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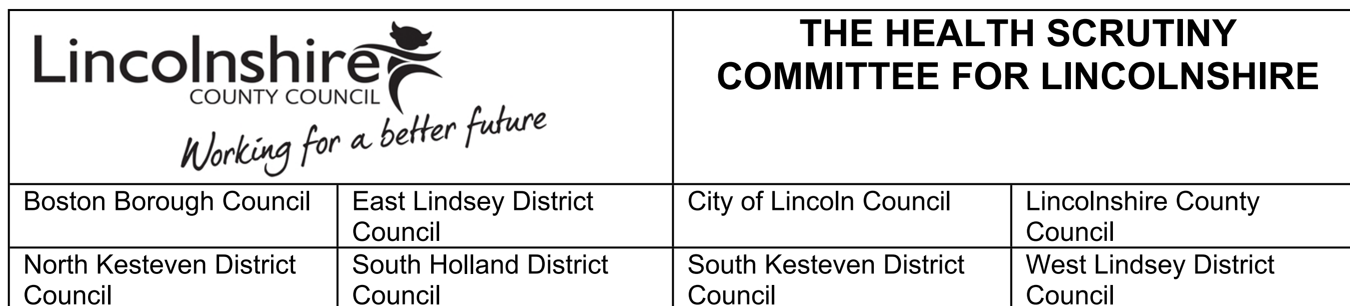

THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

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Lincolnshire County Council
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Newland
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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 18 April 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 H Trollope-Bellew, M A Whittington and R A Renshaw

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
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interests**	
3	**Minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 21 March 2018**	3 - 16
4	**Chairman's Announcements**	17 - 26
5	**United Lincolnshire Hospitals NHS Trust - Financial Special Measures Update** *(To receive a report on behalf of United Lincolnshire Hospitals NHS Trust, which provides the Committee with an update on Financial Special Measures)*	27 - 42

Item	Title	Pages
6	**Lincolnshire Sustainability and Transformation Partnership - GP Forward View Update** *(To receive a report from the Lincolnshire Sustainability and Transformation Partnership, which provides the Committee with information on the development of the GP Forward View as part of the Lincolnshire Sustainability and Transformation Partnership)*	43 - 48
7	**Integrated Neighbourhood Working** *(To receive a report from the Lincolnshire Sustainability and Transformation Partnership, which updates the Committee on the progress that has been made in the collaborative design and implementation of Integrated Neighbourhood Working)*	49 - 62
LUNCH 1.00PM - 2.00PM		
8	**Non- Emergency Patient Transport - Report from TASL** *(To receive a report from Mike Casey (Interim General Manager, Thames Ambulance Service Ltd (TASL)), which provides the Committee with the most recent performance activity relating to TASL)*	To Follow
9	**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)*	63 - 66

Richard Wills
Head of Paid Service
10 April 2018

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
21 MARCH 2018

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors Mrs K Cook, M T Fido, R J Kendrick, Dr M E Thompson, M A Whittington and R A Renshaw.

Lincolnshire District Councils

Councillors P Gleeson (Boston Borough 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 W Gray (East Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Robin Bellamy (Wellbeing Commissioning Manager), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Tracy Pilcher (Chief Nurse, Lincolnshire East CCG), Ruth Cumbers (Urgent Care Programme Director, Lincolnshire East CCG), Tim Fowler (Director of Commissioning and Contracting, Lincolnshire West CCG), Samantha Milbank (Accountable Officer, Lincolnshire East CCG), Sarah-Jane Mills (Chief Operating Officer, Lincolnshire West CCG), Andrew Morgan (Chief Executive, Lincolnshire Community Health Services NHS Trust), Richard Henderson (Chief Executive, East Midlands Ambulance Service), Mark Brassington (Chief Operating Officer, United Lincolnshire Hospitals NHS Trust), Ben Holdaway (Director of Operations, East Midlands Ambulance Service NHS Trust), Kerryn Marriott (Clinical Commissioning Group Prescribing Programme Lead), Mike Naylor (Director of Finance, East Midlands Ambulance Service NHS Trust) and Darren Steel (Portfolio Director (Operational Efficiency), STP System Delivery Unit).

72 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors R H Trollope-Bellew, Mrs P F Watson (East Lindsey District Council) and P Howitt-Cowan (West Lindsey District Council).

It was noted that Councillor William Gray (East Lindsey District Council) had attended the meeting on behalf of Councillor Mrs P F Watson (East Lindsey District Council) for this meeting only.

An apology for absence was also received from Councillor Mrs S Woolley, Executive Councillor for NHS Liaison and Community Engagement.

73 DECLARATIONS OF MEMBERS' INTERESTS

Councillor Mrs K Cook advised the Committee that in respect of agenda item 4, she was a Lincolnshire Partnership NHS Foundation Trust Governor; and a Lincolnshire NHS Foundation Trust service user.

74 MINUTES OF THE MEETING OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE HELD ON 21 FEBRUARY 2018

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 21 February 2018 be agreed and signed by the Chairman as a correct record.

75 CHAIRMAN'S ANNOUNCEMENTS

The Chairman brought to the Committee's attention the Supplementary Announcements that had been tabled at the meeting. The Chairman highlighted to the Committee two of the supplementary announcements. These were that on the 20 March 2018, the University of Nottingham had announced the establishment of a new University of Nottingham Lincolnshire Medical School. It was noted that students would be studying for a University of Nottingham medical degree at the University of Lincoln site. The second item highlighted was that TASL was holding a Voluntary Car Driver Open Forum Workshop on Tuesday 3 April at 5.30pm at the TASL Headquarters in Lincoln and that members of the Committee were invited to attend the said workshop.

RESOLVED

That the Chairman's Announcements presented as part of the agenda on pages 17 to 20; and the Supplementary Chairman's Announcements tabled at the meeting be received.

76 LINCOLNSHIRE SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP UPDATE - OPERATIONAL EFFICIENCY

The Chairman welcomed to the meeting Andrew Morgan, Chief Executive, Lincolnshire Community Health Services NHS Trust, Darren Steel, Portfolio Director (Operational Efficiency), STP System Delivery Unit and Kerryn Marriott, CCG Prescribing Programme Lead.

The report provided information on the operational efficiency aspects of the Lincolnshire Sustainability and Transformation Partnership (STP). The report also provided details of the main efficiency schemes undertaken on a system-wide basis as well as reference to those managed individually within organisations.

The Committee was advised that the system approach to the efficiency agenda was focussed around areas developed in the original STP and variations highlighted in the Carter Report and the NHS RightCare initiative. Details relating to the Carter Efficiency Schemes were detailed on pages 25 to 27 of the report; and information relating to a number of schemes that had been implemented to address variations in prescribing costs and implement the efficient management of drugs alongside a number of other prescribing initiatives was shown on pages 27/28.

It was highlighted that the 2018/19 priorities currently under development were:-

- A focus on shared service of back-office functions;
- Temporary workforce solutions;
- Countywide prescribing initiatives;
- Estates rationalisation; and
- Pharmacy and prescribing.

In conclusion, the Committee was advised that the more collective approach for 2018/19 should lead to better system management across Lincolnshire NHS, collective performance monitoring and clearer reporting of system savings. It was highlighted that the system efficiency target remained challenging and that further work was required to continue to develop and implement new specific schemes.

During discussion, the Committee raised the following issues:-

- Efficiency savings – The report presented advised that the original five year STP had outlined an operational efficiency requirement for the Lincolnshire NHS of just over £60m by 2020/21. The Committee was advised that the Operational Efficiency strand was just one element of the STP. Other elements of the STP included clinical service redesign. There was an aim that the Lincolnshire health system would be in financial balance by 2021;
- The impact of patients going out of county for treatment – It was noted that patients were entitled to exercise choice and for many patients an out of county provider would be their nearest provider; CCGs would aim for the best outcomes for patients within the money available to them;
- The importance of ensuring that individuals get registered with a GP as resources followed registration;
- Consultation – Some concern was expressed as to the lack of formal consultation been undertaken to date in respect of the STP. The Committee was reassured that consultation was not being bypassed, but that operational efficiencies were things that the NHS was getting on with day to day, as any other organisations would do with internal efficiencies. In respect of any proposals for Clinical Services redesign, these would be subject to public consultation once finalised;

- Shared low level procurement – Confirmation was given that there was already collaboration between the three provider trusts; which would see a reduction in management fees;
- Some members welcomed the work being done to improve the prescribing and the management of drugs;
- A question was asked as to when the three provider trusts would become one? The Committee was advised that there was no plan for this, as at the moment the three trusts were concentrating on what was required to deliver the integrated services and looking in to the financial situation;
- Lincolnshire CCG structure – Some members of the Committee had learned that the Lincolnshire CCGs were currently in the process of developing a single management structure across the four organisations;
- Hospital medicines optimisation – It was noted that United Lincolnshire Hospitals NHS Trust was looking at how to best manage medicines as part of its own plans, as part of the Pharmacy transformation programme; and
- Workforce efficiencies – The Committee was advised that a lot of work was going on to reduce reliance on temporary staff. One member requested information as to how many non-clinical managers were paid in access of £50,000. The Committee was advised by representatives that this information was not available.

The Committee agreed that going forward there needed to be an update on the STP as more information became available. The Committee agreed to the establishment of a small working group to meet for a maximum of three meetings to receive updates as and when developments occurred.

RESOLVED

1. That the report on the progress on delivering the operational efficiency aspects of the Lincolnshire STP be received.

2. That a small working group be established comprising of Councillors C J T H Brewis J Kirk, C S Macey and M A Whittington to consider updates relating to the operational efficiency aspects of the Lincolnshire STP as they become available.

77 LINCOLNSHIRE URGENT AND EMERGENCY CARE

The Chairman welcomed to the meeting Samantha Milbank, Accountable Officer, Lincolnshire East CCG, Ruth Cumbers, Urgent Care Programme Director, Lincolnshire East CCG and Mark Brassington, Chief Operating Officer, United Lincolnshire Hospitals NHS Trust.

The Chairman advised that at the previous meeting he had announced that he would be seeking to explore the future options for emergency care in Lincolnshire, which would provide information on how the A & E Consultation options were being developed, particularly in relation to Grantham A & E.

Page 42 of the agenda identified that Grantham A & E was out of scope of the Urgent and Emergency Care Strategy 2018-2021. The Chairman requested the presenters as part of their introduction to explain the relationship between Urgent and Emergency Care Strategy 2018-2021 and the emergency care consultation elements of the STP.

The Committee was advised that there was no nationally accepted definition for 'urgent care' and 'emergency care'. It was highlighted that the Lincolnshire Urgent and Emergency Care Strategy 2018-2021 used 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; and
- Emergency Care – immediate or life threatening conditions, serious injuries or illnesses.

It was highlighted further that the Lincolnshire Urgent and Emergency Care Strategy 2018-2021 (a copy of which was attached at Appendix A to the report) was a system approach to the development of urgent and emergency care across Lincolnshire. It was noted that the strategy incorporated national expectations and requirements; and was also aligned to the Lincolnshire Sustainability and Transformation Plan. The top of page 42 of the report provided details of the service areas that fell under the definitions mentioned above; including those services in scope; and those urgent and emergency care services that were not in scope.

Appendix B to the report provided the Committee with a report on the urgent care streaming service. The Committee was advised of the urgent and emergency care system in Lincolnshire and a broad overview of current care service delivery, which was shown on pages 45/46 of the report presented.

It was confirmed that Grantham A & E was outside of the scope of the strategy; and that significant work was being undertaken to design the substantive urgent and emergency care services that would be offered from the site. The work being carried out was taking on board the East of England Clinical Senate report; and was being managed in line with the pre-consultation Business Case being produced by the STP operational delivery unit.

Reassurance was given that where proposals for major reconfiguration of services were developed; they would be subject to full public consultation, including the involvement of the Health Scrutiny Committee for Lincolnshire.

During discussion, the Committee raised the following issues:-

- One member expressed concerns relating to the fact that the report did not provide any clarity concerning Grantham A & E. The Committee was advised that the purpose of the strategy was to ensure that a fair and equitable service was provided across the county to respond to the appropriate need. The representatives present understood the frustrations expressed by some of the Committee; and advised that the outcome of the Acute Services Review was not due to be completed until May 2018;

- The national requirement for 50% of all NHS 111 calls to result in a patient being passed across to a clinician for advice and guidance. It was noted that this target was already being exceeded in Lincolnshire. Reference was also made to the EMAS 'See and Treat Assessments';
- Table 1 on page 34 – One member requested that the number of people who had attended A & E should have been included within the figures, as this would have demonstrated the increased demands on A & E over the three year period. The Committee was advised that the figures for Lincolnshire did not demonstrate any trends; and that Lincolnshire's growth in A & E attendances was in-line with the national position;
- One member enquired as to what was the definition of a Neighbourhood Team; and when was the consultation likely to be carried out in respect of Neighbourhood Teams. The Committee was advised that Integrated Neighbourhood Working would provide care to a defined registered population of between 30,000 and 50,000. It was highlighted that there was a government mandate in respect of consultation. It was reported that at the moment work was ongoing looking at the level of demand required; and then consultation would be done relating to the level of need. It was highlighted that the NHS could not go out for consultation on a matter that was mandatory for them to do. The Committee was advised that an item concerning Neighbourhood Teams was due to be considered at the 18 April 2018 meeting;
- Urgent Treatment Centres – The Committee was advised that under national guidance Urgent Treatment Centres should be developed and co-located at existing Emergency Departments within Lincolnshire. Their purpose was to provide highly effective patient streaming to relevant specialities minimising the requirement for patients to attend Emergency Departments. It was highlighted that work was underway to establish what facilities would be available in the county. It was noted that these would be located in convenient locations, with no-one having to travel more than 20 miles to their nearest Urgent Treatment Centre. Confirmation was given that the 20 mile limit was a national standard;
- Estates – The report highlighted that operational efficiency work streams in the STP were reviewing and integrating where possible the estates between all the statutory providers. Some concern was expressed that if the bids mentioned in Appendix A, Paragraph 6 were unsuccessful, if there was an alternative plan in place. The Committee was advised that realistically not all the bids put in would be successful, but some would be successful. It was highlighted that without the money, the NHS would be unable to comply to the necessary requirements;
- Public perception – The need to ensure that the public were kept well up to date with any changes;
- Staffing of streaming facilities – It was reported that work was being done looking at new models of care; an example given was GP practices working together. Confirmation was given that there was a need for GP Practices to be better equipped to meet the needs;
- The reluctance of ringing 111, when needing an appointment with a GP on the same day;

- The temporary cessation of elective paediatric inpatient activity at Boston hospital. The Committee was advised that this had been done as a system approach to ensure the safety of patients. It was highlighted that this was not a permanent change; it was just a realignment of services to help A & E. The Committee was advised that with the Medical School in Lincoln it was hoped that Lincolnshire would be able to 'grow its own staff more';
- Confirmation was given that there was still a debate ongoing as to whether Louth and Skegness would become Urgent Treatment Centres or become Primary Care Hubs. It was noted that at the moment there was no definite answer. The Committee was advised that there was an Urgent Care Meeting planned for 21 March, and that any outcomes from the meeting would be passed on to the Chairman to share with members of the Committee; and
- One member expressed concern regarding the cost of the implementing the Strategy; and to the financial risks associated if the system should fail.

