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, 21 March 2018 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), Mrs K Cook, M T Fido, R J Kendrick, Dr M E Thompson, R B Parker, R H Trollope-Bellew and M A Whittington

District Councillors: P Gleeson (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 P Howitt-Cowan (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
6	**Lincolnshire Urgent and Emergency Care** *(To receive a report from the Lincolnshire Sustainability and Transformation Partnership which provides information on the Lincolnshire Urgent and Emergency Care Strategy 2018-2021, and the development of the plan to support the delivery of the strategy. Sam Milbank (Accountable Officer, Lincolnshire East CCG) and Ruth Cumbers (Urgent Care Programme Director, Lincolnshire East CCG) will be in attendance for this item)*	31 - 58
7	**Non-Emergency Patient Transport Service - Contract Management and Performance Update** *(To receive a report from Lincolnshire West Clinical Commissioning Group (CCG) which provides a summary of the actions taken by Lincolnshire West CCG in order to seek to secure improvement by Thames Ambulance Service Ltd (TASL). Performance data for February 2018 will be circulated to the Committee separately in advance of the meeting. Sarah-Jane Mills (Chief Operating Officer, Lincolnshire West CCG) and Tim Fowler (Director of Commissioning and Contracting, Lincolnshire West CCG) will be in attendance for this item)*	59 - 66
LUNCH 1.00PM - 2.00PM		
8	**East Midlands Ambulance Service NHS Trust Update** *(To consider a report from Richard Henderson (Chief Executive of the East Midlands Ambulance Service NHS Trust (EMAS), on the developments and performance of EMAS in Lincolnshire. The item will focus on how the national Ambulance Response Programme (ARP), introduced in July 2017, is progressing. The ARP is introducing a new performance management regime to ambulance services in England)*	To Follow
9	**Arrangements for the Quality Accounts 2017-2018** *(To receive a report by Simon Evans (Health Scrutiny Officer) which invites the Committee to consider its approach to the* Quality Accounts *for 2018 and to identify its preferred option for responding to the draft* Quality Accounts *which will be shared, by local providers of NHS-funded services, to the Committee)*	67 - 72
10	**Health Scrutiny Committee for Lincolnshire - Work Programme** *(To receive a report from Simon Evans (Health Scrutiny Officer) which invites the Committee to consider and comment on the content of its work programme)*	73 - 76

Richard Wills
Head of Paid Service
13 March 2018

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
21 FEBRUARY 2018

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors Mrs K Cook, M T Fido, R J Kendrick, Dr M E Thompson, R B Parker, R H Trollope-Bellew and M A Whittington.

Lincolnshire District Councils

Councillors P Gleeson (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 P Howitt-Cowan (West Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Liz Ball (Executive Nurse, South Lincolnshire CCG), John Brewin (Chief Executive, Lincolnshire Partnership NHS Foundation Trust), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Dr Sunil Hindocha (Chief Clinical Officer, Lincolnshire West Clinical Commissioning Group (LWCCG)), Ian Jerams (Director of Operations, Lincolnshire Partnership NHS Foundation Trust), Wendy Martin (Executive Lead Nurse and Midwife Quality and Governance, Lincolnshire West CCG), Sarah-Jane Mills (Chief Operating Officer, Lincolnshire West CCG), Andrew Rix Chief Operating Officer, South Lincolnshire CCG), David Stacey (Programme Manager, Public Health), Mike Casey (General Manager, TASL) and Rachel Redgrave (Head of Commissioning for Mental Health, Autism & LD, South West Lincolnshire CCG) and Chris Miller (TASL).

County Councillor R A Renshaw attended the meeting as an observer.

63 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

There were no apologies for absence received.

64 DECLARATIONS OF MEMBERS' INTEREST

Councillor Mrs K Cook advised the Committee that in respect of agenda item 7, she was a Lincolnshire Partnership NHS Foundation Trust Governor; and a Lincolnshire Partnership NHS Foundation Trust service user.

Councillor Mrs P F Watson advised the Committee that she was currently a patient of United Lincolnshire Hospitals NHS Trust.

65 MINUTES OF THE MEETING OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE HELD ON 17 JANUARY 2018

The Chairman highlighted that Councillor A Stokes had been omitted from the list of councillors attending the meeting as observers.

The Committee was also advised that the STP Project Plans and additional information on the Dental Services would be circulated to members of the Committee when they were available.

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire, held on 17 January 2018, be agreed and signed by the Chairman as a correct record, subject to Councillor A Stokes being added to the list of councillors attending the meeting as observers.

66 CHAIRMAN'S ANNOUNCEMENTS

The Chairman referred to the announcements circulated within the agenda pack which included the following areas:-

- Grantham and District Hospital – Overnight Closure of Accident and Emergency Department;
- Lincolnshire's Community Maternity Hubs; and
- Director of Public Health – Derek Ward.

A set of supplementary Chairman's Announcements was tabled at the meeting for members of the Committee to consider. The supplementary information provided the Committee members with an update relating to:

- Grantham A & E Overnight Closure;
- Extended GP Hours in East Lindsey;
- Hospital Waiting Times – South West Lincolnshire CCG Area;
- Winter Pressures: Temporary Change of Use of Rochford Unit, Pilgrim Hospital, Boston; and
- Winter Pressures: Hospitals Alerts (Operational Pressures Escalation levels) in Hospitals in Neighbouring Counties.

The Committee was also advised that the two additional papers circulated at the meeting relating to:

- Information relating to A & E attendances at Lincoln County Hospital for the first two weeks of February 2018, which related to the Walk-in Centre Item;
- A revised performance table for the Thames Ambulance Service item. The sheet provided a replacement for the table shown on page 76 of the agenda pack and included validated figures for KPI16a (Renal Patients); and a new column with week 7 figures.

RESOLVED

That the Chairman's Announcements presented as part of the agenda on pages 19/20; and the supplementary Chairman's Announcements tabled at the meeting be received.

67 ALTERNATIVE PROVISIONS TO THE WALK-IN CENTRE

Pursuant to Minute Number 48 from the meeting held on 13 December 2017, the Committee gave consideration to a report from the Lincolnshire West Clinical Commissioning Group (CCG), which provided an update on the progress that had been made in implementing plans to enhance primary care services and the CCG's public awareness campaign as to alternative provisions to the Lincoln Walk-in Centre.

The Chairman welcomed to the meeting Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group (LWCCG), Dr Sunil Hindocha, Chief Clinical Officer (LWCCG), and Wendy Martin, Executive Lead Nurse and Midwife - Quality and Governance (LWCCG).

The Chief Clinical Officer introduced the report and advised the Committee that NHS Lincolnshire West CCG's Governing Body had met on 29 November 2017 and 24 January 2018 to consider the details on the progress of the alternative provision plans. The alternative provision plans addressed six key areas: GP appointments and access; Urgent Care Provision; Clinical Advice and GP Access for Children; University of Lincoln Practice Plans – Students; Homeless and Vulnerable Patients and Communication and Engagement Plans. It was highlighted that at the 24 January 2018 meeting, the Governing Body had been assured and had agreed to support the recommendation to close the Walk-in Centre by the end of February 2018; but retain weekend opening only during the month of February 2018.

Attached to the report for the Committee's consideration were the following Appendices:-

Appendix 1 – Lincoln Walk-in Centre - Alternative Provisions Plan 2017;
Appendix 1A – Lincoln Walk-in Centre Consultation 2017 - Alternative Provisions Description;
Appendix 2 – Lincoln Walk-in Centre Consultation 2017 – Alternative Provisions Communications Review;

Appendix 3 – Lincoln Walk-in Centre Consultation 2017 – Alternative Provisions Engagement Plan;
Appendix 4 – Lincoln Walk-in Centre Consultation 2017 – GP Practice Case Study Summary; and
Appendix 5 – Lincoln Walk-in Centre Consultation 2017 – A & E (Lincoln) Activity Summary for Lincolnshire West CCG Patients.

In presenting the report to the Committee, the Executive Lead Nurse and Midwife - Quality and Governance, provided an update concerning the alternative provisions which made reference to the following:-

- GP Optimisation – It was reported that GP Workflow Optimisation had been implemented across the CCG's Practices to ensure the most effective use of primary care resources;
- The extension of clinical skills in the Primary Care team. It was highlighted that many practices were employing community pharmacists. It was highlighted further that four additional pharmacists had been employed, whose roles would be developed to enable them to see patients, which would release GPs to see patients who really need to see a GP;
- Same Day Access for Urgent Need – The Committee was advised that same day access for Urgent Need was currently available at all practices. Clarification was given that same day access for urgent need would happen when a patient was unable to get an appointment the same day, but considered that their need was urgent, then either a nurse or GP would call the patient back in these circumstances. If following the phone conversation, it was deemed urgent, the nurse or GP would then book the appointment for that day. It was noted that this would apply for both children and adults;
- The University Practice – It was reported that the University Practice had seen a net increase in registrations totalling some 3,150 students. The practice had also increased its same day capacity to provide an additional five pre-booked daily appointments. It was highlighted that the practice had introduced a new phone system, which would avoid patients having to wait long periods of time to speak to someone to make an appointment. The Committee also noted that the University Practice was also available to non-students;
- GP Out of Hours Service - The Committee was advised that this service was provided by Lincolnshire Community Health Services. The Out of Hours Service was accessed by calling 111, which was the recommended route for accessing urgent medical care. It was noted that in Lincolnshire the Out of Hours Service was provided from bases in Lincoln, Gainsborough, Grantham, Boston, Louth, Skegness and Spalding. The Committee noted that the capacity of Out of Hours provision at weekends would be monitored to ensure that there were facilities to support any additional demand that was assessed as requiring face to face treatment by the Clinical Assessment Service or 111;
- Clinical Assessment Service – It was noted that the Clinical Assessment Service had been launched within the NHS 111 system. It was noted further that 111 calls would be picked up by a trained health advisor, supported by a team of clinicians; and

- Community Engagement – Appendix 2 and 3 to the report provided the Committee with details of the Alternative Provisions Communications Review and Engagement Plan.

The Chief Operating Officer, Lincolnshire West Clinical Commissioning Group, advised the Committee that there had not been any significant impact on A & E attendance figures. An updated A3 spreadsheet showing A & E attendances was circulated to members at the meeting. The Committee noted that Urgent Care streaming had been in place since October 2017, which had enabled patients to be diverted from A & E. It was also reported that there had been a reduction in the number of patients self-presenting.

It was reported that all practices that were likely to have been affected by the closure of the Walk-in Centre, arrangements had been put in place to support patients needing same day appointments. Appendix 4 to the report provided the Committee with a document which summarised current available capacity to accommodate need. The Committee was advised that the Abbey Medical Practice had been busier since the Walk-in Centre had closed. It was noted that most patients were within the catchment area of the practice and were registered, but were using the Walk-in Centre as a GP practice. The Abbey Practice had been receiving extra support to help them meet demand but this situation had improved over the last two weeks.

It was reported that the LWCCG had been working with the Lincolnshire Community Health Service who provided the Walk-in Centre Service. It was confirmed that all staff had secured alternative employment with the majority of the team taking up posts within essential urgent care services. Thanks were extended by the Chief Clinical Officer to all staff who handled the extra pressures over the Christmas and New Year period.

The Committee was advised that LWCCG Governing Body were actively monitoring data and performance relating to A & E. Appendix 5 to the report provided the Committee with such data. It was highlighted that the average monthly A & E attendances in October 2017 to December 2017 (Q3) had dropped compared to the average monthly A & E attendances January 2017 to September 2017 (Q1 to Q3), and that 2017 attendances were less than those recorded in 2016.

The Committee was advised further that the LWCCG would be continuing to roll-out the alternative provisions as identified in the Appendices to the report. The Committee was advised further that the CCG would support, post closure of the Walk-in Centre, for a period of additional General Practice Out of Hours provision at weekends (from 1 March 2018 to 8 April 2018). This was to ensure that an effective and safe transition to the alternative services had been achieved.

During debate, the Committee raised the following issues:-

- Some members of the Committee extended their congratulations to the LWCCG for the progress that had been made with regard to alternative provisions;

- Reference was made to the confusion experienced by members of the public on the different types of services available; for example although not relevant to this item, the signage at Louth Hospital still identified the hospital as having an A & E rather than Urgent Care provision;
- Abbey Road Practice – Confirmation was given that arrangements were still in place with the practice. Confirmation was given that same day access was a standard requirement for all practices. In cases where this was not happening, patients needed to voice their concerns through their practice Patient Participation Groups. It was highlighted that Healthwatch had recently undertaken a targeted survey;
- Praise was extended by one member of the Committee to the Primary Care Streaming at Lincoln Hospital, who had found the service to be quick and efficient. The Committee was reminded that the purpose of an A & E was to deal with serious life threatening injuries; and the streaming of patients who attended A & E had enabled the more minor injuries to be dealt with in urgent care;
- Some concern was expressed relating to the number of patients who had open access to the Walk-in Centre would be let down by the system. The Committee was advised that the Abbey Road Practice had taken on additional staff to deal with the increase. Members noted that currently the facilities at Abbey Road Practice had some constraints as they were currently operating from two sites. Going forward, it was hoped to extend the facilities onto one site;
- A further concern was expressed as to whether enough had been carried out to contact the difficult to reach people to make them aware of the changes to service provision. It was reported that work with this particular group was ongoing and that this particular group of individuals did not use the Walk-in Centre. It was also reported that a range of media releases had been used to target hard to reach groups. Engagement activities had also been undertaken by using facebook, twitter, engagement events at Children's Centres; and the use of information leaflets;
- A further concern was raised as to whether the Lincoln GP practices would reach a point of saturation due to an increase in the number of patients. It was highlighted to the Committee that the patients were not new patients, as they were already on GPs list. It was highlighted further that patients that were registered with a GP had access to routine appointments and urgent care;
- Some concern was expressed to the fact that urgent same day appointments were not available in the Sleaford area. The Chief Clinical Officer of Lincolnshire West CCG indicated that he would pass this observation to South West Lincolnshire CCG, in whose area Sleaford was located;
- One member highlighted that the definition of urgent care varied from GP to GP. It was further highlighted that Healthwatch tended only to receive complaints when patients had failed to receive a good service. The Committee was advised that sometimes the reasons for not providing a good service were as a result of staff shortages/or a lack of understanding by staff. There was agreement that there was a lack of understanding by the public on the definitions of emergency care and urgent care; and what services were provided by A & E. It was felt that more publicity and education would help in

this matter. The Committee noted that there needed to be a more consistent approach to urgent care and that some reception staff needed to receive further training in relation to this matter. Some members felt that this training needed to be done sooner rather than later. Officers advised that receptionists had received care navigation training in the last six months; and that training was an ongoing to ensure the enhancement of all staff. It was highlighted that if a patient was unable to get an appointment with a GP, they could always ring 111. Officers agreed that more publicity needed to be undertaken in relation to the arrangements relating to the proposed grouping of practices; and for late night and Saturday opening times. Confirmation was given that where provision was required out of hours, the route would be through the 111 service;

- One member enquired as to whether lessons had been learnt as a result of the process. The Committee was advised that some workshops sessions had been planned to look at lessons learnt;
- Some members expressed concern that the Committee had not received all the relevant information to make an informed judgment, particular reference was made to the usage of the Walk-in Centre during the January 2018 period compared to the alternative provision usage i.e. increase in the number of GP appointments; increase in the number of 111 requests. It was also felt further information relating to the number of bookable GP appointments in Lincoln would also be useful; and
- One member enquired as to whether there was anything members of the Committee could do to help with patient registration. The Chief Clinical Officer agreed to send the Health Scrutiny Officer information which could be circulated to all members of the Committee.

