the opening hours of the Grantham A&E Department were implemented.

Emergency admissions to ULHT

Appendix 7 shows the average number of emergency admissions to each of the ULHT hospitals

- The average number of emergency admissions to LCH prior to 16th August 2016 was 85 and since then to 9th October was 85.
- The average number of emergency admissions to PHB prior to 16th August 2016 was 61 and since then to 9th October was 60.
- The average number of emergency admissions to GDH prior to 16th August 2016 was 15 and since then to 9th October was 12.

Summary

There has been negligible change in emergency admissions since the 17th August.

Emergency admissions to LCH and PHB from the Grantham and Sleaford area

Appendix 8 shows the number of emergency admissions to the Lincoln and Pilgrim Hospitals for the period 2 weeks prior to the change in opening hours of the Grantham A&E Department, and the average since the changes were implemented, for patients living only in the following post code areas: NG31, NG32, NG33 and NG34

- The average number of emergency admissions to LCH from these post codes 1st April 2016 to 16th August was 10 and since then to 9th October was 12.
- The average number of emergency admissions to PHB from these post codes 1st April 2016 to 16th August was 3.6 and since then to 9th October was 3.2.

Summary

There has been a slight increase in emergency admissions to LCH and PGB from the Grantham and Sleaford post codes since the 17th August.

Discharges from ED at LCH to Grantham post codes

Appendix 9 shows the number of patients discharged by hour of the day from the Emergency Department at Lincoln Hospital to the Grantham and Sleaford post code areas; NG31, NG32, NG33 and NG34.
There has been an increase from 3.8 to 7.6 in the number of patients discharged to Grantham and Sleaford post codes out of hours since August 17th.

Quality Impact

Length of stay and hospital standardised mortality (through Dr Foster intelligence) from GP practices in the NG31 area are being monitored but at present it is too early to be able to provide any information. From our incident monitoring process through Datix, there have been no serious incidents reported to date although we are aware of issues relating to some poor patient experience.

In addition, there have been daily and weekly telephone conference calls with the clinical commissioning groups, LCHS and EMAS to discuss any issues along with the impact the changes have had on patients, their services and staff.

Summary effects on attendances, admissions and discharges since the hours of opening at the ED at GDH were reduced from August 17th 2016

Attendances

- Overall there has been no significant effect on attendances to the EDs at LCH and PHB.
- There has been a decrease of 28 (86 to 58) in patient attendances to the ED at GDH.
- From NG post codes 31, 32, 33 and 34 there has been an increase in attendances (8), by patients, to the EDs at LCH and PHB.
- EMAS 999 conveyances to the EDs at LCH and PHB have increased and decreased by 2 each respectively.

Admissions

- Overall there has been a marginal reduction in admissions to LCH (4), PHB (6) and GDH (2).
- From NG post codes 31, 32, 33 and 34 there has been an increase in overall admissions to LCH (1) and a decrease at PHB (0.5)

Discharges

- Approximately 4 more patients are discharged out of hours to NG post codes 31, 32, 33 and 34 since the changes were made.

Quality

- Overall there have been no serious issues reported that we are aware of but we continue to remain vigilant.

Patients in ED at GDH at time of doors closing at 18.30

Appendix 10 shows that there is a marginal reduction (14. to 12.6) in the number of patients in the department at the time of closing its doors, than before the changes were implemented.

4 hour A&E performance standards

Appendix 11 provides details of ULHT's performance against the A&E 4 hour standards. Since the changes were implemented there has been a slight deterioration in 4 hour standards for LCH and PHB but an improvement at GDH. The overall Trust performance has decreased by 1.61% but this needs to be set against previous performance.

2.0 Impact on EMAS

EMAS conveyances to ULHT from May to September 2016

Appendix 12 shows EMAS conveyances to ULHT. There has been no significant change to conveyances to LCH and PHB. There is a downward trend for GDH which was present for three months prior to August and has been accentuated since then.

Weekly EMAS conveyance from GH to LCH, PHB and other sites between 18.00 and 10.00 hrs for 59 days before and after 17th August

Appendix 13 shows data provided by EMAS that there has been a reduction from 15.1 to 7.2 in weekly transfers from GDH to other sites.
The greatest reduction is from ED at GDH to LCH and PHB (10.3 to 3.2) with no corresponding change to transfers to other sites as a consequence

EMAS job cycle time for 59 days before and after 17th August 2016

Appendix 14 shows details provided by EMAS of the job cycle time for crews.
For double crewed ambulances there has been no alteration to the length of time to get spent on scene or time taken to arrive. The overall job cycle time has increased by 5 minutes and there is a reduction in the number of call outs by 64 from 1389.

For rapid response vehicles the time spent on scene has decreased by 3 minutes and the time spent travelling increased by 1 minute. The overall job cycle time remains unchanged and the number of call outs increased by 27 from 704.

EMAS R1 performance data in SW Lincolnshire for 59 days before and after 17th August 2016

Appendix 15 shows performance data as provided by EMAS
There has been no deterioration for the 8 and 19 minute targets.

EMAS waits and handover for July 2016 and since 17th August 2016

Appendix 16 shows that there has been an increase in the average ambulance handover times and the number of ambulances waiting more than 30 minutes at LCH and PHB.

Calls to EMAS from Grantham and Sleaford post codes NG31, 32, 33 and 34 for May – September 2016

Appendix 17
There has been no significant change in the calls made to EMAS from these post codes.

Summary of impact on EMAS

- Overall there has been no significant change to conveyances to ULHT but there is a reduction, specifically to GDH.
- There has been no deterioration in EMAS R1 performance data or overall job cycle times.
- There has been deterioration in ambulance waits over 30 minutes and handover times.
- There has been no significant change to calls to EMAS from the Grantham and Sleaford post codes.

EMAS have provided the following statement:

"Given the short period of time since the restricted hours at GDH, it is difficult to assess the impact and draw a firm conclusion from the data; however, there is a definite trend in the reduced admissions via ambulance into GDH and the handover delays at the other acutes has seen an increase. There has been an increase in the significant late finishes for crews and an implication that patients are declining transport due to not having access to GDH".

2.1 Impact on out of hours service

Appendices 18 and 19 highlight the use of out of hours service provided by LCHS

There has been a decreasing trend in patients using the out of hours service before changes to GDH were made. This has continued since the 17th August. There is negligible use of the newly developed LCHS run walk in minor injuries unit.

Summary and comments from LCHS

- There has been a reduction in patients being diverted away from A+E due to:
    - the service being relocated to the Kingfisher unit and therefore away from the front door(ED)
    - the reduced opening hours for the A+E department.
- There has been a reduction in patients walking in to the service. This might be to a change in behaviour such as accessing alternative healthcare – GPs, pharmacy etc.
- There have been no increase in home visits locally since the reduction in ED hours.
- There has been no increase in footfall through the Enhanced Out of Hours Minor Injury service.
- There has been increased ED attendance at Peterborough. SW CCG have identified this as averaging 1 additional ambulance per day.

2.2 Anticipated impact on the Lincolnshire Police

The notes of all patients brought to the ED at GDH, by the police, from 1st April to 14th August 2016 were reviewed. On average up to 3 patients per week were brought to the department after 18.30 and before 09.00. It was felt that approximately 2 patients per week would warrant treatment in an urgent care centre or minor injuries unit.

3.0 Engagement with staff, stakeholders and the public

Engagement by ULHT
Appendix 20 contains the letter we have sent to organisations listed below for their comments on the impact of changes made to the Emergency Department at GDH. The comments in italics below are from their responses. A regular update bulletin has also been widely circulated along with regular media updates including local Gravity FM

Staff

- There have been weekly updates to and from the staff at GDH. As a consequence of feedback this has led to the development of enhanced standing operating procedures for children, extended ED staff presence after closing and better signage for patients.

LCHS

- See section 2.1

EMAS

- see section 2.0

LPFT

- *From 18th August to 10th October there were only 4 presentations at Lincoln A&E out of hours, from people with a Grantham area GP to LCH*
-

Commissioning CCG

- *To date we haven't been able to detect any direct impact from the Grantham changes on LECCG specifically and no issues have been escalated to us from our GP Practices*.

Healthwatch Lincolnshire

- *Please find below a small number of comments raised directly with us relating to Grantham A & E closures. We have already shared these with the Trust so you may have already had sight of them.*
- *Grantham Hospital - Closure of this main hospital is outrageous. Expanding footprint of newcomers is vital as is the services.*
- *Patient commented they were taken to LCH A&E after passing out, they felt the treatment (drip) was not completed properly, really hurt. Patient did not feel listened to and stated 'if Grantham hospital hadn't closed we would have not had to travel so far'*
- *Patient called 111 service where an ambulance was called, given the option to be taken to LCH but would have to make their own way home to Grantham which patient felt was unacceptable as would need to go by bus, so patient declined to go to hospital at all. Patient commented 'we need the hospital A&E in Grantham'*

Lincolnshire Police

- *In the 8 weeks that Grantham A and E have been operating their current hours, Lincolnshire Police have used other hospitals on 8 occasions totalling 78 police hours in circumstances where they would normally use Grantham. The impact of this 'time' abstraction will be many and varied however, for the purpose of this report at this stage, please refer to the total hours*.
- Also see section 2.2

Army Training Regiment

- See Appendix 21

NUH

- There has been no formal correspondence from them but informally and from direct conversation with NUH, there has been no noticeable consequence

Peterborough

- There has been no formal correspondence from them but informally and from direct conversation with NUH, there has been no noticeable consequence

Newark

- There has been no formal correspondence from them but informally and from direct conversation with NUH, there has been no noticeable consequence.

Engagement with community organisations by ULHT

Appendix 22 documents in detail all the work ULHT has done in engaging and communicating with community organisations.

We have met with a number of groups including those relating to age, race, disability, carers, maternity, low income and others. Sixteen of these were from the Grantham area with 6 more planned. A further 16 groups have had information sent to them at their request (rather than wanting to meet with us).

A wide geographical area has been covered including: Grantham central, Sleaford, Ruskington, South Lincolnshire, Allington, Corby Glen.

Overall, we listened to 124 people at meetings and over 200 at St Wulfram's Church meeting, plus 65 who commented on Facebook. We reached far more people on social media. The Facebook posts had a combined reach of 3,117 with 42 shares and 65 comments. Twitter posts had 549 impressions.

Grantham staff

Accident & Emergency

A specific meeting to canvass views, was held last week between the nursing and medical ED staff and the Deputy Chief Executive, Chief Nurse, Medical Director and the Director for Human Resource.

The following areas were discussed or raised as concerns:

1. Need to change the SOP with reference to sick patients queueing in the morning before the department has opened.
2. Whether the OOH/MIU could deal with minor illnesses?
3. Nurse staffing levels were already down by 6wte and may be depleted further for when we plan to reopen.
4. Reassurance was needed to be satisfied that the new arrangements will be satisfactory for winter
5. Pay protection will continue for all staff on the basis that this remains a temporary arrangement.
6. A more detailed discussion with the medical ED staff was required to discuss whether their attendance to LCH can be extended beyond 3 months
7. Concerns about Lincoln shift patterns changing for GDH medical staff at short notice (5 days).
8. Concerns about GDH medical staff doing night shifts at LCH
9. Continued concern by all staff about continued uncertainty about an extended temporary closure
10. Interaction with EMAS
11. Need to review nursing shift patterns
12. Need guide lines for nursing indemnity
13. There was a desire for the ED to reopen 24/7

Grantham Medical Advisory Meeting

An extraordinary meeting was held between the consultant medical staff and the Deputy Chief Executive, Medical Director and the Director for Human Resource.
The following were discussed or raised as concerns:

1. To review communications from ULHT about ED at GDH
2. Unhappy how GDH is portrayed in the media
3. Physicians were unhappy about patients remaining under their care on EAU whilst waiting for transfer to elsewhere
4. Concerns over the difficulty with recruitment in the ED at LCH
5. Concern that the potential new medical staff would not be sufficiently well versed with medical practice in the UK and therefore may take more time to get up to speed
6. Impact on GDH brought about by continued uncertainty
7. A need to separate issues affecting GDH from those affecting LCH and PHB
8. Concern over the impact on trainees
9. Concern over the re-opening criteria

4.0 Timeline to review the decision

- 20th October
    - Discussion with ULHT's Clinical Management Board (Clinical directors and Executive team) for a recommendation
- 21st October
    - Discussion with and feedback from Grantham ED nursing and medical staff 09.00
    - Discussion with and feedback from an extra ordinary Grantham Medical Advisory Committee (MAC) 12.30
    - Discussion with and feedback from Grantham ED nursing and medical staff 14.00
    - Preliminary discussion with NHS Improvement and NHS England
- 21/25th October discussion with SWCCG
- 26th October discussion with Lincolnshire System Executive Team (all four Lincolnshire CCGs, LPFT, LCHS and public health and social care)
- 1st November discussion and decision by ULHT's Trust Board
- 2ndth November review decision with Lincolnshire System Executive Team
- 8th November review by A&E Delivery Board
- 11th November discussion with NHS Improvement and NHS England and agree outcomes

5.0 Summary of discussions with ULHT's stakeholders on reviewing the impact of the change

Clinical management board (CMB)

The CMB considered four options for the ED at GDH. These were:

1. To reopen to 24/7
2. To continue with the reduced opening hours
3. To increase the opening hours to 12 hours
4. To reduce the opening hours even further

Following a detailed discussion based on the available information, the Clinical directors concluded:

1. that recruitment of ED doctors had improved
2. that the aim of recruiting 21 substantive or long term locum middle grade doctors was possible but unlikely to be achieved before January/February 2017
3. on grounds of patient safety, continued support by the A&E medical staff at GDH, for the A&E department at LCH was still required
4. it was not possible to extend the opening hours at GDH
5. a further reduction in opening hours at GDH was undesirable and not necessary
6. the reduced opening hours in Accident & Emergency at GDH should be extended by at least 3 months.
7. A monthly staffing update be brought for review and assessment by the CMB

NHS Improvement

This took place between the CEO for ULHT and NHS Improvement. Particular concern was expressed by NHSI about trying to make changes in the middle of winter, such as February. It was suggested that the reduced opening hours should be extended beyond 3 months, possibly up to 6 months for sufficient staff to be recruited and the potentially busier winter period avoided.

South West Lincolnshire CCG

This took place by telephone between the Medical Director and the GP Chair and Executive Committee Chair. Based on the continuing fragility of A&E medical staffing recruitment, there was a recommendation for the continuation of reduced opening hours for a minimum of 3 months.

Lincolnshire System Executive Team

The available information and analysis was reviewed. There was recognition of the need for the temporary arrangements and support for continuing with the temporary closure of the A&E department at GDH until 31st March 2016. However, it was felt that this should be kept under review in the light of the pressure of winter. Re-assurance was also required with reference to the winter resilience for EMAS.

6.0 Summary

Reducing the A&E Department opening hours at GDH to 09.00 – 18.30, has enabled the A&E Department at LCH to be supported up to an additional 85 hours per week by the middle grade and consultant staff from the A&E Department at GDH.

There is the potential to recruit to 21 middle grades for ULHT however, this is subject to a number of actions beyond the influence of ULHT. It is highly unlikely that these doctors would be in employment before January or February 2017 and would need a further period to be inducted and made fully operational. The recruitment of middle grade doctors to LCH remains challenging but appears to be a very slowly improving picture.

Since the overnight closure of the A&E department at GDH, the overall impact on ULHT has been minimal and as expected.

Within this activity, there has been an increase (8) in attendances by patients from the Grantham and Sleaford area with post codes; NG 31, 32, 33 and 34 to the A&Es at LCH and PHB. In addition, EMAS 999 conveyances to LCH and PHB have increased by 2. Approximately 4 more patients are discharged out of hours to NG post codes 31, 32, 33 and 34 since the changes were made.

The significance of the impact on EMAS is unclear. Key performance indicators remain unchanged but there appears to be deterioration in ambulance handover times and an effect on finishing times of the crews.

The impact on surrounding stakeholders appears to be minimal. There remains serious concerns about the closure of the A&E department by the public and some staff.

7.0 Recommendation

The Trust Board is asked to note the contents of this paper, including the views of the CMB, staff, public and stakeholders including regulators and commissioners.

All options have been considered with an aim to deliver a safe service for all three Emergency Departments at ULHT. The provision of emergency services, particularly at LCH, remains fragile and requires the continued support of A&E medical staff from GDH on grounds of patient safety.

When the decision was taken in August to reduce the opening hours of the Grantham A&E Department, a threshold of a minimum of 21 wte middle grade doctors would be required to safely staff the three A&E Departments (Lincoln, Pilgrim and Grantham).

This report has demonstrated that the recruitment drive has identified the potential to reach this threshold, but not until February 2017. It is not clear that the anticipated new medical staff will be sufficiently well versed with the NHS to be working autonomously from the outset of their employment.