RESOLVED

1. That the Lincolnshire Urgent and Emergency Care Strategy 2018 - 2021 attached at Appendix A to the report be received.

2. That the Urgent Care Streaming Service attached at Appendix B to the report in the context of the Lincolnshire Urgent and Emergency Care Strategy 2018 – 2021 be received.

3. That regular updates be received by the Health Scrutiny Committee for Lincolnshire.

Note: Councillors M A Whittington, Mrs R Kaberry-Brown (South Kesteven District Council) and P Gleeson (Boston Borough Council) wished it to be recorded that they had abstained from voting in respect of this item.

78 NON-EMERGENCY PATIENT TRANSPORT SERVICE - CONTRACT MANAGEMENT AND PERFORMANCE UPDATE

Pursuant to Minute number (62) from the 17 January 2018 meeting, the Committee gave consideration to a report from the Lincolnshire West Clinical Commissioning Group, (LWCCG), which provided a summary of the actions taken by Lincolnshire West CCG to seek to secure improvement by Thames Ambulance Service Ltd (TASL).

The Chairman welcomed to the meeting Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West CCG and Tim Fowler, Director of Commissioning and Contracting, Lincolnshire West CCG.

The Committee was advised that hard copies of the Supplementary Report from Lincolnshire West CCG circulated by email during the previous day relating to the February 2018 performance position had been circulated at the meeting for their consideration.

In guiding the Committee through the report the Director of Commissioning and Contracting extended his thanks to staff from TASL for ensuring that a service was provided during the snowy conditions.

The report provided a step by step commentary from LWCCG. Since the December 2017 meeting, at which the Health Scrutiny Committee for Lincolnshire had expressed a vote of no confidence, it was reported that for the months of December 2017 and January 2018, TASL had failed to achieve the level of performance improvement they had put forward in their Remedial Action Plan (RAP). In accordance with the process set out in the Contract, LWCCG had issued formal contractual Exception Notices for December 2017 and January 2018. These Notices gave TASL 20 operational days from the date of the Notice to meet the performance standard to which the Notice related; and in the absence of the achievement, a penalty of up to 2.0% of the monthly contract value could be retained by the CCG. The Committee was advised that this penalty had been applied for the December failure and would be reviewed for the January failure once the February performance data was available.

It was highlighted that the LWCCG had advised TASL that it would consider exiting the Contract if the required improvements in the RAP were not reached by the end of March. The Committee was advised that this decision would not be taken lightly by LWCCG, due to the disruption caused by a potential change in provider.

The Committee was advised that although TASL still had a long way to go to meet the required standards, they were heading in the right direction with invalidated weekly performance data for February and March showing some improvement.

The Supplementary Report provided the latest performance information up to February 2018. Details relating to performance were shown on page 2 of the Supplementary Report.

The LWCCG welcomed the reported achievement of the recovery trajectory for 2 KPIs; and the month on month improvement in all KPIs for February 2018. The Committee was also advised that LWCCG was pleased to note the significant improvement in reported performance for call answering.

The Committee was advised further of the Care Quality Commission Inspection (CQC) of TASL sites in Grimsby, Scunthorpe and Canvey Island in September /October 2017. The main areas of concern highlighted related to: lack of systems and processes for reporting; lack of a means for assessing, monitoring and mitigating risk; lack of a clear reporting structure for concerns and actions for improvement in relation to specific aspects of safety and quality. The Committee was advised that the CQC had undertaken an inspection of TASL's Lincolnshire sites on 9 March 2018, and as yet no details were known.

In conclusion, the LWCCG identified that challenges still remained; and that the improvements reported in February were a step in the right direction. The Committee was advised that the LWCCG would review the March performance information before considering what further action should be taken.

Attached at Appendix A to the report was a copy of the Operational KPI Summary; and Appendix B provided information concerning TASL's performance against the Remedial Action Plan trajectory.

During discussion, the Committee raised the following issues:-

- Some members acknowledged the improved performance; and the LWCCG optimism; but some concerns were expressed as to whether enough improvement would be made by the end of March 2018;
- Some concern was expressed to the difficulty of finding another provider if the need arose; and whether a more realistic date should be set as to when TASL would be able to achieve the required performance. LWCGG agreed that finding another provider would be a challenge and confirmed that in relation to performance, March was a key date. It was hoped that the new TASL management structure and the support TASL was receiving from the parent company would be instrumental in helping improve TASLs overall performance;
- Penalties – The Committee was advised that within the Contract there were a number of elements of service where the KPI had to be achieved, which were expressed as a %; and were measured on a monthly basis. Where a KPI was not achieved an automatic penalty was applied. It was noted that the maximum penalty was 2.5%. Also, if the recovery plan milestone was not met a further fixed penalty of 2% would be applied;
- One member highlighted that the data did not identify the number of trips completed. The Committee was advised that since the start of the contract activity had been down by 15 – 20%;
- A question was asked as to whether hospitals were being reimbursed when alternative transport had been arranged. It was highlighted that TASL could be charged; however there was still discussion to be had concerning reimbursement;
- Use of Volunteers – The Committee was advised that it was up to the provider as to whether they used volunteers or not. The LWCCG could not advise TASL what to do. It was however noted that TASL was now aware that the use of volunteers was a key part of the service;
- The need for improved journey planning – The Committee was advised that this was an area LWCCG was working with TASL on;
- Letting of the Contract – The Committee was advised that the contract had been let based on the information presented, not on what was projected in the media; and
- One member asked whether liquidated damages were included within the Contract. The Committee was advised that this was a standard feature in NHS Contracts.

RESOLVED

1. That ongoing monthly reports be received by the Chairman of the Health Scrutiny Committee for Lincolnshire and the Health Scrutiny Officer; and

that monthly updates be received by the Committee as part of the Chairman's Announcements.

2. That performance reports concerning the Non-Emergency Patient Transport Service – Contract Management from the LWCCG be received by the Committee on a quarterly basis.

The Committee adjourned at 1.05pm and re-convened at 2.00pm.

Additional apologies for absence for the afternoon part of the meeting were received from Councillors Mrs K Cook, M T Fido and Dr B Wookey (Healthwatch).

79 EAST MIDLANDS AMBULANCE SERVICE NHS TRUST UPDATE

The Committee gave consideration to a report from the East Midlands Ambulance Service NHS Trust, which provided information from the East Midlands Ambulance Service on:-

- Response time information by Clinical Commissioning Group area, in accordance with the new Ambulance Response Programme standards;
- Handover delays at hospitals;
- The role of Lincolnshire Integrated Voluntary Emergency Services (LIVES);
- The Ambulance Response programme and its impact on staff rotas and the types of vehicles; and
- The new Urgent Care Tier (from 1 April 2018).

The Chairman welcomed to the meeting Richard Henderson, Chief Executive, East Midlands Ambulance Service NHS Trust, Ben Holdaway, Director of Operations, East Midlands Ambulance Service NHS Trust, and Mike Naylor, Director of Finance, East Midlands Ambulance Service NHS Trust.

Appendix A to the report provided the Committee with NHS England Ambulance Response Programme Standards.

The Chief Executive, East Midlands Ambulance Service Trust introduced the report and responded to questions raised, which included the following issues:-

- Ambulance drift from areas such as Skegness to out of county, how this still impacted on ambulance cover. The Committee was advised that all efforts were made to hand over patients in a timely manner; at A & E departments, but at times crews were delayed; and that if an ambulance crew was drawn away from its area, another crew would be moved closer to the area to respond to any emergencies;
- One member felt that there needed to be dedicated ambulance provision along the coastal strip during the summer. It was reported that the summer months did put pressure on the service; and that to accommodate demand the service worked differently with its partners. The Committee was advised that there was a specific summer plan and that additional resources for that period

had already been booked. One member felt that it would be useful for the Committee to have sight of the summer plan;

- Confirmation was given that EMAS worked alongside LIVES and the Fire and Rescue Service;
- Handover Delays – It was reported that Lincolnshire had some of the highest handover delays in the EMAS region. A table on page five of the report provided the Committee with a breakdown of handover times, Both Lincoln County and Boston Pilgrim's figures were highlighted as having the highest number of handover delays. The Committee was advised that the correct figures for Lincoln County should read 300 for 1hr+ losses; and 985 for Total Hrs Lost. The Committee was advised further that EMAS was working with United Lincolnshire Hospitals NHS Trust (ULHT) to improve the position. It was highlighted that the handover delays were putting significant pressure on EMAS to respond to patients in the community, which then in turn had an impact on response times. It was reported that the handover delays were as a result of the non-availability of consultants and nurses. It was also highlighted that the handover delays were not just a problem for Lincolnshire, it was a national issue as well;
- Confirmation was given that the Emergency Ambulance Cost Adjustment was still applied to ambulance finances;
- Urgent Care Tier – The Committee was advised that on 2 April 2018 EMAS was introducing an Urgent Care Tier. This tier of transport would be predominantly allocated to jobs that had been requested by a Health Care professional who had requested transport, for one of their patients to go to hospital. The main purpose of the tier was to reduce some of the long delays for patients that fell into this category often experienced;
- Consideration of the New Ambulance Response Time Standards as detailed at Appendix A;
- Ambulance Response Programme – It was reported that on 13 July 2017, NHS England had announced that all English Ambulance Trusts would move to a new way of working, using a revised clinical code. It was noted that EMAS had migrated to the ARP pilot on the 19 July 2017;
- Double-Crewed Ambulances – A question was asked as to how much the new model was costing. The Committee was advised that the new model would rely upon more Double Crewed Ambulances and less on Fast Response Vehicles. A table on page 7 provided details relating to the current and proposed figures relating to Double Crewed Ambulances and Fast Response Vehicles. The Committee was advised that the new rotas did not include any additional staff, as EMAS was re-profiling its staff in a different way to best meet the Ambulance Response Programme. It was highlighted that the on cost for a double crewed ambulance was approximately £70.00 an hour;
- EMAS recording system – The Committee was advised that EMAS had a new data recording system, which was working very well; and
- EMAS confirmed that they were involved with eight STP Plans; and that they would be making sure that they were aware of any local changes.

The Committee welcomed the report and agreed to accept quarterly progress updates from EMAS going forward.

RESOLVED

1. That the East Midlands Ambulance Service NHS Trust – Update Report be received.

2. That a progress report from EMAS be received by the Health Scrutiny Committee for Lincolnshire on a quarterly basis.

80 ARRANGEMENTS FOR THE QUALITY ACCOUNTS 2017-2018

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which invited 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 would be shared with the Committee, by local providers of NHS-funded services.

Pages 69 and 70 of the report outlined the Options for Handling Quality Accounts in 2018 to be considered. The Committee agreed that Option 2a should be taken forward for this year only. Option 2a comprised of the following:-

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

The Committee agreed to a working group arrangement. The following members volunteered to be part of the working group: Councillors C J T H Brewis, R J Kendrick, J Kirk, P Gleeson, C S Macey and M A Whittington.

The Committee also agreed to working with Healthwatch Linolnshire.

The Health Scrutiny Officer agreed to make arrangements for the said working group meetings.

RESOLVED

1. That Option 2 A from Section 4 of the report presented be adopted as the Committee's approach to Quality accounts for 2018.

2. That the Committee indicated that it would be pleased to work with Healthwatch Lincolnshire in relation to any of the Quality Accounts.

3. That the Committee agreed to the establishment of a working group for the Quality Account process for 2018 and that the membership of the said working group be comprised of the following Councillors C J T H Brewis, R J Kendrick, J Kirk, P Gleeson, C S Macey and M A Whittington.

81 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 focussed where it would be of greatest benefit.

Detailed within the report were populated work programmes up to 11 July 2018. On page 76 was a list of items to be programmed. The Health Scrutiny Officer advised that confirmation had not been received from ULHT that they would be attending the 18 April 2018 meeting.

The Committee was advised that the Developer and Planning Contribution for NHS Provision item had been put forward for consideration by the Overview and Scrutiny Management Board as a potential scrutiny review item.

Items put forward from the Committee included the following:-

- Dental Services;
- CCG Updates;
- Staff Survey results; and
- Prostate Cancer.