The Committee agreed that some progress had been made, and that more information need to be provided to evidence the said progress.

RESOLVED

1. That the Health Scrutiny Committee for Lincolnshire acknowledged that whilst some progress had been made, the decision for the phased closure the Walk-in Centre had been made by the Lincolnshire West Clinical Commissioning Governing Body on 24 January 2018.

2. That the Committee was still not clear from the evidence provided that sufficient progress had been made relating to improved access to General Practice and to the development of alternative provisions.

3. That as a result of (2) above, further information be requested relating to these areas being presented to the Committee for review in three months' time.

68 NON-EMERGENCY PATIENT TRANSPORT SERVICE FOR NHS LINCOLNSHIRE CCGS - THAMES AMBULANCE SERVICE LIMITED (TASL)

Pursuant to Minute No 49 (2) from the meeting held on 13 December 2017, the Committee gave consideration to a report from the Thames Ambulance Service Limited (TASL), which provided the Committee with an update on service provision, and an overview of the actions being taken by Lincolnshire West Clinical Commissioning Group.

At the meeting held on the 13 December 2017, the Committee had recorded a vote of no confidence in relation to the non-emergency patient transport service provided by the Thames Ambulance Service Limited. The Committee had also requested that performance reports should be received on a monthly basis, and that such reports should include any available comparative information on the service provided by Thames Ambulance Service Limited in other areas.

The Committee had received a revised table to replace page 76 of the circulated agenda. The revised information included validated figures for KPI6a (Renal Patients); and a new column with week 7 figures.

The Chairman welcomed to the meeting the following presenters from TASL, Mike Casey, Interim Manager for Lincolnshire, and Chris Miller.

The Interim General Manager advised that he was aware of the concerns and the vote of no confidence agreed by the Committee at their meeting on 13 December 2017; and reference was also made to the concerns raised with TASL (Risk Summit) led by NHS England on behalf of Lincolnshire, Leicestershire and Northamptonshire Clinical Commissioning Groups. Details of the main concerns raised were detailed on page 74 of the report presented.

It was reported that the Lincolnshire West Clinical Commissioning Group (LWCCG) was continuing to work very closely with the management team at TASL. The Committee were advised that following the issue of a Contract Performance Notice on the 7 November 2017, TASL had been issued with an Exception Notice for failure to achieve the agreed trajectory in the Recovery Action Plan (RAP) in January 2018, in line with the NHS Contract.

The Committee was advised that TASL was determined to drive change within its organisation to ensure continuous improvement to service delivery. The Committee was advised further that TASL wholeheartedly recognised the current organisational pressure they were under with regards to service delivery and contractual commitments. Some assurance was given that the appointment of a new management structure, including a new Chief Executive, the current recovery action plan, and support from the parent company HTG, TASL were expecting improvements to service delivery to be seen in the first few weeks of 2018, to continue and become more sustainable to deliver the contracts KPIs from April 2018.

There was a recognition that TASL had expanded too quickly in a short space of time without having robust processes and systems in place to accommodate the increased workload. The Committee was advised that there had been significant involvement from the Parent Company of TASL, HTG. This involvement had included the provision of a stronger internal governance structure, and direct support for the leadership of the organisation.

The Committee noted that following reporting to the Quality Surveillance Group; NHS England had called a Risk Review meeting on 20 November 2017 with all interested parties; this was then followed up with meetings held in December 2017 and January 2018. It was highlighted to the Committee at the January 2018 meeting with NHS England, NHS England had agreed that progress had been made; and as a result NHS England had agreed to move from monthly to two monthly reporting.

During discussion, the Committee raised the following issues:-

- Some members felt that the item should have been included on a future agenda at a later date, as little progress had been made. The Committee was advised that for the March meeting representatives from the Lincolnshire West CCG would be attending the Committee to provide an update relating to Non-Emergency Patient Transport contract monitoring of TASL. Then, at the April meeting representatives from TASL would be providing the Committee with an update report identifying progress made;
- Some members welcomed the changes to the TASL Management Team and to the openness and honesty of the two representatives in attendance at the meeting;
- Some members felt that having sight of the Recovery Action Plan would help them see the direction of travel and help them identify what was happening with regard to organisational cultural issues relating to voluntary drivers. The Committee was advised that TASL was more than happy to share the action plan, subject to the agreement of the CCGs, as it was a key driver as to what needed to be achieved by TASL. With regard to organisational cultural issues, representatives from TASL advised that a significant amount of work had been carried out with voluntary car drivers; and at a recent North East Lincolnshire meeting apologies had been extended to voluntary car drivers in that area for TASL's hasty decision in applying processes. It was noted that work was ongoing with voluntary car drivers relating to uplifting mileage, training for drivers and the provision of mobiles. The Committee was advised that a significant amount of work had been undertaken with regard to TASL's complaints, as the complaints system had not been fit for purpose. It was highlighted that a required action from NHS England had been to set up a central complaints system, a better government structure; and changes to organisational policies. It was noted that some progress had been made with the NHS;
- One member requested a further breakdown of patient activity, as it was felt that each category of patient were equally as important. Representatives from TASL advised that the information presented was standard activity. It was felt that information might be able to be broken down further into ward activity;

- One representative acknowledged that there had been some improvement, however, the fact remained that complaints were still being received. One area highlighted was the eligibility criteria. The Committee was advised that the initial model provided, which had been the national model was currently under review with commissioners. The TASL representative confirmed that a copy of the action plan once it had been signed off would be forwarded on to the Health Scrutiny Officer to circulate to all members of the Committee, subject to the agreement of the CCG;
- One member enquired as to whether TASL had reversed its decision in relation to voluntary car driver's mileage from home to first pick-up. The Committee was advised that the arrangements had been changed to enable volunteer car drivers to qualify after the first ten miles;
- Clarification was given by TASL that all complaints were being dealt with by central complaints, even those prior to November 2017;
- Number of journeys not meeting deadlines – The Committee was advised that in some areas, hospitals had brought third parties to provide non-emergency patient transport, which would be an additional cost to the NHS;
- Some questions were asked with regard to certain aspects of the contract, which included: whether TASL had put in enough money to recruit employees to deliver the KPIs; and whether the organisation had the right calibre of staff to deliver the contract; and when it was anticipated the majority of KPIs would be changing to either amber or green. Confirmation was given that TASL was now moving forward in the right direction with the establishment of a new management team. Reassurance was given that TASL would be focussing on call handling, journey planning; transporting patients to and from hospital in a timely manner; and having positive conversations with voluntary car drivers to get them back to helping bridge any gaps in service, as TASL was committed to drive changes to ensure better service provision. The Committee was also advised that there was sufficient money in the contract to deliver the service; and that that the parent company HTG was 100% committed to making the contract a success.

The Chairman on behalf of the Committee extended his thanks to the two presenters form TASL for being open and honest in their responses.

RESOLVED

That two monthly progress reports be received from TASL concerning the performance of non-emergency transport services, with the next report at the Committee's April meeting.

Note: At 12:40pm, the Committee adjourned for lunch and re-convened at 2.00pm.

69 LINCOLNSHIRE SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP: MENTAL HEALTH PRIORITY

The Committee gave consideration to a report from the Lincolnshire Sustainability and Transformation Partnership and Lincolnshire Partnership NHS Foundation Trust,

which provided information relating to recent progress and strategic activity in relation to the NHS direction for delivery of Mental Health Services in Lincolnshire.

The Chairman welcomed to the meeting John Brewin, Chief Executive, Lincolnshire NHS Partnership Trust, Ian Jerams, Director of Operations, Lincolnshire Partnership NHS Foundation Trust, Andrew Rix, Chief Operating Officer South Lincolnshire CCG and Rachel Redgrave, Head of Commissioning for Mental Health, Autism and Learning Disability, South West Lincolnshire CCG.

The Chief Executive, Lincolnshire NHS Partnership Trust in his introduction advised the Committee that Lincolnshire Partnership NHS Foundation Trust (LPFT) was the specialist, regulated NHS Mental Health Care Provider for Lincolnshire, providing a range of mental health crisis, inpatient and community services over a range of services in over 56 locations in Lincolnshire to over 65,000 patients per year.

Paragraph 2 of the report listed provided a list of successes to date that had been delivered/planned through the Sustainability and Transformation Partnership.

Appendix A to the report provided the Committee with Lincolnshire's position against future Mental Health and Learning Disability Service ambitions for 2018/19.

It was highlighted that the Lincolnshire Sustainability and Transformation Partnership was facing the challenge of finding investment for the purposes of nationally directed mental health development and transformation of new services, within a Lincolnshire health system with a collective forecast deficit of circa £110m. A further additional pressure for LPFT funding was from regulators concerning the standard of mental health estate. It was reported that the Care Quality Commission had recommended that the Trust work towards the replacement of inpatient facilities, which still offered dormitory bedroom accommodation. It was noted that the cost of meeting this recommendation was estimated to be up to £30m. It was noted further that capital monies had been spent on the introduction of the Psychiatric Intensive Care Unit, which had resulted in significant system financial savings as well as a quality benefit to patients, carers, and families.

It was reported that the current national profile of Mental Health and Learning Disability services was unparalleled, particularly with a recent Royal profile. It was noted that the Lincolnshire system had a great opportunity to implement the proposals detailed in the report, and that recent NHS Planning Guidance for 2018/19 had re-emphasised the need for systems to ensure services were in place in the timescales described.

A discussion ensued, from which the following issues were raised:-

- Some members indicated that they would like to see more detail than that contained in the report. The Committee was urged to look at Appendix A which provided more information. In response to an observation that limited detail had been included as to how services had improved and whether targets had been achieved. It was noted that some services were new and performance information was still to be received;

- Older Adult Transformation Plans at Pilgrim Hospital, Boston – The Committee was advised that this was still at a consultative stage;
- Some questions were raised relating to Neighbourhood Teams, particularly in the Lincoln area. It was noted that there needed to be a mental health component in Neighbourhood Teams; and that the progression of neighbourhood teams were at different rates in different areas within the county;
- One member extended congratulations to the Lincolnshire Partnership NHS Foundation Trust for their decision to move from dormitory accommodation to individual rooms. Reference was also made for the need for the crisis team to be strengthened to enable patients to receive care in the community;
- Housing Accommodation for those in transition. The Committee was advised that work was ongoing with District Councils regarding this matter. Community support was an important area, as loneliness was a major contributory factor to mental health;
- Page 87 - One member enquired as to whether the Trust had all the necessary staff to deliver mental health crisis and liaison services by 2021. The Committee was advised that the Trust would have enough staff if they employed a further 24 FTE;
- Page 88 – Increase employment support services by 100% - One member enquired whether there was any information relating to the cost of the system. It was reported that at the moment there was no cost information;
- One member suggested that more could be done with employers to take on more voluntary work experience individuals;
- Problems encountered from 'legal highs' – The Committee was advised that the taking of drugs/consumption of alcohol had a massive impact on individuals with mental health issues. It was highlighted that problems had increased since there had been a reduction in support in these areas; and
- A question was asked as to how the proposals affected the STP. The Committee was advised that there would be discussion with the community in relation to where the STP was going in due course. The Committee was further advised that the STP fitted into a system approach for which CCGs had responsibility.

The Chairman extended his thanks on behalf of the Committee to the presenters from Lincolnshire Partnership NHS Foundation Trust.

RESOLVED

That the progress made in putting systems in place to deliver mental health services in Lincolnshire be received and that further update reports on the Mental Health priority within the STP be received at six monthly intervals.

70 JOINT HEALTH AND WELLBEING STRATEGY UPDATE

Consideration was given to a report from Derek Ward, Director of Public Health, which asked the Committee to comment on the proposed approach to, and the findings from the engagement by the Health and Wellbeing Board for Lincolnshire, as

part of developing the next Joint Health and Wellbeing Board Strategy for Lincolnshire.

Appendix A to the report provided the Committee with details of the proposed structure and governance arrangements for the new Joint Health and Wellbeing Board Strategy.

David Stacey, Programme Manager Strategy presented the report to the Committee and made reference to the following issues:-

It was reported that the purpose of the JHWS was to set the strategic commissioning direction for the next five years for all organisations who commissioned services in order to improve the health and wellbeing of the population and reduce inequalities. It was highlighted that the current JHWS produced by the Health and Wellbeing Board for Lincolnshire was due to end in 2018, and the Health and Wellbeing Board for Lincolnshire had been engaged on the development of a new JHWS based on the evidence included within the newly refreshed JSNA for Lincolnshire.

It was highlighted that there had been a high degree of commonality across the different engagement stages and the overall emerging priorities identified from the engagement were:-

- Adult Mental Health
- Mental Health and Emotional Wellbeing (Children and Young People)
- Housing
- Carers
- Physical Activity
- Dementia
- Obesity

The Committee was advised that the Health and Wellbeing Board for Lincolnshire at its 26 September 2017 meeting had agreed that further work would be undertaken on the priorities, which had included consideration of the thematic areas as well as the Joint Strategic Needs Assessment priority areas. It was noted that the Health and Wellbeing Board had supported the need to include safeguarding as a cross cutting theme based on the opportunity for the JHWS to also act as the Children and Young People Plan for Lincolnshire; and had also agreed to the governance arrangements required for further developing the final JHWS and its subsequent delivery.

During discussion, the Committee raised the following issues:-

- That the consultation events should have been more evenly spread across the county, particular reference was made to the fact that an event had not been held in Boston. The Programme Manager Strategy confirmed that this would be taken on board for future engagement sessions going forward. One member extended congratulations to officers for the interactive event held in Lincoln;

- One member enquired whether there had been engagement with the health service and social care. The Committee was advised that the Health and Wellbeing Board membership comprised of representatives from health and social care. Confirmation was also given that there was continued overlap between the two areas. The Committee was advised further that the issue of Delayed Transfers of Care (DTOCs) was an item that was considered by Adults and Community Wellbeing Scrutiny Committee; and
- One member enquired as to how the plans Sustainability and Transformation Partnership could be influenced by the JHWS. It was confirmed that future engagement sessions would have invitations extended to representatives working on the STP.

RESOLVED

That the information on the proposed approach to and findings from the engagement by the Health and Wellbeing Board for Lincolnshire as part of developing the Joint Health and Wellbeing Strategy for Lincolnshire be received.

71 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

Consideration was given to a report from Simon Evans, Health Scrutiny Officer which enabled the Committee to consider and comment on the content of its work programme to ensure that scrutiny activity was focused where it would be of greatest benefit.

Detailed within the report were populated work programmes up to 18 April 2018 meeting. Pages 99/100 also provided a list of items to be programmed.

Items put forward from the Committee included the following:-

- Dentistry;
- Specialised Commissioning;
- Adult Immunisation;
- Developer and Planning Contributions for NHS Provision;
- Winter Pressures – reflection on 2017/18; and
- ULHT Update – Double Special Measures.

RESOLVED

That the work programme as presented be agreed subject to the inclusion of the items mentioned above.