Based on the evidence provided in the report, the Trust Board is asked to consider which of the four options is the most appropriate to implement, after 17th November 2016.

5) To re-instate a 24 hour Accident & Emergency Department at Grantham District Hospital
   a) If yes, when should this commence?
6) To keep the current opening hours of 09.00 – 18.30
   a) If yes, then for how long?
7) To extend the opening hours beyond its current position
   a) If yes, to what?
8) To reduce the opening hours from its current position
   a) If yes, to what

   In addition, Trust Board is asked to acknowledge the contribution made by the A&E medical staff at GDH to ensuring the provision safe care of patients in the A&E department at LCH

Appendix 1

EXCLUSION PROTOCOL
Ambulances / GPs SHOULD NOT bring / send these patients to Grantham and District Hospital A&E department and Emergency Assessment Unit

The following Specific Patient Groups

- Acute surgical admission
- Acute stroke
- Gastro-intestinal haemorrhage (fresh blood or melena).
- Severe abdominal pain and acute abdomen (refer patient directly to LCH.)
- A female of childbearing age with lower abdominal pain.
- A male under 30 years of age with testicular pain.
- A patient with a suspected abdominal aortic aneurysm.
- Patients with an ischaemic limb needs admission to the on-call vascular team at PHB
- All Obstetric and Gynaecological patients
- Head injury – Glasgow Coma Score < 15
- Neutropenic sepsis
- Patients requiring dialysis
- Patients with renal transplants
- Ophthalmological emergencies (e.g. acute glaucoma)
- Severe ENT emergencies (e.g. bleeding)

Patients with Major Injuries

- All major trauma involving head, cervical spine, chest, abdominal or pelvic injuries.
- All suspected and actual spinal trauma and patients with abnormal spinal neurological examination
- Multiple peripheral injuries involving more than one long bone fracture above the knee or elbow.
- Head injuries with a Glasgow Coma Score < 15
- All gunshot wounds.
- All penetrating injuries above the knee or elbow.
- Scalds and burns covering >15% body surface area.
- Burns to face, neck, eyes, ears or genitalia.
- Electrical burns, significant inhalation injuries or significant chemical burns.

Patients with Significant Mechanism of Injury who need Admission or Assessment

- Ejection from vehicle.
- Death in same passenger compartment.
- Roll over RTA.
- High speed /impact RTA (speed > 30mph, major vehicle deformity, passenger. compartment intrusion, extraction time > 20 mins).
- Motorcyclist RTA > 20mph or run over.
- Pedestrian thrown, run over or > 5 mph impact.
- Falls > 3m.

ADMISSION PROTOCOL

A patient MAY be brought to Grantham and District Hospital if they require immediate Airway and/or Breathing resuscitation.

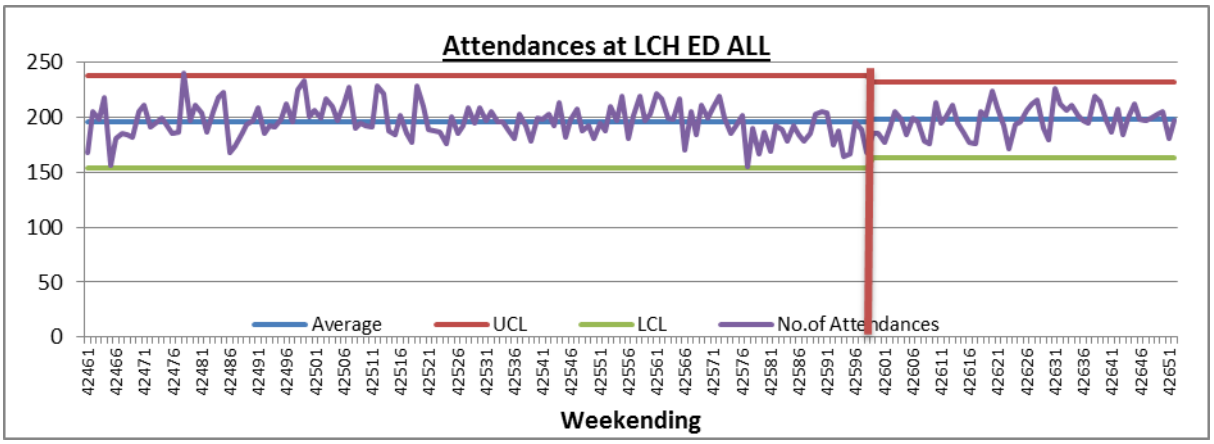
Trauma involving just the peripheral skeleton MAY still be brought to Grantham A&E.

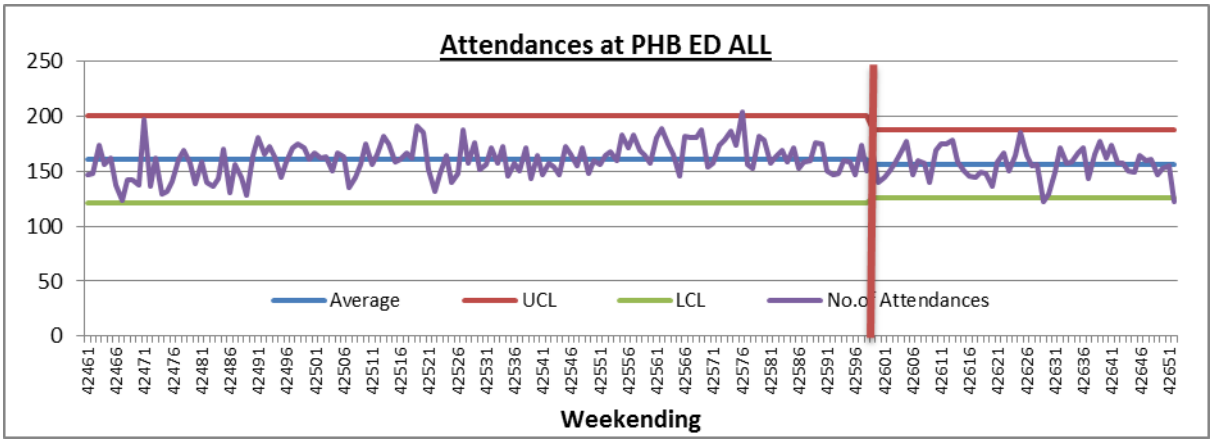
For example:

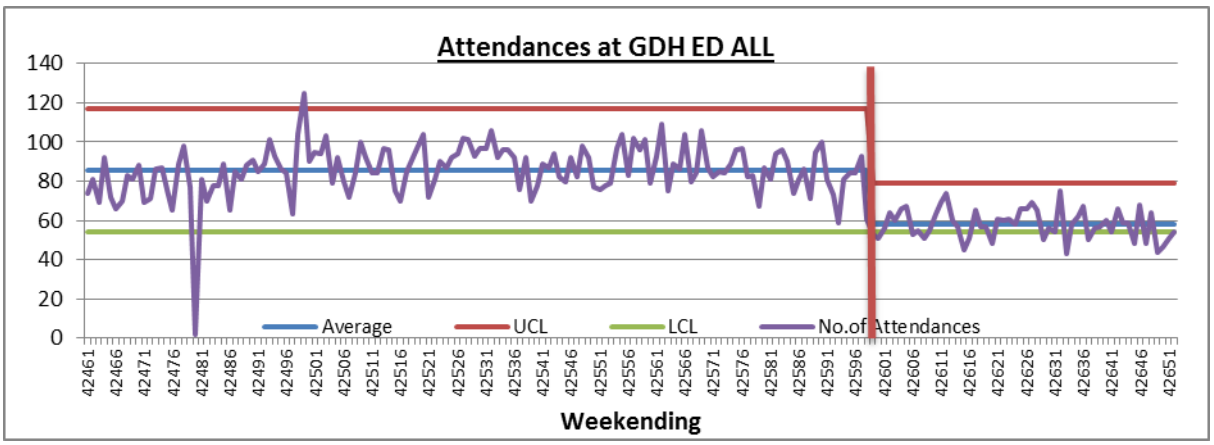
- All suspected shoulder, arm, wrist and hand fractures (including compound [open]).
- All suspected hip fractures.
- All suspected femoral, tibia, ankle and foot fractures (including compound [open]).
- All suspected joint dislocations, shoulder, elbow, wrist, hip, knee, and ankle.
- All suspected peripheral soft tissue injuries, sprains, strains, lacerations, haematomata.
- All hand injuries (may require subsequent transfer after assessment).
- Children's suspected fractures. If confined to one area and are haemodynamically stable may be brought to Grantham. (May require subsequent transfer after assessment).

Appendix 2

Attendances to the EDs at LCH, PHB and GDH before and after reduced ED opening times at GDH

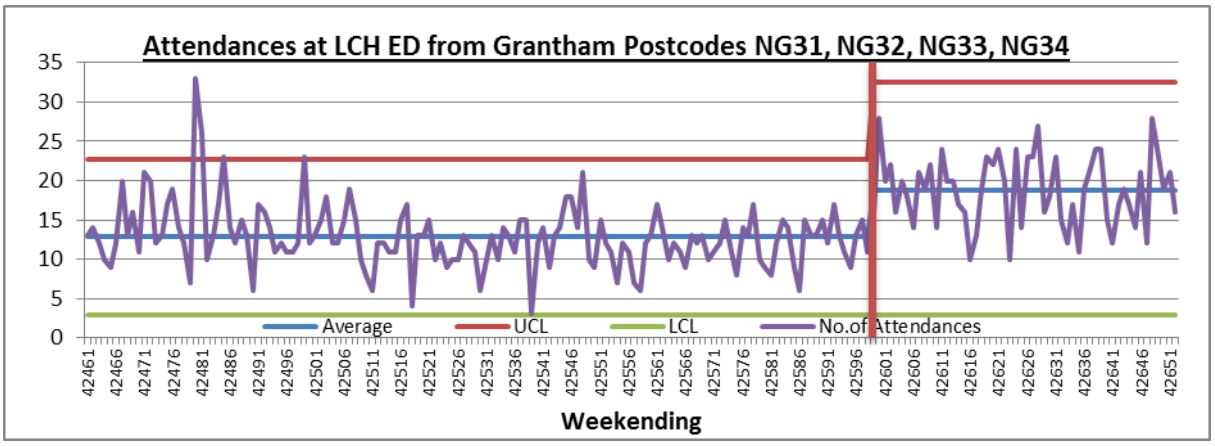


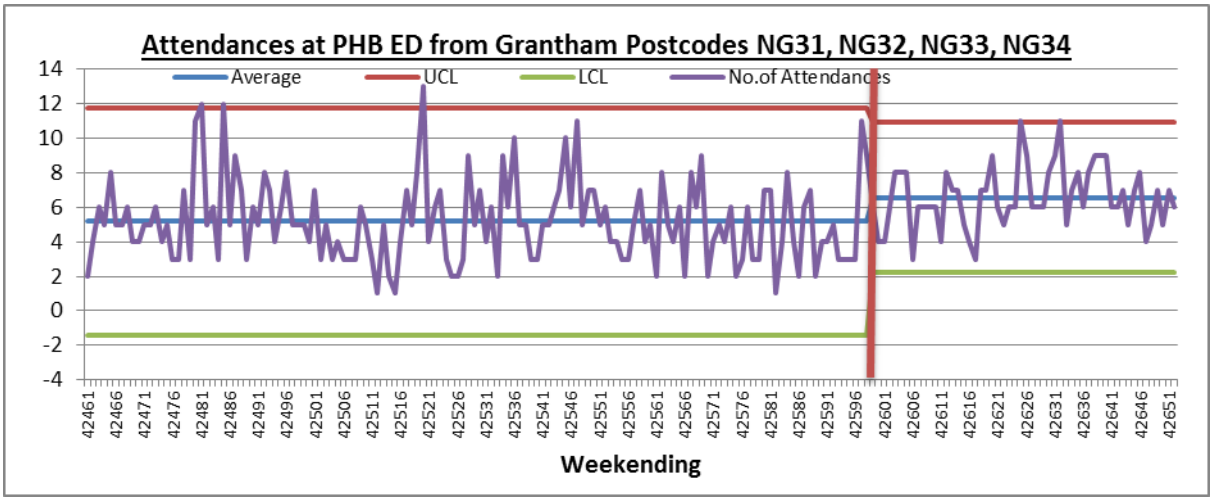




Appendix 3

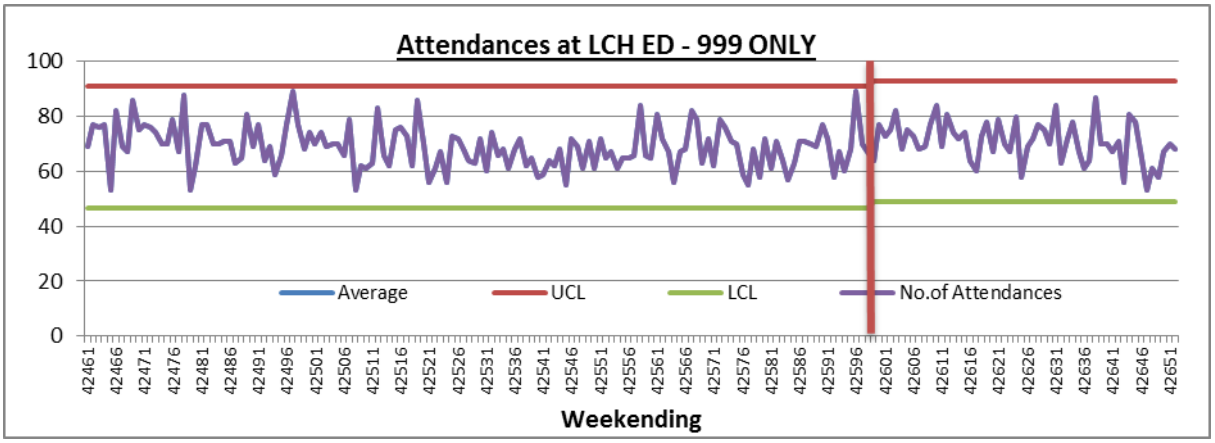
Attendances to EDs at LCH and PHB from Grantham and Sleaford post codes NG 31, 32, 33 and 34

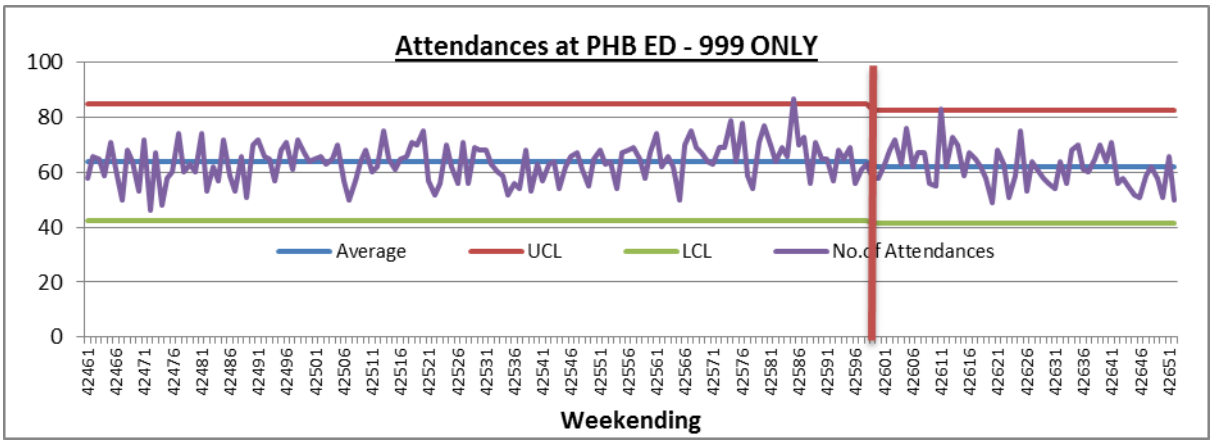




Appendix 4

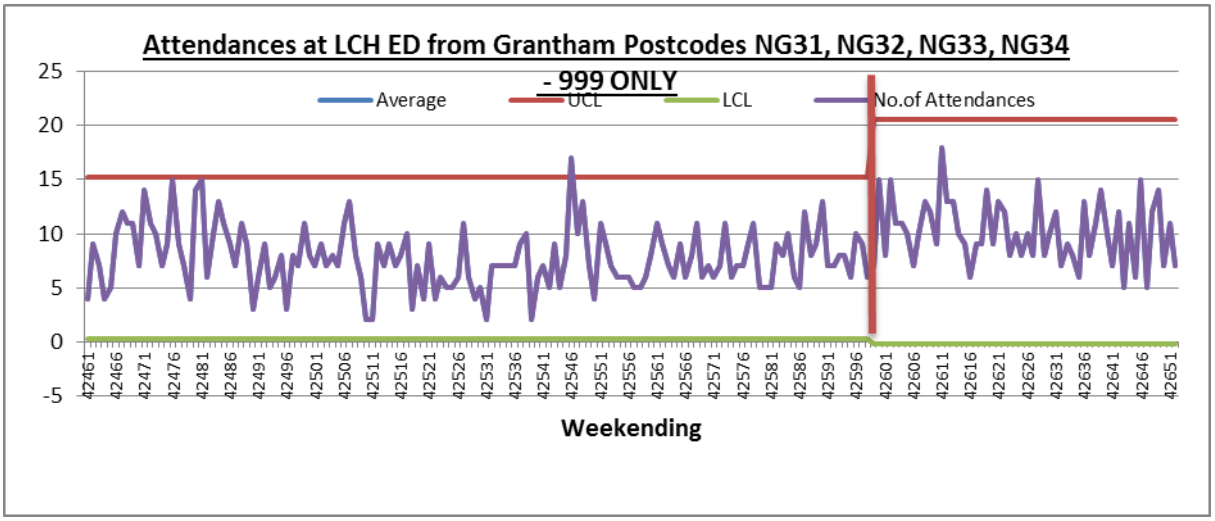
Attendances to EDs at LCH and PHB by 999