RESOLVED

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

The meeting closed at 3.25 am

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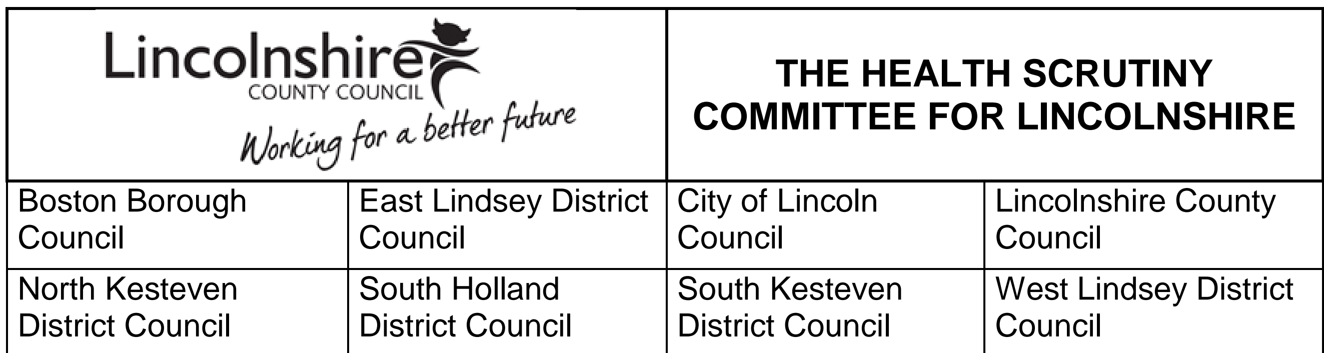

Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 April 2017**
Subject:	**Chairman's Announcements**

1. Grantham and District Hospital – Lincolnshire Acute Services Review

Members of the Committee have received an email from several members of the public on proposals for removing 'orthopaedic trauma' from Grantham Hospital. I have replied to this email and copied my reply to members of the Committee.

I would like to stress that United Lincolnshire Hospitals NHS Trust has stated that no changes to orthopaedic trauma have taken place at Grantham Hospital, or are planned in the immediate future. As stated in my letter, I believe there have been discussions on this topic as part of the Lincolnshire Acute Services Review. However, the Acute Services Review is a very early stage in the process of developing a formal proposal. The Acute Services Review is also subject to approval by NHS England, and following any approval by NHS England, a pre-consultation business case has to be prepared, again for submission to and approval by NHS England. All of this is in advance of any formal public consultation.

The Committee's powers are set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, and these powers have most effect, when there is a formal public consultation. The Committee will consider any proposals for Grantham Hospital at this stage.

Furthermore, if any changes are implemented on the grounds of safety of patients, the public or staff, these will be considered by the Committee as a matter of urgency, but no such changes have taken place or are planned.

The Committee is obliged to work within its legal powers. These powers are concentrated on formal public consultations.

2. Humber Acute Services Review

On 22 March 2018, an update for stakeholders was issued by the Humber Acute Services Review programme, which is part of the Humber, Coast and Vale Sustainability and Transformation Partnership.

The Humber Acute Services Review programme has produced an Issues Paper, which is available at the following link:

http://humbercoastandvale.org.uk/wp-content/uploads/2018/03/Issues-document_final_webversion1.pdf

The *Issues Paper* provides some detailed information about the challenges in the Humber area, and the reasons for undertaking a review of hospital services. It identifies a shortage of clinical staffing across a number of disciplines, resulting in a 40% increase in spending on agency and locum staff.

The Humber Acute Services is relevant for Lincolnshire patients from West Lindsey and East Lindsey who may use Northern Lincolnshire and Goole hospitals. As reported to the Committee in March, there are particular issues affecting Diana Princess of Wales Hospital in Grimsby, and Scunthorpe General Hospital, such as:

- Since 1 September 2017, all inpatient Ear, Nose and Throat services have been provided in Grimsby instead of Scunthorpe. Day case procedures and outpatient appointments continue at Scunthorpe.
- Since 1 September 2017, emergency urology services (for patients requiring admission) have been provided at Scunthorpe, but inpatient care, day case procedures and outpatient appointments continue at Grimsby.
- From October 2017, a group of complex chemotherapy treatments moved from Grimsby to Castle Hill Hospital in Cottingham near Hull. Outpatient and day case procedures continue at Grimsby and Scunthorpe.

The *Issues Paper* stresses that the above changes are temporary and it is important that the views of patients, public, clinicians and other stakeholders are taken into account when considering the long term future of these services, which have been given priority within the Humber Acute Services Review.

The *Issues Paper* also identifies a gap in finances in the Humber Health and Care System of around £320 million by 2020, if no changes are made. In the 2017/18 financial year, the collective deficit of the NHS organisations in the Humber area was forecast to be around £60 million.

3. North Lincolnshire Non-Emergency Patient Transport Service

On 26 March 2018, North Lincolnshire CCG announced that it would commission a new patient transport service. Thames Ambulance Service (TASL) began providing non-emergency patient transport (PTS) in North Lincolnshire in October 2016 and North Lincolnshire CCG had been working closely with them for a number of months to address ongoing performance issues. The Care Quality Commission had also required TASL to improve in a number of areas.

North Lincolnshire CCG stated that whilst it has seen improvements in performance, patients are still continuing to experience difficulties with the service provided. As a result North Lincolnshire CCG served notice to TASL advising them of its intention to commission a new service.

North Lincolnshire CCG would continue to work closely with TASL to ensure the service to patients would not be affected and that people working for the organisation in North Lincolnshire were kept informed and fully supported to ensure a smooth transition to a new service.

4. Planning, Assuring and Delivering Service Change for Patients

On 29 March 2018, NHS England issued an updated version of *Planning, Assuring and Delivering Service Change for Patients*. This document is described as a good practice guide for commissioners on the NHS England assurance process for major service changes and reconfiguration. This document is relevant to the Committee's future consideration of service reconfigurations proposed as part of the Lincolnshire Sustainability and Transformation Partnership and any other STPs which impact on Lincolnshire residents.

The executive summary has been copied into Appendix A to these announcements, while the full document is available at the following link:

https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

5. East Midlands Clinical Senate

On 22 March 2018, East Midlands Councils circulated information prepared by the East Midlands Clinical Senate, which is seeking to raise its profile. The relevant extracts of the information received is set out in Appendix B to these announcements.

PLANNING, ASSURING AND DELIVERING SERVICE CHANGE FOR PATIENTS
(NHS England – Updated Version March 2018)

E X E C U T I V E   S U M M A R Y

Key Messages

- There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.
- Service changes should align to local Sustainability and Transformation Partnership plans and the service, sustainability and investment priorities established within them.
- NHS commissioners and providers have duties in relation to public involvement and consultation, and local authority consultation. They should comply with these duties when planning and delivering service change.
- The public involvement and consultation duties of commissioners are set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs.
- NHS trusts and foundation trusts are also under a duty to make arrangements for the involvement of the users of health services when engaged with the planning or provision of health services (s.242 NHS Act 2006).
- The range of duties for commissioners and providers covers engagement with the public through to a full public consultation. Public involvement is also often referred to as public engagement.
- Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") made under s.244 NHS Act 2006. This is in addition to the duties on commissioners and providers for involvement and consultation set out above and it is a local authority which can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.
- Where a proposal for substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider.
- Both commissioners and providers need to ensure that they have satisfied their statutory duties to involve and consult. In general, where there is commissioner led consultation with the local authority on a substantial service change, full public consultation will also be required.
- In practice, where there are public involvement and consultation duties on both commissioners and providers it should be possible to coordinate and consolidate any involvement and consultation requirements so that they are run in parallel to consultation with any relevant local authorities. In those circumstances a provider can make arrangements to satisfy its duty to involve and consult service users through a commissioner led consultation.

Nevertheless, providers would need to engage with commissioners and address consultation responses in order to comply with their duties.

- There is no legal definition of 'substantial development or variation' and for any particular proposed service change commissioners and providers should seek to reach agreement with the local authority on whether the duty is triggered. Regular local authority engagement should continue through the lifecycle of service change.
- Service reconfiguration and service decommissioning are types of service change.
- Change of site from which services are delivered, even with no changes to the services provided, would normally be a substantial change and would therefore require consultation with the local authority and public consultation.
- Effective service change will involve full and consistent engagement with stakeholders including (but not limited to) the public, patients, clinicians, staff, neighbouring STPs and Local Authorities.
- All service change should be assured against the government's four tests:
  - Strong public and patient engagement.
  - Consistency with current and prospective need for patient choice.
  - A clear, clinical evidence base.
  - Support for proposals from clinical commissioners.
- Where appropriate, service change which proposes plans significantly to reduce hospital bed numbers should meet NHS England's test for proposed bed closures and commissioners should be able to evidence that they can meet one of the following three conditions:
  - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and the new workforce will be there to deliver it; and/or
  - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
  - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).
- Prior to public consultation NHS England will assure proposals for substantial service change in accordance with the process set out within this guidance.
- For any service change requiring public consultation which also requires capital funding, NHS England and NHS Improvement will assess any proposals to provide assurance that they do not require an unsustainable level of capital expenditure and that they will be affordable in revenue terms.
- Not all substantial service changes require capital expenditure. However where this is the case and the scheme has been assessed by NHS England and NHS Improvement as having a reasonable expectation that the level of capital required will be available, public and local authority consultation should be undertaken before a Strategic Outline Case for capital funding is submitted to NHS Improvement.
- When service change proposals are being considered, early engagement with NHS England Regional Offices who can provide further information and support is recommended.

Information Sheet: What is the Role and Core Purpose of the Clinical Senate?

Our Role, the Breadth of our Membership, and our Offer to STPs/ Commissioners

Clinical Senates are a source of independent, strategic advice and guidance to commissioners, Sustainability and Transformation Partnerships (STPs), and other stakeholders, to assist them to make the best decisions about healthcare for the populations they represent. The Clinical Senate Council co-ordinates and manages the Senate's business. It maintains a strategic overview across our region and it is responsible for the formulation and provision of clinical advice working with the broader Senate Assembly.

The role of the Head of Clinical Senate is to provide oversight and management of all aspects of Senate activity. The Head of Clinical Senate is supported by a Senate Administrator. The Senate Office is the support function and these are the only paid positions. All Senate Council and Assembly members work in a voluntary capacity.

How we develop advice for STPs/commissioners

Clinical Senates review the service change proposals through **clinical review panels.** Review panels are made up of a group of clinicians and patient representatives brought together for that specific purpose. Review panel members are not associated in any way with the proposals and are primarily drawn from the Clinical Senate Assembly. With the Head of Clinical Senate, the sponsoring organisation determines the question on which it is asking the Clinical Senate to provide advice. Once that has been developed, terms of reference will be agreed and panel members secured. The panel members will review the case for change and evidence and agree the key lines of enquiry for the panel day.

The review panel is usually one day or less and may include site visits if it is considered to be appropriate for the matter under review. On the panel day, the panel convenes and meets with members of the sponsoring organisation for them to be able to answer any questions panel members may have. The panel then has confidential discussions on the case for change and evidence presented and formulates its advice which is provided in a confidential report.

The Role of Clinicians and Patients in the Senate

The Clinical Senate Council has two co-chairs and the Council is a multi-professional Steering Group, including patient representatives. The wider Assembly membership is made up of clinicians and patient representatives.

How the Clinical Senate works in collaboration with Patient and Public Involvement (PPI) Groups

The Academic Health Science Network (AHSN) is a non-voting member of the Senate Council. The Clinical Senate works closely with AHSN's PPI Senate through this established link and PPI Senate members have participated in clinical reviews representing a patient voice, which is on a par with clinicians.

How Evidence from other Senates' Work is used

The Clinical Senates have developed a central repository of all our work across the twelve geographic footprints (in 2017-18), and this is currently being populated – This will enable the East Midlands Senate to easily search the extensive activity that has been undertaken elsewhere in the country by other Clinical Senates.

How do STPs and Members of the Public Access Information, Resources, and Clinical Reviews?

Each clinical senate has its own website and independent clinical reviews undertaken are published here (the outputs, reports and recommendations from the Clinical Senates are the property of the sponsoring organisations. Public domain access to the clinical senate review reports is made only on the express permission of the sponsoring organisation). Work is currently underway to look at a single hub for all twelve clinical senates.

The Senate's mandate

This is clearly articulated in the joining instructions/ acceptance letter. The integrity of the Clinical Senate needs to be maintained at all times, including managing potential conflicts of interest to ensure that clinical advice remains independent and impartial.

Does the Senate Consider Cost in its Clinical Reviews?

Whilst clinical senates are independent in their clinical advice given, they all adhere to the NHS England Single Operating Framework to ensure consistency and accountability.

At the heart of the NHS England assurance process for service change are the four tests from the Government's Mandate to NHS England. The four tests, intended to apply in all cases of major NHS service change, are:

- strong public and patient engagement
- consistency with current and prospective need for patient choice
- a clear clinical evidence base
- support for proposals from clinical commissioners

In addition to these four tests, NHS England also identifies a range of best practice checks for service change proposals, these include:

- clear articulation of patient and quality benefits
- the clinical case fits with national best practice and clinical sustainability
- an options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations

As part of the NHS England assurance process, clinical senates are requested to review a service change proposal against the appropriate key test (clinical evidence base) and the best practice checks that relate to clinical quality.

Does the Senate Receive Feedback on the Clinical Advice provided as part of Clinical Reviews?

The Clinical Senate would always endeavour to provide feedback to all members who participate in its clinical reviews, including patient representatives.

Any final decision rests with the sponsoring organisation (for example, the clinical commissioning group) that commissioned the Senate to undertake a clinical review; however, the Senate endeavours to maintain a dialogue to be aware of may have happened as a result of the recommendations.

Purpose of Clinical Senates[1]

The purpose of clinical senates is clearly defined in NHS England's Operating Framework – it is important to remind STPs, as they develop and mature, about how clinical senates can support more broadly, and that by maintaining a positive dialogue with the STPs, this will ensure that they are reminded of how we can help.

Clinical senates support health economies to improve health outcomes of their local communities by providing **independent, impartial and evidence-based clinical advice.**

Clinical senates engage a wide range of health and care professionals, with patients and the public, so that clinical advice draws on a **breadth of knowledge, expertise and leadership.**

Guiding Principles

Clinical senates have a set of values to guide their work, consistent with the NHS Constitution.

Clinical senates support commissioners to put outcomes and quality at the heart of commissioning, and to promote the needs of patients above the needs of organisations or professions.