The meeting closed at 4.00 pm

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 March 2017**
Subject:	**Chairman's Announcements**

1. Accident and Emergency Provision – Paediatric Services, Pilgrim Hospital, Boston

On 27 February 2018, United Lincolnshire Hospitals NHS Trust (ULHT) issued a statement, in which it indicated that it had temporarily stopped all planned (non-urgent) paediatric surgery at Pilgrim Hospital. ULHT has stated that the reason for this is that it does not always have enough paediatric nurses both to support A&E and to provide emergency and non-urgent care on the children's ward 24 hours a day, seven days a week. There is a national shortage of appropriately trained paediatric staff, including both nurses and doctors, in addition to shortages of A&E staff and ULHT is seriously affected by this.

ULHT has stated that in the short term it has reduced the number of inpatient paediatric beds at Pilgrim, so nurses can be released from the children's ward to support A&E staff to care for ill children who attend A&E. Children whose routine operations have been cancelled will be given appointments at Lincoln.

ULHT has also referred to the increased pressures on its A&E: it has seen and treated more people in its A&E departments than in any other previous December. January was among the busiest on record. Attendances were 5% higher than the previous winter.

2. Temporary Change of Use of Rochford Unit, Pilgrim Hospital, Boston

It was reported to the Committee on 21 February 2018 that a temporary change of use of the Rochford Unit at Pilgrim Hospital to support winter pressures in Lincolnshire had been planned. (The Rochford Unit is a 17-bedded mixed sex specialist assessment and treatment unit for older people experiencing complex mental health needs, based at the Pilgrim Hospital site, and managed by Lincolnshire Partnership NHS Foundation Trust).

However, on 21 February 2018 it was announced that there was a lack of capacity in the wider health system to provide additional staffing support to Rochford Unit, in particular there was a lack of resources to provide home treatment services to support older adult mental health patients at home and prevent inpatient admissions. As a result, it was decided not to proceed with the temporary change and the Rochford Unit remains as an older adult mental health ward.

3. Lincolnshire Pharmaceutical Needs Assessment

On 27 March 2018, the Health and Wellbeing Board is due to be invited to approve the Lincolnshire Pharmaceutical Needs Assessment (PNA), following a consultation period between 11 December 2017 and 11 February 2018. This Committee previously established a working group which considered the draft PNA on 19 December 2017 and the Committee approved its response to the PNA on 17 January 2018.

Overall, there were 18 responses to the draft PNA, and it is understood that as a result of the consultation there will be no significant changes to the final PNA.

The final version of the Lincolnshire PNA, pending approval of the Board, will be made available on the Lincolnshire Research Observatory website from 29 March 2017.

4. Humber Acute Services Review

In February 2018, the Humber, Coast and Vale Sustainability and Transformation Partnership, which includes North and North East Lincolnshire posted information on its website on the Humber Acute Services Review (ASR). The Humber ASR includes within its scope Diana Princess of Wales Hospital in Grimsby, and Scunthorpe General Hospital, so this review has the potential to affect Lincolnshire residents. The services will be considered in the following waves:

Wave 1 will include three priority individual specialties that have been identified as 'fragile': Clinical Haematology, Ear Nose and Throat, and Urology. These are the service areas that were identified as being under immediate patient safety concerns.

Wave 2 will include the following services:

- Urgent and Emergency Care services (including Accident and Emergency, Acute Medicine, Elderly Medicine, Respiratory Medicine, the acute model for specialist medical and surgical services and Critical Care) - Urgent and emergency care services are the most significant in terms of the levels of resource required for service delivery, the volumes of inpatient activity and the potential impact of service changes on the future shape of hospital service provision in the Humber area.
- Maternity
- Cardiac Services
- Neurology

- Clinical Immunology
- Dermatology

Wave 3 will include the following services:

- Planned and Specialist Services (including Gastroenterology, Gastro-intestinal Surgery, Oral and Maxillofacial Surgery, Ophthalmology and Orthopaedics)
- Radiology

Wave 4 will include the following services:

- Any further services identified as needing review on the basis of ongoing quality or service issues.

Detailed review activity on the first wave began in January 2018, with the work on the remaining three waves not due until the spring of 2018. Where any proposals for change are identified, there is a commitment to public consultation.

More details are available on the Humber, Coast and Vale Sustainability and Transformation Partnership website :

http://humbercoastandvale.org.uk/humberacutereview/

There are regular contact meetings between the Lincolnshire STP and the Humber, Coast and Vale STP, so that any areas of cross-over can be picked up. Members of the Health Scrutiny Committee will be given regular progress reports on the Humber ASR.

5. NHS Staff Survey 2017

On 7 March 2018, the results of the 2017 NHS staff survey, which was carried out between September and December 2017 across 309 NHS organisations in England, were published. The results of the staff survey can be viewed in detail at the following site:

http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2017/

Lincolnshire Community Health Services NHS Trust (LCHS) and Lincolnshire Partnership NHS Foundation Trust (LPFT) have highlighted the positive outcomes from the survey:

- Nearly 60 per cent of staff responded to the survey at both LPFT and LCHS.
- Both LPFT and LCHS scored above the national average for staff engagement when compared with organisations of a similar type, each scoring 3.85 out of 5. This indicates how staff feel they are able to contribute towards improvements at work, motivation is good and in many cases they would recommend their organisation as a place to work or receive treatment.
- LPFT performed above the national average for mental health trusts in 18 of the 32 key findings in the report, in particular making improvements in

communication between staff and senior managers and staff feeling confident in reporting unsafe clinical practice. LPFT in line with the national average for a further 13 of the national indicators.

- LCHS also recorded improvements compared to 2016 in staff satisfaction. This included the levels of responsibility and involvement staff have, effective use of patient/service user feedback and the recognition and support they receive from their managers and the organisation.
- LCHS performed above average for community trusts in seven of the national indicators, with 23 others in line with the national average and two areas slightly below.

6. Dr Mark Howard, GP at Welton Family Health Centre

Doctor Mark Howard, who worked as senior partner at the Welton Family Health Centre, passed away unexpectedly at home on 22 February 2018 at the age of 45. Dr Howard had been a GP at Welton Family Health Centre for seventeen years. He was dedicated to the practice and patients, and was instrumental in the development of the practice and the local federation, striving for the best possible care for patients.

Lincolnshire West CCG is supporting the practice through this difficult time.

Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
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Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 March 2018**
Subject:	**Lincolnshire Sustainability and Transformation Partnership Update – Operational Efficiency**

Summary:

This report provides information on the operational efficiency aspects of the Lincolnshire Sustainability and Transformation Partnership (STP).

Actions Required:

To consider the progress on the delivery of the operational efficiency aspects of the Lincolnshire STP.

1. Introduction

1.1. National Context

Sustainability and Transformation Plans, subsequently renamed as Partnerships (STPs), were introduced nationally in 2015/16 as a way of enabling local health and care organisations to plan and deliver services within their own geographical footprint.

1.2. Lincolnshire Context

The Lincolnshire STP set out a programme of work, to be delivered by 2020/21, split into two broad areas:

- Clinical Service Redesign, which incorporated the previous Lincolnshire Health and Care programme (LHAC)

- Operational Efficiencies, which concentrated on improving efficiency and value for money across the system.

These programmes are all supported by a number of cross-cutting enabling work streams in respect of technology, estates, workforce and organisational development, finance, and communications and engagement.

The Lincolnshire NHS is currently in the process of reviewing its 2018/19 priorities, which will support the further development of a system-wide approach to managing its resources.

Whilst the Health Scrutiny Committee for Lincolnshire receives routine STP updates as a whole, this paper provides further details specifically for the operational efficiency aspects. It is intended to give detail of the main efficiency schemes undertaken on a system-wide basis as well as an indication of those managed individually within organisations.

2. Operational Efficiency Overview

The original five-year STP outlined an operational efficiency requirement for the Lincolnshire NHS of just over £60m by 2020/21.

As separate statutory bodies in their own right, each of the seven Lincolnshire NHS organisations is ultimately responsible for delivering its own aspects of operational efficiency, and each reports separately to its own Board and regulator. The operational efficiencies are therefore essentially delivered through a number of routes:

- By individual providers
- By individual commissioners
- Collectively at a system level.

Schemes internal to each of the trusts continue to be implemented through their own project teams, including the acute trust to which applies the bulk of the focus of the Carter recommendations. (The Carter report was aimed at acute trusts and as this is the largest provider within the county, it incurs the greatest spend and has the greatest target for savings).

Many of the operational efficiency schemes operate 'behind the scenes', rather than having direct impact on the delivery of services. However, given the Health Scrutiny Committee's interest in reviewing matters relating to the planning, provision and operation of health services, the report does indicate where a scheme has a more direct link to service delivery (largely in respect of prescribing initiatives).

The system approach to the efficiency agenda was focused around the following broad areas in the development of the original STP and addressed variations highlighted in two national reports:

a. The Carter Report, published in February 2016, "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations" – identifies areas in NHS provider trusts where the report suggests a range of areas in which efficiencies may be made.

   To put this into local context:

   - Of the £60m operational efficiency 5-year target; £44m relates to efficiencies under the Carter recommendations

   - This almost exclusively applies to the provider trusts, which collectively spend about £700m a year (about £450m on pay and £250m on non-pay).

b. The NHS RightCare initiative for medicines optimisation – aimed at CCGs, this highlights variation in prescribing practice which can be targeted for efficiencies.

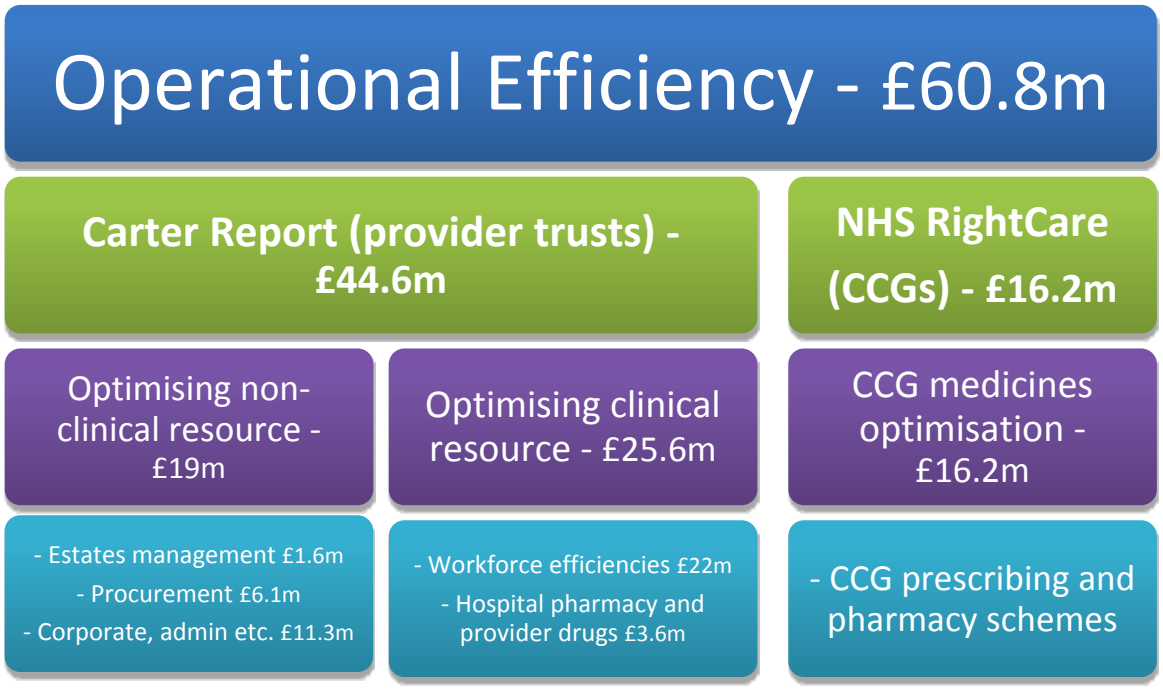
   To put this into local context:

   - Of the £60m operational efficiency target for 5 years by 2020/21; £16m relates to prescribing efficiencies

   - The CCGs currently spend about £150m on prescribing per annum.

The majority of this report focuses on the work which has been addressed at system level, although the narrative does also make reference to the main efficiency areas targeted by the Carter report. The report does not include every single operational efficiency scheme which is being undertaken within each trust; all of which are collectively contributing towards the £60m efficiency goal.

The overall operational efficiency target can be further broken down as follows.



Further details of schemes within each area are given in section 3.

3. Operational Efficiency Portfolio Overview

The operational efficiency team within the STP delivery unit is now established and has been working with the system to identify priorities and project briefs. The team has also established the governance routes for its areas of work. Shown below is an outline of the projects it has been implementing or supporting to date, together with an indication of where and how some of the other themes are being addressed.

As part of the system review of priorities, specific 2018/19 targets are in the process of being set for operational efficiency schemes. For the initial system-wide work in 2017/18, the broader targets in the STP document were used to prioritise the first work streams and projects.

It is also worth noting that Lincolnshire Partnership NHS Foundation Trust has become a Carter pilot for Mental Health and Community Trusts, working with the NHS Improvement Operational Productivity team to develop how the Carter initiatives may be adopted within the non-acute sector. Any learning will be shared across the NHS community.

The main efficiency schemes being developed as a result of the Carter and RightCare initiatives are outlined as follows. Details of progress to date against the original STP targets are shown in Appendix A. This indicates that of the £60m original target, £23m is being delivered in 2017/18 leaving a further £37m still to be delivered over the three years between 2018/19 and 2020/21. In terms of timeframes, 2018/19 schemes are currently being agreed across the system as part of each organisation's annual planning process; timings of the individual operational efficiency schemes are therefore still to be confirmed within the context of overall plans.

3.1. Carter Efficiency Schemes

a. Estates management: review of corporate / back office estate utilisation.

A detailed project brief has been agreed to determine the scope of the review and a data collection exercise is currently underway to assess how the corporate / back office functions utilise the NHS estate across Lincolnshire, and whether this can be more efficient. The review of the data will take into account existing utilisation measures, best practice policies and stakeholder expectations. It is also linked to the one public estate initiative to identify common accommodation or estates issues. It is expected that a first draft of the report and recommendations will be available in April 2018. Estate used for the provision of clinical services is not included within the scope of this review.

b. Procurement – there are a number of procurement initiatives ongoing.

- Collaboration between the three provider trusts in aligning tenders, sharing systems and policies, utilising e-procurement systems and using the new national purchasing price index benchmarking tool to target potential areas of cost reduction. These are all consistent with the national NHS e-procurement strategy, as recommended by the Carter review. The trusts have also signed up to use the national 'future operating model' for procurement, which will result in unit price procurement savings arising from access to wider purchasing power. The trusts are actively working together towards achieving the national NHS procurement standards, which in turn will lead to more cost effective procurement. (In terms of clinical related supplies, this may not always represent the cheapest unit price: clinicians are involved in purchasing decisions and will also take into account quality, safety and other non-financial factors).