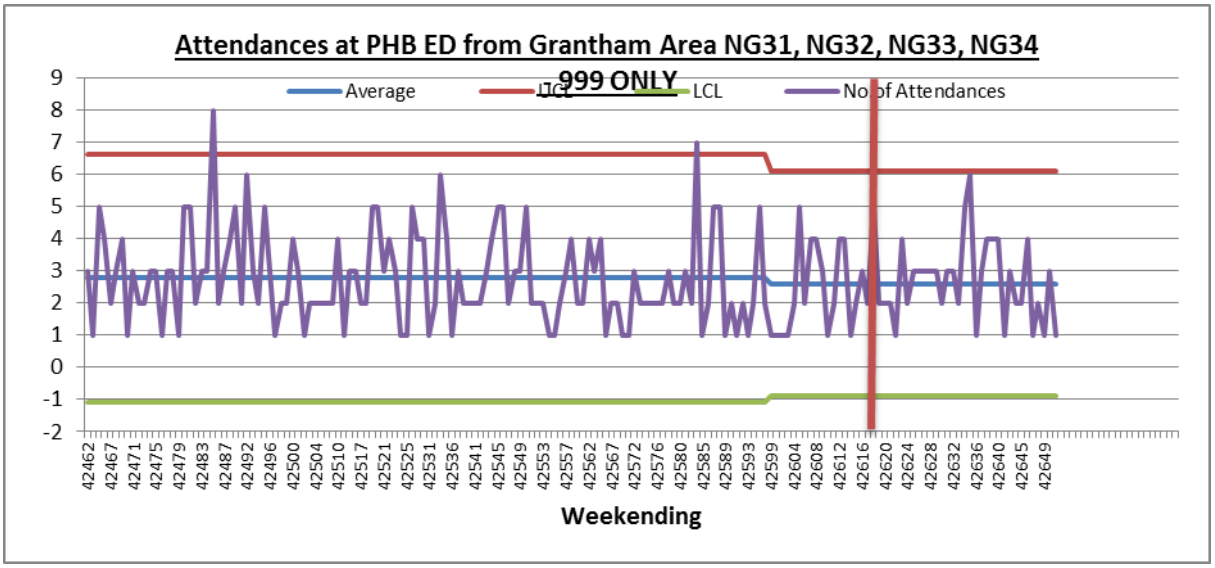




Appendix 5

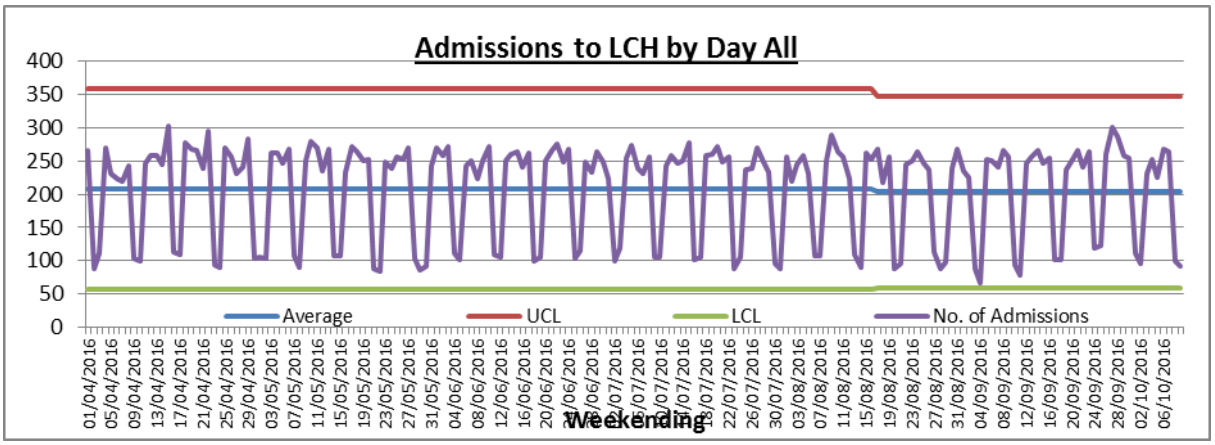
Attendances by 999 to the EDs at LCH and PHB from Grantham and Sleaford post codes NG 31, 32, 33 and 34.