Senate members maintain an objective and impartial view, openly declaring conflicts of interest and respecting the need for confidentiality.

Patients and citizens have an equivalent voice.

Diversity and equality is valued and promoted.

Advice is independent and impartial informed by the best available evidence; where evidence is limited, Clinical Senates seek to build and reflect consensus.

Business processes, decision making, governance and accountability will be open and transparent and adhere to the Nolan principles.

[1] Clinical Senates in England Single Operating Framework 2014-15

Clinical Senates will work together and co-ordinate activities where required, within and between regions, to ensure they reflect cross boundary patient journeys and coherence in advice provided, avoid duplication and secure best value from their collective resource.

Organisational model

Clinical senates are independent advisory bodies comprising a Clinical Senate **Council** and a wider clinical senate **Assembly**.

The Clinical Senate **Assembly** is a diverse multi-professional group enabling ready access to experts from a broad range of health and care professions and the patient and public voice. Members encompass the full spectrum of NHS care.

The Clinical Senate **Council,** a smaller multi-professional leadership group, including the patient and public voice, is responsible for co-ordinating and managing the Clinical Senate's work, assuring the process through which advice is formulated and approving the definitive advice provided.

Each Clinical Senate has a support team funded through a budget allocated by NHS England.

Accountability and Governance

Clinical Senates are non-statutory bodies. Commissioners remain accountable for the commissioning of services and providers remain accountable for service delivery.
The East Midlands Clinical Senate chair is accountable to the Medical Director of NHS England Central Midlands for ensuring that:

- The Clinical Senate operates as a credible source of advice and that its advice is always independent and impartial of any organisation to which it is provided
- The guiding principles are adhered to
- The Clinical Senates' business functions and processes are effective

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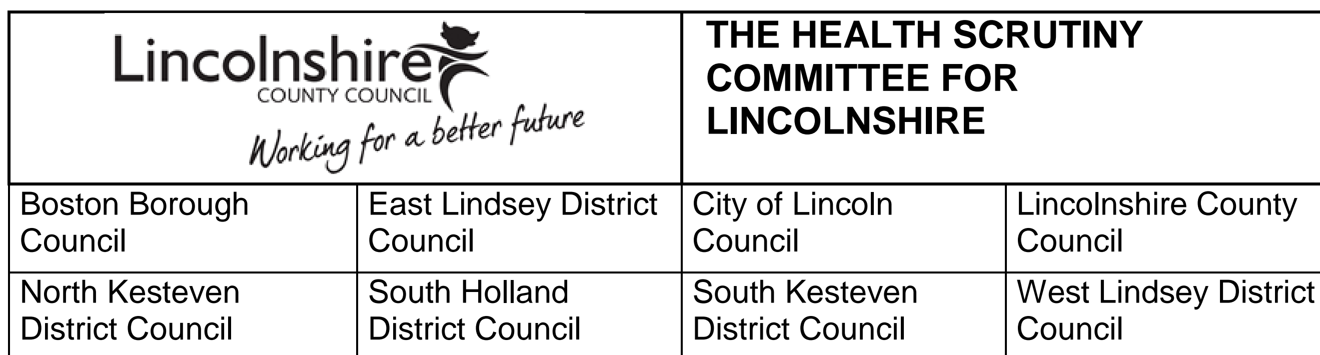
Agenda Item 5



		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 United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 April 2018**
Subject:	**United Lincolnshire Hospitals NHS Trust - Financial Special Measures Update**

Summary:

The Trust entered Financial Special Measures on 1 September 2017.

The Trust has appointed a Turnaround Director and has engaged KPMG to provide support in delivering the plan to become financially sustainable and exit Financial Special Measures.

A recovery plan has been agreed with NHS Improvement to deliver £16m of efficiencies in 2017/18. The Trust is forecast to deliver an £82.4m deficit for 2017/18.

The plan is monitored on a regular basis through the Trust's Financial Turnaround Group.

The Trust has identified £19.7m of efficiencies for 2018/19 with an ambition to achieve delivery of £30m. Based on the identified £19.7m the Trust will deliver a deficit of £73.4m in 2018/19.

In addition, to the information in this report on financial special measures, there are two short update papers included for the Committee's information, prepared by United Lincolnshire NHS Trust, as appendices:

- Update on Quality Special Measures
- Mortality Rates at United Lincolnshire Hospitals NHS Trust

Actions Required:

(1) To consider the information presented on the financial special measures of United Lincolnshire Hospitals NHS Trust.

(2) To note the Update on Quality Special Measures (Appendix A to the report), which will be subject to a further report to the Committee on 13 June 2018.

(3) To note the paper on Mortality Rates at United Lincolnshire Hospitals NHS Trust (Appendix B to the report.)

1. Background

1.1 United Lincolnshire Hospitals NHS Trust was placed in Financial Special Measures (FSM) on 1 September 2017 by NHS Improvement (NHSI).

1.2 The Trust is required to have a Turnaround Director in place and engage external support. The Turnaround Director has been in post since October 2017 and the Trust has engaged KPMG as its external support partner.

1.3 The current financial position is highlighted in the table below, covering Month 11 (up to February 2018).

Financial Duty	Annual Plan / Target £m	Revised Target £m	YTD Plan £m	YTD Actual £m
Delivering the Planned Deficit	(63.3)	(77.0)	(73.5)	(77.7)

- The Trust plan for 2017/18 is a Control Total deficit of £63.3m before sustainability and transformation fund (STF) income.

- The Trust will not deliver its Control Total deficit and a revised 2017/18 deficit of £77m was agreed with NHS Improvement in December 2017 as part of the Financial Special Measures process.

- The Month 11 position was an in-month deficit of £7.7m, which is £1.2m adverse to the planned in-month deficit of £6.5m.

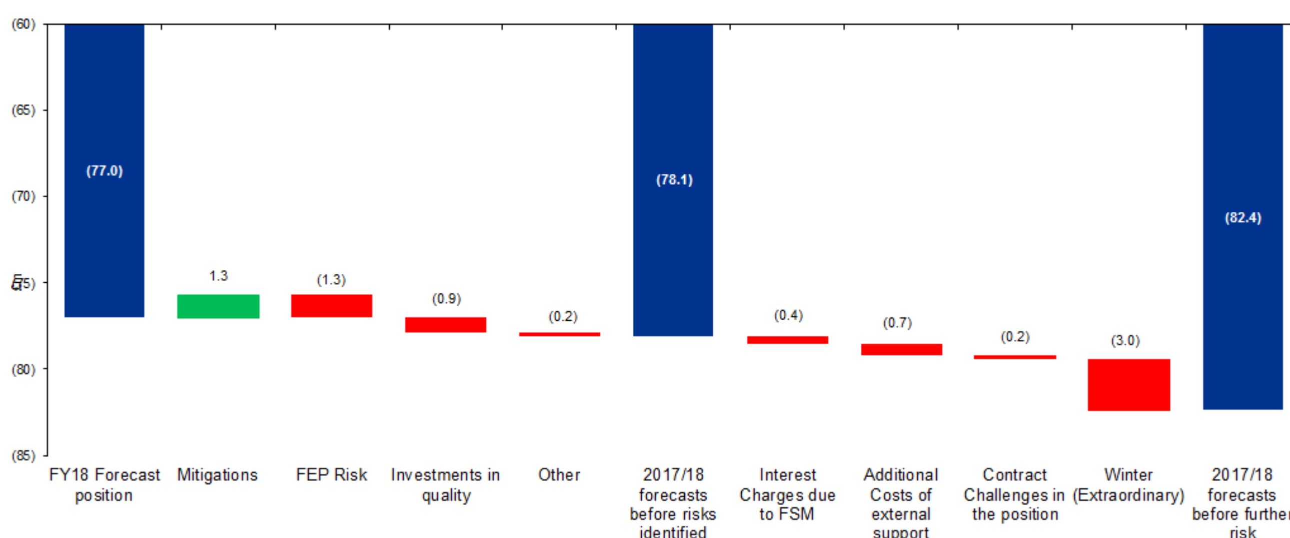
- The £77m deficit assumes full delivery of £16m of financial recovery efficiencies in year.

- A number of risks to delivery of the revised deficit were notified to NHS Improvement in December 2017. These are costs associated with extraordinary winter pressures, loan interest as a result of the FSM loan rate, additional FSM costs, and contractual issues.

- The deterioration in the income and expenditure position directly impacts on cash and the level of borrowings needed in 2017/18. The Trust will require external cash support in line with the forecast outturn in 2017/18.

1.4 The Trust is forecasting a year-end position of £82.4m which is £5.4m greater than the revised control total of £77m agreed with NHSI in December 2017. The £77m was exclusive of a number risks notified to NHSI and deemed to be outside of the control of the Trust that are now part of the forecast and total £4.3m. The balance of £1.1m is deemed to be in the Trust's ability to manage, and further savings opportunities have been put in place to mitigate this where possible and safe.

The waterfall chart below identifies the items that are increasing the deficit from the revised £77m to £82.4m deficit.



1.5 The revised deficit for 2017/18 includes the requirement to deliver £16m of efficiencies. Slippage of £1.3m has occurred in the delivery of these schemes and the Trust has put mitigating actions in place to deliver further opportunities of £1.3m.

1.6 High Level 17/18 Financial Turnaround Programme

Theme	Full Year Effect Plan £m
Corporate, Overheads, Procurement and Estates (COPE)	7.7
Productive Hospital	0.4
Workforce	3.1
Clinical Services Review	0.2
Directorates	4.6
Total	16.0

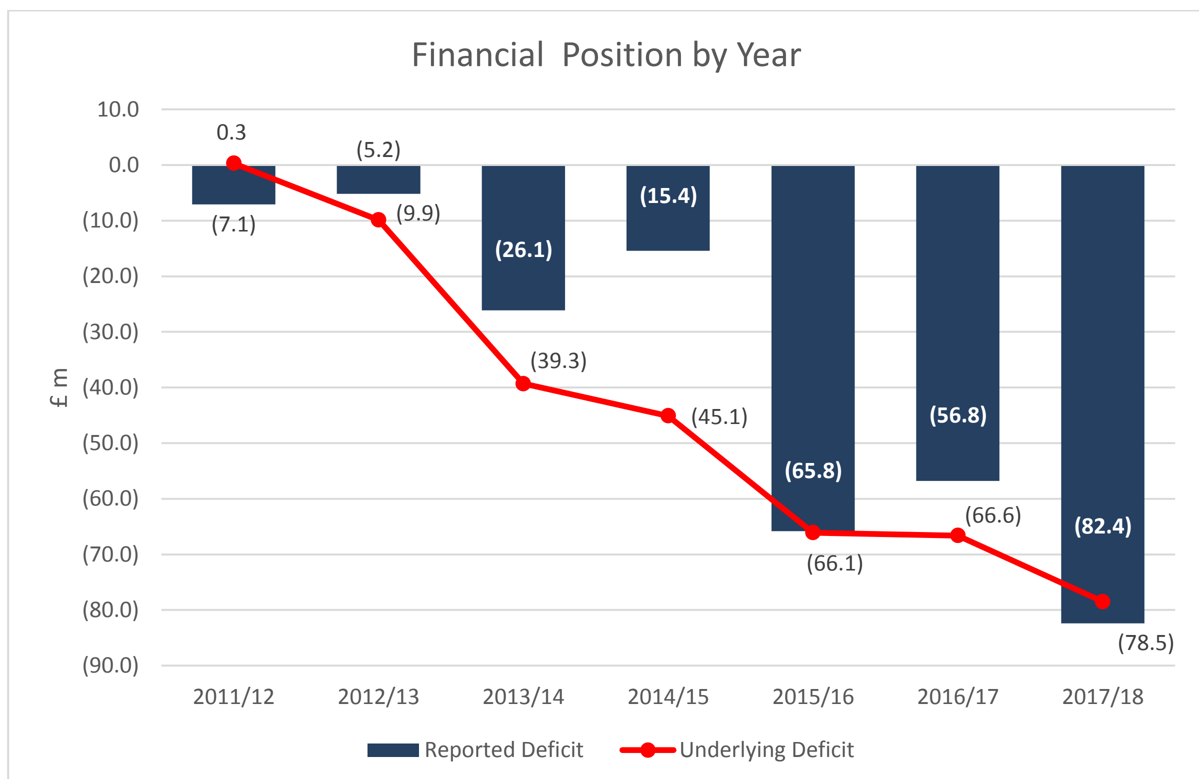
2. Long Term Financial Issues

2.1 The Trust has not achieved a breakeven position since 2011/12 and the graph below identifies that the underlying financial position has been deteriorating since that point. The significant changes in the underlying run rate occurred in 2013/14 and 2015/16.

2.2 In 2013/14 this was driven by increases in staff costs, £11.5m, agency costs, £5.4m and clinical non pay costs, £5.9m. In 2015/16 this was driven by increases in agency staff, £10.2m and Clinical Negligence Schemes for Trusts payments, £6.1m, clinical non-pay costs, £9.9m.

2.3 The issues have arisen by the cost of delivering and investing in services over three main sites and a large rural geography whilst struggling to deliver the national efficiency agenda. This has resulted in a significant structural deficit that the Trust is working with the Lincolnshire health economy to address.

2.4 The position in recent years has been exacerbated by the need to rely on higher than national average levels of agency staff in order to deliver the services in a safe environment due to a large number of clinical vacancies. This has placed a financial burden on the Trust as the agency bill is currently around £30m per year.



3 Impact of Financial Special Measures

3.1 Financial Special Measures has various elements to it, many of which have already been put in place. These are detailed below.