- A number of collective procurement exercises have been undertaken between the provider trusts, including pharmacy services. More significantly, both CCGs and provider trusts are working together to maximise efficiencies from the procurement of pathology services (across the county, total expenditure is in excess of £20m and it is clear from collaborative discussions that there are variations in the unit prices paid by the different organisations to the current provider). Contract values are currently subject to renegotiation as part of the annual contracting discussions with a view to reducing variation and securing better value for money both in the current round of discussion and also looking to the future. Concurrently, there is also a national exercise underway of consolidating the network of pathology services which, for the wider Lincolnshire and Yorkshire areas suggests a combined saving of £5.5m, although is silent on likely timeframes.

c. Corporate and administration (back office) – largely centred around developing county-wide shared services arrangements.

- There are currently three longstanding shared services arrangements between the provider trusts (covering financial services, procurement services and payroll). Several other corporate functions are in the process of developing proposals to collaborate or operate under shared services arrangements. The individual proposals will confirm expected savings and timeframes, but these are expected to start to accrue savings during 2018/19. For example:

    - Communications and engagement services, across all seven NHS organisations in the county are working towards a shared services model
    - Estates and facilities management services, between two of the provider trusts, are looking to provide a combined service
    - Information and communication technology services of the three provider trusts are looking to develop collaborative arrangements.

- A county-wide shared services partnership board has recently been established to provide steer and oversight over the development of shared services arrangements across the county. This board will be looking at governance, priorities, and a consistent approach to the development of shared services as part of a development plan for the next couple of years. It is expected that new services will start to deliver benefits during 2018/19.

d. Workforce efficiencies – a range of initiatives designed to support the workforce to operate more efficiently.

- Most of this work is happening within respective trusts – for example, the introduction of e-rostering systems, utilising benchmarking information (e.g. the national model hospital tool) and costing systems to identify efficiencies, and planning analysis of roles. Benefits are therefore reported internally to each organisation as part of their own plans.

- There is also a system-wide planning exercise underway which is looking at the redesign of clinical services. Once the impact on individual organisations is clear, the operational efficiency implications will be incorporated as part of the service redesign.

- Traditionally, as each organisation has its own statutory targets to meet, each has tended to concentrate on its own staff. However, in order to meet the required efficiencies for the whole NHS community, this area requires a much more collaborative approach in terms of a system-wide, more integrated approach to workforce planning; and this will be a key priority for 2018/19.

- It is also worth noting that the Lincolnshire CCGs are currently in the process of developing a single management structure across the four organisations.

e. Hospital pharmacy – the Carter report required each acute trust to develop a hospital pharmacy transformation plan to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stockholding by April 2020. The aim is to ensure that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities. This Carter initiative therefore relates to the United Lincolnshire Hospitals NHS Trust, and the trust is in the process of implementing its plans.

f. Hospital medicines optimisation – similarly, United Lincolnshire Hospitals NHS Trust is looking at how best to manage medicines as part of its own plans. From a system-wide perspective, the development unit has supported the progression of a business cases for electronic prescribing & robotic dispensing, which will need to be considered against other capital funding priorities: the deadline for decisions will be July 2018.

3.2. RightCare and General Prescribing Schemes

A number of schemes have been implemented this year to address variations in prescribing costs and facilitate more efficient management of drugs, alongside a number of other prescribing initiatives.

a. Introduction of software to manage medicines, leading to both financial and non-financial benefits:

- Blueteq – to control the issue of hospital high cost drugs within quality guidelines. This ensures that drugs are issued in accordance with NICE guidelines (a quality benefit) as well as controlling the cost of these drugs.

- OptimiseRx – software used within primary care which gives information at the point of care about best practice, safer prescribing and cost benefits.

b. Introduction of clinical pharmacists – to reduce the burden on GP time and to ensure effective management of medicines.

- Benefits of clinical pharmacists include a reduction in the volume and cost of unnecessary prescribing of medicines, fewer presentations to A & E or hospital admissions for medication errors or complications related to having multiple medications, and a reduction in the number of drugs that patients may need to manage.

- A GP based pharmacist prescriber can reduce the average cost per prescription item; national studies indicate that carrying out medication reviews in care homes has both quality and financial benefits (suggesting that the average cost per prescription item can be reduced to £5.92 – a 27% reduction from the national average).

- During 2017, six pharmacists completed their non-medical prescribing courses and are eligible to apply for clinical pharmacist roles.

- There are currently eight posts available in the county, four of which have recently been recruited to.

c. Oral Nutritional Supplements – review of how these are provided upon discharge from hospital as part of a system wide approach to the service.

- Patients are discharged from hospital with a sufficient supply of supplements before needing to go to their GP for more, if required.

- Dietetic guidance and supervision is available for a period after initial discharge from hospital.

- The service is focused on individual patient need, is provided for as long as needed, and therefore provides a better experience for the patient.

- The streamlined service also saves money in several areas; a 10% reduction in cost should be a reasonable expectation (which would save £100k in the local context).

d. Standardisation of wound management products and appliances in primary care – by standardising the prescribing formulary between the various organisations, quality is improved, variation reduced, and cost efficiencies available through the supply chains (a 10% reduction in cost would equate to about £700k in the local economy).

3.3. Enabler Work Streams

It is also worth noting that many of the operational efficiency schemes link closely with some of the enabler projects. For example:

- The review of corporate / back office estate usage is linked heavily with the wider NHS estates strategy, and with the one public estate initiative.

- Workforce efficiencies will require support mechanisms for staff to work more efficiently, whether through organisational / personal development and training, culture changes, or technological support (e.g. mobile working, advancement of the care portal, software solutions such as e-rostering and electronic management of prescribing and dispensing).

3.4. 2018/19 Priorities

In terms of 2018/19 priorities currently under development, it is likely that the key operational efficiency themes to be addressed on a system-wide basis will include:

- A focus on shared services of back-office functions
- Temporary workforce solutions (e.g. bank and agency)
- Countywide prescribing initiatives (e.g. repeat prescribing)
- Estates rationalisation
- Pharmacy & prescribing.

4. Conclusion

The collective STP approach to efficiencies has started to drive system-wide changes in delivering some of the required efficiency savings across the local NHS.

Whilst several schemes have now been implemented, the tangible benefits need to be clarified within the individual organisational financial positions in order to understand the collective benefit of all efficiency schemes. The more collective approach for 2018/19 should lead to better system management across the Lincolnshire NHS, collective performance monitoring, and clearer reporting of system savings.

In the meantime, the system efficiency target remains challenging with further work required in continuing to develop and implement new specific schemes.

5. Appendices

These are listed below and attached to this report.

Appendix A	Comparison of STP Target Against Current Trajectory

6. Background Papers

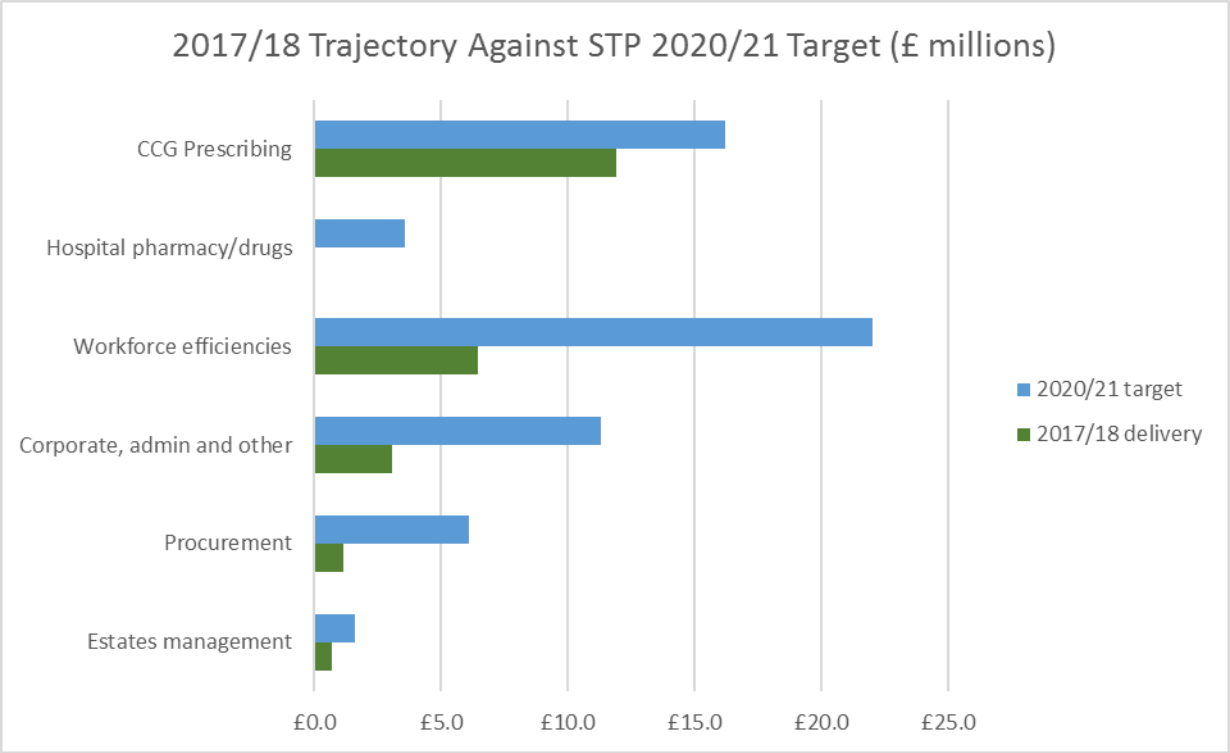
No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Darren Steel, Portfolio Director (Operational Efficiency), who can be contacted on 01522 307315 or darren.steel@lincs-chs.nhs.uk.

APPENDIX A

COMPARISON OF STP TARGETS AGAINST CURRENT TRAJECTORY

These figures are for Month 9 of 2017/18.



The efficiencies still to be delivered will need to be enacted by 2020/21. The figures behind the graph are shown below.

Programme Area	2020/21 target £m	2017/18 delivery £m	Still to deliver £m
Estates management	£1.6	£0.7	£0.9
Procurement	£6.1	£1.1	£5.0
Corporate, admin and other	£11.3	£3.0	£8.3
Non-clinicial resource	£19.0	£4.9	£14.1
Workforce efficiencies	£22.0	£6.5	£15.5
Hospital pharmacy/drugs	£3.6	£0.0	£3.6
Clinical resource	£25.6	£6.5	£19.1
Total Carter efficiencies	£44.6	£11.3	£33.3
CCG Prescribing	£16.2	£11.9	£4.3
TOTAL OPERATIONAL EFFICIENCY	**£60.8**	**£23.2**	**£37.6**

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Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 March 2018**
Subject:	**Lincolnshire Urgent and Emergency Care**

Summary:

This report provides information on the Lincolnshire Urgent and Emergency Care Strategy 2018-2021, and the development of the plan to support the delivery of strategy. .

Actions Required:

(1) To consider and comment on the report, including the Lincolnshire Urgent and Emergency Care Strategy 2018-2021 (Appendix A to this report).

(2) To note the report on the Urgent Care Streaming Service (Appendix B) in the context of the Lincolnshire Urgent and Emergency Care Strategy 2018-2021.

1. Background

1.1 Context

The Lincolnshire Sustainability and Transformation Partnership (STP) developed and approved the Sustainability and Transformation Plan in October 2016. Seven key priorities have been identified one of which being urgent and emergency care. To support this key priority, The Lincolnshire Urgent and Emergency Care Strategy 2018-2021 (the strategy) has been drafted.

Our vision for urgent and emergency care is:

> *"To transform our urgent and emergency care services into an improved, simplified and financially sustainable 24/7system that delivers the right care in the right place at the right time for all of our population."*

The strategy is cognisant of the strategic direction set by the Urgent and Emergency Care Review and the Five Year Forward View.

Consultation has been undertaken amongst organisations via the A&E Delivery board, and the strategy was approved at the System Executive Team (SET) on 24 January 2018.

1.2 Urgent and Emergency Care Definitions

1.2.1 – Urgent and Emergency Care

There is no nationally accepted definition for 'urgent care' and 'emergency care'. The Lincolnshire Urgent and Emergency Care Strategy 2018-2021 uses the following definitions:

Urgent Care – the provision of care for patients who require prompt advice or treatment, but whose condition is not considered life-threatening.

Emergency Care – immediate of life threatening conditions, serious injuries or illnesses.

1.2.2 – A&E Activity Definitions

The A&E Attendances and Emergency Admissions Monthly Return Definitions document sets out national definitions for A&E Attendances and Emergency Admissions monthly returns. Types of A&E Service are:

- Type 1 A&E department – A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients – Lincoln County Hospital and Pilgrim Hospital, Boston are examples of Type 1 A&E departments.

- Type 2 A&E department – A consultant led single speciality accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients. There are no examples of Type 2 A&E departments in Lincolnshire.

- Type 3 A&E department / Type 4 A&E department / Urgent Care Centre – Other type of A&E / minor injury units (MIUs) / Walk-in Centres (WiCs) / Urgent Care Centre, primarily designed for the receiving of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining

characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. An appointment based service (for example an outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours services), or a dedicated primary care service (such as GP practice or GP-led health centre) is not a Type 3 A&E service even though it may treat a number of patients with minor illness or injury.

Examples of UCCs in Lincolnshire are Louth County Hospital, and Skegness Hospital. Examples of MIUs in Lincolnshire are John Coupland Hospital, Gainsborough; Johnson Hospital, Spalding; and Stamford and Rutland Hospital.

The East of England Clinical Senate Report, November 2017, states that:

'The majority of patients presenting at Grantham and District Hospital A&E were type 3 patients, the department did not support patients of higher acuity.'

1.2.3 – Urgent Treatment Centres

The Urgent Treatment Centre Principles and Standards document, published by NHS England in July 2017, sets out a core set of standards for urgent treatment centres to establish as much commonality as possible. By December 2019 patients and the public will:

- Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
- Have a consistent route to access urgent appointments offered within 4 hours and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.
- Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.
- Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS 111, local GPs, hospital A&E services and other local providers.

1.3 Case for Change

The Lincolnshire urgent and emergency care system has been operating under extreme pressure over the past 36 months (see table 1) with consistent failure to achieve the NHS constitutional standard that states that 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours. Whilst the most pressure is evident in the A&E functions, the whole system is not operating efficiently by reactively responding under pressure to manage demand and flow.

In addition to this a confusing picture of urgent care provision is currently in existence in Lincolnshire with the public being presented with a multitude of different

service names and routes into urgent care. Some services with different names deliver the same care and some services with the same name can deliver completely different levels of care. This is further highlighted above with the national definition for type 3 departments covering MIUs, WICs and UCCs.

In summary our current urgent and emergency care system demonstrates the following case for change:

- Complicated service provision, multiple 'front doors'
- High dependency on GP practices, out of hours service and the Clinical Assessment Service (CAS) to deliver increasing demand for same day urgent care services
- Increasing demand for NHS 111 and 999 services
- High number of ambulance conveyances
- Public confusion about where to go for services
- Historical difficulties with recruitment and retention across the urgent and emergency care workforce
- Poor adherence to the NHS constitutional four hour standard.