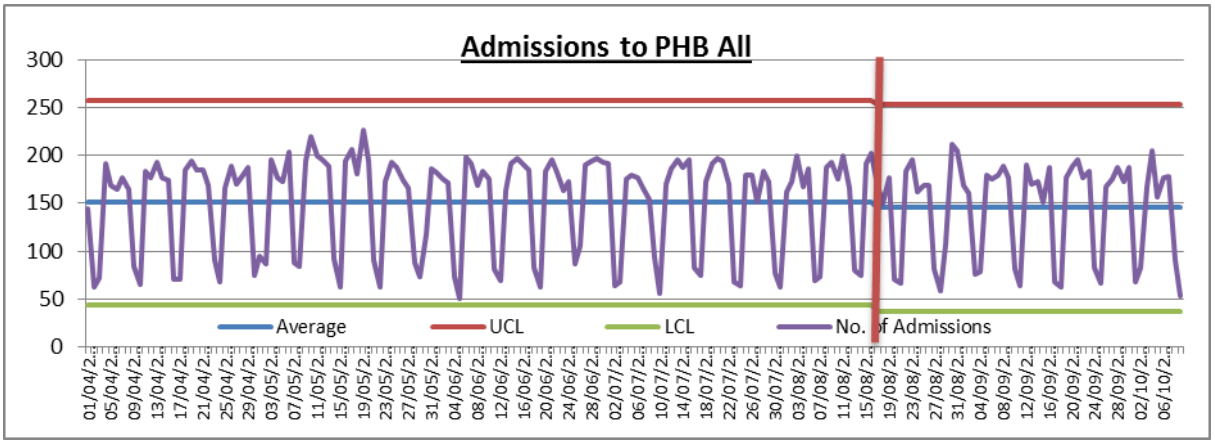


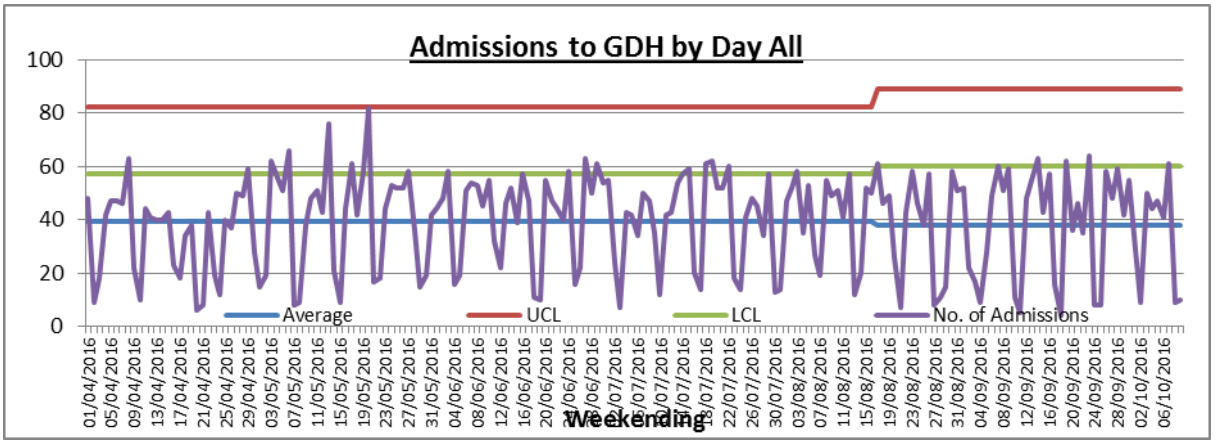


Appendix 6

Total admissions to LCH, PHB and GDH

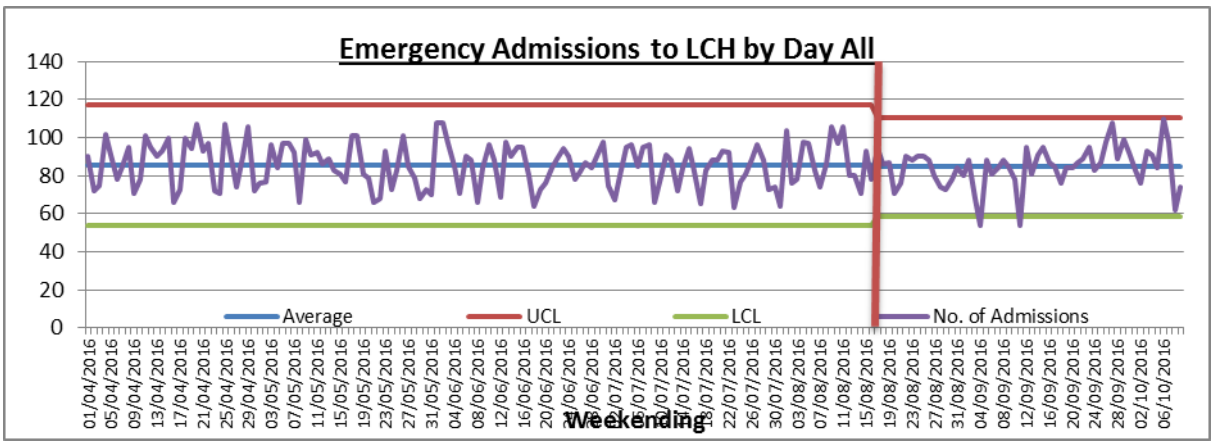


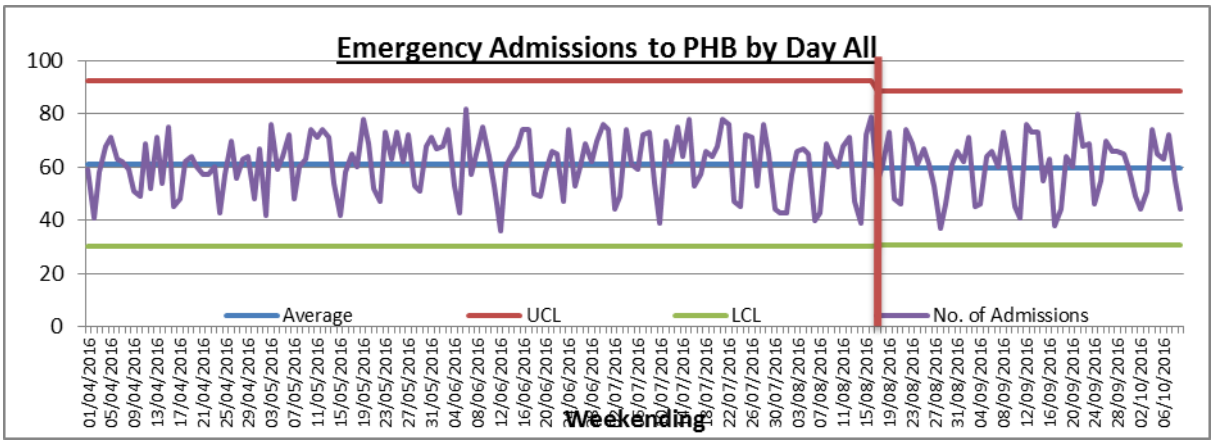


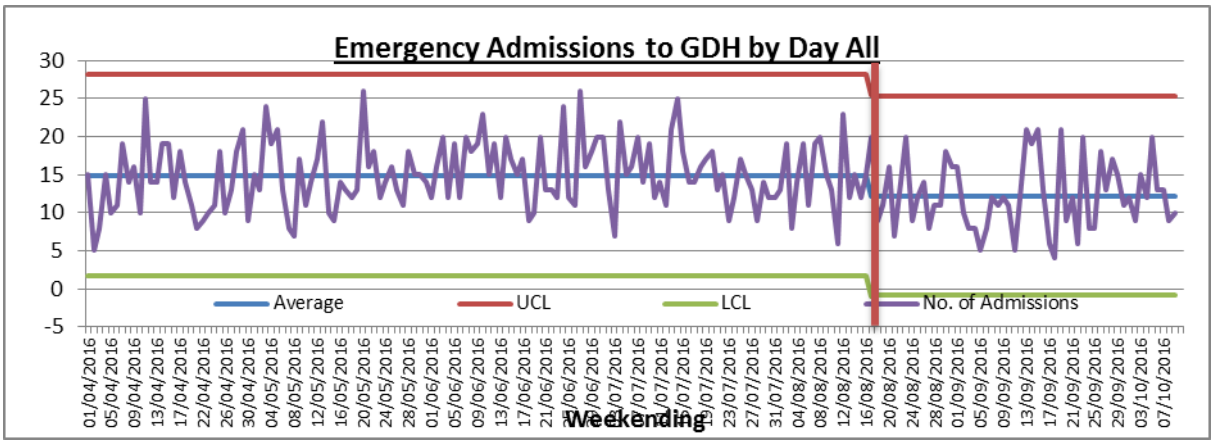


Appendix 7

Emergency admissions to LCH, PHB and GDH

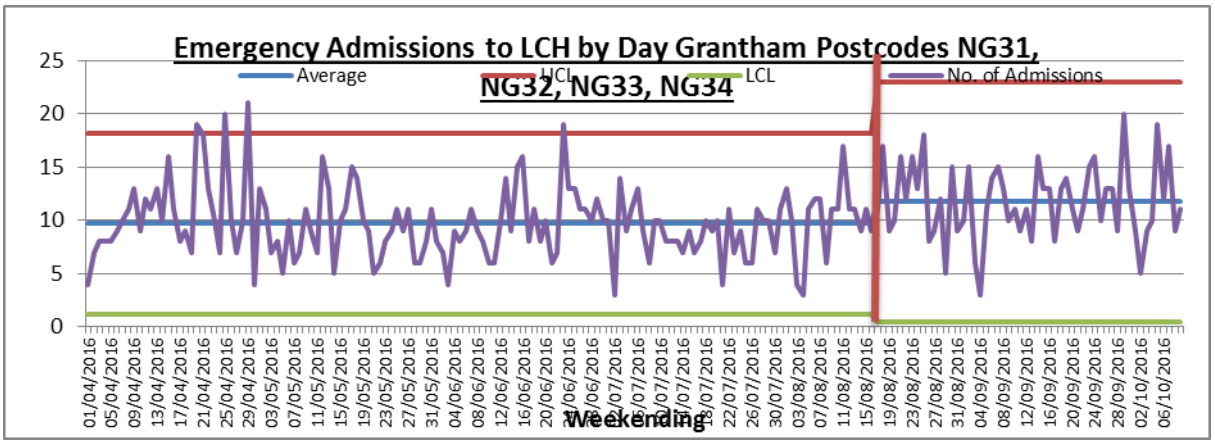


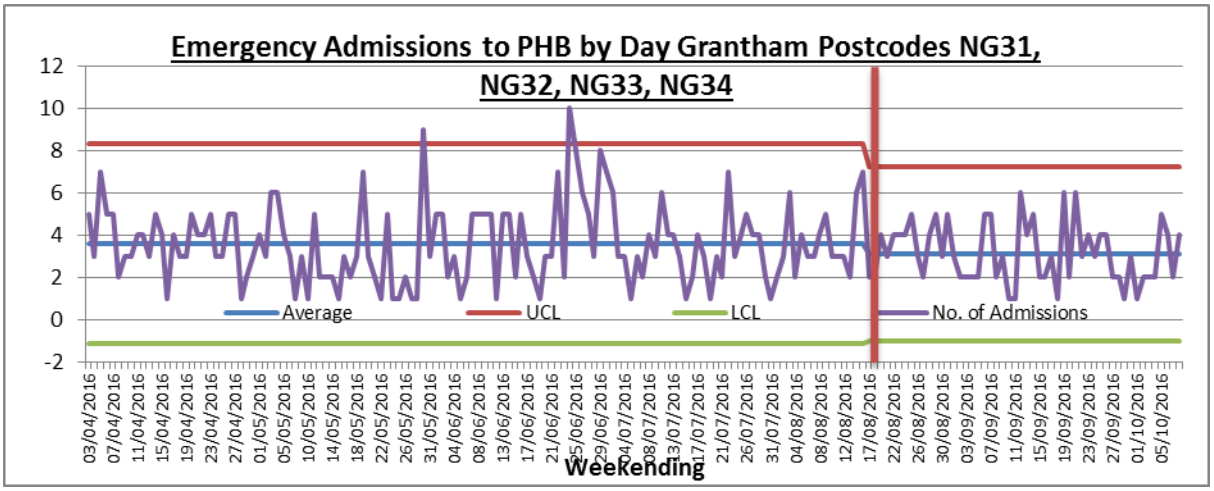




Appendix 8

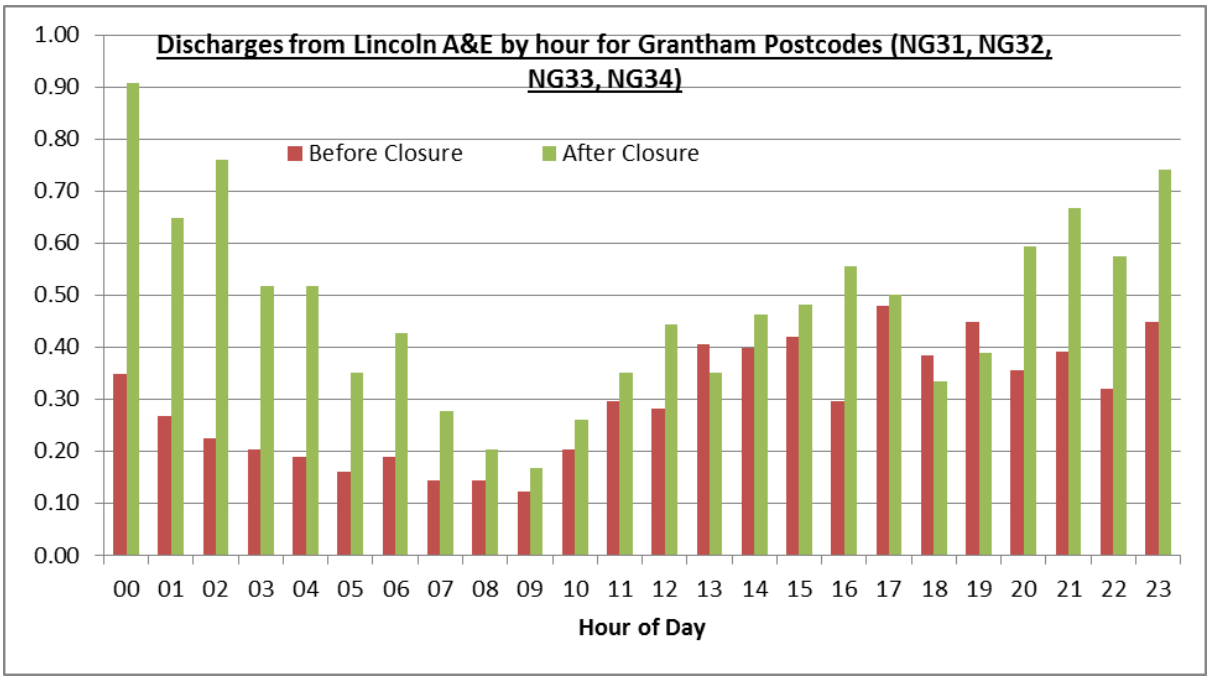
Emergency admissions to LCH and PHB from Grantham and Sleaford Postcodes NG31,NG32, NG33 & NG34





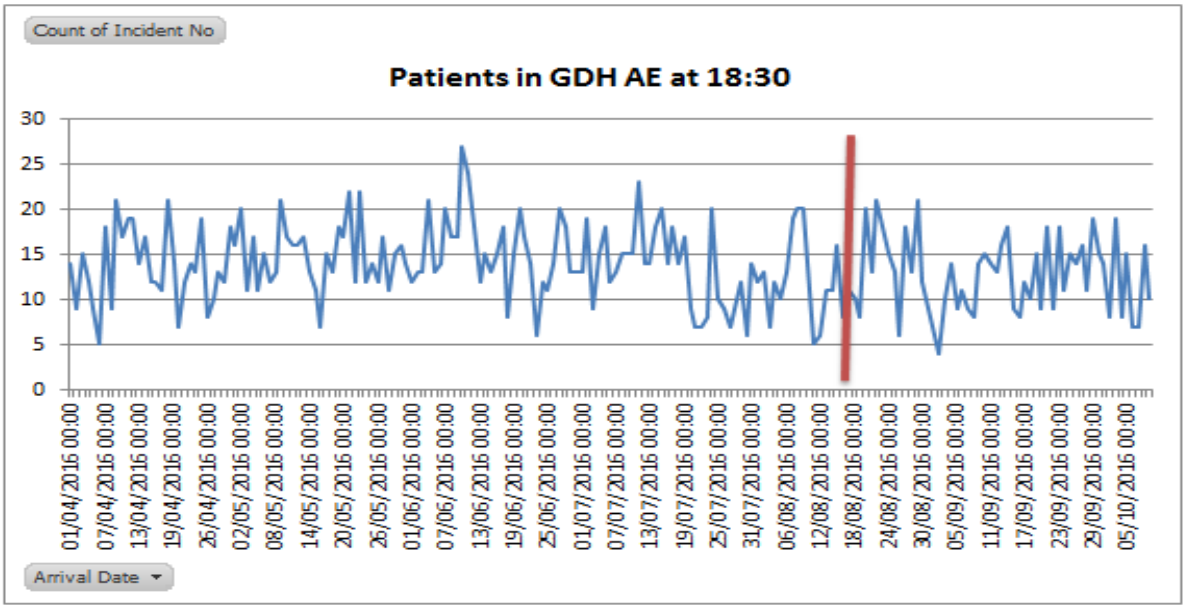
Appendix 9

Discharges per hour from ED at LCH to Grantham and Sleaford post codes NG31, 32, 33 and 34.



Appendix 10

Number of patients in the ED department at GDH when the department is closed at 18.30 hrs



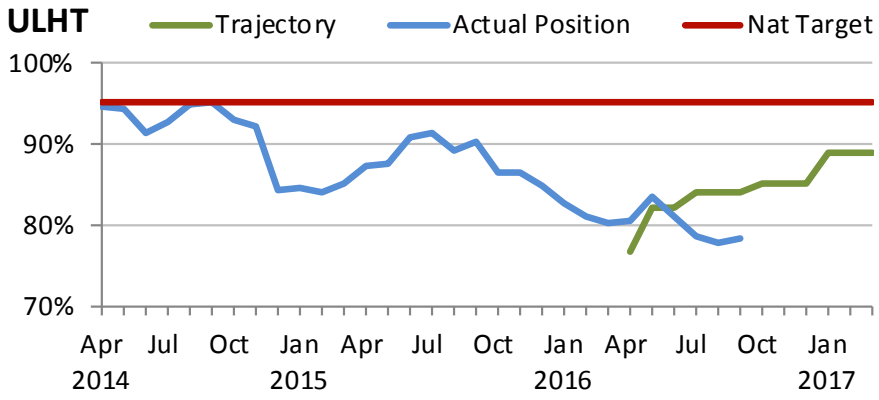
Appendix 11

4 hour performance report 7 weeks before and after the 17th August with historical performance and trajectory.

AE 4hour performance

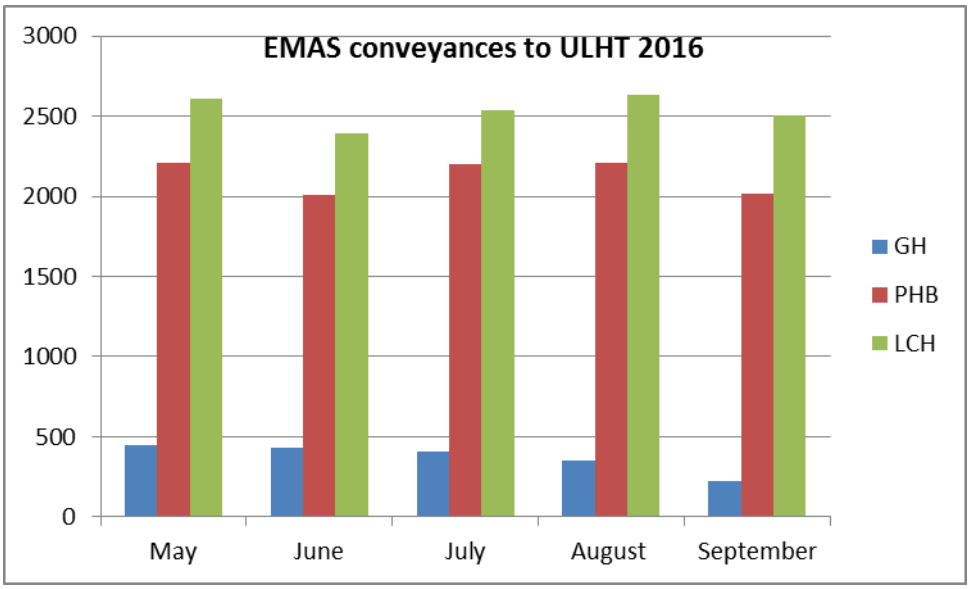
Data taken from Weekly Sitrep reported files

	Grantham	Lincoln	Boston	Trust
7 weeks post closure	95.19%	74.47%	74.56%	77.46%
7 weeks pre closure	90.26%	76.32%	76.07%	79.07%
Variance	4.93%	-1.85%	-1.51%	-1.61%



Appendix 12

Weekly EMAS conveyances to ULHT from May to September 2016



Appendix 13

Weekly EMAS conveyance from GH to LCH, PHB and other sites between 18.00 and 10.00 hrs

	ULHT	LCH	PHB	Other
From GH before	13.8	11	2.7	1.3
From GH after	5.5	4.3	1.2	1.7
From ED before	10.3	8.4	1.9	1.1
From ED after	3.2	2.3	0.99	1.1
Data 59 days before and after closure				
EMAS data				

Appendix 14

EMAS job cycle time

	On scene	Travel	Job cycle	n
DCA before mins	**35**	**13**	**92**	**1389**
DCA after mins	**35**	**13**	**97**	**1325**
FRV before mins	**54**	**8**	**64**	**704**
FRV after mins	**51**	**9**	**64**	**731**
Data 59 days before and after closure EMAS data				

DCA – double crewed ambulance
FRV – fast response vehicle

Appendix 15

EMAS R1 performance in SW Lincolnshire

	75% target 8 mins	95% target 19 mins
Before 17th August	**64.52**	**93.55**
After 17th August	**64.84**	**100**
Data 59 days before and after closure **EMAS data**		

Appendix 16

EMAS handover times and ambulances waiting more than 30 minutes.

Average Ambulance Handover Times

Data taken from EMAS monthly handover data

	Grantham	Lincoln	Boston
Since Closure	00:20:33	00:30:25	00:23:15
July	00:22:24	00:28:30	00:22:16
Variance	00:01:51	00:01:55	00:00:59

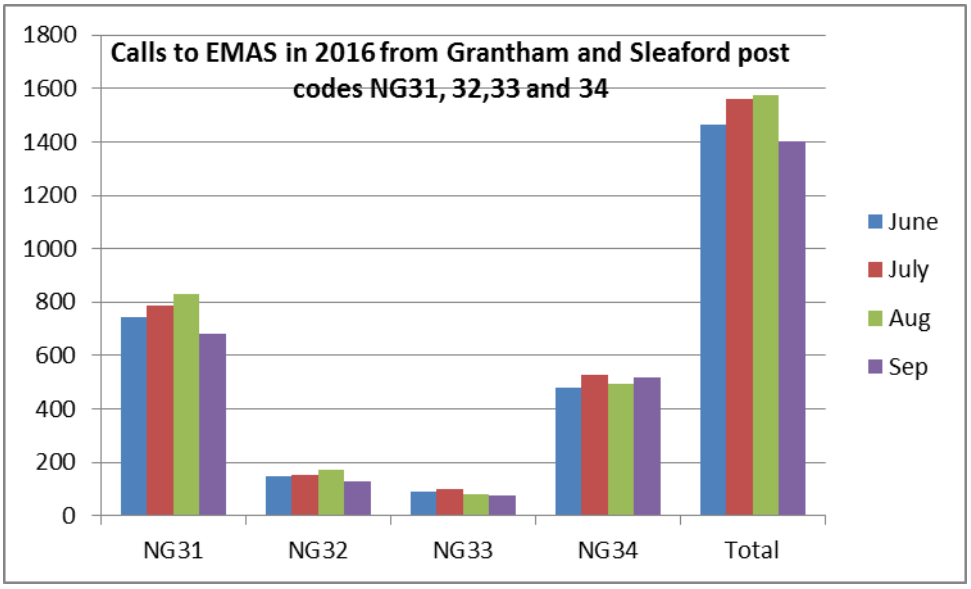
Ambulances waiting more than 30mins (Daily Average)

Data taken from EMAS monthly handover data

	Grantham	Lincoln	Boston
Since Closure	2	28	16
July	3	23	15
Variance	1	-5	-1

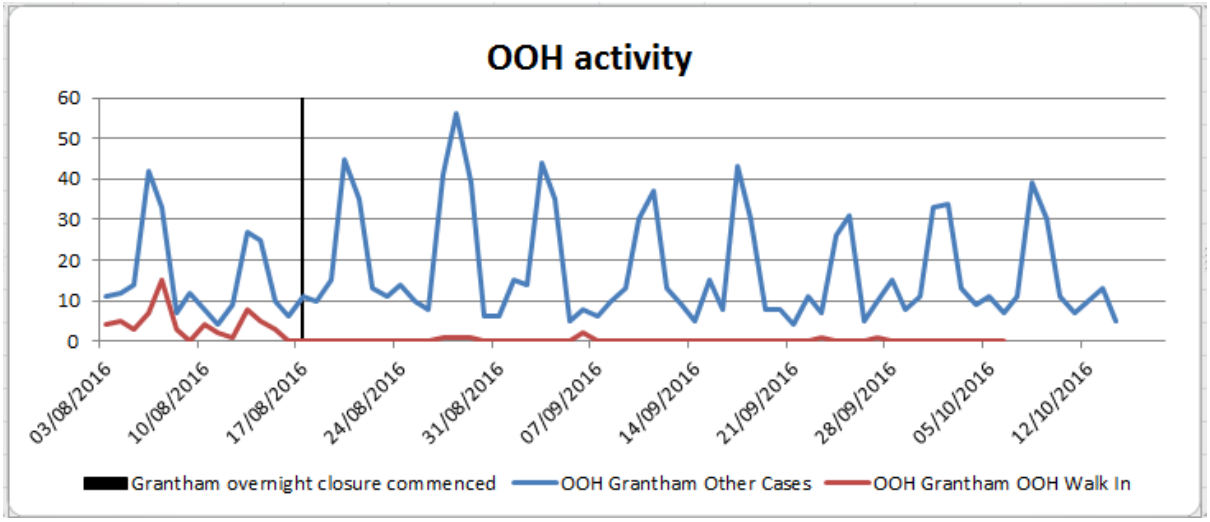
Appendix 17

Calls to EMAS from post codes NG31, 32, 33 and 34

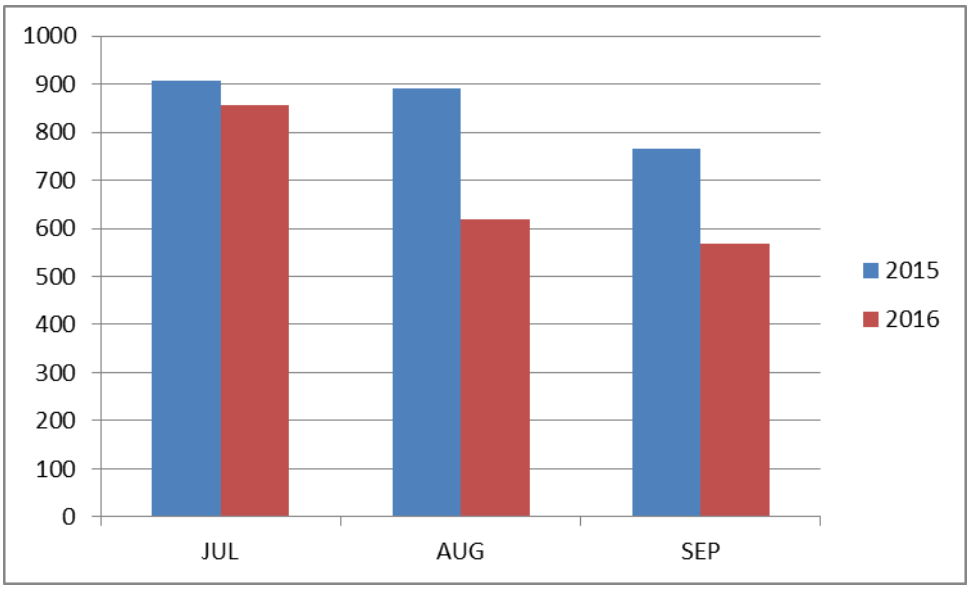


Appendix 18

Out of hours activity and the walk in minor injuries unit



Appendix 19
Number of out of hours cases handled at Grantham Base



September 2016 data is an extrapolated view based on the first 3 weeks of data
LCHS data

Appendix 20

Letter to stakeholder organisations on 19th October

Dear

I'm writing to you to ask for you to share the impact, if any, that the temporary reduction in opening hours of Grantham A&E has had upon your organisation.