- NHS Improvement appoints an executive director sponsor
- An improvement director is appointed by NHS Improvement for each financial special measures provider
- Board vacancies to be filled on the direction of NHS Improvement
- Regular progress reviews are held with NHSI
- Provider is required to publish on its website home page that it is in financial special measures, and the reasons for this
- Potential removal of provider's autonomy over key spending decisions
- NHSI control over applications for Department of Health financing
- A financial improvement notice issued for a time-limited period
- Rapid (by end of week 1) articulation of key issues
- Recovery plan (with milestones) - including accelerated proposals on service consolidation or closure, Lord Carter Review and organisational form and workforce review - with buy-in from key stakeholders
- Provider and NHS Improvement agree the recovery plan (by end of month 1)
- Appointment of turnaround /recovery support (full time), possibly including peer support

4 Exiting Special Measures

4.1 The exiting of Financial Special Measures requires three elements to be completed, as follows:

1) Robust recovery plan setting out the key changes required to remedy the financial position
2) Plan to be approved by ULHT Board and NHSI within 1 month
3) Having a detailed delivery plan and evidence of significant wins within a further 2 months

4.2 NHSI may require evidence of delivery over a further 3 month window and if these elements are not met, NHSI may consider any, or a combination of the following:

1) extend special measures by 3-6 months,
2) make changes to the Board
3) initiate an organisational form change if issues are due to organisational capability or capacity
4) initiate a wider local health economy process,

5 External Support

5.1 As highlighted in 3.1 above, there are a number of support arrangements that are put in place to support the organisation and a number of these are in place already.

5.2 The Trust has already undertaken the following, in terms of obtaining support:

- appointing a Turnaround Director who will support the Board in progress to exiting financial special measures
- appointing an external partner to support the development and delivery of the recovery plan.

- Receiving support from the national NHSI team through a senior financial colleague within the Trust

6 2018/19 Planned Financial Outturn

6.1 The Trust has a Control Total (maximum allowed year-end deficit) set by NHS Improvement of £54.5m pre Sustainability and Transformation Fund (STF) income (national funding given for meeting key performance and financial targets) for 2018/19.

6.2 The Trust submitted a draft plan to NHS Improvement in March 2018 of a year-end planned deficit of £73.4m. This is based on the delivery of £19.7m of efficiencies. The Trust has not yet accepted the control total.

6.3 The Trust has an ambition to deliver £30m of efficiencies in 2018/19 and is working to identify and implement additional schemes to increase the already identified £19.7m.

6.4 High Level 18/19 Financial Turnaround Programme

Theme	Target £m	Identified PYE £m	Identified FYE £m
Workforce	6.0	2.9	4.2
Clinical Transformation	5.1	4.1	4.6
Productive Services	5.6	3.4	4.1
Corporate, Overheads, Procurement and Estates (COPE)	4.5	1.7	2.1
Directorates	4.9	5.0	5.6
Income	2.6	2.6	2.6
Unidentified	1.3	0.0	0.0
Total	30.0	19.7	23.2

Governance arrangements

8.1 Tracking delivery of overall financial recovery plan will be undertaken and monitored as follows:

- Progress against the Finance recovery plan to be presented to Executive Team twice a month
- Finance is one of five key priorities for each Board meeting (the others being quality, fire compliance, A&E performance and Cancer performance)
- Performance meetings with Clinical Directorates will include a focus on finances to raise concerns around slippage and ensuring delivery is on track
- 2021 Finance strategy group already developed and approved an efficiency framework and to lead on developing a long term financial model
- All Efficiency ideas to be documented and to go through a Quality Impact Assessment (QIA) sign off process before being adopted

- Executive or Clinical lead sponsor for each efficiency scheme
- Capacity and capability to deliver to be addressed, in part by recruiting to 2021 PMO

8.2 Financial Turnaround Group

Financial Turnaround Group (FTG) reports to 2021 Programme Board and provides assurance to Finance, Service Improvement and Delivery Committee (FSID) and Trust Board

- Fortnightly meetings chaired by the Chief Executive
- Terms of Reference and Membership agreed
- PMO supports the meeting and records actions

Each efficiency scheme has a Programme Delivery Manager allocated to manage the day-to-day running of the finance programme, co-ordinate delivery of the programme / projects, pro-actively monitor its overall progress against plans, highlight issues to the delivery group and co-ordinate corrective action.

9. Consultation

9.1 This is not a consultation item.

10. Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

10.1 This report is an update on the current position of United Lincolnshire Hospitals NHS Trust with respect to financial special measures and the potential impact on the Strategy.

11. Conclusion

11.1 This report is provided to notify the Committee of the financial position of United Lincolnshire Hospitals NHS Trust, and the steps being taken to become financially sustainable.

12. Appendices – These are listed below and attached to the end of the report

Appendix A	Update on Quality Special Measures
Appendix B	Mortality Rates at United Lincolnshire Hospitals NHS Trust

13. Background Papers

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

APPENDIX A

Update on Quality Special Measures

Summary

This appendix is included for information and gives an overview on quality special measures at United Lincolnshire Hospitals NHS Trust together with a high level update on the CQC work undertaken by the Trust. This has been split into three sections.

- Section 1 explains the process, starting with the original CQC visit in October 2016 and the special measures designation in April 2017.
- Section 2 gives an update on the work the Trust has been undertaking since October 2016.
- Section three outlines the latest inspection which includes the unannounced inspections and the areas that CQC well-led inspection will review during 10 - 12 April 2018.

1. CQC Visit (October 2016) and Special Measures Designation (April 2017)

Quality of care and safety at United Lincolnshire Hospitals NHS Trust is a key priority for our staff and this is reflected by the importance and commitment the Trust Board places it. Quality and safety of care is everyone's business and everyone has a part to play in delivering this. Despite this focus, when the Trust was inspected by the CQC in 2016, the CQC identified deficiencies within Trust. This paper gives an overview on quality special measures at United Lincolnshire Hospitals NHS Trust together with a high level update on the CQC work undertaken by the Trust.

In April 2017, the CQC published its report following the Trust's 2016 inspection. The Trust was inspected against the fundamental standards and the CQC identified a number of areas where care and services were 'good' or 'requires improvement'. However, there were areas where the quality and safety of the services provided by the Trust failed to meet the minimum standards and the CQC judged the Trust overall as 'inadequate'. Following this rating, the Trust was placed into a quality special measures regime by NHS Improvement, and an Improvement Director was appointed to support the Trust in developing and delivering an improvement programme to address the areas of deficiency.

2. Activity Since October 2016

Following the Inadequate rating and placement into quality special measures, with the support of an NHS Improvement Director, the Trust developed its Quality & Safety Improvement Plan. Its focus was to develop a culture of safety whilst making improvements in quality, in line with the Trust's Quality Strategy and the findings of the CQC inspection. The plan identified 17 key areas, each with specific milestones.

The 17 key areas are:

QS01 Developing the safety culture
QS02 Clinical Governance
QS03 Sepsis
QS04 GI Bleed Service
QS05 Airway Management
QS06 Mental Health

QS07 Safeguarding
QS09 Training & Competencies
QS11 Outpatients
QS13 Reducing Variation in Practice
QS14b Clinical Staffing Medical
QS16 Strengthening Support for Pilgrim
QS08 Medicines Management
QS10 Appraisal & Supervision
QS12 Control of Infection
QS14a Clinical Staffing Nursing
QS15 Medical Engagement
QS17 Estates and Environment

Individual leads were identified with responsibility for delivering the improvements, these were monitored and reported internally. Many of the milestones identified with the 17 areas have been completed and resulted in improvements to patient outcomes and the quality of care, , for example: sepsis, airways management, control of Infection. Some areas require further work and all will be subject to a rewrite with new milestones identified for 2018/19. On publication of the report following the current CQC inspection, the milestones will be reviewed to ensure any concerns are incorporated.

On 9 April 2017, ULHT issued a media release as follows: -

Much to shout about as NHS Trust improves its quality of care

Hospitals in Lincolnshire are celebrating the great strides they have made in turning around the quality and safety of services provided to patients.

It's been one year since United Lincolnshire Hospitals NHS Trust (ULHT) was placed into special measures by NHS Improvement, following an inspection by the Care Quality Commission (CQC) regulator.

While the last year has been challenging, staff are also celebrating everything they have to be proud of.

Chief Executive Jan Sobieraj said: "It takes time to turn around the quality and safety of services in a Trust our size but we have collectively achieved so much. Our staff should feel proud of all we have done to improve the quality and safety of services for our patients.

"We recognise that we still have a long way to go, but we've made some good progress in improving the experience of our patients."

"Some of the achievements made during the year include:

- *We now employ more consultants, middle grade doctors, allied health professionals and health care support workers than in 2016.*
- *We're spending £2.5m a month to improve the fire safety of our buildings for staff and patients.*
- *We've invested £4.6m million in new neonatal facilities at Lincoln and maternity services at Pilgrim.*
- *The number of patients waiting over 12 weeks for a first outpatient appointment has halved.*

- *We're better at screening patients for sepsis in our A&E departments, and then ensuring that these patients get the treatment they require within the hour.*
- *We launched our ward accreditation scheme, where wards are now regularly inspected and assessed against a range of 13 quality standards by a team of five new quality matrons.*
- *We opened a new ophthalmology department at Grantham and District Hospital, providing 16 – 18 clinics per week and three and a half theatre lists per week for patients with conditions such as cataracts and glaucoma.*
- *Cancer patients in ULHT are now able to have robotic assisted surgery thanks to a ground-breaking new partnership with University Hospitals of Leicester NHS Trust. Surgical precision of the robot has excellent oncologic and functional results, there is a reduced need for blood transfusions, less post-operative pain and a shorter inpatient stay.*
- *Over 81% of staff have had a flu vaccination this year- one of the highest vaccination rates in the country – helping to protect our patients and each other from getting ill. ULHT was the 15th best performing Trust out of 245 in the country.*
- *We've introduced children's bereavement bags to help youngsters remember their loved ones, to comfort and entertain them and to help them to cope.*
- *Following patient feedback we introduced new 'Ask Me' wristbands to help staff identify patients with sensory impairments so that their needs can be met more efficiently.*
- *The daily "golden hour" was introduced where heads of nursing and matrons do structured checks of the wards to ensure that each area of the hospital is providing the same high quality standard of care.*
- *We launched the Swan scheme to ensure we provide the best quality end of life care for patients and their families. It includes end of life care training for all hospital staff, establishing new volunteering roles to support end of life care and individual memory boxes and bags introduced on wards to help families in these circumstances.*
- *Our 'meet and greet' corridor volunteer guides who are strategically stationed at mobile hubs around its hospitals, have helped point 15,000 patients and visitors in the right direction.*
- *We launched our staff charter, after consultation with staff, which seeks to bring people to account and focuses on the behaviours we expect from everyone.*
- *Some ankle replacement surgery is now being done as a day case at Pilgrim Hospital, Boston. Where appropriate, patients can be admitted and go home the same afternoon, helping to free up hospital beds and save money.*
- *We opened a new rehabilitation gym for patients on Ashby ward in Lincoln as part of a major £900,000 refurbishment which also saw the ward increase from 12 to 18 beds.*
- *Blood transfusions at ULHT are among the safest in the country thanks to our £800k investment in state-of-the-art technology called Blood360.*
- *We are working with the British Red Cross to help get medically fit patients back into their own homes as soon as possible.*

3. Latest Inspection Activity by CQC

The CQC's inspection regime requires the Trust to be re-inspected within a year, and a series of CQC unannounced visits commenced in February 2018. All four sites where the Trust delivers in-patient and outpatient care were visited and number of pathways inspected. These included medicine, emergency medicine, surgery and children's services.

The final stage of the inspection regime is a well-led review, this will be undertaken 10 – 12 April. Between these dates, the CQC will complete a well-led inspection of the Trust which will involve the completion of staff focus groups and a series of detailed interviews with the Trust Board, identified leaders and managers across services provided by the Trust. The focus of the well-led assessment is on ensuring that the leadership, management and governance of the organisation assures the delivery of high quality and patient centred care, supports learning and innovation and promotes an open and fair culture. This is undertaken by focusing on eight key lines of enquiry, these are:

- Is there the leadership capacity and capability to deliver high quality sustainable care?
- Is there a clear vision and credible strategy to deliver sustainable care to people, and robust pans to deliver?
- Is there a culture of high quality, sustainable care?
- Are there clear responsibilities roles and systems of accountability to support good governance and management?
- Are there clear and effective processes for managing risk, issues and performance?
- Is appropriate accurate information effectively processed, challenged and acted on?
- Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
- Are there robust systems and processes for learning, continuous improvement and innovation?

Over the last year, the Trust has focussed on improving against 'well-led' by concentrating in a number of specific areas.

Leadership; recognising that compassionate, inclusive leadership is key to the Trust achieving sustained improvement, the approach is to ensure consistent leadership based around a simple framework.

Safety culture; the culture the Trust wishes to embed is based on the values and the ambitions within the 2021 programme. A systematic approach has been taken, similar to that used successfully at Morecambe Bay NHS Trust, with an emphasis on holding people to account for implementing consistently a revised set of systems and processes, some directly related to safety (e.g. Serious Incident Management), others indirectly so (e.g. workforce acquisition).

Staff Engagement; ensuring strong staff engagement with the ULHT vision ("Excellence in rural healthcare") and the Trust's values (compassion, respect,

safety, excellence, patient-centred) is crucial to delivering excellent services and having a consistent safety culture. Four areas have been emphasised the strategic narrative, employee voice, organisational integrity and the quality of leadership and management.

Good governance; the focus has been on the creation of an organisation focused on continuous learning. Achieving this has required reviewing and strengthening the governance processes from Board to Ward and across Directorates and specialities and ensuring all staff at all levels have an understanding of governance. Specific work has been undertaken to improve incident reporting, serious incident recognition and review, identification and articulation of risk.

4. Conclusion

The report identifies the CQC processes that United Lincolnshire Hospitals NHS Trust has been subject to since October 2016 and the improvement work that has been undertaken. The Trust is currently subject to the final stages of a CQC inspection and awaits the outcome on the CQC's view of the quality of its services.

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Mortality Rates at United Lincolnshire Hospitals NHS Trust

Summary:

This appendix is included for information and provides an introduction to the topic of mortality.

Hospital Standardised Mortality Ratio (HSMR)

The current HSMR reporting period from January 2017 to December 2017 is 101.69 and is within expected limits.

Summary Hospital-level Mortality Indicator (SHMI)

The latest version of SHMI relates to the period of October 2016 to September 2017. The period is currently reporting 114.90 for SHMI and is currently in band 1 outside of expected limits.

Mortality indicators are not a measure of the quality of care. A higher or lower than expected number of deaths should not immediately be interpreted as indicating poor or good performance and instead should be viewed as an alarm which requires further investigation.

Summary Hospital-Level Mortality Indicator (SHMI)

As published on NHS Digital, the latest version of SHMI relates to the period of October 2016 to September 2017.

The period is currently reporting 114.90 for SHMI and is currently in band 1 outside of expected limits. Our reporting database Dr Foster has not yet been updated with the current published NHS Digital SHMI for this time period so an in-depth analysis cannot be undertaken until this has been published.

Overview from NHS Digital is below:

SHMI: 114.90
Spells: 81233

In-Hospital Deaths: 2487 (67.1%)
Outside Hospital Deaths: 1219 (32.9%)

Mean depth of coding elective admissions: 2.8
National Average: 3.9

Mean depth of coding non-elective admissions: 3.8
National Average: 4.4

As the data above clearly demonstrates the trust is below the national average for the depth of coding which is adversely affecting our SHMI. The Trust has ongoing work streams to improve coding which has been reflected on our improving HSMR. As SHMI is currently reporting to September 2017 and HSMR is currently reporting to December 2017, we can see our depth of coding is demonstrating an improving picture within HSMR which should be mirrored for the same time period for SHMI.

Hospital Standardised Mortality Ratio

The current HSMR reporting period from January 2017 to December 2017 is 101.69 and is within expected limits.

The Trust is working on a number of work streams which includes internal and external partners to ensure collaborative working and shared learning.

Details of workstreams:

- Clinical Coding Masterclass which incorporates Dr Foster analysis, coding, income, information support and performance – run tri-annually
- Clinical Coding eLearning is mandatory core training for all Clinicians
- Comorbidity audits with results and action plans presented at Patient Safety Committee
- Mortality and coding are now included in doctors teaching programme
- All mortality alerts for 3 months have an in-depth Dr Foster review completed and a case note review
- A Business Case has been approved to introduce the Medical Examiner role at ULHT
- The in-house data base for palliative care is cross referenced with Dr Foster data to ensure data is reflected accurately
- Bereavement Centres in Lincoln and Pilgrim
- Lincolnshire Mortality Collaborative are working with Nursing Homes and GP's to ensure patients are receiving advanced care packages within the community and to ensure where appropriate are on the Gold Standard Framework.
- The Lincolnshire Mortality Collaborative are working to reduce inappropriate admissions to hospital
- A 2018 – 2021 Mortality Reduction Strategy has been developed and is currently being ratified through the committees.
- Monthly Mortally briefings are disseminated for learning
- Morality is a standing agenda item on Speciality Governance
- MoRAG who provide assurance against the reviews completed within each speciality
- Lincolnshire Mortality Collaborative who review deaths within 30 days of discharge and within 48 hours of admission.

Explanatory Notes:

The table below outlines each mortality reporting stream and any inclusions and exclusions within the extrapolation to the mortality outcome:

Inclusions/exclusions	HSMR	SHMI	Crude Mortality (ULHT internal source)	Crude Mortality (Dr Foster)
All diagnoses	No (56 top diagnosis groups only)	Yes	Yes	No (56 top diagnosis groups only)
Deaths in Hospital	Yes	Yes	Yes	Yes
Deaths out of Hospital	No	Yes	No	No
Palliative care patients inclusion	No	Yes	Yes	No
Risk profiling in calculation	Yes	Yes	No	No

HSMR (Hospital Standardised Mortality Ratio): is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of 56 diagnoses which give rise to around 80% of in-hospital deaths. For all of the 56 diagnosis groups, the observed deaths are the numbers that have occurred following admission in each NHS Trust during the specified time period. The expected number of deaths in each analysis is the sum of the estimated risks of death for every patient. The ratio is of observed to expected deaths (multiplied by 100). If mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. The risk profile for each individual patient is calculated based on the following factors – Sex, age on admission, admission method (non-elective or elective), deprivation, diagnosis/procedure subgroup, co-morbidities, number of previous emergency admissions in the preceding 12 months, year of discharge (financial year), palliative care, month of admission and source of admission.

Dr Foster: is a complex statistical tool which acts as a spotlight for mortality. Its use and validity has been the subject of much debate nationally, but what is clear is that it is not a measure of excessive or avoidable deaths. Dr Foster is used to identify HSMR to point us to possible areas of concern and, when they are identified, we actively review them through case note reviews. The Dr Foster data has a 3 month

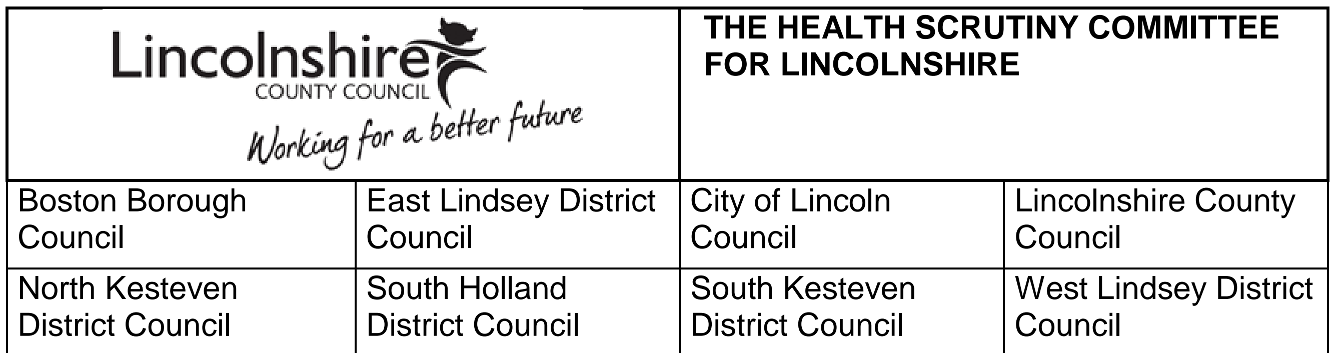
time lapse. Dr Foster data is refreshed monthly over the financial year; previous month's data may change due to ongoing analysis of coding.

SHMI (Summary Hospital-level Mortality Indicator): is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by NHS Digital with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. SHMI is reported every 6 months and has a 6 month time lapse and in hospital death rate should mirror HSMR therefore HSMR can be a predictor for this. NHS Digital does not retrospectively refresh data from the previous reporting period.

Crude mortality: The crude death rate is the total number of deaths to admissions within the hospital and does not take into account the risk of every patient as in SHMI and HSMR calculations. ULHT internal source is aggregated from our deaths and admissions sourced from our internal information support and is used as a predictor for the HSMR and SHMI trend. There is a variance between Internal source and Dr foster's crude mortality due to the fact that the internal source uses all diagnosis groups not just the 56 top diagnosis groups as in Dr fosters reporting tool.

Alerting Diagnosis Groups: All Dr Foster diagnosis groups that alert for 3 consecutive months an in-depth review will be completed and reported to Patient Safety Committee.

Agenda Item 6



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

Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 April 2018**
Subject:	**Lincolnshire Sustainability and Transformation Partnership - GP Forward View Update**

Summary:

This report provides information on the development of GP Forward View as part of the Lincolnshire Sustainability and Transformation Partnership (STP).

The GP Forward View is one of the four current priorities in the Lincolnshire Sustainability and Transformation Partnership, which the Committee decided in October 2017 to consider in greater detail.

Actions Required:

To provide feedback on the progress on the delivery of the GP Forward View.

1. Background

1.1 <u>National Context</u>

The Primary Care Programme is working closely with national NHS England (NHSE) arm's length bodies to bring in expertise to support federations and practices to implement these changes. In particular the Programme will be working with NHSE Sustainable Improvement Team to develop a programme to support delivery of the

10 High Impact Actions (HIA) that have been identified as part of the national Time for Care Programme.

Nationally the General Practice 5-Year Forward View (GPFV) was published April 2016, and builds on NHS England's 5-Year Forward View, published October 2014.

The General Practice Five Year Forward View (GP5YFV) represents a step change in the level of investment and support for general practice from NHS England over the next 5 years.

It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services. This transformation will be built around patients, around the wider workforce, around the redesign of our workload and organisation of care, and creating a satisfying and rewarding career for everyone working in general practice.

The GPFV sets out reform for primary care from its publication through to 2020. It focusses on delivering more convenient access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings, and better integrated with community and preventive services, hospital specialists and mental health care.

1.2 Lincolnshire Context

In Lincolnshire CCGs are accountable for the delivery of the GP Forward View programme of work; however a significant amount of the projects are being facilitated by the STP Primary Care Programme. National funding is available to support delivery of GP Forward View with CCGs currently developing plans to release this into Lincolnshire.

The Primary Care Programme is governed via the GPFV Strategy Group which brings together GP Federations/Super Practice, practices, CCGs and the Lincolnshire Local Medical Committee. The GPFV Strategy Group reports to the STP Executive.

This transformation programme will be built around patients, the wider workforce, the redesign of workload and organisation of care, working across organisational boundaries bringing together primary care and neighbourhood working to ensure a continuity of care for the public and patients.

2 Primary Care Programme

As with all large scale change there is a level of interdependency with other key STP programmes and the projects, in particular Integrated Neighbourhood Working, Clinical pharmacy project and urgent and emergency care.

The Primary Care Programme consists of three projects, detailed below. The three projects are:

2.1 Primary Care Workforce

NHSE identified that Lincolnshire required an additional 76 GPs by 2020. In addition to local initiatives, Lincolnshire, through the Local Medical Committee has been successful in recruiting 26 GPs from abroad. A second bid has been successful for a further 39 international recruits, which will enable Lincolnshire to have reached its target.

As well as recruiting more GPs, Lincolnshire is working with NHSE and national organisations, e.g. medical defence unions, to achieve greater flexibility in the ability to retain current GPs by encouraging them to continue to work on a part-time basis when they cease full time employment in a practice. In order to support this, agreement has to be reached over GP's indemnity.

As well as GP posts, Lincolnshire has a target to increase the number of other (non-GP) staff in primary care. This target is for an additional 53 posts by 2020. To date we have recruited an additional 49 clinical staff and 13 non-clinical staff, providing an additional 62 posts. These posts will support the implementation of new care models such as Neighbourhood Teams (NHT) and federated models of general practice, to embed cross organisational services, which wrap around the patient.

Non-GP clinical posts include nurses, clinical pharmacists, physician associates, paramedics and primary care mental health workers. Lincolnshire is one of three national pilots exploring how paramedics could work on a rotational basis, one rotation being in general practice.

The CCGs and STP are also identifying our highest priority groups of practices so that we can support an increase in their resilience and make sustainable changes to mitigate against any potential loss of services.

2.2 Primary Care Workload & Redesign

Increase in workload is a major challenge for primary care, which compounds the problems created by shortage of workforce. In many areas workload is set to increase as there is a shift of care out of acute hospitals into the community, which includes primary care.

There are two approaches to managing the workload:

(1) Increase in capacity

This is mainly covered in paragraph 2.1 above by increasing the number of current staff.

There is capacity which is currently being used inappropriately; nationally evidenced work identifies that 25% of appointments (for GPs) are avoidable. These either do not need primary care services or treatments, or can be managed by a nurse, other healthcare professional or voluntary sector person. This aspect is considered in section (2) below.

CCGs are also required to commission an increase in the hours that primary care is available, under the Extended Access initiative. This requires an additional 30 minutes of primary care access per 1,000 registered population by October 2018 and plans are being put in place to commence this.

(2) Reduction in workload.

There are a number of initiatives that are being developed in primary care:

- Sign posting service, Primary Care navigation, will be developed within each Practice. There is a national competency frame work to support its development and this will enable practice staff to support patients to access alternative solutions to support their needs within their local community. This development is being implemented as part of a collaborative approach to developing self-care, social prescribing and care navigation.

  There are 2 cohorts consisting of groups of general practices that will pilot this model with work starting early next financial year.

  The expectation is that this will release time and capacity for those people who clinically need the skills of GPs and their clinical staff.

- Lincolnshire is also currently exploring the potential of using GP on-line consultation, with 3 federations and practices about to launch this

- Increasingly General Practices are key contributors to the development of integrated neighbourhood working. It is anticipated that this approach will be able to manage patients across primary and community care, including our voluntary sector and community partners to deliver a more proactive approach, which will help with preventing crisis, avoidable admissions and delayed transfers of care.

- CCGs and GP practices are working with the emergency ambulance service to identify people who regularly call 999, who do not need an emergency response. In these cases care plans are developed for the individual who better supports their needs.

<u>Care Redesign</u>

As identified above significant change is required across general practice. This inevitably requires practices to work differently in many ways, producing a large complex agenda.

Simon Stevens *stated:*

"The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote to improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice."

It is the objective of the primary care programme to support the practices and CCGs to maximise this potential for the benefit of patients and the staff.

As previously identified the Programme will include the 10 High Impact Actions, which are;

- Active Sign Posting
- New consultation types
- Reduce appointments not attended by patients
- Develop the practice team
- Productive work flows
- Personal productivity
- Partnership working
- Social prescribing
- Self-care support
- Develop quality improvement (QI) expertise

Lincolnshire Time for Care launch event is being held in May, which will identify a further programme of accelerated learning events for general practices in redesigning care

2.3 Primary Care at Scale

Additional staff, working differently and managing patients in different areas require significant infrastructure support for them to be effective.

Information management and technology will change to deliver better access and better care. As identified above, GP on-line consultation will provide different access routes for people who have a concern but which is either not urgent or that they can't get into the practice at that time. This will also support sign posting.

These changes will also necessitate better interoperability between information systems, not only between practices, but also with community services. This will provide better sharing of patient information, which will have significant benefits for an individual's care and treatment.

As services change, some of the buildings will also need to change so that services can be delivered in appropriate environment. Co-locating services provides synergy and benefits for patients and staff, this will be particularly significant with the development of NHTs which, along with primary care provide services which wrap around specific populations.

Changes to buildings will generally take longer to deliver, but are a fundamental part of this system change.

Many general practices are now working as part of federations or super practices, although there are a number of practices which remain independent. Federations and super practices offer potential economies of scale and critical mass, bringing

practices together to offer better access across a group, giving wider access to some care as opposed to going to an acute hospital.

Federations also provide the opportunity for closer partnership working with other community care providers, and other services in wrapping care around their populations, providing medical oversight and medical leadership within neighbourhood working. This relationship enables delivery of personalised care, better self-care and reduction of risks.

The above three actions are aimed at enabling practices to support delivery of the wider system change of integrated neighbourhood working, that will ensure local services work together irrespective of which organisation provides them.

This will include integrating primary care and the wider urgent care system to remove duplication of services and bureaucratic hurdles.

3. Consultation

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide health overview and scrutiny committees with a specific statutory role in relation to consultations on substantial variations or developments in NHS services, where there is an obligation on the responsible commissioner to consult.

The GP Forward View is a national initiative, mandated by NHS England. As a result, it does not directly fall within the scope of the 2013 Regulations. However, the Health Scrutiny Committee has an opportunity to provide feedback directly on the implementation of the GP Forward View as part of its consideration of this report.

4. Conclusion

This report outlines the background to the development of the Primary Care Programme, highlights the main priorities, and articulates the work areas that are progressing and developing to address those priorities.

It is presented to inform the Health Scrutiny Committee of current progress in delivering the Primary Care Programme.

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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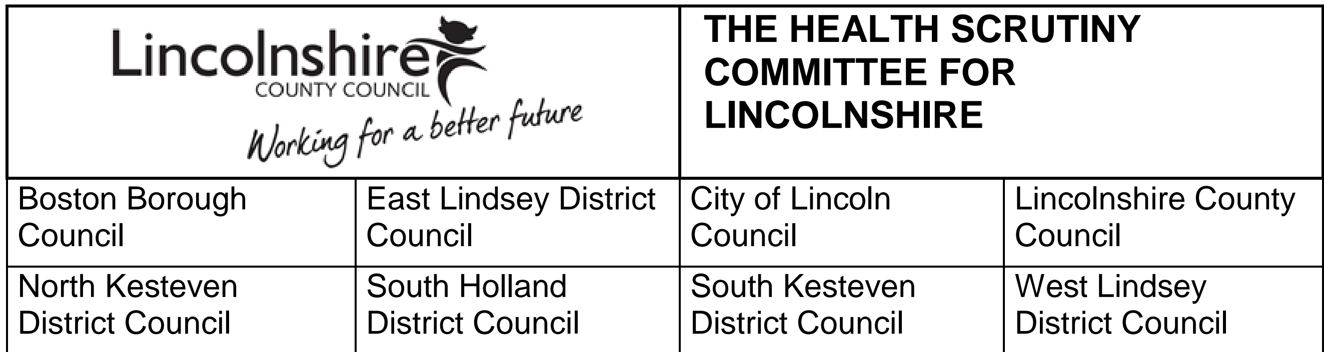

		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 April 2018**
Subject:	**Integrated Neighbourhood Working**

Summary:

To update the Health Scrutiny Committee for Lincolnshire on the progress that has been made in the collaborative design and implementation of Integrated Neighbourhood Working – identifying the key successes and issues and the links to the GP Forward View programme.

Integrated Neighbourhood Working is one of the four priorities in the Lincolnshire Sustainability and Transformation Partnership, which the Committee decided in October 2017 to consider in greater detail.

Actions Required:

To provide feedback on the progress on the delivery of the Lincolnshire Integrated Neighbourhood Working programme.

1. Background

1.1 National Context

The Five Year Forward View (FYFV) published by the Department of Health in 2014 identified a number of interventions to support the sustainability and transformation of the NHS.

Specifically relevant to the Integrated Neighbourhood Working programme is the focus on *Integrated Health and Care services - Helping frail and older people stay*

healthy and independent, avoiding hospital stays where possible and the principles that are identified to support this way of working;

- Increasingly we need to manage across systems – networks of care- not just organisations. Out of Hospital care needs to become a much larger part of what the NHS does
- Services need to be integrated around the individual not a GP or a particular organisation.
- Integrated care locally through service improvement and outcomes
- Co-production with people, voluntary groups, staff and other key stakeholders
- Recognition that 'one size does not fit all' – localisation and understanding population.
- Evolution not 'big bang' – focus on continuous improvement, adaptive change and learning.
- Back energy and leadership where we find it

5 Year Forward View Department of Health 2014

The Primary Care Home Model, which includes a focus on health population management has been developed by the National Association of Primary Care (NAPC) and is seen as a key component part of the GP Five Year Forward View. (GP FYFV)

There are four key characteristics that make up a Primary Care Home:

1. An integrated workforce with a strong focus on collaboration and partnership working – spanning Primary, Secondary and community services (physical and mental health, social care, independent providers & third sector).
2. A combined focus on personalisation of care with improvements in population health outcomes – with a focus on prevention, self-care and self-management.
3. Aligned clinical and financial drivers with shared risks and rewards.
4. Provision of care to a defined, registered population of between 30,000 – 50,000.

Both these national drivers along with the GP FYFV have helped to shape the Integrated Neighbourhood Working programme in Lincolnshire over the last 18 months.

1.2 Lincolnshire Context

In 2013 Neighbourhood Teams was one of the key priorities for the Lincolnshire Health and Care (LHaC) programme to develop integrated services that supported individuals to remain at home or 'closer; to home and avoid unnecessary hospital attendances or admissions.

The programme led to some excellent multi professional working between the main statutory services with Multi-Disciplinary Team meetings being held regularly in parts of the County to identify and support individuals with the most complex or complicated situations.

However the challenge for Lincolnshire and the rest of the Country is not necessarily the individuals who have the most complex or complicated level of need because as a system we know who they are, but we do not coordinate or join up their care very well and this must improve as part of the work programme.

True transformational change will only start to happen when as a community, we start to tackle population health needs as a local system, as a continuum of advice, guidance, coordination, support and care through prevention, self-care, self-management, peer support, case management and or complex case management.

As LHaC became the STP for Lincolnshire it was agreed that a new approach was needed to help drive through real transformational change, learning from national programmes such as the Vanguard sites and the Primary Care Home (PCH)model, Neighbourhood Teams needed to expand to deliver Integrated Neighbourhood Working based on whole populations not just on those individuals with the highest level of need.

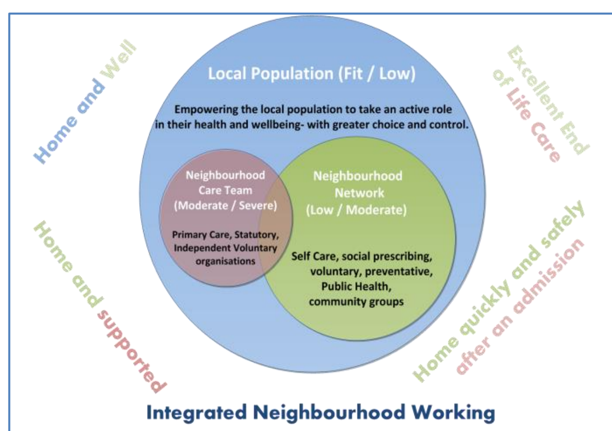
Integrated Neighbourhood Working - 2017 onwards

This large programme of work is the 'flagship' development for the STP. It is a complex, multi stranded development, which is aimed at transforming the way in which people are identified and supported with their local communities, utilising all of the community capacity within each Neighbourhood area.

The vision for Integrated Neighbourhood Working is simple;

'Empowering the local population to take an active role in their health and wellbeing, with greater control and choice.'

Taking the learning from the national programmes it has been agreed to adopt the four key characteristics of the Primary Care Home model for Lincolnshire – with an agreement that the population size would increase to 75,000 and to connect the clear interdependencies between the Integrated Neighbourhood Working and the Primary Care Programmes.



This graphic illustrates the shift to whole population health management in the Integrated Neighbourhood Working programme and the interdependencies between the core team, the network and the wider health determinants.

2. Better Care Funding

A System agreement was reached in the summer 2017 that £4m of the Better Care Funding over the next 2 years should be invested in Integrated Neighbourhood Working to help to increase the scale, pace, leadership and clinical oversight into the programme of work.

CCGs and Primary Care were asked to develop plans with key partners and stakeholders for a decision to be made about the next localities to be supported.

Three key roles were identified as a must have for each agreed neighbourhood;

- Neighbourhood Team Lead
- GP Lead
- Project Manager

2.1 Phase 1 Sites (June 17 onwards)

a. Gainsborough – population 45k – Went live in June 2017
b. Lincoln South – population 55k, phase 1 – Care Homes went live December 2017
c. Stamford – population 30k– Joined the National PCH model in Nov 2016
d. Boston – population 75k
e. South West - Grantham town and rural – Population 77k
f. South - Spalding – Population 78k

2.2 Phase 2 Sites (April 18 onwards)

a. Lincoln North
b. Lincoln City South
c. East Lindsey North – Louth and surrounding villages
d. East Lindsey Middle – Skegness, Horncastle, Woodhall Spa
e. South West – Spalding
f. South – Holbeach, Market Deeping, Little Sutton

3. Integrated Neighbourhood Working Programme

3.1 Leadership, the 'Core' Team and the Network.

Neighbourhood Team Lead

- Responsible for leading the development and implementation of Integrated Neighbourhood Working.
- Cultural and behavioural role model
- Organisationally agnostic
- Mentor / support to the GP Lead
- Developing the team / network through coaching and mentoring
- Accountable to the local Steering Group for the performance of the team and network against the agreed outcomes and the governance framework.
- Updates to partner organisations on performance and progress.

GP Lead

- Clinical lead and advisory lead for the local Neighbourhood.
- GP expert / advisor on the clinical redesign pathways
- Advocate and peer champion for Integrated Neighbourhood Working.
- Ambassador for 'new ways of working'.
- Unblocking and challenging current practice with peers and wider system.
- Recognising and making system connections
- Mentor / support to the NHT Lead

Core Team – (Example of Gainsborough's Members)

- Voluntary Sector infrastructure
- Health Providers (Lincolnshire Community Health Services NHS Trust and Lincolnshire Partnership NHS Foundation Trust)
- Lincolnshire County Council Adult Care
- Carers First
- Alzheimer's Society
- Fire and Rescue
- West Lindsey District Council – Housing
- The Managed Care Network
- Wellbeing Service

The Network - (Example of Gainsborough Network)

- Job Centre Plus
- Domiciliary Care provider
- Care Homes
- Frailty Unit at Lincoln County
- Third sector and voluntary sector

3.2 The Importance of Organisational Development

One of the most critical elements to the success of Integrated Neighbourhood working is the recognition of the level of cultural and behavioural change that is required by the workforce to be able to have a 'different conversation' between themselves, users of services and the public.

The focus of the conversation is to understand 'what matters to the individual' not 'what's the matter with them', using a strength based approach, positive risk taking and de- medicalising their situation when appropriate.

With this in mind we have been developing a comprehensive Organisational Development programme with funding support from the Integrated Personal Commissioning Programme and Lincolnshire Workforce Advisory Board and has personalisation at the heart of it – this has been and is being made available to all sites.

The programme incorporates following elements;

- Diagnostics, team building and individual OD support
- Service Improvement
- Personalised Care and Support Planning working with Helen Sanderson and Associates
- Integrated Assessment – developing trust and understanding roles and responsibilities.
- Enhanced Make Every Contact Count training, to include personalisation and care navigation competencies.

3.3 The Operating Framework (see Appendix A)

The 5 key functions of the operating framework are now clearly identified and defined.

i. Understanding the local population – through an **identification** process such as public health demographics and risk stratification of a local primary care population.

ii. A range of **local area coordination** is required to enable an individual to understand the level of support they require through self-navigation, aided navigation and supported coordination.

iii. The individual, core neighbourhood team and network identify a key worker if required and co-produce a **person centred care and support plan.**

iv. The core neighbourhood team and network deliver the plan supporting the individual to reach their agreed outcomes.

v. The individual care and support plan is regularly reviewed to manage any changing needs and requirements.

3.4 The System Metrics and Integrated Neighbourhood Working Outcomes

The key system metrics are clear for the Out of Hospital programmes of work of which Integrated Neighbourhood Working is one; the others are Urgent Care (Clinical Assessment Service, Urgent Care Streaming, Out of Hours services) and Transitional Care

1. A reduction in avoidable non elective admissions
2. A reduction in A&E attendances
3. A reduction in Delayed Transfers of Care
4. A reduction in Readmissions within 30 days

The trajectory for the Out of Hospital portfolio is based on the original calculations of a 13.9% shift over 5 years from secondary care to community including a 2.5% increase / year in activity.

To be able to demonstrate the impact and outcomes of the Integrated Neighbourhood Working programme on people, workforce and ultimately the system, The Integrated Neighbourhood Working Outcome framework is focusing on 2 key areas;

1. People are better able to manage their health and lifestyle (Care Navigation / social prescribing)
2. People are supported to have a different conversation to develop a personalised care and support plan with individual outcomes and ways of delivery.

4. Progress to date

4.1 Neighbourhood Team Lead – Assessment Centre

A two day assessment centre has just been completed by a number of candidates – supported by over 25 partner and stakeholder organisations including GPs, CCGs, Lincolnshire Care Association, Lincolnshire County Council, Healthwatch, patient expert and health providers.

The focus of the recruitment process was to really understand the individual's behaviours and values as these are seen has critical to the success of the role.

6 NHT Lead posts have been appointed to (1 interim) and have been operational from 1 February 2018.

There are 4 posts outstanding, with a second assessment centre is being held on the 19th and 20th April.

4.2 GP Lead

Each Neighbourhood has identified a GP lead to support their local programme.

4.3 Prevention, Care Navigation and Self Care

These are critical projects for the Primary Care and Integrated Neighbourhood Working programmes, as the focus is helping the System, workforce and the public to make the shift from a medicalised approach to health and wellbeing to an individual strength and asset based approach.

This is being delivered through collaboration between Public Health, the Voluntary sector, Integrated Neighbourhood Working and the Primary Care programmes.

There are four key work streams;

a. Advice and Guidance – working with Lincolnshire County Council in the procurement of a Library of Information for Lincolnshire – go live date 1 August 2018.
b. Health Literacy – training being offered and taken up by a wide range of partner organisations.
c. Care Navigation – Enabling the individual to access the right level of support, at the right time, first time, to help manage a wide range of needs. Working closely with the Voluntary sector infrastructure organisations and the newly recommissioned Wellbeing Service in developing a sustainable model for Lincolnshire. The Make Every Contact Count (MECC) training has been developed to include the bronze competency level of care navigation framework in the GP FYFV and Lincolnshire's Home First principles. This is being offered to all emerging sites.
d. Social Prescribing – is a means of enabling primary care services to refer individuals with social, emotional or practical needs to a range of local, non-clinical services, when a medical intervention or just treating clinical origins is not getting to the root of the individual's problem. The work programme is part of the Care Navigation development.

4.4 Gainsborough

Gainsborough has just reached completed its quarterly review the following outcomes:

a. Introduced personalised care and support planning with the core team
b. Organised and led 4 really well attended stakeholder engagement events which has led to an increase in members of the core team
c. Invested in the local Voluntary Centre Services to develop a referral route into the social prescribing offer from the third sector
d. 150 individuals in a number of settings have been supported with a variety of solutions from advice and guidance, social prescribing, care navigation, case management and advanced care planning.
e. Colocation offer at John Coupland Hospital for the Core team and the wider network.

Lessons Learnt So Far

a. Key enablers need to actively participate in the programme- IM&T / Estates
b. Communication, communication, communication
c. GP engagement is crucial
d. Supporting 3rd sector infrastructure and sustainability.
e. Time is required to develop relationships
f. Contract and commissioning management

4.5 Lincoln South

Lincoln South has just started phase 1 of their programme, with an emphasis on the 17 Care Homes in their Neighbourhood. The Core Team are working with the staff to identify the residents level of frailty and then put in place the appropriate care and support planning, including advanced care plans. They are also supporting the Homes with any identified training needs, advice or guidance. The Core Team are working very closely with the GP Federation who have started to see a reduction in GP call outs due to the responsiveness and skill set of the team.

4.6 Grantham and Spalding

The two GP Federations in the South of the County are working together to implement the GP FYFV and Integrated Neighbourhood Working – recognising that some of the component parts of the operating framework can be done once over a larger population such as the approach to Care Navigation and the voluntary sector infrastructure behind access into local social prescribing offers.

Grantham and Spalding have been identified as their initial sites but they are looking to start to implement the approach much wider over the next 6 months, with a more hub and spoke model, which will include 1 NHT lead each for South and South West with an appropriate infrastructure in place to support smaller Neighbourhoods. The model includes a complex case manager role as a key link between GP practices and the 'core' team and the wider network. They have a clear remit around identifying and proactively working with the older population.

4.7 Boston

Boston have identified their core team and are setting up a Boston Steering Group. They have agreed to focus on Delayed Transfers of Care initially with an agreement that as the pathway is developed, that individuals who are discharged will receive responsive and proactive support around personalised acre and support planning to help reduce the possibility of readmission.

The planning group have shown a really keen interest in Care Navigation and Social Prescribing and the impact this could have on Primary Care workload. They are currently training up the Primary Care workforce and offering this out to the wider community and are in discussion with the Voluntary sector infrastructure about delivering a similar model to Gainsborough.

4.8 Stamford

Stamford are part of the Primary Care Home model and have developed a very clear vision and strategy for the area, they have had a core team operating for some time now with a focus on individuals with a high level of need and complexity but recognise the requirement for extending their scope. The team are starting to collocate in Stamford Hospital.

Stamford are focusing on population identification and segmentation – working with National Association Primary Care, Lincolnshire Public Health and the STP.

The team in Stamford have excellent GP leadership and engagement, plus real support from Peterborough Hospital in the programme of work.

4.9 Next Steps

Phase 1 sites have plans in place and have identified their next steps to ensure that by the 1st April 2018 they **all** will be able to start to demonstrate Integrated Neighbourhood working in their area. This will be through a more targeted approach than was originally used in the first site.

Phase 2 sites will start to implement planning and delivery of Integrated Neighbourhood Working from 1st April 2018.

The progress of each Neighbourhood is being managed through the Countywide Learning and Development forum and each area is accountable to the Integrated Neighbourhood Working Strategic group.

Recruitment to the remaining 5 NHT Lead posts and to start to build up the work programme in the areas which have not been involved so far. This will mainly be in the east of the County.

Work is ongoing on the outcome metrics and framework and how this could be used to shape a different approach to commissioning and contracting for 'place based' care.

Lincolnshire has also been recognised by the Rt. Hon. Jeremy Hunt, the Secretary of State for Health and Social Care, in a speech he made on the 20 March 2018 as one of 3 pilot areas over the next two year that will ensure '*that every single person accessing adult social care will be given a joint health and social care assessment and - critically - a joint health and care and support plan, where needed'* and will be *'offered an integrated health and care personal budget.'*

Being able to deliver the above promise will need to happen through the Integrated Neighbourhood Working programme fortunately we are best placed and geared up to start to deliver that new way of working.

4.10 Links to the GP Five Year Forward View

Out of the 10 high impact actions – Integrated Neighbourhood Working will be integral or contribute to the success of the following

a. Active Sign Posting
b. Develop the practice team
c. Productive work flows
d. Partnership working
e. Social prescribing
f. Self-care support

5. Consultation

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide health overview and scrutiny committees with a specific statutory role in relation to consultations on substantial variations or developments in NHS services, where there is an obligation on the responsible commissioner to consult.

This report is not a statutory consultation item within the scope of the 2013 Regulations. This is because the direct service impacts on patients, for example in terms of accessibility of services, are not substantial. However, the Health Scrutiny Committee has an opportunity to provide feedback on the progress of Integrated Neighbourhood Working as part of its consideration of this report.

6. Conclusion

The report outlines the background to the evolution of the Integrated Neighbourhood Working programme and its links to both national and local priorities. It describes the need for OD support and the role of leaders, the operating framework, and the progress being made in the emerging localities.

It is presented to inform the Health Scrutiny Committee of current progress in delivering Integrated Neighbourhood Working

7. Appendices – These are listed below and attached to the report

Appendix A	The Neighbourhood House

8. 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 Kirsteen Redmile, who can be contacted on 01522 307315 or Kirsteen.Redmile@lincs-chs.nhs.uk

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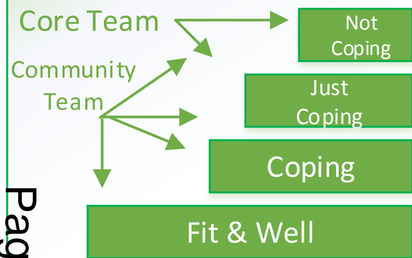
Lincolnshire Sustainability and Transformation Partnership

NHS

(A)
Integrated Neighbourhood Working
Empowering the local population to take an active role in their Health and Wellbeing with greater choice and control

(B) POPULATION IDENTIFICATION

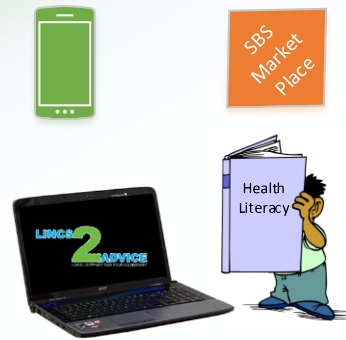
Person selection via data analysis and practitioner assessment



TARGETING THOSE ON THE 'COPING STEPS'

(C) AWARENESS/SIGNPOSTING & NAVIGATION (LOCAL AREA COORDINATION)

(C1) I can do it for myself



(C2) I need help and advice so I can do it by myself

Telecommunications

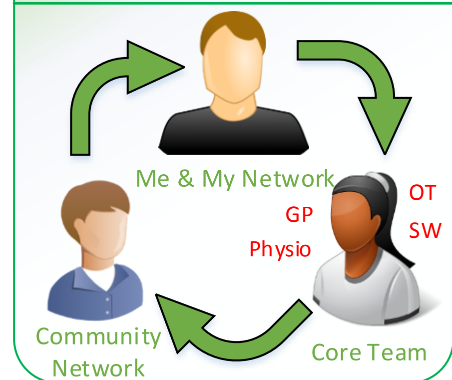
(C3) I need someone to coordinate my care & support

Support Partner

'A guiding hand'

(D) PERSON CENTRED ASSESSMENT, CARE & SUPPORT PLANNING

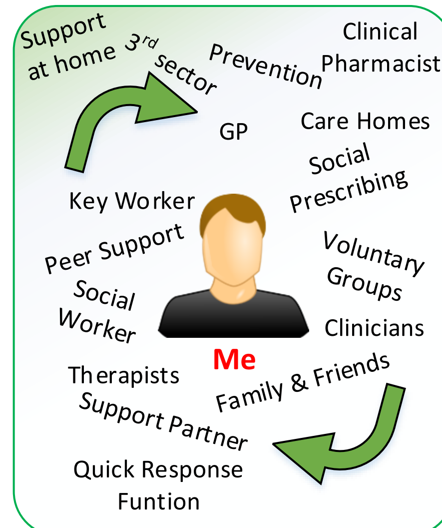
Care Coordination and having a 'different conversation'



(D2) ONE TO ONE SUPPORT

- Self Care Strategies
- Social Prescription
- Peer Support
- My Support Plan & Joint Assessment
- My Anticipatory Plan
- My Escalation Plan

(E) WRAP AROUND LOCAL SUPPORT



(F) INTEGRATED NEIGHBOURHOOD WORKING CORE PRINCIPLES

- F1 HAVING A DIFFERENT CONVERSATION
- F2 HOME FIRST
- F3 ENABLING SELF CARE & PEER SUPPORT
- F4 WHAT'S IMPORTANT TO ME?
- F5 COLLECTIVE ACCOUNTABILITY ACROSS NEIGHBOURHOOD WORKING
- F6 POSITIVE RISK TAKING
- F7 ASSESSING IMMEDIATE NEEDS & ADDRESSING BARRIERS TO IMPROVE QUALITY OF LIFE

(G) OUTCOMES

G1 PERSONALISED

- I know where to get the information I need
- I know who's coordinating my care & support
- I've had a different conversation - **once**
- I have choice & control
- My plan was designed by me with support & guidance from others
- I know how to look after myself with advice and guidance

Me

G2 Workforce

- Enjoy their job
- Feel part of integrated neighbourhood working
- Right skills & competencies
- Have a different conversation

G3 The System

- Reduce DTOC
- Sustainable services
- Reduction in avoidable hospital admissions
- Right people, right place, right time

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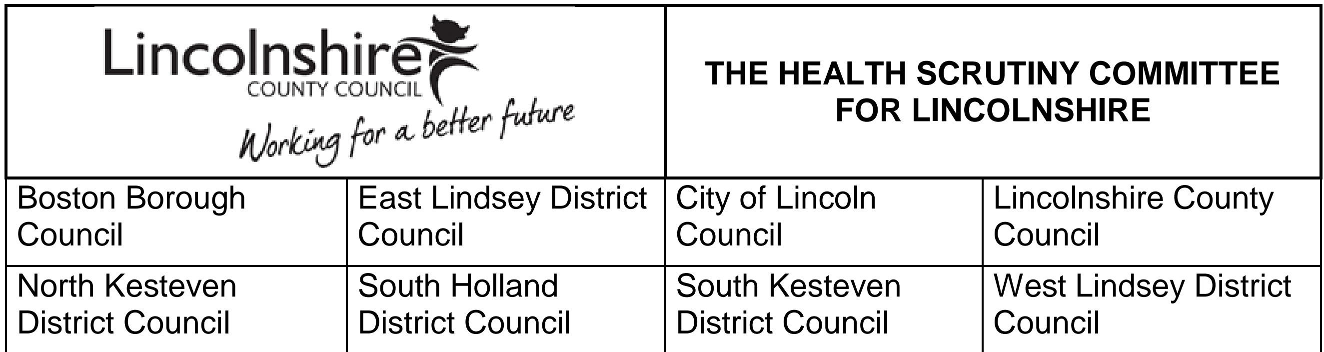
Agenda Item 9



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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 April 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

The items listed for today's meeting are set out below: -

18 April 2018 – 10 am	
Item	*Contributor*
United Lincolnshire Hospitals NHS Trust Update	Jan Sobieraj, Chief Executive United Lincolnshire Hospitals NHS Trust Karen Brown, Director of Finance, United Lincolnshire Hospitals NHS Trust
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

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

16 May 2018 – 10 am	
Item	*Contributor*
Lincolnshire Sustainability and Transformation Partnership – Update (including Acute Services Review)	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
Winter Planning: Review of 2017-18 and Initial Plans for 2018-19	Sam Milbank, Accountable Officer, Lincolnshire East CCG Ruth Cumbers Urgent Care Programme Director, and Senior Responsible Officer, STP Urgent Care Programme

13 June 2018 – 10 am	
Item	*Contributor*
United Lincolnshire Hospitals NHS Trust – Care Quality Update	Michelle Rhodes, Director of Nursing, United Lincolnshire Hospitals NHS Trust
Annual Report of the Director of Public Health	Tony McGinty, Consultant in Public Health, Lincolnshire County Council
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

12 September 2018 – 10 am	
Item	*Contributor*

<u>Items to be Programmed</u>

- Cancer Care (including prostate cancer services)
- 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
- NHS Staff Survey 2017

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
- East Midlands Ambulance Service NHS Trust
- 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