Table 1 – A&E performance figures

Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
84.51 %	83.92 %	85.21 %	87.30 %	87.60 %	90.67 %	91.19 %	89.17 %	90.17 %	86.41 %	86.52 %	84.88 %

Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
82.73 %	81.07 %	80.32 %	80.54 %	83.52 %	81.18 %	78.56 %	77.81 %	78.40 %	81.37 %	82.60 %	77.47 %

Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
75.67 %	75.36 %	79.12 %	82.21 %	76.86 %	81.58 %	78.49 %	77.73 %	76.68 %	77.54 %	79.37 %	69.46 %

Jan 18
66.99 %

1.4 Four Programme Areas

The Transforming Urgent and Emergency care services in England - Urgent and Emergency Care Review end of Phase 1 Report identifies five key elements for the future of urgent and emergency care services in England which must be taken forward to ensure success. The five elements are:

1. Providing better support for people and their families to self-care or care for their dependents.
2. Helping people who need urgent care to get the right advice in the right place, first time.

3. Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
4. Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.
5. Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

Building on these five elements, the strategy has identified four key programme areas for which, when fully implemented, will ensure that urgent and emergency care services operate from a system perspective to provide an improved, simplified and financially sustainable urgent and emergency care system in Lincolnshire.

1.4.1 – Supporting Self-Care / Self-Management and Prevention

- By December 2018, there is a national mandate to have 111 online available to the public. Work is ongoing on a regional basis to identify a provider for this service, with implementation planned for the summer months to meet national deadline.
- The Directory of Services will be further developed to ensure that self-care and voluntary sector services are identified ensuring that the public can be well supported to self-care.
- The delivery of this programme area will closely link with STP self-care work programme and the Joint Health and Wellbeing Strategy

1.4.2 – Helping People with Urgent Care Needs to Get the Right Advice or Treatment First Time.

- Nationally there is a requirement for 50% of all NHS 111 calls to result in the patient being passed across to a clinician for advice and guidance. This target is already being met in Lincolnshire.
- The Clinical Assessment Service (CAS) delivers this service in Lincolnshire and supports the reduction in hospital attendances.
- The CAS service has been developed in recent months to provide direct clinical advice to care homes and paramedics. Pilot programmes for this have recently been completed and the impact identified.

Further projects to support this programme area include:

- A one year pilot to trial CAS undertaking video-consultation as enhancement to telephone based triage
- Roll out of direct booking from hear and treat services into Urgent Treatment Centres (UTCs) and in hours primary care
- To further develop integrated service delivery between urgent care / Integrated Neighbourhood Working same day response / Mental Health and primary care.

1.4.3 – Providing a Highly Responsive Urgent Care Service Out of Hospital So People no longer Choose to Queue in A&E

- The Next Steps on the NHS Five Year Forward View (5YFV) states that by December 2019, urgent care facilities will be provided through UTCs to ensure as much commonality as possible. National Urgent Treatment Centre principles and standards have been published, and in Lincolnshire work is underway to establish where these facilities will be located and timescales for implementation.
- In addition to UTCs based in the community UTC's will be co-located at the Emergency Departments in Lincolnshire. In addition to the principles and standards published nationally, these centres will incorporate the current Urgent Care Streaming Service and have effective streaming to relevant specialities to minimise the need for patients to attend the emergency department.
- Urgent Care Streaming Service – for a detailed report please see appendix B.

Further projects to support this programme area include:

- Progression of GP access hubs
- Further development of effective patient pathways
- Links with palliative care
- Links with community mental health services
- Links with community pharmacy

1.4.4 – Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise changes of survival and a good recovery

Further projects to support this programme area include:

- Review of emergency care arrangements following the acute services review
- Review of workforce model for urgent and emergency care in Lincolnshire
- Review of ambulatory emergency care model to ensure standardisation across all sites in Lincolnshire
- Development of Outline Business Cases (OBC) to support the provision of primary care on the Lincoln, Pilgrim and Grantham site through UTCs.

1.5 Lincolnshire Urgent and Emergency Care Delivery Plan

To support the implementation of the strategy, a comprehensive delivery plan is in the process of being produced. The delivery plan will include the projects identified above to support both the recovery and transformation of urgent and emergency care in Lincolnshire.
Specific milestones and timescales will be identified in the plan to ensure projects are appropriately managed.

1.6 Enabling programmes

Enabling programmes for urgent and emergency care will run across all four of the programme areas, and are closely linked with the STP enabling programmes. They include:

- Information Communication Technology (ICT) – the introduction of 111 online, and direct booking of GP appointments
- Estates – work has been undertaken at the Lincoln and Pilgrim site to support urgent care streaming. Further OBCs are being developed by Lincolnshire CCGs to support the delivery of primary care led UTCs
- Workforce and organisational development – a workforce plan for urgent and emergency care will be developed to support the delivery of the strategy in line with timescales set by Lincolnshire Workforce Advisory Board.
- Finance – the financial implications of the strategy will be developed alongside the delivery plan and will be closely linked to the financial recovery plan for Lincolnshire STP. This will ensure that services are financially sustainable.
- Communication and engagement – ensuring robust and meaningful engagement with patients, carers, staff and stakeholders to support the successful implementation of the strategy.

2. Consultation

This is not a direct consultation item. However, where proposals for major reconfiguration of services are developed, they will be subject to full public consultation, including the involvement of the Health Scrutiny Committee for Lincolnshire.

3. Conclusion

The report outlines the Lincolnshire Urgent and Emergency Care Strategy 2018 – 2021 and identifies the four key programme areas being developed to support the delivery of the strategy.

The strategy incorporates national expectations and requirements and has close links with the Lincolnshire STP. The A&E Delivery Board will receive monthly progress reports to ensure work is progressing as identified in the delivery plan. In addition to this, monthly urgent and emergency care progress reports are submitted to the STP.

4. Appendices

These are listed below and attached to the report

Appendix A	Lincolnshire Urgent and Emergency Care Strategy 2018 – 2021
Appendix B	Urgent Care Streaming Service Report

5. Background Papers

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

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APPENDIX A

Lincolnshire Sustainability and Transformation Partnership

Lincolnshire Urgent and Emergency Care Strategy 2018-2021

Version Control

Version	**1.0**
Document Name	**Lincolnshire Urgent and Emergency Care Strategy 2018 - 2021**
Author	**STP Urgent Care Team**
Approving Board	**SET via A&E Board for their consultation and recommendations**
Approval Date	**24/01/2018**

Version	Section / Paragraph / Appendix	Description of Amendments	Date	Author / Amended by
0.1	Entire document	Complete first draft	05.12.17	Sarah Stringer / Cheryl Thomson
0.2	Entire document	Addition of paragraphs on Transitional Care, updates to UTC section, AEC section. Amendments Ruth Cumbers	07.12.17	Sarah Stringer/Cheryl Thomson
0.3	Entire document	Amendments Sarah Furley	08.12.17	Sarah Stringer/Cheryl Thomson
0.4	Entire document	Updates from consultation feedback from A&E Delivery Board members	08.01.18	Sarah Stringer/Cheryl Thomson
0.5	Section 1.5	Updated to add in strategic intention for reduction in A&E attendances	18.01.18	Sarah Stringer/Cheryl Thomson
0.6	Section 1.2 Section 3.3.1	Additional information on Grantham Inclusion of repeat dispensing changes	23.01.18	Sarah Stringer/Cheryl Thomson
1.0	Entire document	Approved by SET	24.01.18	SET

Contents

1. Introduction:

Our vision is:

> *"To transform our urgent and emergency care services into an improved, simplified and financially sustainable 24/7 system that delivers the right care in the right place at the right time for all of our population."*

1.1 Purpose

The purpose of this urgent and emergency care strategy is to set out our plans for the future development of urgent and emergency care across Lincolnshire in line with our vision.

The strategy has been written in alignment with the Lincolnshire Sustainability and Transformation Plan (Lincolnshire STP) and has close links and interdependencies with primary care, planned care, prevention and self- care, women's and children and access to mental health services. In addition to this, the strategy is cognisant of the strategic direction set by the Urgent and Emergency Care Review, led by Professor Sir Bruce Keogh. The review recognises the growing pressures on A&E departments, citing two specific points for consideration. Firstly, an aging population with increasingly complex needs leads to an increase in the demand for urgent and emergency care, and secondly the inconsistency of services makes a difficult and confusing experience for patients leading to the use of A&E as a default. In addition to this Lincolnshire has also experienced difficulties with recruitment and retention across the urgent and emergency care system, and is facing unprecedented financial pressures.

The Five Year Forward View published by NHS England in 2014 highlights the need to transform urgent care over the next five years, with an emphasis on better support for self-care, integration between urgent and emergency care services, new care delivery models and strengthening primary care. On a local level, Lincolnshire is currently undergoing an Acute Services Review and is in the process of developing a Single System Plan. These will be considered and will influence the development of the Lincolnshire Urgent and Emergency Care Strategy 2018-2021, which will culminate in a streamlined and flexible delivery model for urgent and emergency care in Lincolnshire.

1.2 What is urgent and emergency care?

Whilst there is no one clear definition of 'urgent care' there is general consensus around the meaning. For clarity in this strategy, the term urgent care will refer to:

- The provision of care for patients who require prompt advice or treatment, but whose condition is not considered life-threatening.

The term emergency care will encompass:

- Immediate or life threatening conditions, serious injuries or illnesses.

This strategy is focussed on urgent and emergency care in Lincolnshire and the services that fall under the definitions above. As such the service areas (that apply to all ages) within scope are:

- Self-care
- NHS 111 (triage by phone and online)
- Clinical Assessment Service (CAS)
- Out of Hours Service
- Urgent Treatment Centres
- GP / Primary Care Access Hubs
- Primary Care in hours
- Community Pharmacy
- Mental Health Services
- Integrated Neighbourhood Working (INW) encompassing both integrated neighbourhood networks and integrated neighbourhood care teams
- Ambulatory Emergency Care (AEC)
- 999
- A&E

The following urgent and emergency care services are not in scope:

- Major trauma services
- Emergency surgery
- Intensive Care Services
- Urgent and emergency care services at Grantham District Hospital. Following the overnight closure of Grantham A&E in August 2016, significant work is being undertaken to design the substantive urgent and emergency care services that will be offered on the site. This work is mindful of the East of England Clinical Senate report (December 2017) and is being managed in line with the Pre-consultation Business Case being produced by the STP operational delivery unit. Whilst out of scope for this strategy, any service redesign work will be closely linked and incorporated in the Lincolnshire Urgent and Emergency Care delivery plan.

Lincolnshire's urgent and emergency care network extend across the county borders to other hospitals such as those in Nottingham, Sheffield, Grimsby, Scunthorpe, Peterborough, Leicester and Kings Lynn which already link in to the Lincolnshire hospital network to provide services such as cardiothoracic surgery, neurosurgery, children's specialist surgery and major trauma (multiple breaks such as those in a car accident).

1.3 National Vision

Nationally the Urgent and Emergency Care Review sets out a simple two point vision with the view that if the first part is managed correctly, pressure will be relieved on hospital based emergency services which will allow delivery of the second part:

1. For those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible minimising disruption and inconvenience for patients and their families.
2. For those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.

Recognising the need for local interpretation, the national vision for urgent and emergency care is shared in Lincolnshire.

1.4 Principles / Objectives

The principles for Urgent and Emergency Care (UEC) in England are described in the UEC Review End of Phase 1 Report. The principles outline a system that:

1. Provides consistently high quality and safe care, across all seven days of the week;
2. Is simple and guides good, informed choices by patients, their carers and clinicians;
3. Provides access to the right care in the right place by those with the right skills, the first time; and
4. Is efficient and effective in the delivery and services for patients.

Following national engagement a series of patient focussed objectives for system change were published, these objectives are incorporated in the Lincolnshire Urgent and Emergency Care Strategy:

1. Make it clear how I or my family/carer access and navigate the urgent and emergency care system quickly, when needed.
2. Provide me or my family/carer with information on early detection and options for self-care, and enable me to manage my acute or long-term physical or mental condition.
3. Increase my or my family/carer's awareness and publicise the benefits of 'phone first'.
4. When my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.
5. Improve my care, experience and outcome by ensuring the early input of a senior clinician in the urgent and emergency care pathway.

6. Wherever appropriate, care for and treat me where I present (including at home and over the telephone).
7. If it's not appropriate to care for and treat me where I present, take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to highly specialist care if needed.
8. Ensure all urgent and emergency care facilities can transfer me urgently, and that the transport is capable, appropriate and approved.
9. Real time information, essential to my care, is available to all those treating me.
10. Where I need wider support for my mental, physical and social needs ensure it is co-ordinated and available.
11. Each of my clinical experiences should be part of programme to develop and train clinical staff and ensure development of their competence and the future quality of services.
12. The quality and experience of my care should be measured and acted upon to ensure continuing improvement.

1.5 Strategic aims

The five strategic aims for the future of urgent and emergency care, set out in the UEC Review End of Phase 1 report are stated below:

- Firstly, we must provide better support for people to self-care;
- Secondly, we must help people with urgent care needs to get the right advice in the right place, first time;
- Thirdly, we must provide highly responsive urgent care services outside of the hospital so people no longer choose to queue in A&E;
- Fourthly, we must ensure that those people with more serious or life threatening emergency care needs to receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery; and
- Fifthly, we must connect all urgent and emergency services together so the overall system becomes more than just the sum of its parts.

This strategy will describe how the above national aims will be adopted in Lincolnshire. It is our overarching strategic intention in line with the Lincolnshire Sustainability and Transformation Plan (STP) that we will achieve a 27.5% reduction in A&E attendances (based on a 2015/16 baseline of 358,414). The accountability for delivery of this target goes beyond urgent and emergency care service redesign. Programmes of work spanning all domain areas of the STP e.g. Integrated Neighbourhood Working (integrated neighbourhood networks and integrated neighbourhood care teams) and operational efficiency programmes will all be contributors to achieving this target.

2. The urgent and emergency care system in Lincolnshire

2.1 The current system

In Lincolnshire, as elsewhere in the country, we currently have a confusing picture of urgent care provision. The public are confronted with a multitude of different service names and routes into urgent care. Some services with different names deliver the same care and some services with the same name can deliver completely different levels of care.

If this is our perception of services as health care professionals, then for the public the urgent care system must be even more confusing and frustrating. As we develop this strategy into an ongoing delivery plan all changes we wish to make must involve testing back with the public to sense-check our plans and assumptions.

The following describes the broad overview of current urgent care service delivery:

- The main routes into urgent care are ringing a GP, ringing NHS 111 and walking into A&E or community based walk in centres; minor injury units or urgent care centres. Less utilised routes are using online self-care/self-management or going to a pharmacist as first port of call for advice.
- GP practices deliver the vast majority of the public's urgent care same day needs and enhanced clinical navigation at GP surgeries are beginning to assist in terms of streaming patients to see a practice GP or nurse, go to pharmacist etc.
- There were over 74,000 patients conveyed to hospital by ambulance in Lincolnshire in 2016/17.
- From the start of the Lincolnshire NHS 111 contract with DHU 111 (East Midlands) CIC (October 2016 to October 2017) there were 215,000 calls made to NHS 111 from Lincolnshire patients.
- When the public ring NHS 111 (after a 'Pathways' triage by a health advisor) if a patient needs to speak to a clinician they are put through to the Clinical Assessment Service (CAS) or they are directed to a service (predominantly primary care) after interrogation of the Directory of Service (DoS). The DoS is a critical database maintained by the Lincolnshire Urgent Care Team which signposts patients according to the type of clinical need and level of clinical urgency. The NHS 111 health advisors already have the capability of directly booking the current out of hours GP service.
- Lincolnshire CAS has been in place for over a year and establishing a CAS to deliver higher level clinical triage is an expectation nationally.
- CAS will hear and treat many calls (effectively closing the urgent care episode with self-care) or may advise patients to go to their GP. CAS clinicians also have the capability of deploying a member of staff from the LCHS urgent care home visiting service (physical health needs), a voluntary sector service e.g. HART team or may ask a patient to come in to be seen by an out of hours GP (in any of the OOH bases in Lincoln, Boston, Grantham, Louth, Skegness,

Gainsborough or Spalding). CAS clinicians may also decide an ambulance is required (work is ongoing to allow automatic dispatch capability) or advise a patient to go A&E.