As you will be aware, since Wednesday 17 August, Grantham A&E's opening hours have been reduced to cover 9am to 6.30 pm, seven days a week. This is a temporary decision and was made due to a severe shortage of middle grade doctors in Lincoln and Pilgrim A&Es. Closing A&E overnight helped us to boost the number of doctors at Lincoln and Pilgrim A&Es which are our busiest units.

This wasn't an easy decision to make but it was made to protect patients and maintain safe services.

ULHT has been working hard to recruit permanent and agency doctors to make our rotas more sustainable, this work will continue over the coming weeks and months.

We have always been open that although this is a temporary decision we will only reopen Grantham A&E when our overall staffing levels make it is safe to do so.

In November, our Trust Board will review the closure, impact and progress made in making our rotas more sustainable. Thereafter, it will be making a recommendation to the wider system, including regulators, to decide whether we are able to restore full services or if a different course of action is necessary. Before we do this, I want to take into account a range of views to help inform our decision.

I want to know how the closure is affecting others. With this in mind, would you please send me any information that illustrates how the reduction in opening hours is affecting your services? It would be extremely useful to receive any supporting data in relation to the pre change and post change periods that would support any suggested impacts. If there has been an impact, what steps have you taken to mitigate against these impacts.

Please also share any other thoughts or views you would like ULHT to consider in reviewing our decision.

I'd be grateful if you could send me the information by the close of play on Friday 14 October 2016. It would also be helpful to receive a response even if there has been no impact to report.

I would like to thank you for your support and understanding during what has been a difficult time for our patients and the wider system across Lincolnshire.

Regards,

Appendix 21

Letter from Army Training Regiment

1. I was copied your email (below) by our regimental Adjutant wrt the impact the night time closure of Grantham A+E facilities have had on our staff. I am 2ic of A Sqn, which delivers Army Reserve recruit training within Army Training Regiment (Grantham) to appx 1100 recruits/year. The closure of local A+E facilities has already had, and will have, a definite impact on the medical support we, as an Army training organisation, are required to provide to our soldiers training here on our courses. Consequently, I am taking this opportunity, as you have requested, to comment on the impact of reduced A+E, particularly 'silent hours' facilities at Grantham Hospital.

2. From a practical pre-course planning point of view, we have had to revise our medical support plan to our training comprehensively. During the week M-F 0800-1700 are recruits/trainees are able to make use of our military regional medical facility at RAF Cranwell and they regularly refer our soldiers for further medical review, ie X-ray, at Grantham A+E; this service remains almost unaffected as RAF Cranwell is closed after 1700hrs and opens at 0800hrs; Grantham A+E closes after Cranwell although it doesn't open again until an hour later in the morning. However, during silent hours weekdays and weekends (when RAF Cranwell is closed) after 1830hrs, we now have to travel further to use the 'lower treatment level classified' Minor Injuries Unit (MIU) at Newark Hospital which is open 24 hours. Other than when we are conducting our 72 hour outdoor field training on Beckingham Training Area, when Newark is much closer than Grantham Hospital, this contingency entails additional night time travel from our barracks which can eat considerably into our recruits' and administration personnel's already very intensive trg programme. We currently have a recruits' course w/ 67 persons that started Sat 03 to 18 Sep and have so far had to take 2 x recruits to Newark when Grantham was closed; of these, one had to be referred for further important medical intervention to Kings Mill Hospital in Mansfield. To-date, our service/treatment experience at Newark MIU has been good.

3. Returning to our medical support plan, the contingency for Grantham A+E's night time closure is now for us to utilise Newark MIU which should be able to cater for the majority of our 1st line recruit injuries. I have contacted and spoken with the Deputy Manager of Newark MIU so he was forewarned of our revised silent hours medical plan and our intention to make primary use of his facility, particularly when we train at Beckingham and definitely will require hospital medical cover after 1830hrs that Grantham is not now able to provide us with. Any fully fledged A+E support required when Grantham is closed will now have to be via Lincoln County Hospital which is a considerable imposition on our training delivery time and administration; we have a route card for our drivers to get there but propose to use Newark MIU on the assumption/basis they are closer/quicker to reach, and seem, so far, to process us relatively quickly and would be able to refer us on, after initial professional stabilisation/intervention, for more serious medical issues.

4. Overall, we have had to adjust our medical support plan to suit the facilities available and it has been tested, albeit minimally so far, and proven to work. This said, we will have a better initial assessment after our Beckingham 72 hour field training period this weekend (09-12 Sep) and after this training course is completed on 18 Sep 16; our judgement is out at present but I will admit I am very relieved the planned junior doctors' strike for next week was cancelled!!

1. I hope this gives you an overview of our medical support issues, wrt Grantham's reduced A+E service, to-date. Should you wish to discuss any points or issues I have raised further, pse do not hesitate to contact me.

Appendix 21

Grantham A&E engagement findings report

1. Introduction

We began engagement around Grantham A&E as soon as the decision was made to alter the opening hours of the department for safety reasons. The engagement was informed by the quality impact assessment which identified groups who may be adversely affected by the reduction on opening hours.

This included immediately briefing local MPs, Lincolnshire Health Overview and Scrutiny Committee, local council leads, other NHS bodies, Healthwatch Lincolnshire and stakeholder organisations.

Engagement has taken a number of different forms. We have contacted in excess of 50 groups in the greater Grantham area. Some invited us to attend their meetings to talk about the change, others asked us to send information to them about the change rather than meeting with them.

Resources were created to assist in the engagement. This included a patient information leaflet produced in English, Polish, Russian, Latvian and Lithuanian. [Link to leaflet?}

Posters were created and displayed around Grantham hospital, and extensive awareness-raising carried out using local media, social media and the Trust website.

The engagement meetings were led using the below questions as a structure, apart from where questioning was led by the attendees themselves.

1) What do you understand/know about the change that has taken place?
2) What impact has the change had on you?
3) When was the last time you used Grantham A&E at night?
4) Which groups do you think will feel this change most acutely?
5) What worries you most about the AE being closed at night?
6) What could we put in place to lessen the impact to the community of Grantham?
7) What do you think the solution is long term?
8) Other notes

These questions were also shared on the ULHT Facebook and Twitter profiles, asking followers to email the responses to the communications team or to comment on the posts.

2. Engagement response rates and groups

Since 17 August, we have visited and spoken to 16 groups in the Grantham and district area and sent information to a further 16 groups (they told us they just wanted information).

Overall, we listened to 124 people at meetings and over 200 at St Wulfram's Church meeting, plus 65 who commented on Facebook. We reached far more people on social media. The Facebook posts had a combined reach of 3,117 with 42 shares and 65 comments. Twitter posts had 549 impressions and an engagement of 12.

Geographical areas covered: Grantham central, Sleaford, Ruskington, South Lincolnshire, Allington, Corby Glen.

3. Engagement already carried out:

Group	Protected characteristic	Action	Numbers at event
Disability groups			
Sleaford dementia cafe	Dementia	Meeting 24.08.16	30
Transforming care learning disabilities	Learning disability	Meeting 21.09.16	
Grantham Stroke Club	Stroke	Meeting 29.09.16	19
Grantham dementia alliance	Dementia	Meeting 30.09.16	
Grantham social club for the blind	Blind / communications impairment	Meeting 10.10.16	12
Grantham Hard of Hearing Club	Deaf	Info sent	
Grantham & District Talking Newspaper for the Blind	Blind / communications impairment	Info sent	
South Lincolnshire Blind Society/ Lincolnshire Sensory Service	Blind / communications impairment	Info sent	
Grantham & District Mencap Ltd (Cree Centre)	Learning disability	Info sent	
CANadda	Mental health	Info sent	
Grantham Mencap mothers group	Learning disability	Info sent	
Grantham Breathe Easy group	Serious conditions	Info sent	
United Together	Serious conditions	Info sent	
Age			
Sleaford White heather club	Older people	Meeting 30.09.16	17
Grantham Senior Citizens Club	Older people	Meeting 27.09.16	19
Race			
Grantham migrants forum	Migrants	Meeting 20.09.16	
Migrant community network	Migrants	Info sent	
Pregnancy and maternity			
NCT – Grantham and Sleaford	Pregnancy women and young families	Info sent	
Allington toddler group	Pregnancy women and young families	Info sent	
SSnap Lincoln	Young families and carers	Info sent	

Group	Protected characteristic	Action	Numbers at event
Carers			
Carers First group	Carers, mental health	Meeting 07.10.16	12
Glasshouse Project	Carers	Info sent	
Lincolnshire Carers and Young Carers Partnership	Carers	Info sent	
Low income groups			
Bala House	Homelessness	Info sent	
Other			
St Peter's Hill PGG	All	Meeting 16.08.16	6
Sleaford dementia care	Age	Meeting 16.08.16	
Corby glen PPG	All	Meeting 13.09.16	
LPFT listening event	Mental health	Meeting 14.09.16	
Ruskington PPG	All	Meeting 20.09.16	9
Health Overview and Scrutiny Committee	All	Meeting 21.09.16	
South Kesteven District Full Council	All	Meeting 22.09.16	
Fighting for Grantham hospital group	All	Meeting 29.09.16	c 200
South Lincolnshire Healthwatch provider meeting	All	Meeting 29.09.16	
LSWCCG Patient Council	All	Meeting 30.09.16	
Fighting 4 Grantham Hospital group	All	Meeting 06.10.16	
Addaction	Substance misuse and migrants	Info sent	

4. Themes

1) What do you understand/know about the change that has taken place?
Every person spoken to said that they understood the change had taken place because of a shortage of doctors, most said the change had been well publicised in the local media and generally understood why the decision had to be made.

A large number of respondents said they were aware that the doctor shortage was not at Grantham hospital, but at other hospitals in Lincolnshire. Overall most people said they felt that the people of Grantham are considered less important than residents of other parts of Lincolnshire.

Comments included: "This has happened because ULHT took over the hospital, when it was just Grantham hospital it wasn't under threat all the time."

The majority of people had heard that the change has put a major strain on the ambulance service. Around half were aware that there is an extended out of hours service.

A small number of people said they felt the change was made because it's part of a slow downgrade of Grantham hospital overall and felt there was a conspiracy. A small number also said they felt the reason for the change was because of hospital managers not planning staffing adequately or seeing the problem coming.

2) What impact has the change had on you?
Only one person we spoke to had been directly impacted by the change so far. The main impact of the decision, expressed by nearly everyone we spoke to, has been the feeling of worry, fear and stress caused to the population of Grantham. People said they felt vulnerable and anxious without an overnight A&E near to their homes.

Comments included: "I worry that one of my family could be taken ill and not get the treatment they require."

And: "It has caused added stress as I have disabled children and need local services. The alternatives are too far away and it is not acceptable."

A few people mentioned they were concerned that if people go to Grantham A&E just before 6.30pm, they could be sent home before treatment has finished because the department would close.

A small number of people quoted the impact they have heard reported, not direct impact, in response to this question. Generally there was a feeling of a lack of confidence in the Trust.

3) When was the last time you used Grantham A&E at night?
The majority of respondents said that they had never used Grantham A&E at night. Two people had used the A&E recently at night and a small number had used it in the last two years.

A small number of people said that they felt this question was not relevant, as it was not about when they last used A&E, but the availability of the service for the future.

4) Which groups do you think will feel this change most acutely?
The general feeling was that everyone in Grantham and the surrounding area would feel the impact of this change. Particular groups mentioned frequently in response included older people, those who don't drive, have no transport or are on a low income and children. It was raised that the cost of a taxi to Lincoln from Grantham was around £70.

There was frequent mention of the impact the change has had on the ambulance, police and fire services.

A small number of individuals said they felt other groups were feeling the change acutely, including people with mental health conditions and learning disabilities, pregnant ladies, carers and people with chronic conditions and allergies.

Comments included: "It's older people I worry about because they won't ring an ambulance because they don't want to put anyone out."

Respondents in the Sleaford and Ruskington area mostly said that they already expect to travel for hospital care, and that although they had heard about the change it did not unduly concern them, as Lincoln is not much further away for them than Grantham.

5) What worries you most about the A&E being closed at night?

The most common response to this question was that people were concerned about the East Midlands Ambulance Service (EMAS) being under pressure, there being a shortage of ambulances and ambulances queueing outside A&Es.

Comments included: “I worry that there will not be enough ambulances to come out to you when you need it.”

Many people said that they were concerned people would die because of a delay in getting treatment when being transferred to other hospitals, particularly as winter approaches and the road conditions deteriorate.

Comments included: “Someone is going to die if they can’t get access to immediate medical attention.”

Many mentions were made of the fact that Grantham is growing, saying that demand for hospital services is only going to grow. A number of people also mentioned the proximity of Grantham to the A1 and what would happen if there was an accident on the road at night.

A small number of respondents said they felt this was the start of A&E being closed completely or that they believe it won’t re-open at the same level it was before. These same people mentioned their concern that there had been no consultation on the decision.

Mental health groups raised a specific concern that without the A&E there was a lack of provision for mental health problems at night.

6) What could we put in place to lessen the impact to the community of Grantham?

Everyone we talked to said the biggest thing that could be done was to fully re-open the A&E department 24 hours a day.

Accepting that this was not immediately possible, most people said that the biggest thing that would make a difference would be directing more ambulance resources in the Grantham area to cope with increase in numbers.

A small number of people said more should be done to publicise the out of hours service. Others also suggested providing transport between Lincoln and Grantham to bring patients back after A&E treatment, improving the quality of the 111 service or providing accommodation near Lincoln- a patient and visitor hotel.

7) What do you think the solution is long term?

Around half of those spoken to said they would like to see hospital services re-instated at Grantham.

Comments included: “Reinstate all services that have been taken away from Grantham.”

Many of those we spoke to said that the long term solution is around the recruitment and retention of doctors, suggesting financial incentives, better working conditions, flexibility and advertising to make people want to come and work in Lincolnshire.

Comments included: “You need to be able to offer more money and better terms and conditions to doctors to attract them to work here.”

Suggestions were also made by small numbers of people around considering putting in place a 24 hour minor injuries unit alongside A&E, working more closely with EMAS and Lincolnshire Police to understand the impact on them and listening to and speaking to local people and use their views to shape decisions.

A number of respondents said they would like to see a change in the management of the hospital away from ULHT or to a private provider.

8) Other notes

A small number of respondents expressed a suspicion that ULHT is not telling the truth on figures and reasons for the change.

Two people said they recognised that the A&E issues are a knock-on effect of current difficulties in getting a GP appointment in some areas.

5. Impact on protected characteristic groups

The majority of people we spoke to said the change had not had an impact on them, but when prompted said it would impact on groups in the following ways:

Age

- Impact on older people who don't drive, who have to rely on public transport or ambulances.
- Families with young children struggle with transport.

Disability

- Concerned about how they would get to A&E if they don't drive. Would rely on ambulances or public transport.
- No provision for people with mental health problems at night.
- Those with suicidal thoughts and mental health issues can be regular users of A&E. Can't wait long for an ambulance after a suicide attempt.
- Blind/partially sighted- lack of transport.
- Need a mental health specific A&E service.
- Very few disabled taxis if you needed to get a taxi.

Pregnancy and maternity

- Impact on pregnant women who may have problems with their pregnancy and need to access A&E.

Social deprivation

- People may rely on taxis to get to hospital, not affordable for those on low incomes
- Low social-economic backgrounds will rely on ambulances alone, so will be disadvantaged compared to those with transport.

6. Next steps

Further engagement meetings planned, as below.

We are also continuing to contact other groups to see if we can come to their meetings or send them information, including those covering migrants, mother and baby, mental health, substance misuse, respiratory, pregnancy and carers.

Group	Protected characteristic	Action
Carers First Sleaford	Carers, mental health	Meeting on 19.10.16
Grantham U3A	Older people	Meeting on 25.10.16
Alzheimer's group	Older people, carers, disability	Meeting on 26.10.16
Grantham Locality Forum – ULHT meeting	All	Meeting on 02.11.16
Grantham and area PPG representatives	All	Meeting on 21.11.16
Social media engagement	All	Regular posts asking for comment

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 by Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 November 2016**
Subject:	**United Lincolnshire Hospitals NHS Trust: 2021 Strategy and Change Programme**

Summary:

The purpose of this report is to provide the Health Scrutiny Committee for Lincolnshire with an update on the development of United Lincolnshire Hospitals NHS Trust's *2021 Strategy and Change Programme* to deliver the strategy.

Actions Required:

The Health Scrutiny Committee for Lincolnshire to provide initial views on the development of United Lincolnshire Hospitals NHS Trust's *2021 Strategy and Change Programme*.

1. Background

United Lincolnshire Hospital's Trust (ULHT), like many other NHS Trusts, currently faces significant service and financial challenges which need to be balanced against maintaining the quality and provision of health care services for the communities of Lincolnshire.

ULHT is developing a 5 Year Strategy, the "2021 Programme" which will align to Lincolnshire's Sustainability and Transformation Plan (STP) and has agreed that this will be managed by the 2021 Programme Board. The Trust has identified six high level improvement priorities which are the foundations for the Trust to achieve future sustainability. Within the Trust, the 2021 Change Programme will be overseen by the 2021 Programme Board, led by the Chief Executive.

The purpose of this report is to share with the Health Scrutiny Committee the launch of an engagement exercise with the public, patients and staff to contribute to the development of our 2021 Programme.

Sustainability and Transformation Plan

Lincolnshire has worked together over the past three years to develop the Lincolnshire Health and Care Programme (LHAC), which is the Blueprint for future health and care services in Lincolnshire and our new model of care. The development of the STP over the last year has built on this strong foundation and is a major milestone in a very complex and extensive programme of work. The STP has been developed by cross-organisational working; much of its content has already been subject of engagement with the public and with stakeholders through the LHAC process, but there will be more consultation in the new year. The STP sets a foundation for a conversation with the people of Lincolnshire.

Developing our 5 Year Strategy
In developing ULHT's 5 Year Strategy, there has been work to ensure alignment with the STP.

There has been some initial consultation and engagement within the Trust and with key stakeholders to develop our outline ambitions and key priorities. This paper forms part of our initial open consultation to setting out the framework for our strategy, and will be followed up with consultation on our Strategy in the new year outlining what we will be delivering to meet the ambitions:

Our Services will:	Be Centres of excellence Be secure in Lincolnshire where possible Get things right first time, valuing patient's time
Our Patients will:	Want to choose us for their care and be our advocates Shape how our services run
Our Staff will:	Be proud to work at ULHT Always strive for excellence and continuous learning and improvement Challenge convention and improve care

These ambitions will be realised through the delivery of key priorities, which are being developed into improvement programmes. These programmes will be managed by the 2021 Change Programme which will provide the transformational change platform to enable the organisation to achieve future sustainability. The programmes are:

Redesign our clinical services to extend future sustainability by:

- Implementing our Clinical Strategy which will be aligned to the STP.
- Continuous clinical service review programme to identify improvement and benchmark against best practice.
- Redesign clinical pathways to improve patient care.

Productive Hospital to improve our Market Share seeing and treating more patients who currently access their elective care outside ULHT by:

- Urgent care redesign to release internal capacity.
- Protecting/expanding elective capacity.
- Improved theatre utilisation.
- Outpatient capacity improvement.

Review our workforce to address future gaps, design new roles and develop more flexible models of delivery by:

- Developing a detailed workforce plan for 2021.
- Developing recruitment and retention plans.
- Developing workforce intelligence systems.
- Education, training and skills development.
- Developing a Reward Strategy.

Improve productivity, efficiency and Estates to include:

- A 5 year efficiency programme.
- Implementing Lord Carter, **G**etting **I**t **R**ight **F**irst **T**ime.

Improve staff engagement – deliver safer and better outcomes for patients by:

- Leadership development.
- Developing recognition strategies.
- Ensuring effective appraisals.
- Embedding values and behaviours.

Targeting quality improvement through:

- Mortality reduction.
- Meeting safe staffing levels.
- Improving patient safety.
- Improved hygiene and infection control.

2. Engagement

The development and delivery of the 5 Year Strategy will be underpinned by communication, engagement and consultation. So far:

- There has been initial engagement with our Locality Forums to socialise the draft ambitions and workstreams for the 5 Year Strategy and generate engagement in their development.
- There have been presentations provided to the Senior Leadership Forums within ULHT and through our Clinical Management Group.

The engagement and consultation plans are being finalised to support the 5 Year Strategy which will include a range of approaches:

- Communication utilising internal and external mediums.
- Staff surveys.
- Public facing surveys.
- Staff and patient focus groups.
- Series of internal and external presentations

Key questions will include:

1. **Are there some services that you think need to always be delivered locally, and why?**
2. **Are there services that you believe are better centralised, and why?**
3. **On what basis should we look at providing services in the community rather than at hospital?** (e.g. availability of staff, specialist imaging)
4. **We have six priorities for our plan. Can you give ideas of work we can do in each of these areas?**
   - Re-designing clinical services and how they are delivered
   - Being more efficient and productive
   - Freeing up capacity in our hospitals to care for more people within Lincolnshire instead of hospitals outside the county
   - Engaging and involving our staff more in what we do, leadership development and recognition.
   - Improving staff recruitment and education and training.
   - Improving the quality of services- focus on patient safety, infection control, safe staffing levels and reducing mortality
5. **How can ULHT reduce waste or save money?**
6. **How can we be more creative with our workforce to do things differently?**
Prompt – nurses, doctors, therapists, pharmacists
7. **Do you have any other ideas on how we could deliver services differently?**
(e.g. telehealth, use of video technology for some consultations, web chats)

3. Conclusion

The Health Scrutiny Committee is asked to:

- Note the approach to engagement to developing the Trust's 2021 Strategy.
- Invite, if appropriate, any comments or observations on the Trust's ambitions and priorities.

4. Appendices - These are listed below and attached at the back of the report

Appendix A	Presentation Slides

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 Jan Sobieraj, who can be contacted @lincolnshire.gov.uk

ULHT2021 – Overview

5 Year Strategy / 2021 Programme

Setting out our ambitions

Our Services	Our Patients	Our Staff
will: • Be centres of excellence • Be secure in Lincolnshire where possible • Get things right first time, valuing patient's time	Will: • Want to choose us for their care and be our advocates • Shape how our services run	will • Be proud to work at ULH • Always strive for excellence and continuous learning and improvement • Challenge convention and improve care

How we will deliver it

Redesign our **clinical services**	Improve our **elective market share**	**Review our workforce** to address future gaps, design new roles and develop more flexible models of delivery	Improve **productivity efficiency** and **Estates**	Improve **staff engagement** – deliver safer and better outcomes for patients
• Implementing Clinical Strategy • Continuous clinical service review programme • Clinical pathway redesign	• Urgent care redesign • Protecting/expanding elective capacity • Improved theatre utilisation • Outpatient capacity improvement.	• Workforce plan for 2021 • Recruitment and retention plans • Developing workforce intelligence systems • Education, training and skills development • Reward strategy	• 5 year efficiency programme • Carter, Getting It Right First Time	• Leadership development • Recognition strategies • Effective appraisals • Embedding values and behaviours • Inclusion

Targeting **quality improvement**
• Mortality reduction, Safe staffing, Patient safety, Hygiene and infection control

5 Year Transformation Programme

ULHT2021 – How does it all link up

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 Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 November 2016**
Subject:	**Lincolnshire East Clinical Commissioning Group Update**

Summary:

This report provides the Health Scrutiny Committee for Lincolnshire with an update on the activities of Lincolnshire East Clinical Commissioning Group (LECCG). It includes information on the lead commissioning arrangements undertaken by the LECCG; financial and performance information; and patient engagement activity.

Actions Required:

(1) To consider and comment on the information presented by Lincolnshire East Clinical Commissioning Group.

1. Background

Lincolnshire East CCG (LECCG) is now in its fourth year of commissioning services for our population 245,000 patients. During the last twelve months we have seen the NHS facing unprecedented demands for services and, at a time of austerity in all public services, this is proving to be a particularly challenging time. It is clear that the CGG and the NHS generally is going to have to change and adapt in order to meet the needs of patients, and find ways to become more effective and efficient. We need to secure a sound future for the NHS locally and ensure that the needs of all patients continue to be met in the most comprehensive and accessible way possible, whilst putting the NHS onto a more sustainable footing.

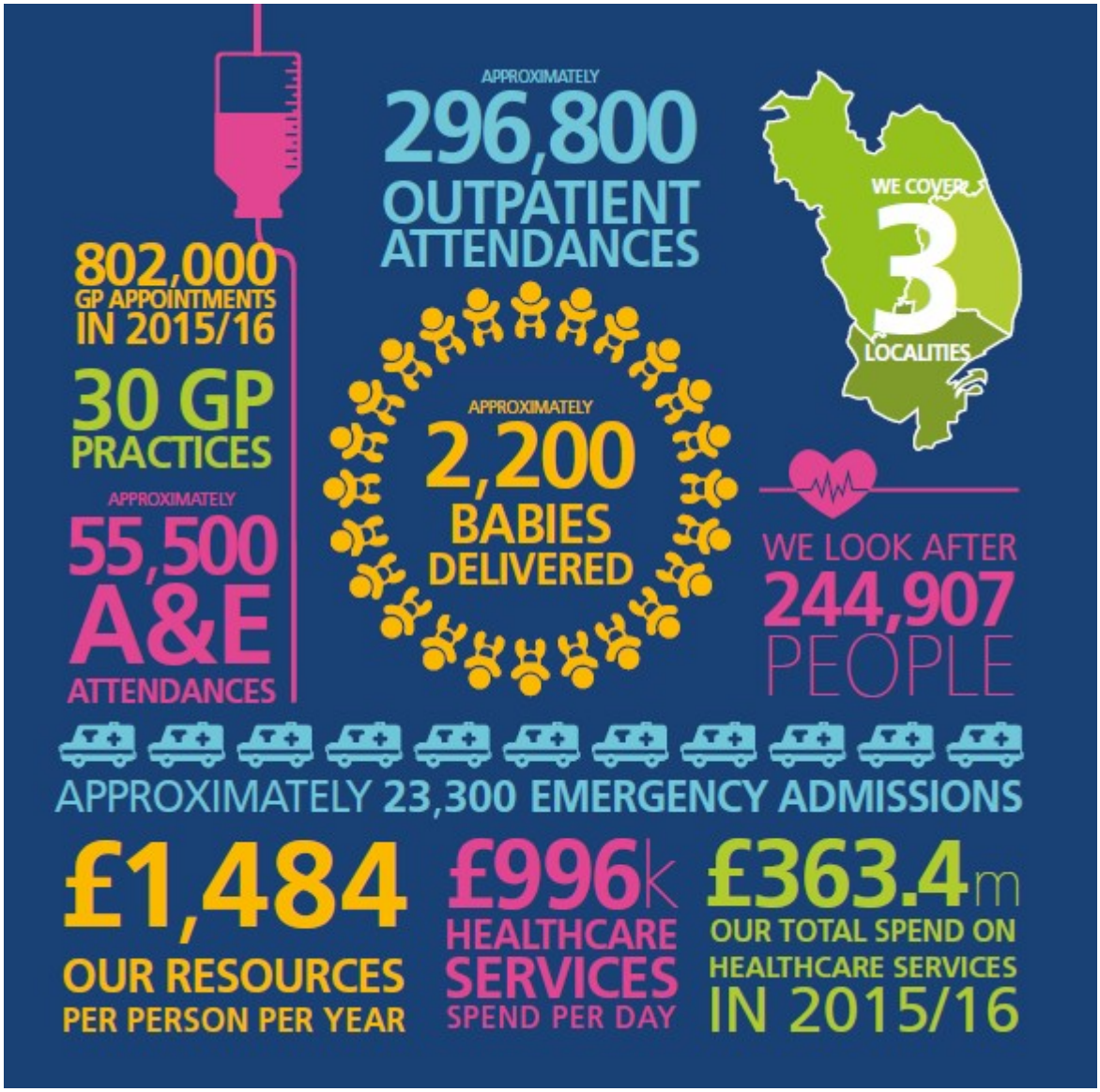


Figure 1 – Some key facts and figures for LECCG

2. The Past Year in Commissioning

During the last year the CCGs in Lincolnshire have reviewed the lead commissioning arrangements (the organisations that each CCG commissions on behalf of all Lincolnshire CCGs). LECCG is now lead commissioner for United Lincolnshire Hospitals NHS Trust, whereas previously we commissioned Lincolnshire Community Health Services, East Midlands ambulance Service, Non-emergency patient transport and NHS 111 services. This has required a change in focus for the CCG and the development of new relationships with ULHT. We feel this has gone well and that relationships are challenging but positive. We were pleased to achieve agreement on the 2016-17 ULHT contract on time and without recourse to arbitration for the first time in over a decade. This is good for the NHS and for patients, because it is an indication of the service working together and not getting engaged in lengthy bureaucratic issues.

The CCG has fully delegated authority for Primary Medical (General Practice) services. The commissioning of GP services is managed through the Primary Care Co-commissioning Committee (PCCC) which is constituted to avoid any conflict of interest

with GPs as members of the CCG. The PCCC has focussed for this year on the sustainability of general practice, developing a primary care strategy and managing the development and investment of GP services. The PCCC has also been developing quality dashboards for GP services in order to supplement the CQC quality regime with more locally focussed and responsive quality systems.

Over the past year we have

- Addressed isolation in rural areas through Talk, Eat, Drink (TED) in partnership with East Lindsey District Council
- Developed a Diabetes service specification
- Delivered care home schemes in Boston and Skegness
- Worked on dementia support services
- Addressing antimicrobial resistance
- Invested in our GP Practices to deliver case management for the over 75s

3. CCG Finances

During 2015-16 the CCG spent £363.4 million on the purchase of healthcare. This is 98% of our total resources. The largest expenditure (60%) is on buying services form NHS trusts. Prescribing costs accounted for 14% of our total, and administrative costs were 2% or £4.5m, much of which goes into 'back office' support services from our commissioning support unit. Our spend on health care is show in figure 2 below.

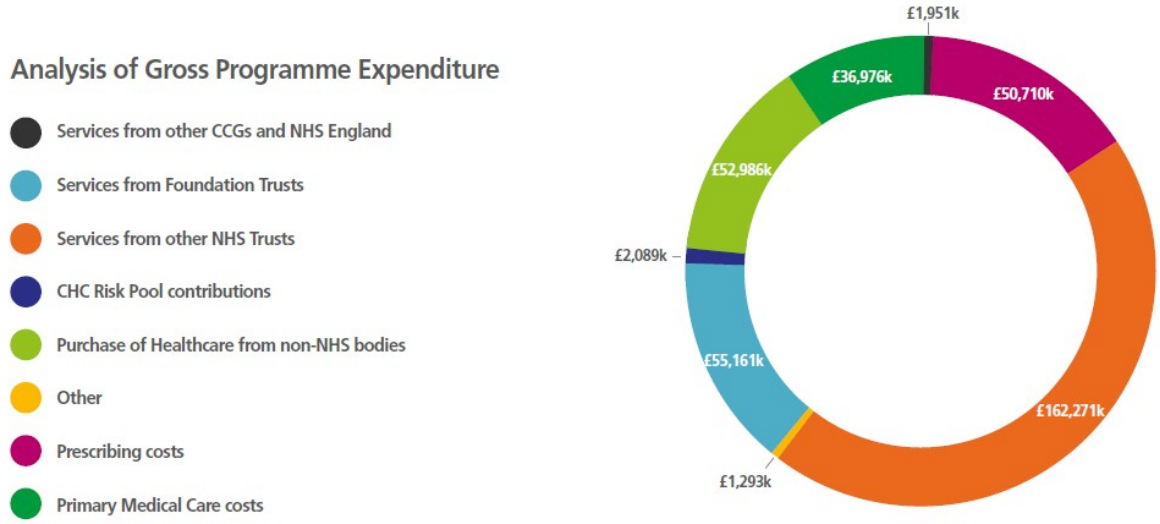


Figure 2 – Use of LECCG Program Funds

The CCG did receive an increase in funding for 16-17 but nevertheless increasing demand for services in a time of relative funding constraint is leading to some significant pressures on budgets. Pressure is particularly arising from the increases in demand and admissions for urgent care, increases in prescribing costs, and increases in the costs of continuing health care (support packages for people being supported at home and in care homes with long term needs).

The CCG is reacting to this pressure by taking measures to improve productivity and by focussing on services which are the highest priority. Obtaining value for its publicly funded budget is always a priority for a commissioner but at times of austerity it becomes even more important to ensure that every penny is being invested where it will bring the greatest benefit to patients.

Measures that the CCG is taking to manage the financial pressures include:

- Improving the cost effectiveness of prescribing by focussing on the best value medications such as generic rather than branded medicines, and changing to the most cost effective equivalent product
- Consulting the public about over the counter medications and whether some of the spend on these (approximately £4m for LECCG) should be prioritised elsewhere
- Seeking care in the most cost effective setting, for example in community surgical schemes rather than hospitals if possible
- Reviewing the clinical guidelines for procedures of low clinical value, to ensure compliance and that patients are receiving the most appropriate care at the most appropriate time

4. Performance of the CCG

CCGs are assessed through a performance framework of quarterly reviews and an annual summative conducted by NHS England. For 2015-16 LECCG, in line with all CCGs in Lincolnshire, was rated overall as 'Requires Improvement'. The CCG performance on each of the assessment framework domains was:

Well Led:	Good
Delegated Functions:	Good
Finance:	Requires Improvement
Performance:	Requires Improvement
Planning:	Requires Improvement

Overall 'Requires Improvement' was the commonest CCG rating nationally with 92 CCGs being assigned this outcome. Because of the way the framework is applied it is not possible to achieve a better rating than 'requires improvement' unless the finance element is also rated as 'Good'. The 'Performance' rating of the CCG framework principally refers to the performance of the system in meeting constitutional standards for patients.

Clinical priority baselines were published for the first time this year and for LECCG these are shown in Figure 3. We are pleased with our 'Top Performing' rating for

diabetes given how prevalent this is in the CCG, representing a huge challenge. The CCG has plans for improvement in place for dementia and cancer services.

The clinical priority ratings are an initial baseline and the data period used varies between indicators. They are intended to identify areas for focus going forward for the CCG and are a snapshot in time. For example, the CCG benchmarks as slightly better than the national average for cancer survival but has had significant problems with cancer staging, which is a measure of the degree of progression seen in a cancer at time of diagnosis.

5. Patient engagement

The CCG has been focussing on increasing its engagement with the public and has now established a patient council and patient viewpoint panel in addition to the active patient participation groups attached to GP practices.

We use a number of national patient feedback systems to listen to opinions of patients, and also proactively seek patient opinion by reaching out to our communities in specific events. The national feedback systems we use includes:

- CQC patient surcvey programmes in mental health, inpatient, accident and emergency, and maternity
- The Friends and Family test
- GP Patient Surveys
- Digital Feedback reports form NHS Choices and Patient Opinion
- Complains and concerns

Our local engagement approaches include:

- Patient Participation Groups at GP Practices
- Quality Visits to providers
- Public listening events
- Listening Clinics in our GP Practices
- Youth Workshops to reach out to young people
- A health bus programme to take health messages and access out into our communities

We feel we have made major improvements in patient engagement this year through this range of activities and this will be especially important as the CCG moves toward public consultation of the STP and LHAC plans.

NHS Lincolnshire East CCG					
Clinical Priority Area	**Overall Rating**	**Indicator Ratings**			
Cancer	Greatest Need for Improvement	**36.5%**	**72.1%**	**68.8%**	**85.9%**
		New of cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed	Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral	of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis.	of responses ,which were positive to the question "Overall, how would you rate your care?"
Dementia	Greatest need for improvement	**64.0 %**		**75.1%**	
		Estimated diagnosis rate for people with dementia		of patients diagnosed with dementia whose care plan has been received a face-to-face review in the preceding 12 months	
Diabetes	Top performing	**39.3%**		**15.9%**	**73.3%**
		of diabetes patients have achieved all the NICE-recommended treatment targets		of people with diabetes diagnosed for less than a year who attended a structured education course	of GP practices that participated in the National Diabetes Audit
Learning Disabilities	Needs improvement	**69**		**47%**	
		Rate of inpatients per million GP registered adult population for each Transforming Care Partnership. CCGs are then assigned the score of the TCP they belong to		of people with a learning disability who are on the GP register and receiving an annual health check during the year. Measured as a percentage of the CCG's registered learning disability population	
Maternity	Needs improvement	**83.2**	**68.0**	**6.5**	**14.1%**
		The score out of 100 for women's experience of maternity services based on the 2015 CQC National Maternity Services Survey	The score out of 100 for choices offered to women in maternity services based on the National Maternity Services Survey	The rate of stillbirths and deaths within 28 days of birth per 1,000 live births and stillbirths, reported at CCG of residence level by calendar year.	of women who were smokers at the time of delivery
Mental Health	Needs improvement	**52.3%**		**0.0%**	
		of people who were initially assessed as "at caseness", attended at least two treatment contacts, are coded as discharged, and are assessed as moving to recovery		of people with first episode of psychosis starting treatment with a NICE-recommended package of care and treated within 2 weeks of referral	

Figure 3 – Baselines for CCG Clinical Priorities

6. System Leadership

LECCG takes a leadership role across the county in a number of areas. In addition to our lead commissioning role for ULHT we also provide the lead commissioning role for urgent care across the County. In the STP and LHAC programs the CCG has led on Urgent Care, Women and Children's Care, and on the development of the Local Digital Roadmap which is the digital strategy to support the STP programme.

7. Sustainability and Transformation Plans and Lincolnshire Health and Care Programmes

In partnership with other commissioners and providers across Lincolnshire LECCG has been working on the Strategic Transformation Plan which incorporates the clinical redesign started in the Lincolnshire Health and Care (LHAC) programme. The Sustainability and Transformation Plan (STP) has been submitted to NHS England (NHSE) and after a review by NHSE will be published so that the CCG can continue the dialogue with the patients of Lincolnshire. The STP is an important strategic plan that aims to establish the NHS in Lincolnshire on a path to improved and more sustainable services. LECCG has taken a lead in urgent care and women and children's services in the STP and has been engaging with parents and women in particular regarding the challenges around women and children's services.

8. Conclusion

This is an extremely challenging period for the NHS in which we are seeing unprecedented levels of demand and a system that is struggling at times to meet constitutional standards. LECCG continues to focus on the needs of its patients whilst understanding that this has to be done in the context of services that will work for Lincolnshire as a whole. We think that our improvements in public engagement and continued strong clinical leadership make us well placed to lead the NHS system for the patient of Lincolnshire East and to address the challenges ahead.

9. Consultation

There is no consultation required as part of this item.

10. 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 Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group, who can be contacted via
Gary.James@lincolnshireeastccg.nhs.uk

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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, Central Midlands

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**23 November 2016**
Subject:	**NHS Dental Services Overview for Lincolnshire**

Summary:

This report will provide an overview of the NHS dental services commissioned in Lincolnshire, brief on and update on the new Special Care Dentistry Service arrangements from 1 December 2016.

Actions Required:

The Health Scrutiny Committee for Lincolnshire are:

i) requested to note the contents of the report; and

ii) invited to consider and comment on the report.

1. Background

National Context

NHS England is responsible for commissioning primary and secondary care dental services since April 2013.

The government has made a commitment to oral health and dentistry with a drive to:

- Improve the oral health of the population, particularly children
- Introduce a new NHS primary dental care contract
- Increase access to primary care dental services.

NHS England's clinical aim for each dental practice is to deliver high quality NHS clinical services defined as:

"patient-centred and value for money primary care dental services, delivered in a safe and effective manner, through a learning environment, which includes the continuing professional development of dentists and other dental professionals"

NHS England's over-arching aims for primary dental service provision are:

- To improve oral health and to reduce inequalities in health and wellbeing
- To improve access to NHS dental services and to improve the experience of all service users
- To develop excellent integrated and more localised services
- To ensure that key evidence based, preventive, consistent messages and interventions are communicated and delivered by all
- To ensure access to unscheduled and elective dental care is available to all
- To provide evidence informed care according to identified need
- To promote choice by services users, by ongoing consultation and engagement.

Local Context

Central Midlands Local Office is responsible for commissioning NHS primary, community and secondary care dental services. The Central Midlands Local Office has two locality teams that manage dental and optometry commissioning. Lincolnshire is part of the North Locality, which covers Leicestershire, Rutland and Lincolnshire.

There are 69 practices within Lincolnshire delivering 76 contracts:

- 49 providing general dental services (10 are restricted contracts, for example children under the age of 18 years, 19 years if in full time education and/or exempt patients)
- 1 pilot contract providing general dental services
- 15 providing general dental and orthodontic services
- 5 contractors providing orthodontic services
- 5 contractors providing minor oral surgery services
- 1 Special Care Dentistry Service contractor

One contractor is piloting a new prototype dental contract, which is testing a new remuneration system that blends activity and capitation (patient registration) aligning to financial and clinical drivers with a focus on prevention and continuing care. Seven practices also provide access to urgent and routine care over extended hours, for example 8am to 8pm Monday to Friday, and extended access cover over weekends and Bank Holidays excluding Christmas Day, New Year's Day and Easter Sunday.

Secondary dental care services providing specialist services, for example orthodontics and maxillofacial services for Lincolnshire is delivered by United Lincolnshire Hospitals NHS Trust (ULHT).

NHS Dental Contract

In April 2006, NHS dental contractors were transferred over to the new NHS dental contract. The new dental contracts are activity based and contractors are required to deliver an activity target each financial year. General dental services contracts are monitored against delivery of their unit of dental activity (UDA) target and orthodontic contracts are monitored against delivery of their unit of orthodontic activity (UOA) target. Specialist services delivered in primary care, such as minor oral surgery are commissioned on a cost per case basis.

Since April 2006, patients are no longer registered to a dental practice and are only attached to a dental practice when they are in active treatment. However, practices usually hold a notional list to assist managing their capacity to provide dental services to regular patients/new patients seeking routine or urgent care. Patients can choose any geographical area to access services in NHS England and there are no restrictions on where patients can access NHS dental services.

Patients will be advised by the dental practitioner on their recall interval based on The National Institute for Health and Clinical Excellence (NICE) Clinical Guidance 19 Dental Recall, October 2004. Dental recalls are determined by the patient's oral health and other factors for example age, diet, oral hygiene, fluoride use, tobacco and alcohol. Recall rates for children up to age of 18 years can be every 3/6/9 or 12 months and adult recall intervals can be every 3/6/9/12/15/18 months to 2 years. It is important that young children (up to 2 years) attend a dentist for their first examination to commence monitoring their oral health.

Patient charges were changed with the introduction of the new contract and these were simplified into three treatment bands. NHS dental charges apply if a patient does not meet the exemption criteria. Patients will be charged for one completed course of treatment and the charge is determined by the treatment provided. The patient charges are:

Treatment Band	Type of Treatment	Patient Charge £
Band 1	This covers examinations, diagnosis (including radiographs), advice on how to prevent future problems, scale and polish if clinically necessary, and preventative care (e.g. applications of fluoride varnish or fissure sealant). This band also covers urgent dental care in a primary care dental practice such as pain relief or a temporary filling.	19.70
Band 2	This covers everything listed in Band 1, plus any further treatment such as fillings, root canal work or if your dentist needs to take out one or more of your teeth.	53.90
Band 3	This covers everything listed in Bands 1 and 2, plus crowns, dentures, bridges and other laboratory work.	233.70

Oral Health Needs Assessment and Dental Commissioning Intentions

Public Health England has developed, in conjunction with NHS England Central Midlands Local Office, an Oral Health Needs Assessment (OHNA) for the North Locality covering Leicestershire and Lincolnshire in consultation with the Local Authorities and Clinical Commissioning Groups. The OHNA has been submitted for gateway approval so this can be published. The ONHA is based on a point in time,

is based on NHS dental activity delivered in 2013/14 and relates to patients resident in an area.

The OHNA reviews the demographics of the resident population, provision of services, access to NHS dental services and makes recommendations for the commissioners to consider when developing the dental commissioning intentions to improve service provision. An access measure is used to determine the number of patients seen as a proportion of the resident population and access rates can be affected and influenced by many different factors, for example deprivation or prosperity of the resident population, lifestyle choices etc. It is important to note that a low access rate may not necessarily be solely due to a lack of provision as this can be affected by patient choice of accessing services outside the area or opting for private dental treatment. The OHNA identifies access rates for children under the age of 18 years and adults by Local Authority (LA).

The ONHA identified that the following LA areas access rate is similar to or above the NHS England the Leicestershire and Lincolnshire averages:

- West Lindsey for children and adults
- North Kesteven for children
- South Kesteven for children and adults
- East Lindsey for children and adults

The following LA areas access rate is below the NHS England and the Leicestershire and Lincolnshire average:

- Boston for children and adults
- Lincoln for children and adults
- South Holland for children and adults
- North Kesteven for adults

The Local Office reviewed the outcomes of the draft OHNA along with other intelligence, which includes patient engagement and consultation feedback to develop the dental commissioning intentions. It has been agreed to commission new contracts as part of the dental procurement programme to improve access to general dental services in priority areas identified within the resource envelope available:

- Boston
- Lincoln
- Sleaford (North Kesteven)
- Spalding South Holland)

Any new contract has to be awarded via a procurement process to comply with dental contract regulations, competition and procurement law requirements. NHS England commenced procuring new services in the above areas in January 2016, however, the procurement process was paused in March 2016 following national advice received from NHS England's Primary Care Commissioning Team. The Local Office is planning to recommence the procurement process for the new dental contracts and the timeframes are being finalised. Whilst the procurement is being undertaken to secure new services in Lincolnshire, existing practices have had the

opportunity to request non-recurrent activity to improve access to see new patients and four contractors have been awarded additional non-recurrent activity.

Dental Foundation Training and Recruitment

All newly qualified dentists are required to complete a one year dental foundation training following completion of their dental degree. The Foundation Training process is managed by Health Education England. Foundation dentists are assigned to accredited dental practices and have an identified mentor to support them through their foundation training process. Funding is provided to cover the costs of the Foundation Dentist and funding to support the accredited mentor. Three out of the 26 training places across Leicestershire and Lincolnshire were secured within Lincolnshire practices.

Dental Commissioning Guides

The Dental Commissioning Guides provide a standardised framework for the local commissioning of dental specialties. They provide guidance to Local Offices on improving access to care, based on needs that are criterion referenced, with demonstrable high value health outcomes experienced by patients.

Local Offices will work closely with the Managed Clinical Networks (MCN), the Regional Dental Public Health Consultants and Dental Local Professional Networks (LPN). The aim is to deliver the best patient journey possible, supported by mandatory specialist advice and/or access to care, that meets the needs of the local patient population whilst achieving the nationally expected standards of care provision within existing resources.

The Dental Commissioning Guides have been developed nationally involving the dental profession and commissioners overseen by the Chief Dental Officer in England. The Dental Commissioning Guides published are:

- Special Care Dentistry (Adults)
- Orthodontics
- Oral Surgery and Oral Medicine

Commissioning Guides for Restorative Services and Pediatrics are in development and publication has been delayed.

Local Dental Professional Network (LPN)

The Local Dental Professional Network for Leicestershire and Lincolnshire was established in 2013. The main aims and objectives of the Dental LPN is to:

- Provide robust and quality clinical input to the Local Office
- Improve clinical outcomes
- Address health inequalities
- Putting the patient in the centre of everything that we do
- Engage with the Dental profession across the entire pathway.

The Dental LPN Steering Group develop work priorities each financial year and progress is monitored by NHS England Central Midlands. The Steering Group has good engagement from the dental health community, Health Education England, Public Health and Local Authorities, however, Clinical Commissioning Groups engagement has been a challenge with little interest.

The Dental LPN has been recognised nationally for the work on older patients oral health in Lincolnshire linked into the Oral Health Promotion Strategy.

Work is ongoing to improve general practice implementation of the Delivering Better Oral Health guidance. Training has been provided to dental care professionals to apply fluoride varnish to children at risk of dental caries and the Chief Dental Officer has launched the Smile for Life. The LPN has secured non-recurrent funding to pilot improved access to interpretation services across Leicestershire and Lincolnshire from NHS England.

There are a number of challenges that the LPN has identified within their work priorities and these relate to:

- Access to Restorative Services.
- Formation of Gerodontology MCN to focus on Older peoples, people with Dementia and Mental health issue's Oral health.
- Delivering prevention to families who have experienced extraction with General Anaesthetic for tooth decay.
- Encourage the increase in foundation training practices in Lincolnshire.
- Increasing the level of Oral health promotion activities in Lincolnshire in partnership with Lincolnshire County Council.
- Implementation of Healthy gums do matter toolkit and increase the knowledge of the General Dental practitioner of the relevance of oral health on general health and vice versa.

NHS England has secured dedicated support across Central Midlands to performance manage the dental secondary care contracts, review secondary care dental pathways to improve access and commission new pathways, subject to approval and within the resources envelope.

The LPN has established Managed Clinical Networks for Special Care Dentistry, Orthodontics and Minor Oral Surgery to support delivering the work priorities, review commissioning guidance to improve patient pathways and patient outcomes.

Joint Working with the Lincolnshire County Council

Lincolnshire County Council became responsible for improving health and reducing inequalities for its local population from 1 April 2013. Local Authorities are responsible for commissioning oral health promotion programmes and epidemiology surveys. Lincolnshire County Council has agreed that the oral health promotion and epidemiology is commissioned on their behalf through NHS England's Special Care Dentistry Service contract.

An Oral Health Alliance Group for Lincolnshire has been established to enable joint working across the health community. The group have developed and agreed an Oral Health Promotion in Lincolnshire Strategic Action Plan and non-recurrent funding has been secured from NHS England and Lincolnshire County Council to deliver the three year programme. Lincolnshire County Council has appointed a Programme Officer to manage the delivery of the strategic action plan and the programme commenced in August 2015. The aim of the strategic action plan is to improve oral health promotion of the Lincolnshire population and target identified priority patient groups.

Special Care Dentistry Service Update

NHS England has completed a procurement process to secure service provision of the Special Care Dentistry Service from 1 December 2016. The fixed term contract was awarded to Community Dental Services (CDS-CIC) in June 2016. The contract has been awarded on a 7 year contracting term with the option to extend for a further 3 years. The service was procured on the basis that there would be continuity for patients with the service being delivered by the same experienced team, from the same locations as before to minimise impact on patients.

Since June 2016, NHS England has been working with Lincolnshire Community Healthcare NHS Trust and Community Dental Services to ensure a smooth transition, whilst staff and the service are transferred between providers. The mobilisation process will be completed at the end of November so the new provider can commence delivering the service from 1 December 2016. The mobilisation process is on track to be successfully completed and it is recognised that the process would not be achieved without the commitment and co-operation of the two providers and the joint mobilisation group.

All referrers across the health community will be advised of the revised referral process, all stakeholders will receive an updated brief and a media release will be published in mid-November.

Community Dental Services will be working with NHS England, Local Dental Professional Network and Managed Clinical Networks to transform the service in line with the Dental Commissioning Guides over the next 12 months.

2. Conclusion

The Health Scrutiny Committee is requested to note the contents of the report and to consider and comment on the content of the report.

3. Consultation

This is not applicable.

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 Jane Green, who can be contacted on 0113 824 9579 or Jason Wong who can be contacted on 07977408890 or jason.wong4@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:	**23 November 2016**
Subject:	**Delayed Transfers of Care – The Next Steps**

Summary:

On 16 March 2016, the Health Scrutiny Committee requested the Adults Scrutiny Committee give consideration to the scrutiny of delayed transfers of care. The Adults Scrutiny Committee has considered delayed transfers of care on three occasions since this request: 6 April, 7 September and 19 October, 2016. In the meantime, references to delayed transfers of care have been included in three reports to the Health Scrutiny Committee (20 April, 21 September and 26 October 2016).

This report invites the Health Scrutiny Committee to consider the next steps for its review and scrutiny of delayed transfers of care.

Actions Required:

(1) To consider the next steps in relation to the Health Scrutiny Committee's review and scrutiny of delayed transfers of care.

1. Delayed Transfers of Care - Previous Committee Consideration

On 16 March 2016, the Health Scrutiny Committee requested that the Adults Scrutiny Committee give consideration to the scrutiny of delayed transfers of care. This request was made on the basis that the Adults Scrutiny Committee is the lead committee for the scrutiny of the Better Care Fund, and for 2016/17 reducing delayed transfers of care is key measurement of the Better Care Fund.

Consideration by the Adults Scrutiny Committee

The Adults Scrutiny Committee has considered two reports where delayed transfers of care formed a substantial element: firstly on 6 April 2016, as part of an item on *Seasonal Resilience of Adult Care*, and secondly on 19 October 2016, when it considered a report entitled *Adult Care Acute Delayed Transfers of Care*. The Committee has also received detailed performance information as part of its Quarter 1 Performance Monitoring report on the Better Care Fund on 7 September 2016.

On 19 October, the Adults Scrutiny Committee resolved to note the information presented. As part of the discussion, it was suggested that the Health Scrutiny Committee take the lead on scrutinising delayed transfers of care in the future. It was also suggested that a joint meeting be held or joint working group be established to give further consideration to the topic.

Consideration by the Health Scrutiny Committee

The Health Scrutiny Committee has continued to receive information on delayed transfers of care as part of its regular consideration of Urgent Care Updates (20 April 2016 and 21 September 2016). The inclusion of this information has reflected the importance of 'patient flow' to ensuring the urgent care system operated effectively. The Health Scrutiny Committee also considered an item on Winter Planning 2016/17 on 26 October 2016, which again made reference to delayed transfers of care.

2. The Next Steps

The Health Scrutiny Committee can continue in its role scrutinising delayed transfers of care as part of its health scrutiny role, focusing on NHS organisations and their efforts to reduce delays, for example as part of its updates on Urgent Care or specifically requesting an item. Similarly, the Adults Scrutiny Committee will continue to receive quarterly performance information on the Better Care Fund, which includes extensive detail on delayed transfers of care performance. The next such report on Quarter 2 is due to be considered on 30 November 2016.

To consolidate and enhance the individual scrutiny activity of each committee, the Health Scrutiny Committee may wish to give consideration to promoting joint activity between the two committees. This could take the form of a joint informal meeting, involving members of each committee, which would focus on delayed transfers of care. Alternatively, the Health Scrutiny Committee may consider establishing a working group to look at this matter in more detail. The Health Scrutiny Committee may wish to consider inviting representatives from the Adults Scrutiny Committee to participate. If this latter option were the wish of the Health Scrutiny Committee, a way forward may be for each committee to nominate three members to serve on the working group. Outcomes from the working group could be reported to each committee.

3. Conclusion

The Adults Scrutiny Committee and the Health Scrutiny Committee have separately considered information on the topic of delayed transfers of care during 2016 – at least three occasions for each committee. In view of this, the Health Scrutiny Committee may wish to give consideration on how it wishes to scrutinise this topic in the future.

4. Consultation

There is no direct consultation as part of this item.

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

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Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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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:	**23 November 2016**
Subject:	**Work Programme and Responses to Consultations**

Summary:

This item invites the Committee to consider and comment on its work programme. The report also sets out the Committee's final responses to two consultations. Attached at Appendix B is the Committee's final response to the Full Business Case for the Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust. Attached at Appendix C is the Committee's final response to the Medicines Management consultation, undertaken by the four clinical commissioning groups in Lincolnshire.

Actions Required:

(1) To consider and comment on the content of the work programme.

(2) To note the response of the Committee to Full Business Case for the Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust.

(3) To note the response of the Committee Medicines Management consultation, undertaken by the four clinical commissioning groups in Lincolnshire.

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

The Boards of Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust met respectively on 27 September and 29 September 2016, to discuss a Full Business Case that sets out in detail the case for merging all clinical and administration functions from 1 April 2017.

The Full Business Case is available at the following link:

https://www.peterboroughandstamford.nhs.uk/about-us/trust-news/hospital-trusts-publish-full-business-case-for-proposed-merger/

Both boards were clear that their approval was subject to the consideration of feedback on the integration of clinical services from the local independent Clinical Senate, and obtaining further views from staff and members of the public at additional engagement sessions to be held throughout October and early November.

On 21 September 2016, the Committee established a working group to draft and finalise the response of the Committee to the Full Business Case for the Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust.

The deadline for responses was 7 November 2016. The Committee's response will be reported to the next meetings of Peterborough and Stamford Hospitals NHS Foundation Trust Board and the Hinchingbrooke Health Care NHS Trust Board, which are taking place on 29 November and 24 November respectively. The submission from the Committee is set out in Appendix B.

3. Medicines Management Consultation

On 26 October 2016, the Committee established a working group to draft and finalise the response of the Committee to the Medicines Management consultation, being undertaken by the four clinical commissioning groups in Lincolnshire. The full report, together with the consultation document, was included as part of the Committee agenda for 26 October 2016.

The submission made on behalf of the Health Scrutiny Committee is set out in Appendix C to this report. The closing date for the submission of responses was 18 November 2016.

4. Conclusion

The Committee is invited to consider and comment on the content of the work programme; and to note the responses submitted on the Committee's behalf on tow consultations.

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
Appendix B	Response of the Health Scrutiny Committee to the Full Business Case for the Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust
Appendix C	Response of the Health Scrutiny Committee to the Medicines Management Consultation

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

23 November 2016		
Item	**Contributor**	**Purpose**
Joint Health and Wellbeing Strategy – Annual Assurance Report	David Stacey, Programme Manager – Strategy and Performance, Lincolnshire County Council Alison Christie, Programme Manager – Health and Wellbeing, Lincolnshire County Council	Update Report
United Lincolnshire Hospitals NHS Trust – Emergency Services Update	Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust	Update Report
United Lincolnshire Hospitals NHS Trust – Five Year Organisational Strategy	Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust	Consultation
Lincolnshire East Clinical Commissioning Group - Update	Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group	Update Report
Dental Services Contracts in Lincolnshire	Jane Green, Assistant Contract Manager, Dental and Optometry, NHS England – Midlands and East (Central Midlands)	Status Report

21 December 2016		
Item	**Contributor**	**Purpose**
Congenital Heart Disease Services – Consultation	Will Huxter, Regional Director of Specialised Commissioning (London), CHD Programme Implementation	Consultation
Lincolnshire West Clinical Commissioning Group Update	Sarah Newton, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group	Status Report

18 January 2017		
Item	**Contributor**	**Purpose**
NHS Improvement – Improving NHS in Lincolnshire	Jeff Worrall (to be confirmed)	Status Report
United Lincolnshire Hospitals NHS Trust - Pharmacy Services	Colin Costello, Director of Pharmacy and Medicines Optimisation, United Lincolnshire NHS Trust	Update Report
Transforming Care: Community Learning Disabilities Support: Long Leys Court	To be confirmed	Consultation
Community Pharmacy 2016/17 and Beyond	Steve Mosley, Chief Officer, Lincolnshire Local Pharmaceutical Committee	Update Report
LIVES [Lincolnshire Integrated Volunteer Emergency Services]	To be confirmed	Update Report

15 February 2017		
Item	**Contributor**	**Purpose**
St Barnabas Hospice	Chris Wheway, Chief Executive, St Barnabas Hospice	Update Report
East Midlands Ambulance Service	Blanche Lentz, Lincolnshire Divisional Manager, East Midlands Ambulance Service NHS Trust	Update Report
South West Lincolnshire CCG Update	To be confirmed	Update Report
Obesity in Adults and Children	To be confirmed	Update Report
Reducing Alcohol Harm in Lincolnshire	To be confirmed	Update report
Butterfly Hospice	To be confirmed	Update report

15 March 2017		
Item	**Contributor**	**Purpose**
South Lincolnshire CCG Update	To be confirmed.	Update Report

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

Lincolnshire COUNTY COUNCIL *Working for a better future*		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
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North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

RESPONSE TO THE FULL BUSINESS CASE FOR THE MERGER OF PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST WITH HINCHINGBROOKE HEALTH CARE NHS TRUST

This statement has been prepared on behalf of the Health Scrutiny Committee for Lincolnshire.

The Health Scrutiny Committee for Lincolnshire's focus is on the services provided to Lincolnshire patients at Peterborough City Hospital, and Stamford and Rutland Hospital, and would like to see the existing services continue or be enhanced at these two hospitals. The Committee also acknowledges that at least 40% of the patients of Peterborough and Stamford Hospitals NHS Foundation Trust are from the South Lincolnshire area, which in turn provides the Trust with approximately 40% of its income.

On the basis of the information received, the Committee supports the full business case for the merger, and is reassured that the outcomes of the merger will not impact directly on Lincolnshire patients. In addition to this, in the event of significant changes of services in the future, the Committee would be seeking to be involved in any consultations on service changes, led by the appropriate commissioners.

The Committee particularly welcomes the commitment to the retention and development of services at Stamford and Rutland Hospital. Evidence of this commitment is the planned installation of a new MRI scanner at the Hospital early in 2017 and the development of the facility preliminary eye cataract consultations. The Committee would like to see continued engagement between the new trust and Lakeside, particularly to avoid duplication on the Stamford and Rutland Hospital site. The Committee looks forward to further developments from the newly merged organisation in the future.

A recurring theme throughout the NHS in 2016 is the recruitment and retention of clinical staff. The full business case sets out the benefits to recruitment and retention from the merger, through the integration of staff groups from the two organisations, with the larger staff groups leading to, for example, a reduction in the time each consultant would spend on call. The Committee would not like to see a loss of emphasis on recruitment and retention, and would like to see the new organisation become an attractive employer for new clinicians.

The Health Scrutiny Committee for Lincolnshire notes that savings of at least £9 million will accrue as a result of the merger, which will make contribution to closing the combined deficit of the two existing organisations, which stands at £56 million. The Committee has been advised that all staffing reductions from the merger will be among administrative staff, with no effects on patient-facing staff.

The Committee supports the proposed arrangements for naming the new trust through a public ballot.

The Health Scrutiny Committee for Lincolnshire supports the proposed arrangements for the council of governor constituencies, in terms of the number of public governors; and the number of staff governors from each hospital site.

Health Scrutiny Committee for Lincolnshire is grateful to the senior managers from Peterborough and Stamford Hospitals NHS Foundation Trust for engaging with the Committee initially on the outline business case, and subsequently in a working group format on the full business case. The Committee looks forward to this engagement continuing from the merged organisation in the future.

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RESPONSE TO THE MEDICINES MANAGEMENT CONSULTATION

This is the response of the Health Scrutiny Committee for Lincolnshire to the Medicines Management Consultation, undertaken by the four Lincolnshire Clinical Commissioning Groups between 4 October and 18 November 2016.

Proposal 1: To restrict providing over the counter / minor ailment medicines for short term, self limiting conditions

The Committee supports the principle of self-care for very minor ailments. The Committee notes that some medicines such as paracetamol or ibuprofen are cheap and widely available in supermarkets or local convenience stores. However, some over the counter medicines, such as cough syrups, thrush creams or ointments, or child paracetamol are not as cheap, nor as readily available. For this reason, the Committee records its concern that this proposal may have an impact on low income families, as some more expensive over the counter medicines may no longer be affordable to these families.

The Committee accepts that in addition to the financial saving from this proposal, there would be a benefit of more GP appointments becoming available. While pharmacists have the skills to offer advice and provide medicines in most instances, there may be a small number of instances where pharmacists should recommend a GP appointment, so that patients can receive the required medical advice, and potentially a prescribed medicine.

Proposal 2: To restrict the prescription of gluten-free foods.

The Committee supports the proposal to limit prescribing of gluten-free foods to loaves of bread, bread-flour and bread mixes (in accordance with Coeliac UK's recommended quantities). However, GPs should be advised always to take account of the impact of these arrangements on particular individuals, and allowed the discretion in exceptional circumstances to prescribe other products.

If this proposal is implemented all GPs should receive guidance from the clinical commissioning groups, in terms of what should be prescribed and in what quantities, and also advised that they should take account of exceptional circumstances.

Proposal 3 - To restrict prescribing of baby milks and specialist infant formula

The Committee notes that specialist baby milks and infant formulas may cost four times as much as standard milk and formulas. The Committee is concerned about the potential impact on low income families and believes that GPs should be allowed the discretion to take account of exceptional circumstances, including any serious financial impacts on families. GPs should be provided with the guidance to enable them to exercise their discretion on this.

Proposal 4 – To restrict prescribing oral nutritional supplements

The Committee strongly supports the "food first" approach for those with low appetite or a degree of malnourishment. There is a concern that some care homes rely too much on nutritional supplements, when they should be encouraging their residents to eat food.

However, the Committee is mindful that there may be exceptional circumstances, and GPs should be advised of the need to take account of the impact on low income families.

General Comments

The Committee notes that each proposal includes the word "restrict", rather than "discontinue". This provides an element of reassurance that discretion will be applied by GPs, who can take account of individual and exceptional circumstances, in particular impacts on low income families.

The Committee is concerned that the six week period of consultation has been too short, although the Committee acknowledges the pressures on the four clinical commissioning groups to reduce expenditure during the remainder of the 2016/17 financial year. The Committee is also concerned that the consultation document has not been widely circulated, as some GP practices have decided not make the consultation document available in their waiting rooms. Efforts to promote the consultation are acknowledged.

In view of this, the Committee will be seeking feedback from the clinical commissioning groups on the numbers of responses received; and an analysis of the types of patient and their geographical location.

Whatever is determined by the clinical commissioning groups on this proposal, the Committee would like to emphasise the importance of publicising the new arrangements, to ensure patients are aware of the new arrangements and the reasons for their introduction.