- On ringing NHS 111 callers identified to have mental health needs are passed directly through to the Lincolnshire Partnership Foundation Trust (LPFT) mental health single point of access, or can be routed to this service by CAS. Patients with mental health needs who attend A&E often have needs that by this point are escalated and require mental health crisis team intervention.
- See and treat urgent care service provision is delivered via the following facilities:
    - A minor illness and injury unit at Sleaford (minor injuries 7 days and Urgent Care evenings and weekends),
    - Three minor injury units at Gainsborough, Spalding and Stamford,
    - Two Urgent Care Centres in Louth and Skegness.
- All patients arriving at one of our three A&E departments go through the urgent care streaming service to ascertain if their clinical needs could be met through a primary care service/GP out of hours or by a social worker/a mental health specialist etc. instead. Direct streaming into relevant specialist departments within the hospital also take place to avoid a hospital admission e.g. into Ambulatory Emergency Care (AEC) departments.

The NHS constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours. Within Lincolnshire, the four hour A&E performance has been falling since the winter of 2014/15 leading to a system wide recovery plan being developed to support the consistent re-achievement of the standard.

2.2 Case for change

In summary our currently configured urgent and emergency care system demonstrates the following clear case for change:

- Complicated and confusing urgent care service provision (different service names, misleading road-signs, unclear website signposting). Multiple ‘front doors’.
- High dependency on GP practices, out of hours service and CAS to deliver increasing demand for same day urgent care services.
- Under developed empowerment of the public to self-care/self-manage with low investment in advice, guidance and online clinical triage.
- Increasing demand for NHS 111 and 999 services.
- High number of ambulance conveyances (East Lincolnshire area being the highest in the East Midlands region).
- Public confusion about where to go for services
- The need for further development between existing ‘hear and treat’ services
- Integration between mental health and physical health urgent care services
- Poor adherence to the NHS constitutional four hour standard

- Historical difficulties with recruitment and retention across the urgent and emergency care workforce.

3. Success in 2021 for urgent and emergency care

Our vision for an improved, simplified and financially sustainable urgent and emergency care system will be achieved though strengthening the development of self-care/self-management and highly responsive urgent care services delivered in the community, allowing the emergency departments to focus on caring for the most sick and vulnerable patients.

3.1 Supporting self-care / self-management & prevention

The focus for reducing the requirement of patients experiencing urgent care needs is of paramount importance in terms of preventing unnecessary contacts, calls and attendances.

This will be achieved by a two-fold approach:-

- Increasing the empowerment of both patients and carers to self-care, self-manage their health and care needs and
- Increasing connection and support to statutory agencies, private health and care sectors e.g. care homes, voluntary sector and informal groups that deliver preventative care.

To deliver this aspect of the strategy close links will be developed with the STP self-care strategy and Joint Health and Wellbeing Strategy.

3.2 Helping people with urgent care needs to get the right advice or treatment first time

Getting the public who have urgent care needs the right level of advice and treatment is critical to prevent further escalation that may result in ambulance conveyance and/or A&E attendance/hospital admission.

The development of an NHS 111 online solution is mandated nationally to be in place by December 2018. The NHS 111 online solution essentially takes the same clinical governance route that is delivered when a person calls NHS 111 in terms of triaging patients and searching on the local Directory of Services.

NHS 111 continues to be advocated and will be increasingly marketed to the public as the gateway for urgent care health needs. National targets are in place (already being met in Lincolnshire) that 50% of all NHS 111 calls result in the patient being passed across to a clinician for advice and guidance. In Lincolnshire this service is delivered by the Clinical Assessment Service which will be continually developed to support the reduction in hospital attendances.

3.3 Providing a highly responsive urgent care service out of hospital so people no longer choose to queue in A&E

3.3.1 Community Pharmacy

A key element of provision of urgent care services out of hospital is the continued development of our community pharmacy provision. Our intention is to utilise community pharmacies to consistently achieve the following deliverables:

- Providing emergency supplies of prescription medicines;
- Supporting self-care of minor illnesses and providing minor ailment services;
- Providing flu vaccinations;
- Reducing repeat prescription workload in general practice through repeat dispensing;
- Supporting people with long term conditions to get the most benefit from their medicines;
- Minimising adverse effects and admissions related to medicines;
- Helping people understand new medicines and changes to medication (especially on discharge from hospital).
- Any changes to repeat dispensing arrangements

3.3.2 Integrated Neighbourhood Working

Integrated Neighbourhood Working through the delivery of both integrated neighbourhood networks and integrated neighbourhood care teams will support admission avoidance through the delivery of patient centred, individualised care in the community. Integrated neighbourhood working will provide same day response at a local level, supporting the patient being treated in their own home. In addition to this the function will interface with urgent care services at a countywide level should the acuity dictate.

The four key characteristics that make up integrated neighbourhood working are:

- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care;
- A combined focus on personalisation of care with improvements in population health outcomes;
- Aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards and
- Provision of care to a defined, registered population of between 30,000 and 50,000.

3.3.3 Transitional Care

Transitional Care is a component part of Integrated Neighbourhood Working that provides a period of recovery, rehabilitation, reablement and or assessment to determine immediate and longer term needs and or funding requirements for individuals in a local neighbourhood.

Transitional Care's main principles are 'HOME FIRST', Care Closer to Home and coordinating and managing the 'flow' of individuals across the system.
The range of integrated functions / services are designed to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. It is a function rather than a distinctive service, so will incorporate over time a wide range of different services and organisations from across Lincolnshire.

3.3.4 Patient Pathways

To support the delivery of a simplified, streamlined urgent and emergency care service a number of existing and developing patient pathways will be aligned. These will include but will not be limited to:

- Frailty
- End of Life Care
- Long Term Conditions
- Psychological Wellbeing
- Deep Vein Thrombosis (DVT)

3.3.5 Primary Care/GP Access Hubs

The GP Five Year Forward View suggests ways to transform primary care into a more sustainable and attractive field. The move toward more integrated urgent care, enabled by the proposed nationally recommended GP access hubs, will reduce demand within the urgent care system.
The model for GP access hubs will be developed through engagement with all relevant stakeholders in primary care.

3.3.6 Community Mental Health Provision

Linking to the Multi-Agency Review of Mental Health Crisis Services in Lincolnshire, the strategy will support:

- The need for the person experiencing crisis to be at the centre of the process with services working flexibly and in a joined up way.
- For out of hours services to be of the same consistency and quality as those provided during 9 to 5 hours with regard to staffing levels and range of options available
- For there to be greater clarity regarding which services do what and when so that people can access the right service at the right time when support is most needed
- To improve access to the range of options that help prevent crisis
- To embed in the clinical pathway access to those with lived experience in peer support roles at times of urgent need
- To improve access to third sector support provision to extend the range of choice at times of urgent need.

3.3.7 Urgent Treatment Centres

Urgent Treatment Centres in the community

"Urgent Treatment Centre" will be adopted as the consistent way of describing those community-based facilities that are led by general practitioners and which provide both booked and "walk-in" urgent appointments for illnesses and injuries typically managed in General Practice.

All Urgent Treatment Centres are required to meet the new national Urgent treatment centres principles and standards. Work is underway to establish which facilities will be in the county and under what timescales they will be established

Urgent Treatment Centres at the front-door of Emergency Departments

Under national guidance Urgent Treatment Centres will be developed and co-located at the Emergency Departments within Lincolnshire. These centres will incorporate the existing Urgent Care Streaming Service and evolve to provide highly effective patient streaming to relevant specialities minimising the requirement for patients to attend the ED. By having urgent treatment centres co-located with ED's they will act as an effective filter between urgent and emergency care.

3.4 Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery

Whilst this strategy is focussed on the development of self-care/self-management and the strengthening of highly responsive urgent care services being delivered in the community, it is recognised that there is still a cohort of patients who will require the services of an Emergency Department (ED).

The Safer, Faster, Better: good practice in delivering urgent and emergency care guide identifies clear evidence regarding the damage caused by poor patient flow and crowding in Emergency Departments. This strategy will ensure effective patient flow is in place in the EDs and will be closely linked to the Lincolnshire system recovery of the constitutional four hour standard, leading to sustained achievement against the A&E quality indicators.

In line with the recommendations made by the East of England Clinical Senate in December 2017, a single A&E team will support the delivery of standardised clinical pathways and processes across the three main hospital sites, enhancing training opportunities and removing unnecessary variation.

3.4.1 Ambulatory Emergency Care (AEC)

AEC is defined as the provision of same day emergency care for patients being considered for emergency admission. The aim of AEC is to manage as many patients as possible who, in the absence of an ambulatory care facility, would need to be admitted to an inpatient ward.

All patients should be considered for AEC management as a first line unless they are clinically unstable. Patients should be streamed to AEC based on fulfilling four simple rules:

- The patient is sufficiently clinically stable to be managed in AEC
- The patient's privacy and dignity will be maintained in the AEC facility
- The patient's clinical needs can be met in the AEC facility
- The patient requires emergency intervention

As well as having a dedicated trolley area, the AEC will work closely with the UTC at the front door of the ED to ensure that patients are seen in the most appropriate area to manage their need.

4. Workforce and organisational development

A key component of the delivery of this strategy is the development of a robust workforce plan which will encompass:

- The development of a highly skilled workforce for urgent and emergency care with the ability to flex to the areas of greatest need
- The development of new roles in urgent and emergency care with (but not limited to) the following:
    - Clinical pharmacists
    - Nursing associates
    - Allied Health Professionals
- Standardisation of roles across urgent and emergency care services
- Opportunities for personal and career development are offered to make urgent and emergency care an attractive place to work.

5. Information Management and Technology (IM&T)

The Integrated Urgent Care Delivery Plan will work in parallel with the Lincolnshire STP Digital Roadmap e.g. the development of the Care Portal. The ambition of national teams (delivered by NHS Digital) is to encourage the public to think of accessing advice and guidance online is a desirable alternative to calling their GP or going to A&E. The aim is to move technological solutions from:

- running as companions to patients decisions e.g. GP online appointment bookings,
- to substituted delivery e.g. NHS 111 online triage/telemedicine solutions to ultimately having
- consumer led technology e.g. health on demand apps, Artificial Intelligence e.g. Alexa.

Whilst we are on this long-term route the Health Secretary has challenged the NHS to deliver digital services nationwide and expects every patient in England to be able to do the following online by the end of 2018:

- Access NHS 111 online;
- Access their healthcare record;
- Book a GP appointment;
- Order repeat prescriptions;
- Express their organ donation preferences;
- Express their data sharing preferences; and ·
- Access support for managing a long term condition.

These technological solutions must be put in place in order to meet national designation standards for both Urgent Treatment Centres and Clinical Assessment Services (CAS).

6. Estates

Operational efficiency workstreams in the STP are reviewing and integrating where possible the estates between all statutory providers of health and care services. Various Estates, Transformation, Technology Funds (ETTF) bids are in process this year (2018) and these will be closely linked to this strategy to support urgent care delivery. As this work develops it will be reflected in the UEC Delivery Plan.

7. Communications and Engagement

In order to facilitate comprehensive communications and engagement planning we will establish the following:

- Engage with all relevant commissioners and providers to ensure we are all working to one shared vision.
- Links to our assigned STP communication and engagement leads.
- Engage with patients, relatives and carers and staff to baseline and test the intentions of the strategy and identify areas to change.
- To re-establish an Expert Reference Group of clinicians, key stakeholders e.g. Healthwatch and service users to co-produce our key developments in the Delivery Plan.
- To participate in county-wide STP promotion events and conduct appropriate engagement with key groups (districts, county council, voluntary sector etc).
- Regularly update STP website and newsletters.
- To develop a network of stakeholders who will regularly contribute to the further development of the strategy's delivery plan.
- To develop a comprehensive public awareness campaign for urgent and emergency care.

8. Conclusion/Next Steps

The intention is that the final version of this strategy is developed into a comprehensive Integrated Urgent and Emergency Care Delivery Plan that will be a working document from April 2018. This document will inform the progress reporting to all stakeholders on how the strategy up to 2021 is being delivered. The first version of this delivery plan will encompass the critical milestones over the next three years, with detailed project planning for the financial year 2018-19.

The strategy and plan will be presented to all relevant key stakeholders (including all statutory health and care organisations commissioners and providers, patient and carer groups, county and district councils etc.). There will be particular attention given to making deeper strategic connections with groups leading the other domains of the STP. This strategy will be flexible to adapt to additional recommendations and decisions made from the wider health and care community for example future Clinical Senate reports, the Acute Services Review, the Single System Plan and any other local or national recommendations.

Impact assessments will be jointly conducted with relevant STP areas to ensure a thorough approach to how the urgent care strategy is interpreted and how it is adapted as a result of these tests. These will include but will not be limited to:

- Activity flows/capacity and interdependencies e.g. out of county provision, to downstream/upstream services
- Quality and Equality
- Workforce
- Transport
- Estates
- Finance
- Engagement
- Accessibility of services

The delivery of this strategy by 2021 will ensure high quality, patient-centred, consistent county-wide care that is delivered through a simplified and effective patient journey, ensuring both the financial and operational sustainability of urgent and emergency care in Lincolnshire.

REPORT ON URGENT CARE STREAMING SERVICE

1. Background

1.1 Context

On 9 March 2017 NHS Improvement (NHSI) and NHS England (NHSE) wrote to all trusts and CCG's detailing a number of actions to support the recovery of the A&E performance target. One of these actions was to:

> *Ensure every hospital implements a comprehensive front-door streaming model by October 2017, so that A&E departments are free to care for the most urgent patients*

Grantham District Hospital already has a GP integrated within the Accident and Emergency Department; therefore the implementation of an Urgent Care Streaming Service (UCSS) is focussed at Lincoln County Hospital (LCH) and Pilgrim Hospital, Boston (PHB).

National evidence suggested that approximately 30% of self-attendees at emergency departments have problems that can be managed effectively by primary cares. In addition, local audits indicated that between 30-40% of attendances at A&E could be managed in an alternative setting. It was agreed that 35% of attendances at LCH and 30% of attendances at PHB will be streamed away from the A&E department and seen in the primary care element of the streaming service in Lincolnshire.

The Urgent Care Streaming Service (UCSS) was developed in partnership by commissioners, United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Services NHS Trust (LCHS), with stakeholder involvement from Lincolnshire Partnership NHS Foundation Trust (LPFT), Lincolnshire County Council Adult Social Care, East Midlands Ambulance Service (EMAS) and primary care. The UCSS has been operated as an integrated service with ULHT delivering the initial streaming assessment and LCHS delivering the primary care element of the service. The service is operational between the hours of 08:00 and 23:00 365 / 366 days of the year. The service commenced in Lincolnshire on 27 September 2017 on a phased implantation, and was fully operational by 31 October 2017.

The UCSS has two key elements, the initial streaming assessment and the primary care element. The initial streaming assessment, provided by ULHT, should be carried out within 15 minutes of the patients walking into the A&E department, and should be conducted by a nurse with appropriate assessment experience and training. The primary care element of the UCSS will treat minor illness and ambulatory care, and is provided with a mixture of GPs and Advanced Nurse Practitioners provided by LCHS.

An UCSS Programme Board was set up to oversee the implementation of the service, with an operational delivery group convened to mobilise the service. This delivery group reported to the Programme Board who in turn reported progress to

the A&E Delivery Board. In addition, a Clinical Governance group has been instigated for the service. This group that meets monthly is chaired by the CCGs with representation from both sites and providers.

1.2 Urgent Care Streaming Service Performance.

The tables below demonstrate the number of attendances seen through the Urgent Care Streaming Service from the commencement of the service on 27 September 2017 to 4 March 2018. The tables highlight that the percentage of A&E attendances has not been achieved thus far with an average of 11.48% across both sites.

Table 1 – LCH and PHB combined total

	Total
Attendances	57025
Urgent Care Streaming	6544
Streaming As A % Of Attendances	11.48%
Returned To ED % Of Attendances	2.01%

Table 2 – Pilgrim Hospital Boston

	Total
Attendances	25252
Urgent Care Streaming	2370
Streaming As A % Of Attendances	9.39%
Returned To ED % Of Attendances	1.99%

Table 3 – Lincoln County Hospital

	Total
Attendances	31773
Urgent Care Streaming	4174
Streaming As A % Of Attendances	13.14%
Returned To ED % Of Attendances	2.02%

1.3 UCSS Review

The UCSS Programme Board requested that, following full implementation of the service on 31 October 2017, a comprehensive review was undertaken to evaluate the effectiveness and identify any opportunities to further develop the service. This review was led by the CCG Urgent Care Team, with input from the commissioners, providers and stakeholders. The review concentrated on the following areas:

- Quality
    - Visits from the CCG lead nurses for Quality and Safety were undertaken on both the LCH and PHB sites. The reports identified areas of good practice as well as some areas that required further development, especially with regard to the standardisation of the streaming assessment. Actions and recommendations from these

visits were fed into the review report and are being followed up in the clinical governance group.

- A clinical audit was undertaken by the LCHS Medical Lead for Urgent Care. The audit had 3 clear aims:
  - Review patients recorded as "returned to ED" to establish whether there was a justified reason for return
  - Review a random selection of patients seen in the ED to establish whether any of these cases would have been appropriate to be seen through the UCSS
  - Identify any potential changes to the streaming specification and or clinical staff skill set which would increase the % of patients that could be seen through the service.

  The audit demonstrated that further work is required regarding the acceptance of streamed patients by specialities in the hospital. This regularly constituted a return of the patient to the ED to have further diagnostics or for the patient to be seen in the department

  The audit concluded that more patients could be seen through the UCSS if the service has access to:
  - Plain radiology
  - Blood testing
  - Additional training for streaming clinical staff (minor injury / gynaecology / assessment of neonates and infants)
  - Improved direct referral pathways to specialities

- Data
  - Number of attendances through the UCSS is monitored on a daily basis and the information shared amongst health partners on the daily performance call.
  - Data was reviewed against the Key Performance Indicators to identify compliance / areas for improvement
  - Incident reporting – Throughout the 3 month review period, 11 incidents were recorded, these were discussed at the clinical governance meetings and any recommendations fed into the review.
  - Finance – cost of delivering the service
- Operational feedback
  - Monthly review group meetings were held with attendance from commissioners, providers and stakeholders. Each aspect of the service was discussed in detail with a different focus at each meeting. In addition to this, the meetings provided the group with an opportunity to identify any areas of the service that required small yet important changes to assist in the smooth running of the service.
  - Feedback from complaints / compliments. Throughout the 3 month review process, 1 concern was raised and dealt with on a local level. 0 complaints and 0 compliments
  - Feedback from primary care – communication was actively pushed out to primary care with a clear route into the review process. The review team was asked to attend the Boston practice managers meeting, and feedback from this session was captured in the review process.
- Review the service specification and make recommendations.
  - The review group revised the service specification in line with the findings from the review and made the following recommendations:

- To support the safety of the UCSS, basic observations to be recorded to generate a National Early Warning Score (NEWS) / Paediatric Early Warning Score (PEWS) score to be included as part of the streaming assessment. This has been implemented with immediate effect.
- Introduction of basic diagnostics tests to the primary care element of the UCSS
    - Including but not limited to point of care testing for bloods, x-rays, swabs and urinalysis
- Removal of the exclusion and acceptance criteria to ensure all patients are to be considered appropriate for the primary care element of the UCSS unless the streaming assessment deems otherwise

1.4 Next Steps

The UCSS review report was taken to commissioners on 9 February 2018. The recommendations were accepted, along with the decision to move to a single provider model for the UCSS. It was agreed that the initial streaming assessment be carried out by a practitioner with primary care expertise to increase the numbers accessing the service.

Both ULHT and LCHS were approached and LCHS has agreed to be the single provider for the UCSS. This has occurred at PHB, with LCHS now delivering the streaming assessment.

From 1 April, the service will move to a single provider specification with the exclusion criteria removed to allow further scope for patients to be seen through UCSS. It is recognised that the introduction of diagnostics will require additional training for staff and therefore a phased roll out of this will take place to ensure that clinical safety is paramount when delivering the UCSS.

2. Consultation

This is not a direct consultation item.

3. Conclusion

The report gives an overview of the introduction of the Urgent Care Streaming Service in Lincolnshire, and of the review process undertaken post introduction of the service.

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 Cheryl Thomson, who can be contacted on 07976 759374 cheryl.thomson@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 Lincolnshire West Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 March 2018**
Subject:	**Non-Emergency Patient Transport Service – Contract Management and Performance Update**

Summary:

Thames Ambulance Service Limited (TASL) took over as provider for the non-emergency patient transport service (NEPTS) on 1 July 2017 following a competitive tender process. Lincolnshire West Clinical Commissioning Group (LWCCG) is the lead commissioner for non-emergency patient transport services on behalf of the four Lincolnshire CCGs.

TASL is a national company with a number of contracts, and at the date that the service started in Lincolnshire had been already been delivering services in Hull, and in North and North East Lincolnshire. TASL secured a further contract for NEPTS for Northamptonshire that commenced on the same day as the Lincolnshire service and subsequently secured a further contract for Leicestershire and Rutland which commenced in October 2017.

Concerns related to the performance and delivery of each of the NEPTS contracts held by TASL have been raised by each of the lead CCGs and the issues related to delivery in Lincolnshire have been the subject of reports to and discussion at the Health Scrutiny Committee for Lincolnshire. The issues in Lincolnshire are not dissimilar to those arising in contracts held by neighbouring CCGs.

This report has been written to provide the Health Scrutiny Committee for Lincolnshire with a summary of the actions that Lincolnshire West CCG has been taking in order to seek to secure improvement by TASL. At the date of submitting this report, the latest monthly performance positon for February 2018 was not available as data is scheduled to be available to the CCG on the 15th of the month following the month to which the data relates. A supplementary report detailing the February performance position will be prepared and circulated to the Committee in advance of the meeting.

The Committee is asked to note that whilst this paper states that financial penalties have imposed on TASL in line with their Contract, the specific value of the penalties has not been included in the report as this is considered to be commercially sensitive information.

Actions Required:

The Health Scrutiny Committee is asked:

(1) To consider this report including the commentary on the current performance and delivery position and contract and other actions being taken to manage the provision of the patient transport service in Lincolnshire.

(2) To consider when and how further updates on the position are required from LWCCG.

1. Background

Lincolnshire West Clinical Commissioning Group (LWCCG) is the lead commissioner for non-emergency patient transport services on behalf of the four Lincolnshire CCGs. Thames Ambulance Service Limited (TASL) took over as provider for the non-emergency patient transport service in Lincolnshire on 1 July 2017 following a competitive tender process. TASL is a national company with a number of contracts, and had been already been delivering services in Hull, and in North and North East Lincolnshire. TASL secured a further contract for NEPTS for Northamptonshire that commenced on the same day as the Lincolnshire services and subsequently secured a further contract for Leicestershire and Rutland which commenced in October 2017.

NEPTS is a complex service. It is a service that needs to be right as the impact on patients, hospitals and community services of getting it wrong is hugely significant.

In Lincolnshire, as with other areas where TASL operate, TASL have not been delivering the level of contract performance required by their contract and have in too many instances failed to deliver an acceptable level of service to patients. TASL have also seen frequent changes to their senior and middle management teams resulting in a lack of demonstration of grip and lack consistency of instructions and operational actions. This has been further compounded by a lack of robust governance and operational systems and processes with this issue being recognised in the recently published CQC report following inspection at TASL's Grimsby, Scunthorpe and Canvey Island sites (see below).

TASL recognised these shortcomings in their attendance at the February meeting of the Committee and outlined the steps they had taken and further steps they expect to take to deliver improvements in their service.

2. LWCCG Commentary

Performance and wider service delivery associated with the Lincolnshire NEPTS contract has been unsatisfactory since the date that the contract started. In addition to significant complaints from patients and hospitals, TASL failed to meet any of their performance targets for each of the months from the date of service commencement in July 2017 to January 2018. Improvement was recorded for each key performance

target from July 2017 to August 2018, but this improvement was not maintained for September and performance for each indicator for October 2017 was worse than the September 2017 position. TASL have accepted that a contributory factor in the drop in performance from October 2017 was as a result of the start of the Leicestershire contact diverting attention from Lincolnshire.

The most recently available performance information which is up to January 2018 is attached as Appendix A to this report. As noted above, performance information for the month of February 2018 is not scheduled to be with the CGG until 15 March 2018 and a supplementary report with this information will therefore be prepared and circulated to the Committee in advance of the March Committee meeting.

Financial penalties for failure to meet key performance targets are included in the contract and have been applied by the Lincolnshire CCGs each month since service commencement to date. The maximum value of financial penalties allowable under the Contract for a failure to meet key performance targets is 2.5% of the quarterly contract value.

LWCCG has engaged significant in dialogue with TASL regarding poor performance and service delivery including establishing weekly director level meetings and escalation to the TASL parent company and investors. In Lincolnshire, the concerns over the performance of TASL have been escalated to the System Executive Team, A and E Delivery Board and Winter Task Force.

TASL performance and delivery issues were fully reported by the lead CCGs for Lincolnshire, Northamptonshire and Leicestershire to NHS England Midlands and East. NHSE in put in place an assurance process through a series of risk review meetings which included the lead CCGs, hospital representatives, members of Healthwatch, NHS Improvement and TASL. The next NHSE risk review meeting is scheduled for 16 April 2018. The NHSE risk process and contract management process in Lincolnshire are complimentary and are designed to work together to seek to secure improvement. NHSE, LWCCG and representatives from Leicestershire CCGs have held two escalation meetings with the TASL parent company and investors who have stated that they are committed to improving the service and achieving performance standards

On the back of September data being made available in Mid-October and due to increasing comment from patients, hospitals and others, on 7 November 2017, LWCCG issued to TASL a formal Contract Performance Notice (CPN) under General Condition 9 of the NHS Standard Contract. The contract management processes in the NHS Standard Contract are relatively complex but in essence the CPN gives the provider a reasonable time to restore and sustain performance and deliver to the level set out in the Contract. The process provides for added financial penalties in addition to KPI penalties, and ultimately allows termination of the Contract if the required improvements are not made.

A formal meeting to discuss the Contract Performance Notice was held with TASL on 17 November 2017 and a Remedial Action Plan (RAP) setting out improvement actions and planned completion dates together with a performance improvement trajectory was required by the CCG. The RAP was received on 24 November 2017. This was reviewed by LWCCG and suggestions were made on how it could be made more robust and targeted. A revised RAP was received on 1 December 2017 and was agreed by the CCG. The trajectory put forward by TASL and agreed by the CCG set out phased

improvement for TASL to meet the key performance standards included in the Contract for the month of March 2018 and to sustain these thereafter. The performance improvement trajectory included in the RAP and actual performance against this is attached as Appendix B to this report.

LWCCG closely monitors the achievement of the RAP milestones and improvement trajectory. The key milestones actions in the RAP are for improved call handling, capacity, journey planning and control. The action plan is too long to be attached to this report but is monitored monthly by LWCCG. The February update on achievement against the milestones in the recovery plans indicated that 10 milestones had not been achieved by the due date. TASL have also recently updated and shared their internal improvement plan which is also reviewed by LWCCG.

For the months of December 2017 and January 2018, TASL failed to achieve the level of performance improvement they had put forward in the RAP and in accordance with the process set out in the Contract, LWCCG therefore issued formal contractual Exception Notices for December and January. These Notices give TASL 20 operational days from the date of the Notice to meet the performance standard to which the Notice relates and in the absence of this achievement a penalty of up to 2.0% of the monthly contract value is retained by the CCGs. This penalty has been applied for the December failure and will be reviewed for the January failure once February performance data is available.

LWCCG has made it clear to TASL that it will consider exiting the Contract if the required improvements in the RAP are not made by the end of March. This decision will not be taken lightly and will have due regard to improvements made by TASL, the potential for them sustain performance and delivery at the required level, the impact on staff, and the disruption that would be caused by a potential change to a new provider. In making a decision to exit the contract and appoint a new provider or providers, the CCGs would need to have due regard to procurement law and guidance.

Whilst TASL still have a way to go to meet the required performance standards and provide a robust service to patients, there are signs of some steps in the right direction with unvalidated weekly performance data received for February and early March showing improvement for some performance measures. This has been supported by the recent appointment of a senior lead manager for Lincolnshire and direct support in the UK of executives from TASL's parent company. ULHT operational staff have also been complimentary of the support from TASL during the recent bad weather with TASL staff being complimented for going above and beyond their roles during this time.

Currently, it is too early to judge whether the measures put in place by TASL will achieve the required improvements by the end of March deadline set out the RAP. It should also be noted that LWCCG expects to maintain the current level of monitoring and management of the TASL contract for some time after full achievement of performance and delivery standards.

2.1. Care Quality Commission Inspection

The Care Quality Commission CQC inspects patient transport services but does not provide a rating for these services as it would do, for example, for hospital services. The (CQC) inspected TASL's sites in Grimsby, Scunthorpe and Canvey Island in September and October 2017. The CQC report for this inspection was published on the

CQC website on 20 February 2018. The main areas of concern highlighted in the report related to:

- TASL's lack of systems and processes for reporting, investigating, and learning from, incidents and safeguarding concerns;
- TASL's lack of a means for assessing, monitoring and mitigating risk;
- a lack of clear structure for reporting and escalating concerns;
- a risk that the service was not identifying and highlighting areas of concern and actions for improvement in relation to specific aspects of safety and quality.

Following the inspection and in advance of the publication of the report CQC issued a Section 29 Notice to TASL requiring TASL to make a number of immediate improvements in their system of governance and submit an action plan to the CQC detailing how and when these improvement would be made.

The CQC undertook an inspection at TASL's Lincolnshire sites on Friday, 9 March 2018. At the date of writing this report details of the findings from this inspection were not formally available although LWCCG understands from TASL that the CQC were positive about the progress being made towards the required improvements set out in the Section 29 Notice. A further update will be provided to the Committee once the findings of the inspection in Lincolnshire are confirmed.

The Lincolnshire CCG's have undertaken a number of quality assurance visits to TASL premises and hospital sites and met with crews and patients. Findings from the visits are similar to those set out in the CQC report and are being discussed with TASL through the Contract Management process.

3. Conclusion

LWCCG, as the lead commissioner for non-emergency patient transport is actively addressing the concerns with regards the quality of services being provided to Lincolnshire residents.

Contract management and escalation processes continue in place and include the use of financial penalties as well as site visits and informal meetings.

LWCCG continues to work closely with the lead commissioners in Hull, North and North East Lincolnshire, Northampton, Leicester and Rutland and NHSE in order to secure improvements.

4. Consultation

This is not a consultation item.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Operational KPI Summary
Appendix B	TASL performance against Remedial Action Plan trajectory

6. 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 Tim Fowler, Director of Commissioning and Contracting, Lincolnshire West CCG, who can be contacted on: Tel 01522 513355 xtn 5534 or by email
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Appendix A

Key performance indicators
Performance against target – July 2017 to January 2018

			Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Indicator	**Description**	**Target**	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**
KPI 1	Calls answered within 60 seconds	80%	Not reported	77%	66%	56%	42%	44%	43%
KPI 2	Journeys cancelled by provider	0.50%	2%	1%	1%	2%	0%	1%	1%
KPI 3a	Same day journeys collected within 150mins	95%	74%	84%	91%	78%	74%	68%	78%
KPI 3b	Same day journeys collected within 180mins	100%	78%	85%	93%	82%	80%	72%	83%
KPI 4a	Renal patients collected within 30 mins	95%	53%	65%	65%	52%	62%	64%	71%
KPI 4b	Non-Renal patients collected within 60 mins	95%	53%	64%	82%	66%	73%	68%	76%
KPI 4c	All patients collected within 80 mins	100%	59%	67%	85%	71%	79%	78%	85%
KPI 5	Fast track journeys collected within 60 mins	100%	85%	95%	79%	71%	52%	58%	72%
KPI 6a	Renal patients to arrive no more than 30 mins early	95%	41%	50%	53%	42%	44%	54%	56%
KPI 6b	Patients to arrive no more than 60 mins early	95%	47%	74%	74%	59%	65%	65%	68%
KPI 7	Journeys to arrive on time	85%	52%	77%	80%	68%	72%	74%	78%
KPI 8	Patients time on vehicle to be less than 60 mins	85%	60%	70%	73%	66%	69%	72%	75%

Appendix B

Performance against Remedial Action Plan Trajectory

		Dec-17		Jan-18		Feb-18		Mar-18	
Indicator	**Description**	**RAP Target**	**Actual**	**RAP Target**	**Actual**	**RAP Target**	**Actual**	**RAP Target**	**Actual**
KPI 1	Calls answered within 60 seconds	60%	43.6%	68%	43.0%	74%		80%	
KPI 2	Journeys cancelled by provider	0.50%	1.4%	0.50%	0.8%	0.50%		0.50%	
KPI 3a	Same day journeys collected within 150mins	90%	67.6%	95%	78.2%	95%		95%	
KPI 3b	Same day journeys collected within 180mins	95%	72.4%	100%	82.8%	100%		100%	
KPI 4a	Renal patients collected within 30 mins	70%	63.6%	80%	71.1%	90%		95%	
KPI 4b	Non-Renal patients collected within 60 mins	75%	67.7%	80%	76.3%	85%		95%	
KPI 4c	All patients collected within 80 mins	85%	78.3%	90%	84.8%	95%		100%	
KPI 5	Fast track journeys collected within 60 mins	90%	58.3%	100%	72.4%	100%		100%	
KPI 6a	Renal patients to arrive no more than 30 mins early	50%	54.1%	60%	55.6%	80%		95%	
KPI 6b	Patients to arrive no more than 60 mins early	75%	64.6%	80%	68.3%	85%		95%	
KPI 7	Journeys to arrive on time	80%	74.1%	82%	78.4%	84%		95%	
KPI 8	Patients time on vehicle to be less than 60 mins	75%	71.8%	80%	75.3%	85%		85%	

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:	**21 March 2018**
Subject:	**Arrangements for the Quality Accounts 2017-2018**

Summary

The Health Scrutiny Committee for Lincolnshire is invited to consider its approach to the *Quality Accounts* for 2018 and to identify its preferred option for responding to the draft *Quality Accounts*, which will be shared with the Committee, by local providers of NHS-funded services.

Actions Required:

(1) To determine which option from those set out in Section 4 of the report, the Committee would like to adopt as its approach to *Quality Accounts* for 2018.

(2) Depending on the option selected in (1) above, to indicate whether it would wish work jointly with Healthwatch Lincolnshire in relation to any of the *Quality Accounts*.

(3) Depending on the option selected in (1) above, to establish a working group for the *Quality Account* process for 2018.

1. Legal Framework for Quality Accounts

The legal framework for *Quality Accounts* became effective on 1 April 2010, and has been amended since that time to reflect changes in NHS organisational structures and to further prescribe the content of each *Quality Account*. Each significant provider of NHS-funded services is required to submit their draft *Quality Account* to*:*

- their local health overview and scrutiny committee;
- their local healthwatch organisation; and
- their relevant clinical commissioning group.

The definition of 'local' is the local authority area, in which the provider has their principal or registered office. Five providers of NHS–funded health care have their registered office in Lincolnshire. Whilst there is a requirement for local providers to submit their draft Quality Account to their local health overview and scrutiny committee, there is no obligation for such a committee to respond.

Role of the Health and Wellbeing Board

The regulations do not include a formal role for health and wellbeing boards. However, providers may share their draft *Quality Account* with their local health and wellbeing board for comments, if they wish. NHS England emphasises that any involvement of health and wellbeing boards is discretionary.

2. What is a *Quality Account*?

The content of a *Quality Account* is prescribed by regulations. In addition there are additional elements prescribed by NHS Improvement for NHS bodies. It must include:

- three or more **priorities for improvement** for the coming year;
- an account of the progress with the **priorities for improvement** in the previous year; and
- details of:

  - the types of NHS funded services provided;
  - any Care Quality Commission inspections;
  - any national clinical audits;
  - any Commissioning for Quality and Innovation (CQUIN) activities;
  - general performance and the number of complaints; and
  - mortality-indicator information.

In addition foundation trusts are required by NHS Improvement to prepare a Quality Report, which in effect must incorporate all the required elements of a *Quality Account*, together with additional requirements set by NHS Improvement.

It should be noted that statements prepared need not be limited to a response to the content of the draft *Quality Account*, but could in addition reflect the views of the Committee on the quality of services provided during the course of the year by the provider.

No Financial Content

The term *Quality Account* has been used by the Department of Health since 2010 and has caused some confusion. For the purposes of clarity, a *Quality Account* does not focus on finances, but represents an account of the quality (as opposed to an account of the finances) of a particular organisation. Overall financial information on a particular trust is found in their annual report.

3. What Should a Statement on a *Quality Account* Cover?

The Department of Health has previously issued guidance to bodies making statement on *Quality Accounts,* which encourages these organisations to focus on the following questions: -

- Do the priorities included in the *Quality Account* reflect the priorities of the local population?
- Have any major issues been omitted from the *Quality Account?*
- Has the provider demonstrated that they have involved patients and the public in the production of the *Quality Account*?
- Is the *Quality Account* clearly presented for patients and the public?
- Are there any comments on specific local issues, which the Health Scrutiny Committee have been involved with?

The Health Scrutiny Committee is entitled to make a statement (up to 1,000 words) on the draft *Quality Account*, which has to be included in the final published version of the *Quality Account.*

4. Previous *Quality Account* Arrangements 2010 - 2017

Quality Accounts were first introduced in 2010, and over the last eight years the Health Scrutiny Committee has made statements on the *Quality Accounts* of some or all of the following providers of NHS-funded services:

- Boston West Hospital (Ramsay Healthcare)
- East Midlands Ambulance Service NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- North West Anglia NHS Foundation Trust (formerly known as Peterborough and Stamford Hospitals NHS Foundation Trust)
- United Lincolnshire Hospitals NHS Trust
- St Barnabas Hospice

Many of the above statements have been jointly compiled with Healthwatch Lincolnshire.

4. Options for Handling *Quality Accounts* in 2018

There are several options for the consideration of *Quality Accounts* for 2018, which are set out below:

<u>Option 1 - Lincolnshire Based Providers of NHS-Funded Services</u>

- Boston West Hospital (Ramsay Healthcare)
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- St Barnabas Hospice
- United Lincolnshire Hospitals NHS Trust

Option 1A – Lincolnshire Based Providers of NHS-Funded Services plus EMAS

- Boston West Hospital (Ramsay Healthcare)
- East Midlands Ambulance Service NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- St Barnabas Hospice
- United Lincolnshire Hospitals NHS Trust

Option 2 – Lincolnshire Based NHS Providers

- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust

Option 2A – Lincolnshire Based NHS Providers plus EMAS

- East Midlands Ambulance Service NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust

Option 3 – Providers with Significant Quality Challenges
(Rated as 'Inadequate' by Care Quality Commission)

- United Lincolnshire Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust

Option 3A – Providers with Quality Challenges
(Rated as 'Inadequate' or 'Requires Improvement' by Care Quality Commission)

- East Midlands Ambulance Service NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust

Option 4 – Significant Providers of NHS-Funded Services to Lincolnshire Residents

- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- East Midlands Ambulance Service NHS Trust
- North West Anglia NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust

Option 5 – All Local Providers
(Providers where the Health Scrutiny Committee has had previous *Quality Account* involvement)

- Boston West Hospital (Ramsay Healthcare)
- East Midlands Ambulance Service NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- North West Anglia NHS Foundation Trust (formerly known as Peterborough and Stamford Hospitals NHS Foundation Trust)
- United Lincolnshire Hospitals NHS Trust
- St Barnabas Hospice

Option 6

No participation in the Quality Account process.

The Health Scrutiny Committee is requested to consider which option it would like to adopt.

6. Working with Healthwatch

The Health Scrutiny Committee for Lincolnshire has worked jointly with Healthwatch Lincolnshire for the last three years. Healthwatch Lincolnshire has indicated that it has decided to set up a Quality Account Task and Finish Group to work on the *Quality Accounts*. Healthwatch has indicated that it responds to the *Quality Accounts* of 'out of county' trusts via other local Healthwatch organisations and Healthwatch Lincolnshire works across the East Midlands on EMAS.

Healthwatch Lincolnshire has indicated that that it is not against working jointly with Health Scrutiny Committee, but is aware of the logistics of setting up joint working group meetings.

7. Working Group Arrangements

If the Committee were to adopt a working group arrangement, it is requested that the Committee indicate whether it they would wish to volunteer for this activity. This would involve meeting three or four times in total during April, May and early June.

8. Conclusion

The Committee is invited to make arrangements for the *Quality Account* process for 2017-18.

9. Consultation

This is not a consultation item. However, as part of the annual *Quality Account* process, the Health Scrutiny Committee for Lincolnshire is entitled to make a

statement up to 1,000 words on the content of each local provider's draft *Quality Account*. This process is detailed throughout this report.

11. **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

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:	**21 March 2018**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary:

This item enables the Committee to consider and comment on the content of its work programme, which is reviewed at each meeting of the Committee so that its content is relevant and will add value to the work of the Council and its partners in the NHS. Members are encouraged to highlight items that could be included for consideration in the work programme.

Actions Required:

(1) To review, consider and comment on the work programme set out in the report; and

(2) To highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

1. Work Programme

Planned items for the Health Scrutiny Committee for Lincolnshire are set out below:

21 March 2018 – 10 am	
Item	*Contributor*
Lincolnshire Sustainability and Transformation Partnership Update – Operational Efficiency	Andrew Morgan, Chief Executive, Lincolnshire Community Health Services NHS Trust Darren Steel, Portfolio Director (Operational Efficiency)
Lincolnshire Urgent and Emergency Care	Sam Milbank, Accountable Officer, Lincolnshire East CCG Ruth Cumbers, Urgent Care Programme Director, Lincolnshire East CCG
Non-Emergency Patient Transport Service – Contract Management and Performance Update	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West CCG Tim Fowler, Director of Commissioning and Contracting, Lincolnshire West CCG
East Midlands Ambulance Service NHS Trust Update	Richard Henderson, Chief Executive, East Midlands Ambulance Services NHS Trust
Arrangements for the Quality Accounts 2018-19	Simon Evans, Health Scrutiny Officer

18 April 2018 – 10 am	
Item	*Contributor*
Lincolnshire Sustainability and Transformation Partnership: Priority – Neighbourhood Teams	Contributors to be confirmed
Lincolnshire Sustainability and Transformation Partnership: Priority – GP Forward View	Contributors to be confirmed
Non-Emergency Patient Transport	Mike Casey, Interim Manager, Thames Ambulance Service
United Lincolnshire Hospitals NHS Trust Update (Item to be confirmed.)	To be confirmed.

16 May 2018 – 10 am	
Item	*Contributor*
Lincolnshire Sustainability and Transformation Partnership – Update (including Acute Services Review)	John Turner, Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership Sarah Furley, Programme Director, Lincolnshire Sustainability and Transformation Partnership
Lincoln Area – Urgent Care Provision at GPs (Replacement Provision for Walk-in Centre)	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West CCG
Annual Report of the Director of Public Health	Tony McGinty, Consultant in Public Health, Lincolnshire County Council
Winter Planning: Review of 2017-18 and Initial Plans for 2018-19	Sam Milbank, Accountable Officer, Lincolnshire East CCG

13 June 2018 – 10 am	
Item	*Contributor*
Specialised Commissioning	Contributors to be confirmed.

11 July 2018 – 10 am	
Item	*Contributor*
Lincolnshire Sustainability and Transformation Partnership – Update	John Turner, Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership Sarah Furley, Programme Director, Lincolnshire Sustainability and Transformation Partnership
Non-Emergency Patient Transport	Mike Casey, Interim Manager, Thames Ambulance Service

Items to be Programmed

- Cancer Care
- Lincolnshire East Clinical Commissioning Group Update
- Lincolnshire West Clinical Commissioning Group Update
- South Lincolnshire Clinical Commissioning Group Update
- South West Lincolnshire Clinical Commissioning Group Update
- Commissioning of Continuing Health Care
- Adult Immunisations
- Developer and Planning Contributions for NHS Provision (This could be included as part of each CCG Update)
- Dental Services

Other Items to be Programmed – No earlier than September 2018

- Lincolnshire Sustainability and Transformation Plan Consultation Elements:
  - Women's and Children's Services
  - Emergency and Urgent Care
  - Stroke Services
- North West Anglia NHS Foundation Trust Update
- Lincolnshire Sustainability and Transformation Partnership: Mental Health Priority
- Joint Health and Wellbeing Strategy Update

2. Conclusion

The Committee's work programme for the coming year is set out above. The Committee is invited to review, consider and comment on the work programme and highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

3. Background Papers

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

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk