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

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 14 November 2018 at 10.00 am in Committee Room One - County Offices, Newland, Lincoln Lincs LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), Mrs K Cook, M T Fido, R J Kendrick, C Matthews, R A Renshaw, R H Trollope-Bellew and R Wootten

District Councillors: P Gleeson (Boston Borough Council), C L Burke (City of Lincoln Council), Mrs P F Watson (East Lindsey District Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and P Howitt-Cowan (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
6	**Lincolnshire Urgent and Emergency Care - Progress with the Development of Urgent Treatment Centres** *(To receive a report submitted on behalf of the Lincolnshire Sustainability and Transformation Partnership on the progress with the development of urgent treatment centres in Lincolnshire. Urgent treatment centres are a national initiative led by NHS England and the aim is that a network of these centres will be open from December 2019 across the country. The report was written by Ruth Cumbers, Urgent Care Programme Director and Sarah Stringer, Urgent Care Programme Manager)*	49 - 66
7	**Annual Report of Lincolnshire East Clinical Commissioning Group** *(To receive a report from Samantha Milbank, Accountable Officer, Lincolnshire East Clinical Commissioning, which enables the Committee to give consideration to the Annual Report for 2017/18 for Lincolnshire East Clinical Commissioning Group)*	67 - 106
LUNCH 1PM - 2PM		
8	**Delivery of the NHS England National Cancer Strategy in Lincolnshire** *(To receive a report submitted on behalf of the Lincolnshire Sustainability and Transformation Partnership on the progress with the delivery of the NHS England National Cancer Strategy (Achieving World-Class Cancer Outcomes) in Lincolnshire. This report was written by and will be presented by Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group)*	107 - 118
9	**Integrated Community Care Portfolio** *(To receive a report submitted on behalf of the Lincolnshire Sustainability and Transformation Partnership on the Integrated Community Care Portfolio and the progress made in four of the key programme areas: neighbourhood working; the GP Forward View; the 'Integrated Accelerator Programme'; and other work related to data modelling, business change and integrated care. This report was written by and will be presented by Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group)*	119 - 136
10	**Health Scrutiny Committee for Lincolnshire - Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its work programme)*	137 - 142

Keith Ireland
Chief Executive
6 November 2018

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
17 OCTOBER 2018

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors Mrs K Cook, M T Fido, R J Kendrick, R A Renshaw, R H Trollope-Bellew and R Wootten.

Lincolnshire District Councils

Councillors C L Burke (City of Lincoln Council), Mrs P F Watson (East Lindsey District Council), Mrs R Kaberry-Brown (South Kesteven District Council) and P Howitt-Cowan (West Lindsey District Council).

Healthwatch Lincolnshire

Dr Maria Prior.

Also in attendance

Tracy Pilcher (Chief Nurse, Lincolnshire East CCG), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Katrina Cope (Senior Democratic Services Officer), Ruth Cumbers (Urgent Care Programme Director, Lincolnshire East CCG), Simon Evans (Health Scrutiny Officer), Jane Marshall (Director of Strategy, Lincolnshire Partnership NHS Foundation Trust), Sarah-Jane Mills (Chief Operating Officer, Lincolnshire West CCG), Rachel Redgrave (Head of Commissioning for Mental Health, Autism & LD, South West Lincolnshire CCG), Simon Evans (Director of Operations, United Lincolnshire Hospitals NHS Trust) and Christopher Higgins (Deputy Director of Operations, Lincolnshire Partnership NHS Foundation Trust).

County Councillors Dr M E Thompson (Executive Support Councillor for NHS Liaison and Community Engagement), Mrs S Woolley (Executive Councillor for NHS Liaison and Community Engagement) and Mrs Penny West (Member of the Public) attended the meeting as observers.

40 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors C Matthews, P Gleeson (Boston Borough Council), C J T H Brewis (South Holland District Council) and Dr B Wookey (Healthwatch).

The Committee was advised that Dr Maria Prior (Healthwatch) was the replacement member for Dr B Wookey (Healthwatch) for this meeting only.

41 DECLARATIONS OF MEMBERS' INTEREST

Councillor Mrs K Cook advised the Committee that she was a patient; and on the governing body of Lincolnshire Partnership NHS Foundation Trust.

Dr M Prior advised the Committee that she was on the governing body at Lincolnshire West CCG.

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

Councillor Mrs R Kaberry-Brown advised that she was currently a patient of United Lincolnshire Hospitals NHS Trust.

42 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 12 SEPTEMBER 2018

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 12 September 2018 be agreed and signed by the Chairman as a correct record.

43 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, the Chairman brought to the Committee's attention the Supplementary Chairman's announcements circulated at the meeting.

Some members of the Committee expressed their support to the action taken by the Chairman relating to the Grantham and District Hospital – Overnight Closure of Accident and Emergency Department. The Committee was advised that the Chairman had sought clarification from the Minister of Stare on the status of the referral made by the Committee on 31 January 2018; and whether the Minister's letter represented a determination of the January 2018 referral. The Chairman advised that he would update members of the Committee as soon as a response was received.

RESOLVED

That the Chairman's Announcements presented as part of the agenda on pages 19 – 26; and the supplementary announcements circulated at the meeting be noted.

44 WINTER PLANNING

The Chairman welcomed to the meeting Ruth Cumbers, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group and Simon Evans, Director

of Operations, United Lincolnshire Hospitals NHS Trust, which updated the Committee on Winter Planning across the Health and Care Economy in Lincolnshire.

The Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group advised the Committee that winter planning had started even earlier this year to work out the best way of responding to winter pressures as a county.

The Committee noted that for several years' winter pressures for the health and social care system in Lincolnshire had continued throughout the whole of the year; and that it was no longer just through the winter period. It was highlighted that it was known that there was increased need for urgent care and emergency departments across Lincolnshire during the winter months. To help with the pressure points, part of the solution was to encourage patients to access alternatives to emergency care where appropriate.

The Committee was advised that in September 2018, the Urgent Care Team had launched the ASAPLincs app and website. It was highlighted that ASAP had been designed to support individuals to make the right choice and signpost citizens to the most appropriate service for their condition. The report highlighted that the most common referral method to ED in Lincolnshire during 2017/18 was self-referral. It was noted that in Lincolnshire 58% of the self-referrals could have been dealt with elsewhere. The Committee was advised that following the introduction of a similar app in Gloucestershire, 15,000 people had downloaded the app in its first year and that A & E attendances had dropped by 16,000 across two acute sites, as had GP appointments involving minor ailments. It was highlighted that the public needed reassurance to look at other options and the ASAP was one way of helping with that reassurance.

The Committee was advised that the Winter Plan had been produced by the Urgent Care Team with contributions from partners across the health and care community. The plan confirmed organisational resilience and business continuity mitigations. Page 4 of the report provided the Committee with details on how the system aimed to manage pressures. It was highlighted that to support winter planning the Delivery Board had agreed to set-up a "winter room", which would be staffed seven days per week with representatives from across the urgent care system to support day to day operational resilience to manage demand, capacity and flow. It was highlighted further that the system had also put plans in place to improve ambulance conveyance to the acute hospital sites. The Committee was advised that "Home First Prioritisation" would run throughout the winter period.

It was reported that week commencing 15 October 2018, a piece of work with the East Midlands Ambulance Service had commenced to review the qualitative reasons behind conveyances. This would help crews understand the way they worked. The auditing of the work would focus on frail and older people (over 75). It was noted that the emphasis was on identifying frailty and how the system worked to reduce the number of avoidable A & E attendances and admissions for frail elderly patients. Details of the frailty work within the United Lincolnshire Hospitals NHS Trust was shown at the bottom of page 6 of the report.

The Committee was also advised that the Pilgrim Hospital site was now nearing completion if its ambitious 'Big Change' programme with the new 12-bed orthopaedic ward set to open on 1 October 2018. It was noted that Pilgrim Hospital had undergone some major reconfiguration of its urgent, emergency and ambulatory care services. It was noted that the entire 'Big Change' programme was to improve the patient experience and journey through the hospital, in addition to alleviating pressure on the emergency department; and ensuring patients did not experience long waits in A & E.

It was reported that the new integrated assessment unit would allow patients to be seen and assessed quicker; with all teams working together to ensure that the most appropriate treatment was delivered as soon as possible. It was highlighted that the £1.8 million capital investment project was a major improvement for services at the Pilgrim Hospital site.

In relation to Primary Care, the Committee was advised that GPs were now offering appointments outside of core working hours, making it easier for patients to get an appointment; and that appointments were available in advance and to book on the day.

The Committee was advised that the Winter Plan would be assured by Regulators NHS England and NHS Improvement, and was due to be signed off by the Lincolnshire Urgent and Emergency Care Delivery Board by 31 October 2018.

During discussion, the Committee raised some of the following points:-

- One member enquired as to where Louth fitted into the Winter Planning. The Committee was advised that there were plans in place for patients at Louth. There was some discussion on confusion caused by the A & E sign at Louth Hospital and the problems this caused relating to public perception. The Committee was advised that there was a cost associated with the removal of the said sign, and contact details would be provided for the relevant Highways Team;
- Launch of the ASAPLincs app. Some members enquired as to where the launch had been publicised. The Committee was advised that the app had been advertised through social media, on the back of buses countywide, various papers countywide; and that there had been a huge launch week commencing 5 September 2018 across Lincoln. The next phase would involve schools, children's centres and the media up to Christmas. Other members highlighted that every publicity route should be explored as not everyone had access to computers. Officers took on board the comments raised and also highlighted that leaflets had been issued to all district and parish councils. The Committee requested further information on the Communications Plan;
- One member enquired how patients would be made aware of the changes to GP appointments and their availability. The Committee was advised that there would be communication made available to the general public from their surgeries regarding the changes to opening times outside of core working hours;

- Some concern was expressed that some patients were being sent for treatment in Lincoln, when the service was available at Boston. The Committee noted that some services were centralised for example the cardiac service provision. It was highlighted that it was not the intention to make people travel when there was no need. It was noted that Pilgrim Hospital, Boston could be used to support Lincoln County Hospital; when demand was high. Likewise, during the summer Lincoln County Hospital was taking patients that Boston could not accept, due to increased demand;
- One member enquired whether the Communication Plan included how to get the message out about the new ASAPLincs app to community groups across the county. The Committee was advised that a lot of communication had been done in the community sector for example in local gyms, coffee shops and any other meeting places. One member highlighted that GP surgeries could be help get the message out by placing a message on their in-practice notification screens;
- A question was asked as to when the NHS would know if they were likely to receive additional funding for the proposed winter schemes. The Committee was advised that the system was better prepared this year. During the summer 16 schemes had been prioritised and were already in a position for a bid to be made should funding become available;
- One member enquired as to what the Winter Communication Plan consisted of and what platforms were intended to be used. It was noted that similar plans were in place as they had been in the previous year to reduce routine and elective operations before Christmas; and that priority would be given to urgent cases and cancer care;
- Concern was expressed that in the previous year there had been a reduction in the number of beds for the children's departments, so that staff could support the A & Es. With the extreme pressures on services currently at Pilgrim Hospital, Boston, a question was asked whether it was proposed to reduce or suspend services further to deal with pressures as they arose; and if such action was to be taken when would the Committee be advised of such happenings. The Committee was advised that to sustain services through the winter, services had to be more resilient. Steps had been taken to make services more resilient such as streaming in A & E; steps were also being taken in Primary Care and other services, so that there were contingency plans in place for A & E. With regard to paediatrics there were a number measures in place that the Committee was already aware of and it was not expected that these would change. There was fragility especially with sickness and leave but locums would be used to bridge any gaps;
- One member extended thanks personally to staff at Pilgrim Hospital, Boston for their impressive emergency service; and
- A question was asked as to why some cardiac patients were still sent to Glenfield Hospital, when Lincoln had a superb unit. Confirmation was given that Lincoln was an excellent centre, however, it still was unable to deal with some specialist procedures; and a minority of patients were dealt with by Glenfield Hospital.

The Chairman extended thanks on behalf of the Committee to the two representatives.

RESOLVED

1. That the approach to this year's winter planning be noted.

2. That a request be made for the Committee to be kept informed of the situation over the winter period and is made aware of any fragilities as soon as possible; and a request is made for an update on the successes or failings of the plan after the winter period.

45 LINCOLNSHIRE SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP: MENTAL HEALTH

The Chairman welcomed to the meeting the following representatives:-

Jane Marshall, Director of Strategy, Lincolnshire Partnership NHS Foundation Trust, Rachel Redgrave, Head of Commissioning, Mental Health, South West Lincolnshire Clinical Commissioning Group and Christopher Higgins, Deputy Director of Operations, Lincolnshire Partnership NHS Foundation Trust.

The Chairman also advised that a member of the public, Mrs Penny West had requested to address the Committee with regard to the report. The Chairman invited Mrs West to speak for a period of 3 minutes to address the issues set out in the report.

In her short address to the meeting Mrs West raised the following questions:-

- Page 30 of the report - The provision of community mental health services for working age adults (People aged 18 to 65). Whether people aged 66 and over would be disadvantaged; and whether this was an example of age discrimination. Reassurance was given that there was no discrimination on the basis of age, but traditionally mental health services had been organised into 0 – 18, 18 – 65, and 65+. Confirmation was given that people would be able to access services regardless of age;
- Page 34 of the report – Older Adult Services. Whether the beds provided were short term and whether issues of patient isolation were being addressed. Clarification was given that works were about to commence to upgrade patient environment at Brant Ward, Lincoln to create single rooms to protect patient dignity. Confirmation was given that day room facilities would also be available; and
- Page 32 of the report – Workforce Development – whether there would be 'deskilling' of staff. The Committee was advised that the workforce plan was to support the service transformation. To ensure successful delivery it was critical there was a skilled and well-supported workforce, who was trained to deliver evidence based interventions at the right level. It was highlighted that nurses would always be supported by a doctor. It was highlighted further that the changes to roles were to help meet the recruitment difficulties Lincolnshire was facing.

In guiding the Committee through the report presented there was an acknowledgement of the Health Scrutiny Committee for Lincolnshire and the Lincolnshire Health and Wellbeing Board's support to mental health work stream.

It was highlighted that the content of the report focussed on what was in the Lincolnshire Sustainability and Transformation Partnership (LSP). It was highlighted further that the priorities for the Lincolnshire Partnership NHS Foundation Trust (LPFT) were the repatriation of mental health patients back to Lincolnshire, and the transformation of the community mental health teams. Page 29 of the report detailed that the LPFT was currently looking at bringing back both male and female patients who currently went out of county for bed based psychiatric intensive care and acute mental health placements. The report highlighted that since the start of the programme the number of male patients going out of area for psychiatric intensive care had been reduced to zero and the total number of patients who went out of area for care had reduced and regularly dipped below the trajectory of 18 patients. It was highlighted further that the plan was to reduce the number going out of county further.

The report highlighted that part of the solution to reduce the numbers was to improve the provision in Lincolnshire through the transformation of community mental health teams. The Committee was advised that over the last 18 months, the division had listened to patients and stakeholders; and that their comments had been used to shape the current service plan to ensure that it was fit for purpose. It was noted that the service plan consisted of three distinct pathways: Long Term Care, Psychosis/Trauma and common mental health disorders. Details relating to the transformation were shown on pages 30 to 32 of the report.

The Committee was advised that the Lincolnshire Mental Health Crisis Concordat had been successful in securing capital funding of £640k to develop 'places of safety' in both Lincoln and Pilgrim Emergency Departments; and to build a mental health crisis hub. The Committee noted that LPFT had also received additional income for perinatal mental health services for women and families; and that the county council continued to support the improvement of mental health services for children and young people with investment in Healthy Minds, in addition to the Section 75 Contract for Adult Care and the Managed Care Network. It was also highlighted that Lincolnshire had excellent community services in place for children and young people; and an excellent inpatient unit for Child and Adolescent Mental Health Services in Lincolnshire based in Sleaford.

Reference was also made to the Lincolnshire Multi-Agency review of crisis care commissioned by Lincolnshire County Council to obtain a clear picture of commissioned mental health crisis services across Lincolnshire. Details of the key issues of the review were listed on page 33 of the report. It was highlighted that the review had not demonstrated anything that was not already known, but had provided an opportunity to reflect on how Lincolnshire needed to work across the system of provision to respond.

In conclusion, the Committee noted that the Lincolnshire Sustainability and Transformation Partnership and the Lincolnshire Health and Wellbeing Board were

supporting mental health and learning disability developments for the benefit of Lincolnshire patients.

During discussion, the Committee raised the following points:-

- Some reassurance was sought as to when patients were sent out of area, they were receiving the same excellent care that was provided in Lincolnshire. Reassurance was given that adult contracts were regularly reviewed and visits were made. It was noted that for Children and Young People the LPFT worked closely with NHS England. Further reassurance was given that part of the commissioning role was to do quality and safety checks to make sure appropriate standards were maintained;
- Some concern was expressed relating to the transition from children to adults; and the responsibilities up to the age of 25. Clarification was given that the 0 – 25 age range for responsibility was for Special Educational Needs and Disabilities. For mental health services, the service would work with the young person up to the age of 24, and then steps would be taken on an individual needs basis dependent when transition took place;
- Whether staffing levels at the Psychiatric Intensive Care Unit (PICU) been maintained. It was reported that it had been a challenge to recruit staff, due to its nature and environment. There had however been an increase in the salary, which had seen some benefit with regard to maintaining staffing levels;
- The number of Child and Adolescent Mental Health Services (CAMHS) placed out of area. The Committee was advised that the number of children place out of area fluctuated. It was noted that out of area placements were sought for the most complex and specialist needs and that these were the responsibility of NHS England;
- Had the refurbishment work at Ash Villa been completed? The Committee was advised that the refurbishment work had been completed;
- Location of the Physical Healthcare Clinics – It was reported that some localities now had physical healthcare clinics, details of which would be shared with the Committee;
- Numbers of people attending the benefit groups. It was noted that it was on the increase and that the Grantham Community Mental Health Team was trialling benefit drop in sessions to support patients with this dimension of living. One member enquired whether this was a role for the Citizens' Advice Bureau (CABx) and not for mental health professionals. Reference was also made by a member to a reduction in funding to the CAB from the County Council which had affected some the CABx, particular reference was made to the Lincoln CAB. Clarification was given that the CAB did also receive funding from other organisations; and to the fact that the Grantham CAB had continued to expand;
- Whether waiting times for psychology services had reduced. The Committee was advised that waiting times had reduced significantly; and that work would continue on reducing the waiting times to a single referral route in for patients and a multi-disciplinary team working together to make sure that the patient saw the most appropriate professional for their care;

- Some concern was expressed to the 18 patients placed out of area; of which 11 were female being away from their families. Some assurance was sought that this figure needed to be reduced; and what steps were being taken. The Committee was advised that the matter was being considered and at the moment it was felt that a female PICU was not the answer and that a different approach was needed. It was highlighted that a bid had been put in as part of the STP to develop estate and that more would be known in November;
- Where the Bi-Polar Group met and how many attendees were from Lincolnshire. The Committee was advised that this information would be provided after the meeting;
- Crisis Hub – The Committee was advised that the Lincolnshire Mental Health Concordat had been successful in securing capital funding to develop places of safety and to also build a crisis hub. It was reported that the new hub would provide space for patients and carers to access advice and support from LPFT mental health services, alongside supporting organisations such as housing, homelessness support, relationship advice, debt management and drug and alcohol services;
- The increase in young people needing mental health support. One member enquired whether there were enough resources. The Committee was advised that GPs would advise that there were enough resources in place, but children had to be quite poorly to get in to them. The Committee was advised that Healthy Minds was now promoted in schools to ensure that children received help earlier; and
- A request was made for a copy of the Workforce Plan and details of the localities of the physical healthcare clinics to be made available to the Committee.

The Chairman on behalf of the Committee extended thanks to the three representatives for their informative presentation.

RESOLVED

1. That the progress of the STP mental health priority be noted.

2. That a copy of the Workforce Plan and details of the locations of the Physical Healthcare Clinics be made available to the Committee.

3. That a report on Home Treatment Services be presented to the Committee when released in early 2019.

46 ANNUAL REPORT OF LINCOLNSHIRE WEST CLINICAL COMMISSIONING GROUP

The Chairman welcomed to the meeting Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group (LWCCG).

The Committee was asked to give consideration to the Annual Report for 2017/18 for LWCCG (pages 1 to 54 only), a copy of which was detailed at Appendix A to the report.

The Committee were invited to ask questions from which the following points were raised:-

- Page 74 Involving Patients and the Public – The Committee was advised that the CCG had well established communication and feedback mechanisms in place to keep patients and the public well informed, which were used to promote local and national campaigns, and services provided;
- Page 5 – some concern was expressed concerning the diseases that impacted most upon life expectancy in Lincolnshire West, particular reference was made to deaths under 1 years of age;
- Page 92 – Women and Children, particular reference was made to maternity choices. The report highlighted that it was essential that women and children had safe, high quality care, at the right time and at the right place; and as close to home as possible; with a choice of place of care wherever possible; and that the care delivered was by the most appropriate levels of staff with the skills and expertise required. It was highlighted that the Local Maternity Systems Group continued to work across the system; and that the transformation team were hosted by Lincolnshire East CCG;
- Page 58 – Better Care – Some concern was raised at the CCG's performance for Maternal smoking at delivery; choices in maternity services. A question was asked what was being done to improve performance. The Committee was advised that the Lincolnshire approach was being driven through the Better Births Lincolnshire Programme, whose work included supporting smoking cessation during pregnancy; encouraging breast feeding; and reducing neonatal mortality and still births. It was highlighted that smoking prevalence during pregnancy was a Lincolnshire wide issue and that work was being undertaken by the four CCGs and Public Health regarding this matter. It was highlighted that every still birth was a tragedy and that 20% of mums had been smoking throughout their pregnancy;
- It was highlighted that the report made reference to the stopping of services that did not deliver good results; as there appeared to be no detail as to what these areas might be. It was highlighted that any substantial changes to a service would lead to a full consultation; where a specific treatment had no clinical or minimal benefit to the patient, it was unlikely there would be a consultation. It was highlighted that even before any consultation, a full equality impact assessment would be carried out as many changes would be countywide not just in LWCCG area;
- The likely location of the two primary hubs. The Committee was advised that the likely location of the two primary hubs would be south of Lincoln and in the Gainsborough area;
- Actions that were being taken to improve areas not meeting the minimum criteria, such as dementia care, psychosis, physiological therapies, staff engagement etc. It was noted that work was ongoing to look at ways to provide mental health services differently;
- The Committee noted that there was a will to develop integrated care with a system approach. To improve what was already available, Lincolnshire would

need to identify people who needed diagnostic testing earlier and then have the necessary follow up support available as a system;

- Page 86 advised of a number of objectives that needed to be met. Confirmation was sought as to whether these had been met. The Committee was advised there was number of the cancer targets not meeting the 62 day standard, there was however targeted work ongoing to meet the cancer pathway. It was highlighted that in the last six months the United Lincolnshire Hospitals Trust was now in the top 70, as some positive improvements had been made. There was a realisation that this figure was still not good enough; and there was a will to achieve 85% for a longer period. It was also noted that improvements had been made to get men to have a blood test earlier for the detection of prostate cancer. The Committee was advised that Cancer Care was an item included in the agenda for the 14 November 2018 meeting.

The Chairman on behalf of the Committee extended his thanks to the representative.

RESOLVED

That the Annual Report of Lincolnshire West Clinical Commissioning Group be noted and that the Committee receive an update on the 360 degree stake holder survey to a future meeting of the Committee.

47 LOUTH COUNTY HOSPITAL INPATIENT SERVICES - SURVEY

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which asked the Committee to finalise its response to the survey being undertaken by Lincolnshire East Clinical Commissioning Group on Inpatient Services at Louth County Hospital.

The Health Scrutiny Officer confirmed that a copy of the draft response had been circulated by email, a copy of which was circulated at the meeting. It was highlighted that the response had been based on the views of the working group who were in support of Option 2.

During consideration of the draft response document, the following comments were raised:-

- Reference was made to the East Lindsey District Council Resolution from their 10 October 2018 meeting; which urged the Lincolnshire East Clinical Commissioning Group (LECCG) to maintain the level of excellence at Louth County Hospital and for LECCG to engage in full and proper consultation with the community before any decision was made. Reference was also made to the Louth Town Council Resolution from their 9 October 2018 meeting which recognised the reduction in hospital bed provision that should only be introduced when there was adequate neighbourhood working and social care and that support for Louth Hospital was extended for continued services in both outpatient and inpatient departments and that this should be built on. (Copies of which were circulated at the meeting);

- Page 1 of the response letter to Dr Stephen Baird – A suggestion was made that the second sentence in the last paragraph should be amended to include social care. The Committee following a short discussion agreed that reference to social services should not be included in the response as LECCG was not responsible for social services and a suggestion was made that East Lindsey District Council should write to the Leader of the Council Councillor M J Hill OBE if it wished to raise any issues regarding social care; and
- Page 2 of the response letter to Dr Stephen Baird – That the heading Arrangements for the Survey Period should be amended to read '*Arrangements for the Engagement Period'* and that other references throughout the response should be amended accordingly.

RESOLVED

1. That the attendance of Councillors Mrs P F Watson and C Matthews at the engagement events held in Louth on 2 October 2018 be noted.

2. That the Health Scrutiny Committee for Lincolnshire approves its final response to Louth Hospital In-patient Engagement exercise, based on the draft response of the working group, subject to the above amendments being made.

48 INTEGRATED CARE PROVIDERS CONTRACT ARRANGEMENTS - CONSULTATION

The Committee gave consideration to a draft response document concerning the Integrated Care Provider Contract, which had been emailed out to members of the Committee, a copy of which was tabled at the meeting.

The Health Scrutiny Officer presented the draft response of the working group.

The Committee noted that a separate response was also being prepared on behalf of the Lincolnshire Health and Wellbeing Board.

RESOLVED

That the working group's response to the Integrated Care Providers Contract Arrangements be approved.

49 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 scrutiny activity was focussed where it could be of greatest benefit.

The Committee gave consideration to the work programme as detailed on pages 106 to 107 of the report presented. The Committee noted that the Dental Services in Lincolnshire item was to be deferred to a future meeting.

RESOLVED

That the work programme presented be agreed subject to the change as detailed above.

The meeting closed at 12.40 pm

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 November 2018**
Subject:	**Chairman's Announcements**

1. NHS Long Term Plan

On 18 June 2018, the Prime Minister announced a long-term funding settlement for the NHS: an average annual real terms growth rate of 3.4% over five years. In return, the Government has asked NHS England and NHS Improvement to set out by the end of November 2018 a long term plan for the NHS which:

a. delivers on the NHS's existing Five Year Forward View commitments;
b. sets out a five year plan to deliver clear improvements and financial stability for the NHS; and
c. articulates ten year high level ambitions for further improvements to patient outcomes.

The Government also specified five financial criteria to put the NHS on a sustainable footing:

a. improving productivity and efficiency;
b. eliminating deficits;
c. reducing unwarranted variation so people get consistently high standards of care wherever they live;
d. managing demand effectively; and
e. effective use of capital investment.

NHS England and NHS Improvement have stated that from November 2018 until March 2019 they will work with the NHS locally and regionally, including Sustainability and Transformation Partnerships, to map out implications of the national priorities for local services and people.

In view of the importance of the long term plan for the NHS, the Committee is invited to consider including an item on its December agenda.

2. North West Anglia NHS Foundation Trust – Care Quality Commission Inspection Report

On 24 October 2018, the Care Quality Commission (CQC) published its inspection report on North West Anglia NHS Foundation Trust, which manages Peterborough City Hospital and Stamford and Rutland Hospital, as well as Hinchingbrooke Hospital in Huntingdon. The CQC report was based on inspections, which took place between 5 June and 12 July 2018.

This was the first inspection report since the creation of the newly merged trust in April 2017. Overall the trust was rated as 'requires improvement'. However, both Peterborough City Hospital retains its 'good' rating. Stamford and Rutland Hospital also retains its 'good' rating, but was not inspected in June or July.

3. United Lincolnshire Hospitals NHS Trust – Senior Management Retirements

Chief Executive

On 25 October 2018, the Chair of United Lincolnshire Hospitals Trust (ULHT) Board, Elaine Baylis, reported that Jan Sobieraj, the Chief Executive of ULHT, had announced his intention to retire in 2019. Jan Sobieraj, who became Chief Executive of ULHT in December 2015, has spent the last three years of his forty year managerial career at ULHT, and he feels that as the Trust will be entering its next phase of transformation next year now is the right time for him to retire.

Elaine Baylis also stated that Jan Sobieraj had brought a fantastic degree of energy and ambition into ULHT and, as a result, in 2019 ULHT expected to be well placed to exit quality and financial special measures.

Elaine Baylis thanked Jan Sobieraj for the drive, determination and the unrelenting personal commitment he had made in leading ULHT during a period of unprecedented demand. As Jan Sobieraj wished to ensure a smooth transition for his successor, an exact date had not been set for his departure, but it is expected to be in Spring 2019.

Director of Finance

Karen Brown, ULHT's Director of Finance, announced her retirement at the beginning of September. Jan Sobieraj, the Chief Executive, stated that Karen Brown had worked tirelessly for the NHS for 29 years, with over 15 years at a senior level in finance, including six years in Lincolnshire. Jan Sobieraj thanked her for her significant contribution to the local finance agenda, and for her support to the Board at ULHT over the last few years.

4. Non-Emergency Patient Transport – Thames Ambulance Service - Monthly Performance

The latest available performance by Thames Ambulance Service Ltd, the provider of non-emergency patient transport services in Lincolnshire, is not available for circulation with this agenda, but will be made available at the meeting.

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

Open Report on behalf of United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 November 2018**
Subject:	**Children and Young Persons Services at United Lincolnshire Hospitals NHS Trust - Update**

Summary:

This paper is an update to the papers presented to the Health Scrutiny Committee on 16 May, 13 June, 11 July and 12 September 2018.

This follows the severe difficulties and challenges faced by the children's and young person's services at Pilgrim Hospital, Boston, caused by a significant shortage of doctors and nurses. The Trust set up a Task and Finish Group, including representatives from the wider NHS system, as described in the papers presented previously to the Health Scrutiny Committee.

A model of care has been worked up to provide safe care as described in the paper presented to the Health Scrutiny Committee on 11 July 2018. This model went live on 6 August 2018. This consists of an enhanced paediatric presence in the Pilgrim Hospital Emergency Department and an acute paediatric assessment unit with a twelve-hour length of stay. Outpatient clinics and surgery continue at Pilgrim Hospital. The interim model sees 98% of activity remaining at Pilgrim Hospital.

Private ambulances, crewed by paramedics, have been commissioned to transfer any patients who need a longer admission. During the first three months of operation of the new service model (Monday 6 August to Wednesday 31 October) 105 patients have been transferred, 99 children and six in utero transfers. All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported, although it is acknowledged that the transfers of patients have caused disruption to those patients and their families.

The gestational age for delivery at Pilgrim Hospital has been increased from 30 to 34 weeks; however as at 12 October only six transfers had taken place due to the increase in gestational age alone.

The situation remains fragile and business continuity plans have been developed and have been published internally, to ensure maintenance of the service in the event of acute staff shortages.

A comprehensive communications plan is in place and regular public meetings are taking place to inform the public, listen to concerns and adapt the service model in light of the dialogue.

Actions Required:

To note the information presented by United Lincolnshire Hospitals NHS Trust on Children and Young Persons Services.

Background

To address the severe difficulties and challenges caused by a severe shortage of doctors and nurses faced by the Children and Young Persons Services at Pilgrim Hospital, Boston, the Trust set up a task and finish group, including representatives from the wider NHS system, as described in the papers presented previously to the Health Scrutiny Committee.

The temporary service model described at the June meeting of the Health Scrutiny Committee is in place and became operational on 6 August 2018. This consists of an enhanced paediatric presence in the Pilgrim Hospital Emergency Department and an acute paediatric assessment unit with a twelve-hour length of stay. Outpatient clinics and surgery continue at Pilgrim hospital.

This matter has been considered at each monthly Board of Directors meeting of United Lincolnshire Hospitals NHS Trust (ULHT) since April 2018. The paper presented to the most recent Board meeting on 26 October is attached at Appendix A to this report.

<u>Dedicated Transport Arrangements</u>

The dedicated transport provision began as two ambulances available 24 hours per day. This has been reduced and the contract extended until 31 December 2018. Under the extended contract, there is one ambulance on each twelve hour shift and an additional ambulance on a twelve hour shift from noon to midnight to assist with potential peaks in demand. This reduction in ambulances was decided upon following analysis of the first six weeks' data, which showed there were no instances where two ambulances were needed at the same time. The provider is, however, able to increase this number of ambulances at short notice, should it become required during any heightened demand.

The ambulance resource continues to provide the ultra-safe provision for patients, whereby transfers required can be completed in the shortest possible timeframe. The services of the air ambulance have not been required since the service commenced.

Patient Transfers

During the first 12 weeks of operation of the new service model (6 August – 31 October) 2018, 674 patients have been seen in the Paediatric Assessment Unit, with 99 children transferred. All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported, although it is acknowledged that the transfers of patients have caused disruption to those patients and their families.

In addition, there have been six in-utero transfers of pregnant ladies, making a total of 105 transfers overall.

Staffing

A new Trust wide rota is in place to operate the temporary model at Pilgrim. However, the consultant paediatric medical team remains concerned about the safety of a middle grade medical rota consisting almost entirely of locum / agency doctors. No incidents of patient harm have been reported.

The current position remains, as in previous months, that over 60% of weekend and night shifts would be covered almost entirely by the locum / agency doctors. This equates to 65 hours of the 168 hours of the week. To mitigate this risk an additional middle grade doctor to support the rota has been agreed.

National and international recruitment continue to be pursued by the Women and Children's Clinical Directorate. The Clinical Directorate continues to work with medical agencies, irrespective of financial cost, to find agency and locum medical staff to support the rota at Pilgrim in order to keep Children's Services running safely.

Long Term Solutions

The final stakeholder meeting convened by NHS Improvement to discuss the move towards the long term solution for acute children and young people's services in Lincolnshire as part of the Acute Service Review took place on 12 October 2018

Financial Impact

A full financial assessment for the project has been completed, the total impact of the new service model until December 2018 is £1.75m, with loss in income accounting for 21%, pay accounting for 53% and non-pay accounting for 26% of the projected costs.

Income

Income in A&E will decrease by 12.26% based on the repatriation information as described in previous papers.

Pay

Consultant and medical staffing have been calculated using agency premiums and extra duty to cover all rotas, this has been negated by current funding available for substantive vacancies.

Risk Management

Risks continue to be managed through the project risk register, which has been presented to the stakeholder oversight group. Incidents are being tracked through the Trusts incident reporting system, Datix. No incidents of patient harm have been reported

Contingency Plan

The contingency plan is to centralise paediatric services from the Pilgrim site onto the Lincoln County Hospital site if services cannot be maintained at the Pilgrim site. The extensive reconfiguration and building update managed through estates build programme dictates the timeline for which any contingency area is available for use in extremis. The Proposed Relocations Diagram is set out in Appendix B. The Health Scrutiny Committee's previous written questions on the contingency plan are set out in Appendix C.

Over the next six months, there are three incremental plans, dependent on build:

1) Immediate capability - At the beginning of October 2018, the following areas will be available should they be required:

   - An increased bed capacity on Rainforest Ward, from 19 to 24 beds,

   - Side rooms available on Nettleham Ward to use as birthing rooms to accommodate any displacement of birthing rooms at Pilgrim. Nettleham Ward can accommodate eight maternity beds displaced from Pilgrim.

2) Short term capability - During November 2018, the enabling works continue to enable:

   - An additional five neonatal cots from Pilgrim to Neonatal Unit at Lincoln (space exists currently for the additional cots),

   - Twelve paediatric beds to be available on 1st Floor Maternity tower block increasing the Paediatric bed base at Lincoln site to be 36. A standard operating procedure is being developed for this area.

3) Medium term capability - The enabling works will continue from November to May 2019, which will further result in further space being made available;

   - Relocate Breast services from 4th floor tower block Lincoln to refurbished old microbiology block in order to create additional space / potentially create space for a Midwifery led unit,

- Vacated maternity wing on 4th floor, tower block Lincoln , the space on this floor will be configured with ward facilities, but not designated as additional beds to allow for a fluid designation to be undertaken dependent on the needs of the service at the point when contingency plan needs to be invoked.

Feedback from Engagement Events and Communications Plan

The Health Scrutiny Committee requested at its September meeting that the Trust provide some details regarding patient feedback at the engagement events, which the Trust ran during July, August and September. Below is a summary of what we heard on each of the three themes:

Emergency Access

- Would like the Trust to keep the level of service we've got now.
- Would like the Trust to consider family support and access, including transport, public transport and ambulances
- The Trust should be clearer on our offer for trainee doctors. Use facebook to advertise jobs. Offer money, stability, job satisfaction, incentives.
- The public would like reassurance about ambulance transfers being available.
- The public would like to see more ways of communicating with the public through schools, pre-schools and nurseries.

Children's Ward/Paediatric Assessment Unit

- Could the Trust offer help with accommodation for family if a child is transferred.
- The public would like to see a consultant presence at the ward until 10pm (Monday to Sunday) plus assessment unit.
- For children regularly admitted for longer than twelve hours at Boston, make sure Lincoln are prepared so it is not such a surprise when they arrive, and have a proper care plan in place.
- Offer parents and families a chance to visit Lincoln to be shown around.
- Keep parents informed about what service is available and what's going on, including using children's centres to share information.

Maternity and Neonates

- The public would like Pilgrim to have a higher level 2 neonatal unit.
- Need reassurance that neighbouring trusts are able to handle the increased numbers.
- Look at providing accommodation for the family unit.
- Identify early if there's going to be long term need – involve carers organisations.

Full feedback notes from the event have been shared with our women's and children's managers, to be used in development of the service and ensuring current and future service models meets the needs of our patients. Details of a patient survey, carried out

earlier in the year and attracting over 700 responses, have also been shared with the service.

The communications plan remains with regular newsletters, public engagement and staff engagement sessions. The next engagement session is planned for 6 November 2018 and further information regarding the previous and current engagement is outlined in Appendix D.

A further patient survey is also planned to gain feedback from those patients and their families recently in receipt of services and to receive suggestions regarding the transfer process.

Impact on Patients

During the first three months of operation of the new service model (6 August – 31 October 2018) 674 patients have been seen in the Paediatric Assessment Unit at Pilgrim with 99 children transferred, as well as six in-utero transfers taking place.

Improved Patient Care

- Non-elective activity has shown an improvement at the Pilgrim Hospital since the introduction of the interim model.

- The model used to calculate the number of patients that would require transferring to another hospital due to the 12 hour maximum wait was based on the then length of stay and calculated at 60%.

- The number of non-elective admissions for the period 6th August to 31st October 2018 was 674, up 4% from last year (649) which is not statistically relevant for this comparison. However the number of transfers due to the 12 hour limit was 99 - a transfer rate of 14.6%. There has been no change in ambulance conveyance patterns and no other apparent change in behaviour pre-admission.

- Work is underway to better understand the reason for the reduced number of patients requiring transfer. Initial findings are that the multi-disciplinary team have adopted Virginia Mason principles and looked to improve the child's care management and removal of delays from the system by focussing on red and green hours, not days.

Births

- The number of births at the Pilgrim hospital increased slightly on last year from 484 to 486.
- Since the introduction of the interim model, three babies from the Pilgrim area (under 34 weeks gestation) have been born at Lincoln. Two of those were repatriated back to Pilgrim.

There were no other changes in flow between the Pilgrim Hospital and Lincoln County Hospital.

Transfers

All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported, although it is acknowledged that the transfers of patients have caused disruption to those patients and their families.

There have been no delays reported for the transfer of children as a direct result of the introduction of the Paediatric Assessment Unit at Pilgrim Hospital. Where delays to discharge have occurred, these have been through the non-adherence of standard operating procedures, for example delays in availability of 'to take out' prescriptions and test results. These instances have been raised through the Datix reporting system, investigated and appropriate corrective action taken.

Each transfer direct from Pilgrim to Lincoln, has taken on average 90 minutes. Up to end of October there were 99 transfers from the Paediatric Assessment Unit, owing to the interim model. 88 of the transfer were to Lincoln County Hospital. The main reasons for transfer were: continued intravenous antibiotics, surgery and continued observation, e.g. baby feeding up to 50%.

Children on Adult Wards

The Trust can also report that no children have been put on adult wards, against the child or parent/carer's wishes. No children were transferred to an adult ward from the Assessment Unit. One patient chose to exercise their choice to be admitted to an adult ward during October.

2. Consultation

This is not a consultation item.

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

N/A

4. Conclusion

To address the significant difficulties and challenges caused by a severe shortage of doctors and nurses in the children's and young person's services at Pilgrim Hospital, the temporary service model described at the June meeting of the Health Scrutiny Committee, became operational on 6 August 2018.

This consists of an enhanced paediatric presence in the Pilgrim Hospital Emergency Department and an acute assessment unit with a twelve hour length of stay. Outpatient clinics and surgery continue at the Pilgrim Hospital.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Children & Young Persons Services at United Lincolnshire Hospitals NHS Trust (ULHT) - Risk to the sustainability of the Service (26 October 2018)
Appendix B	Contingency Plan – Proposed Relocation Plan
Appendix C	Health Scrutiny Committee – Questions on Contingency Plan – September 2018
Appendix D	Communications and Engagement Plan Update – United Lincolnshire Hospitals NHS Trust (29 October 2018)

6. Background Papers

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

This report was written by Dr N Hepburn Medical Director United Lincolnshire Hospitals NHS Trust who can be contacted at neill.hepburn@ulh.nhs.uk

APPENDIX A

United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Dr Neill Hepburn
Date:	26th October 2018

Title:	**Children & Young Peoples Services at United Lincolnshire Hospitals NHS Trust (ULHT) Risk to the sustainability of the Service**

Author/Responsible Director:

Dr Neill Hepburn, Medical Director

Purpose of the Report:

This paper is to provide an update regarding the interim Paediatric service model in place at the Pilgrim hospital and also the continuing work to address the significant challenges faced by the Children & Young Peoples Services (C&YP), which also have clinical interdependencies within Neonatal and Maternity Services at United Lincolnshire Hospitals NHS Trust (ULHT).

The interim service model described in previous Trust Board papers is in place and remains operational. The medical Trust wide rota continues to operate the interim model at Pilgrim.

In addition, the paper provides an update on the contigency options available , as well as recommendations for the immediate mitigation of the imminent risks to the current C&YP services associated with the interim service model until a longer term strategic direction can be confirmed.

The Trust Board is asked to note progress and to consider the current position and options.

The Report is provided to the Board for:

Information	X	Assurance	X

Summary/Key Points:

In order to update the Board, the paediatric directorate reports that:

- The interim service model described at previous Trust Board remains in place and is operational.

- As in previous months the workforce remains heavily dependent on locum and agency doctors to provide weekend and shifts. There is now one substantive middle grade doctor and six agency locum middle grade doctors within the current rota.

- National and international recruitment continues by the Women's & Children's Clinical Directorate (W&CCD). The Consultant paediatric medical team remain, as in previous months, concerned about the safety of a potential middle grade medical rota consisting almost entirely of locum / agency doctors.

- During the first ten weeks of operation of the new service model, 6th August – 12th October 2018, 601 patients have been seen in the paediatric assessment unit with 82 patients transferred. All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported, although it is acknowledged that the transfers of patients have caused disruption to those patients and their families.

- The gestational age for delivery at Pilgrim Hospital has been increased from 30 to 34 weeks; however as at 12th October only 6 transfers had taken place due to the increase in gestational age alone. Other transfers occurred but they did not cover the gestation age of 30 34 weeks.

- The dedicated transport provision has been reduced and the contract extended until 31st December 2018. Under the extended contract, there is 1 x ambulance on each 12hr shift and an additional ambulance on a 12hr shift from noon to midnight to assist with potential peaks in demand. As reported last month, this reduction in ambulances was decided upon following analysis of the first six weeks data, which showed there were no instances where two ambulances were needed at the same time. The provider is, however able to increase this number of ambulances at short notice, should it become required during any unpredicted demand. The ambulance resource continues to provide the ultra-safe provision for patients, whereby transfers required can be completed in the shortest possible timeframe.

- Transport needs for level 1 patients. A further meeting was held on the 16th October to review provision. It was agreed that a blended solution should be developed that would include the following:

    - An option appraisal based on a mapping exercise to be held on 18th October 2018

    - Agree review and update our SOPs and guidelines based on SOPs we have received from NUH. Comet have agreed to provide details of training and the required skill set for our nursing staff that they require to become compliant

- Relevant equipment required to support high flow patient transfers will be identified and procured.

- The contingency plan has now been written encompassing the changes in the estates building work, required as a result of the fire plan and asbestos removal work. The original build and subsequent contingency plan has been altered to reflect the changes in build. The contingency plan applies in the event that the current interim, model fails, focusing on the possible centralisation of some services to Lincoln.

- Risks continue to be managed through the project risk register, which has been presented to the stakeholder oversight group. A summary of the risk register is included in the body of the report and a copy of the register is included in appendix 1

- Incidents continue to be tracked through Datix. 114 x IR1 reports have been submitted and relate largely to length of stay exceeding 12 hrs. 2 x IR1 for low harm have been reported this month. The Task and Finish group reviews all Datix reports and escalates any issues, identifies any changes to operating procedures and provides assurance and governance to the Directorate in this regard.

- Stakeholder meetings, chaired by NHS Improvement and involving key stakeholders from the Trust, NHSI, NHSE, CCG, GMC, HEEM, CQC have now ceased as it is considered that there is a high level of assurance that the interim model is safe and operating effectively. Oversight is to be provided via the monthly System Improvement Board (SIB). NHSI convened a meeting on Friday 12th October with the intention of gaining final assurance that the temporary solution is operating safely and remains viable.

- As reported last month, the clinical senate met this and gave an indication that the Sustainability and Transformation Partnership (STP) plan to develop a long-term model for women's and children's services across the county for the future is provisionally accepted. The STP team are currently working will now continue to refine the model and develop proposals for the future plan. Although the plan is now moving ahead, it remains at this time that there is still a lack of a confirmed plan at this time, the concern remains for patients and their families until the detail and timeline of a plan is known.

- The comms plan remains in place with regular stakeholder and staff newsletters, social media messaging, public and staff engagement sessions.

Recommendations:

- Trust Board to acknowledge the performance of the interim model over the last eight weeks of operation, the number of transfers completed, activity on each site, the issues encountered, and actions undertaken to resolve those issues.

- Trust Board is asked to note that the contingency plan to centralise consultant-led maternity onto the Lincoln County Hospital site if necessary continues to be developed.

- Trust Board is asked to consider carefully the risks raised in this paper relating to the medical, nursing, managerial and leadership challenges that remain during the operation of the interim model and also for the likely future model in the coming months.

- Trust Board is asked to consider each element of the model that has been discussed in this paper for mitigating the immediate risks relating to the medical staffing challenges.

Background

The Women & Children clinical directorate have managed the significant medical and nursing staff vacancies for a number of years within paediatrics.

The medical staffing issues have escalated in recent months resulting in the Trust, in conjunction with stakeholder partners, being required to develop plans to change staffing models and clinical pathways to ensure the continuing safe service at both Lincoln County Hospital (LCH) and Pilgrim Hospital Boston (PHB).

Paediatric nursing and medical staffing rotas remain fragile with a number of consultants 'acting down' both in and out of hours to ensure adequate medical cover due to vacant middle and junior doctor posts on both sites. This model is not sustainable and continues to operate as a short-term measure. A medium and longer-term solution is required, albeit with a different model to maintain Paediatric services at both locations.

Due to the importance of messages reaching a wide public audience, the Trust and directorate, a comprehensive communications plan has been developed to ensure that a single, accurate message goes into the public domain.

Purpose of the Report

This report is intended to update the Trust Board of progress to date and the potential impact of the changes in services and in staff deployed across the Trust.

Body of report

To update the Board regarding progress of the project is summarised:

3.1 Mobilisation

The Paediatric Assessment Unit (PAU) commenced on Monday 6 August at 9am. The internal operational group continue to meet on a weekly basis, attended by the Paediatric clinical leadership team, directorate team and internal support functions to update on progress, review and resolve the risks and cross divisional issues.

The formal oversight arrangements have changed to reflect the level of assurance that NHSI now have regarding the operation of the interim model. The stakeholder meetings, chaired by NHS Improvement and involving key stakeholders from the Trust, NHSI, NHSE, CCG, GMC, HEEM, CQC have now ceased as it is considered that there is a high level of assurance that the interim model is safe and operating effectively. It has been formally requested, and agreed that oversight is to be

provided via the monthly System Improvement Board (SIB) from September onwards. A stakeholder meeting was convened by Kathy McLean, Medical Director, NHSI, on 12th October in order to gain a final assurance that the temporary model is in place and operating safely for all patients and staff.

NHSI have arranged for a follow up meeting on 12th October chaired by Dr Kathy McLean, Medical Director. The key focus will be reviewing the progress of the interim model and future long term models.

3.2 Workforce

As in previous months, the recruitment activity continues at pace, the requirement for a full complement of consultants at Pilgrim for Paediatrics has not changed and remains at 8 x whole time equivalents and the service currently has 4 x full time consultants and 2 x agency locums, making a complement of 6 x whole time equivalents.

The middle grade workforce remains heavily dependent on locum and agency doctors to provide weekend and shifts. To assist in the mitigation of this risk, an additional middle grade doctor to support the rota was agreed last month. There is now one substantive middle grade doctor to complement the six agency locum middle grade doctors within the current rota.

The medical staff rota, with named doctors on each shift, is in place and under constant review regarding fill rates as the proportion of locum and agency staff required to sustain the service remains high. The rota remains as in previous months with Tier 1 doctors on a 1:16 and Tier 2 (middle grade) doctors on a on a 1:10 on call.

Recruitment activity is continuous, as reported last month, one doctor started on the 6th August, an additional six doctors are still going through the recruitment process;

	Clinical attachment	**Start Date**	**Site**	**Comment**
Dr 1	Completed	Started 06/08/18	PHB	Tier 1 for 3 months then Tier 2
Dr 2	Completed	01/10/18	PHB	Tier 1 for 3 months then Tier 3
Dr 3	Completed	01/10/18	LCH	Tier 1 only
Dr 4	02/07 – 13/07/2108	Unknown		
Dr 5	30/07-11/08/2018	Unknown		
Dr 6	25/08-08/09/2018	Unknown		
Dr 7	Completed	10/10/18	PHB	Tier 1 for 3 months then Tier 3

Dr Kollipara, Head of Service, has written new job descriptions now that the interim model is in place and the requirements are clearer. Discussions to gain consensus with the Consultant body regarding the revised job descriptions are in progress. Once agreed, these adverts will be published.

The junior doctors contractual pay issue reported last month is near completion in terms of resolution and is being managed by directorate HR. The HR team have a comprehensive list of those junior doctors affected and are calculating the number of weekend and overnight shifts that the juniors had not undertaken and the projected loss of earnings until the 1st February. HEEM have offered to match fund the gap in pay. The directorate finance team are working with HR to ensure that the funding is received and payments made to individuals.

3.3 Transport Solution

The original 2 x ambulances on each 12hr shifts has been reduced until 31st December 2018, to 1 x ambulance on each 12hr shifts with an additional ambulance on a 12hr shift from noon to midnight to assist with potential peaks in demand. The reduction in numbers of ambulances has been validated and as there were no instances where two ambulances were needed at the same time over this time period and in line with the volumes being experienced.

The provider has given assurance that, should it become necessary, that additional paramedic led crews and ambulances could be provided at short notice to assist in the management of unpredicted peaks in demand.

3.4 Activity

As reported in previous months, the new service model commenced at 9am on Monday 6 August. Clinical pathways have been developed in line with the interim service provision and will be made available following ratification through the Trust Governance process.

Volumes of patients attending either Pilgrim or Lincoln have been very low since the commencement of the interim service model. During the first nine weeks of operation of the new service model, 6th August – 12th October 2018, 601 patients have been seen in the paediatric assessment unit with 82 patients transferred. All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported, although it is acknowledged that the transfers of patients have caused disruption to those patients and their families.

All transfers were undertaken using the dedicated ambulance and no issues were experienced or reported.

3.5 Risk management

The project risk register has been maintained and updated, a copy of the register is included in appendix 1.

In summary:

- At the commencement of the project, 22 risks have been identified with scores 20 and above,
- Mitigations against these 22 risks were implemented, reducing the number

with a score greater than 20 to 3 risks

- Further mitigations to arrive at the best possible score for each risk have been identified which identify a single remaining risk scoring 20 as “risk to reputation if service is not returned to previous model at PHB in 12 months”.

The change in Directorate leadership has been added as a risk to the project risk register, although short term, the experienced General Manager left the business on 21st September, an interim General Manager has been appointed. This risk is partially mitigated through the appointment of the Directorate Managing Director and a new management structure which increases the level of managerial cover within the directorate as a whole and will, going forward, be able to provide the Directorate with clear triumvirate based management processes in the medium term. The dedicated project manager left early, at request of NHSI, on 5th October and a replacement is being sourced.

The project risk register continually feds directly into both the directorate and the corporate risk register. It is worthy of note that the directorate and corporate risk scores differ in scoring against each of the risks identified as the impact changes in relation wider issues as the scale broadens. The likelihood is also affected, but to a lesser degree.

The corporate team, via the Corporate Risk Manager, are sighted on the project risk register, receive updates to the project risk register to ensure continuity and enable updating as appropriate.

3.7 Management of incidents

The Datix system has been configured to include a new mandatory field relating to the new service model. Each incident can be identified readily and managed appropriately. Incidents are being reviewed weekly at the operational task and finish group meeting each Monday.

3.8 Contingency and future capacity plan

The contingency plan is to centralise paediatric services from the Pilgrim site onto the Lincoln County Hospital site if services cannot be maintained at the Pilgrim site.

The extensive reconfiguration and building update managed through estates build programme dictates the timeline for which any contingency area is available for use in extremis.

Over the next six months, there are three, incremental, plans dependent on build.;

1) Immediate capability - At the beginning of October 2018, the following areas will be available should they be required;

   - An increased bed capacity on Rainforest ward from 19 to 24 beds,

   - Side rooms available on Nettleham ward to use as birthing rooms to accommodate any displacement of birthing rooms at Pilgrim,

- Nettleham ward can accommodate 8 x maternity beds displaced from Pilgrim,

2) Short term capability - During November 2018, the enabling works continue to enable;

- An additional 5 x Neonatal cots from Pilgrim to Neonatal unit at Lincoln (space exists currently for the additional cots),

- 12 x Paediatric beds to be available on 1st Floor Maternity tower block (resulting in the total Paediatric bed base at Lincoln site to be 36 beds)

3) Long term capability - The enabling works will continue from November to May 2019, which will further result in further space being made available;

- Relocate Breast services from 4th floor tower block to refurbished old microbiology block in order to create additional space / potentially create space for a Midwifery led unit,

- Vacated maternity wing on 4th floor, tower block, the space on this floor will be configured with ward facilities, but not designated as additional beds to allow for a fluid designation to be undertaken dependent on the needs of the service at the point when contingency plan needs to be invoked.

Daily ward safety huddles continue three times each day at both Pilgrim and Lincoln hospitals where capacity and bed status are discussed. Each site ward lead contact each other and identify demand, capacity and any resourcing issues. A daily capacity plan is decided upon and communicated.

Consideration has been given to the existing winter capacity plan, in order to create the best fit for the changes needed should the contingency plan be required, whilst enabling the Trust to concurrently manage winter bed pressures.

3.9 Health Scrutiny Committee

An update paper will be presented to the November meeting which addresses the points raised by HOSC at the September meeting, namely;

- Additional details around the communications plan and communications processes which included feedback and output from the engagement events.

- The capacity on Rainforest Ward at Lincoln in light of the interim model and transfer activity,

- Wait times at Pilgrim for transferring patients,

- Journey times,
- Feedback on patient experience of those patients transferred,
- Details regarding the length of stay for transferred patients,
- How many children have been put on adult wards and if this number had increased under the interim model.

The Project Director will respond with a paper as requested for the November meeting which will provide details to the specific questions raised at the meeting.

3.10 Communications and Engagement Plan

Communication around the current service model, ongoing engagement activity and addressing any public concerns continues through the execution of the communications and engagement plan.

In addition, engagement activity continues as per the plan. This includes public engagement sessions, regular staff engagement meetings and a planned patient survey .

In addition, engagement continues to be carried out with the general public, including face-to-face discussions with affected and interested groups across the East Coast area, and public engagement in Boston marketplace, schools and children's' centres and in local supermarkets.

The findings of all engagement activity is fed directly into the Directorate team, for consideration as part of continuing monitoring and development of the interim model.

This is also reported back in a 'you said, we did' format in newsletters and at public engagement events, to enable participants to see what is being done with their feedback.

Among the issues raised at the public engagement events include concerns about the advice given by NHS 111 about the availability of services at Pilgrim, the current low levels of activity, a wish to return to a 24/7 full ward at Pilgrim and the difficulties of attracting doctors to work at Pilgrim. The next engagement session is planned for 6th November 2108.

3.11 Project Plan

The formal, strategic project plan and audit trail are updated. Additionally, all relevant risks, mitigations and impact of costs in relation to the Trusts financial position are cross referenced to the risk register in order to "close the loop" in terms of governance assurance.

Actions Required

- The Trust Board to recognise and endorse the progress of the project to date, the update in workforce risk management and incident tracking methodology that are in place to provide assurance to all stakeholders

- The Trust Board is appraised of the operational capacity plan, the contingency plan and the methodology in place to ensure capacity is managed effectively to ensure patient safety.

- The Trust Board is asked to note the fragility of the situation and request an update in September with details of activity and any amendments to the service model in light of further operations experience.

Dr Neill Hepburn
Medical Director

APPENDIX A

United Lincolnshire Hospitals NHS Trust

Appendix 1

Project Risk Register

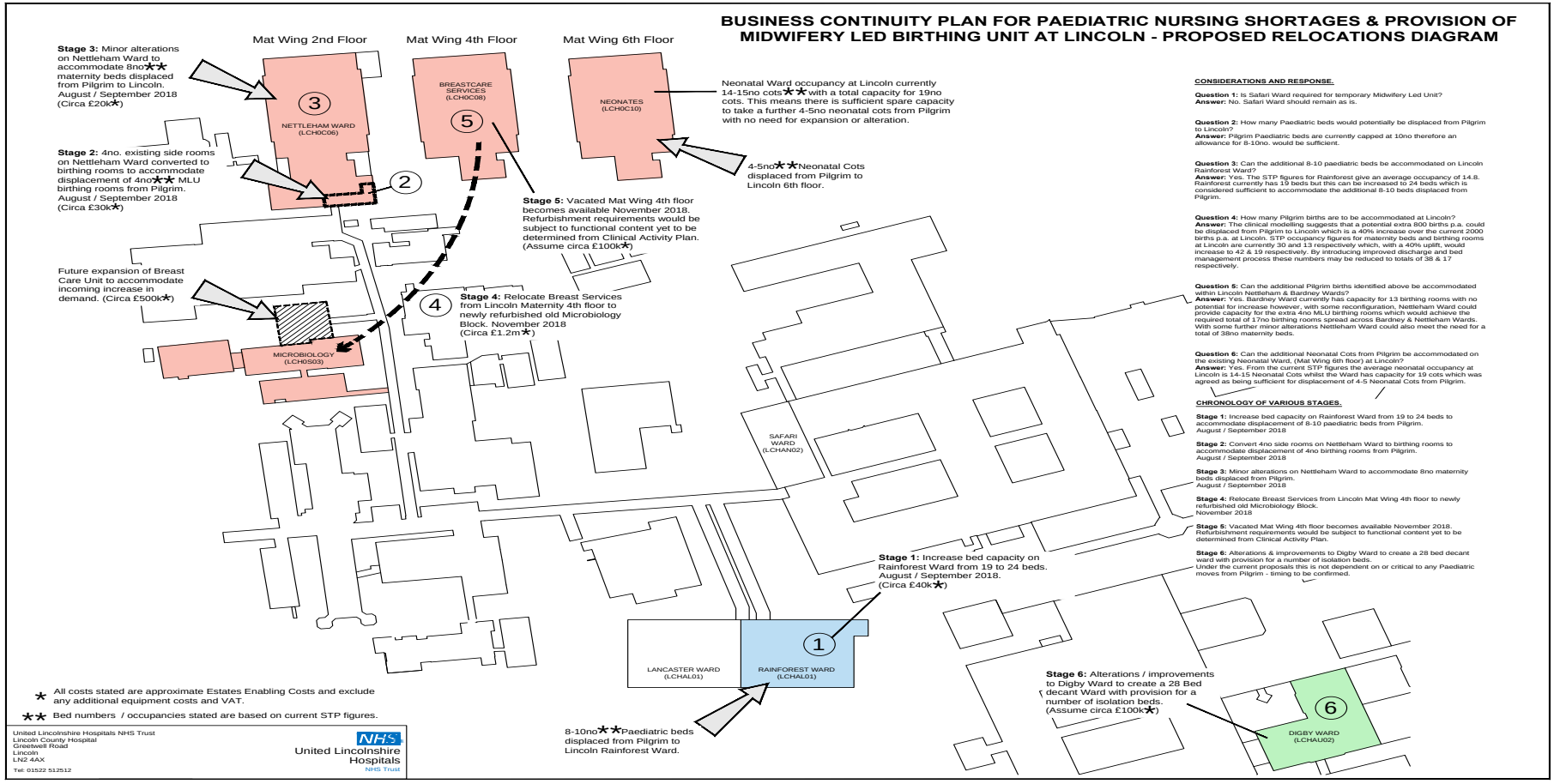
Paediatric Project - Risk Log								Key	L	Likelihood		Maximum mitigated score			
Updated 5th July 2018			Version - 2.0						I	Impact					
									RR	Risk Rating					
UID	Risk		Risk	Risk Assessment			Mitigation	Due Date	Lead	Mitigated Risk			Mitigation	Mitigated Risk		
				L	I	RR				L	I	RR		L	I	RR
Clinical																
1	Paediatric medical workforce has a high proportion of Locum staff	1.1	High percentage of workforce are locum or agency who may opt to leave service with no notice period	5	5	25	1) Consultants continue to "act down" or increase level of remote on call in order to provide cover if required. 2) Recruitment of substantive staff.	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy	4	3	12	1) Percentage of Locums within workforce to be reduced to manageable levels. No prospect however of all vacancies being filled with substantive workforce due to continuing national shortage of Paediatricians	3	2	6
		1.2	Supervision of Tier 1 & 2 Drs potentially compromised as Locums can not provide required standard and HEEM may not endorse trainees on site.	3	5	15	1) Rotas to be created and populated to provide assurance to HEEM that appropriate levels of supervision and training are provided to all trainees 2) Once assurance provided, HEEM to endorse trainees on the PHB rotation. 3) NHSI to provide oversight and agreement to rotas	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy	4	3	12	1) Rotas continue to mitigate against lack of supervision and training	2	2	4
		1.3	There will only be one middle grade doctor available out of hours and at weekends to support the neonate / sick child / young person / Women within the Emergency Department, Maternity Services, Special Care Baby Unit and Children's Assessment Unit from 1st -10th August 2018	5	5	25	1) There will only be one middle grade doctor available out of hours and at weekends which is insufficient medical cover for all specialities. 2) There is potential that there is a delay in the medical assessment of children which will mean treatment is not commenced in a timely manner which may impact upon recovery and length of stay. 3) There is a potential risk that there will be no timely medical support following escalation of a deteriorating child due to only one doctor being available for all specialities as the doctor could be dealing with another sick patient . 4) There could be a delay in the timely response of medical support to emergency call-outs for cardiopulmonary resuscitation and other emergencies. This will result in delays in commencing advanced life support, history taking, medical examination and prescribing of emergency drugs 5) Attendance at unplanned high risk deliveries may be compromised 6) The nurses and unregistered workforce will feel vulnerable and unsupported which will impact on morale and staff retention	Monday, 23 July 2018	Ajay Reddy / Debbie Flatman	4	4	16	1) Consultant Paediatrician on call from home – Consutant stepping down but not sustainable. 2) Nurses are able to recognise and escalate the sick child to the medical team. 3) In utero transfers			0
		1.4	Referral pathways may not be clear to clinicians due to any change of service	5	5	25	1) Pathways to be analysed to ascertain if any changes to existing pathways are required as a result in change to service. 2) PHB will need to demonstrate that they have implemented and communicated pathways and referral protocols across all sites. 3) Confirm MDT scheduling ensures attendance at all MDTs by Consultants to sign off any changes to pathways.	Friday, 6 July 2018	Paul Hinchliffe / Sue Bennion	3	2	6	1) Complete patient pathways which reflect safe and sustainable service provision, 2) MDT agreement that pathways are safe and sustainable	2	2	4
2	Service will not be safe or responsive	2.1	Risk to sustainability of a safe service at PHB.	4	5	20	Trust to confirm service arrangements to ensure a safe and sustainable service	Saturday, 2 June 2018	Neill Hepburn	2	2	4	No further mitigations identified	2	2	4
		2.2	EDs patient who become acutely unwell would not have access to review and advice from a Paediatrician 24/7 365	3	3	9	1) Need to provide further details of proposed pathway for patients who become unwell. 2) PHB ED to confirm the support they need from Paediatricians to ensure a safe service	Wednesday, 6 June 2018	Rao Kollipara / Ajay Reddy	2	2	4	No further mitigations identified	2	2	4
		2.3	ED experiences unplanned attendances which require an overnight bed which results in capacity issues and performance breaches	4	4	16	1) PHB to confirm that they have plans in place to prevent increased unplanned A&E attendances which require an overnight bed due to the implementation of the increased assessment area. 2) Confirmed and agreed escalation processes and action cards	Friday, 6 July 2018	Paul Hinchliffe / Sue Bennion	2	3	6	1) Inclusion in Trust capacity operational plan 2) Winter plan to reflect changes in demand at both PHB and LCH due to change in model (no inpatient peadiatric beds at PHB).	2	2	4
3	Future viability of service	3.1	Paediatric service at PHB will no longer be viable	3	5	15	Trust to confirm future arrangements for a safe and sustainable service.	Wednesday, 11 July 2018	Neill Hepburn	4	4	16	Long term STP plan to ensure that service at PHB is maintained and planned for.	2	3	6
4	Timescales	4.1	Insufficient time to safely implement new service configuration	3	5	15	Ensure that medical and nursing rotas and pathways are agreed by 11/06/18	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy	4	4	16	Ensure that rotas and pathways are sustainable and future proof.	2	2	4
5	Unclear and inconsistent referral pathways	5.1	Patients pathways not clear from 1st August	3	4	12	Definition of pathways and agreement with all specialities in relation to patients to be discussed and agreed at pathway meeting on 6th July at Sleaford.	Friday, 6 July 2018	Rao Kollipara / Ajay Reddy	2	2	4	Changed pathways in place and working	1	2	2
		5.2	Change / increased complexity of transfer of care from PHB to LCH may lead to confusion for staff and patients.	3	2	6	Need to confirm that adequately defined and agreed process for both sites has been implemented	Wednesday, 18 July 2018	Paul Hinchliffe / Sue Bennion	2	2	4	Operational with both sites working to the defined safe standard across all specialites for all patients	1	2	2
		5.3	Lack of clinical criteria for transport of patients from PHB to LCH	2	5	10	Clinical criteria to be developed and agreed during pathway meeting.	Friday, 6 July 2018	Rao Kollipara / Ajay Reddy	2	2	4	Pathways and clinical criteria agreed and in place	1	2	2
		5.4	Lack of transport solution in relation to transition of patients from PHB to LCH	3	4	12	Transport solution to be developed and implemented before 01/08/18	Wednesday, 11 July 2018	Paul Hinchliffe	2	4	8	Patient transport solution in place and active from go live	1	2	2
6	Clinical relationships	6.1	Poor relationships between PHB and LCH could impact on service delivery	3	2	6	Oversight group facilitates and monitors effective collaboration between sites	Wednesday, 25 July 2018	Rao Kollipara / Ajay Reddy	2	2	4	Oversight group ceases and management of operation reverts to business as usual.	1	2	2

Operational																
7	Risk that standards could deteriorate	7.1	Change in service provision and practice could have a detrimental short term effect on maintaining standards.	3	4	12	Oversight group to monitor compliance with standards and oversee the development and implement of any RAPs	Wednesday, 1 August 2018	Paul Hinchliffe / Sue Bennion	2	2	4	Oversight group ceases and management of operation reverts to business as usual.	1	2
8	Communication of Information	8.1	Lack of IT communication integration between sites could impact on patient discussions / decision making.	4	5	20	Safety huddles 3 x daily and communicaton between sites post huddles. Information team to create dashboard and distribute	Wednesday, 1 August 2018	Paul Hinchliffe / Sue Bennion	3	3	9	IT integration across all sites is in place and operational	2	2
9	PHB / LCH does not have adequate staffing levels to mobilise the contingency plan	9.1	Nursing staff	2	5	10	Off duty produced until November. Some risk exists in being able to open all beds at Lincoln site due to ability to obtain an increased number of nursing staff - Lincoln site currently have beds closd due to staff sickness / unavailability.	Wednesday, 11 July 2018	Paul Hincliffe / Sue Bennion	2	3	6	Off duty in pace with no gaps and any sickness covered, business as usual stance	1	2
		9.2	CNS	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6	Issues in recruitment	2	3
		9.3	Health Care Assistant	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6	Issues in recruitment	2	3
		9.4	Consultants and other grades of medical staff	2	5	10	Recruitment of medical satff at all grades continues.			2	5	10	Full compliment of medical staff is unlikely given national staffing levels and national recruitment issues.	2	3
		9.5	Administrative	2	5	10	LCH to confirm adequate staffing levels or recruitment plans			2	3	6			
10	Physical Space	10.1	Capacity to accommodate demand resulting from change in service configuration at PHB	2	4	8	Demand and capacity model data being validated	Wednesday, 11 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	3	6	Demand and capaity managed as business as usual	1	2
		10.2	Capacity to accommodate demand resulting from change in service configuration at LCH	2	4	8	Demand and capacity model data being validated, indications that sufficient beds are avaialble at the LCH site to accommodate patients.	Wednesday, 11 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	2	4		1	2
		10.3	There is the risk that 19 beds may not be an adequate number of inpatient beds for sick children requiring treatment / inpatient care	4	4	16	Management of demand by Matron through regular staff huddles and ward round discharge activity.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	Proactive bed management and balancing of capacity across the network.	2	3
		10.4	A reduction in staffing levels due to staff sickness or a loss of agency nurses.	4	4	16	1) Capping of beds to below 19 for patient safety. 2) Local children from Lincoln, Pilgrim and Grantham sites being transferred out of county to another hospital to receive care.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	1) Dedicated private transport / transfer team required to facilitate and support transfers to ensure ward staffing is not compromised on either site. 2) Immediate temporary uplift of nurse staffing by increasing agency nurses to open additional beds on Rainforest to 20 - 24 beds. 3) Ongoing recruitment plans in place to increase substantive posts to support a further increase in bed numbers.	2	3
		10.5	There are times when the service is likely to require more than 19 inpatient beds for the population of children in the county.	4	4	16	There are currently insufficient Childrens nurses to staff above 20 beds on the Lincoln site on every shift. Occasional 24 beds but needs close monitoring as would need to flex back down due to staffing levels.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	3	4	12	Regular review of all inpatients to identify discharges and facilitate flow by Hot week Consultant, including Fast Track pharmacy for TTO's – supported by Ward Manager, Deputy Matron and Matron.	2	3
11	Patients will have difficulty accessing the LCH service if resident in Boston	11.1	Some patients will have to travel further to LCH	5	2	10	If the child requires a nurse to accompany them on this transfer, this will further impact on nurse staffing levels at the Lincoln and Pilgrim	Wednesday, 18 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	2	2	4	No further mitigations	1	2
		11.2	Patient Journey to PHB is more difficult due to transport links.	4	4	16	1) Patients and families with low incomes may have to reply on charitable means of transport to get to LCH. 2) Patient choice may indicate preference, due to transport, of patients being referred to neighbouring Trusts.	Wednesday, 18 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	3	3	9	No further mitigations	3	3
12	Recruitment and retention of nursing staff at PHB	12.1	Retention of Nursing staff to continue to work at PHB if service becomes unattractive	3	3	9	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 11 July 2018	Sue Bennion / Paul Hinchliffe	3	3	9	No further mitigations	3	3
		12.2	Recruitment of new staff to work at PHB given no inpatient beds.	3	3	9	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 11 July 2018	Sue Bennion / Paul Hinchliffe	3	3	9	No further mitigations	3	3
13	Contingency Plan	13.1	Emergency relocation of service enacted under emergency powers.	5	5	25	1) Trust required to enact emergency powers to relocate service in extremis within an extreme timescale 2) Trust to escalate to Department of Health, Regulator, Commissioners, HEEM, GMC, RCP and other key stakeholders.	Monday, 9 July 2018	Rob Game / Paul Hinchliffe / Sue Bennion	5	5	25	Short term change to provision of service to ensure safe service for patients in place and operating.	3	3
		13.2	Estates work in place to ensure service can be consolidated at LCH with appropriate beds, assessment areas and outpatient facilites	5	5	25	1) Provision of sufficient clinical and bedded space at LCH 2) Enabling works for Breast patients to move to Digby ward with minimal estates work required to enable paediatrics to move to 4th floor maternity block, this in extremis and in contingency. 3) Enabling works for Neonates and Maternity is 6 months 4) Configuration for split services to operate required	Friday, 6 July 2018	Rob Game / Richard Mather / Paul Boocock	3	3	9	1) Digby ward hosting Breast patients in the short term. 2) Digby forms part of the winter plan to house increase in demand of patients across the Trust, risk that breast patients may have to be decanted to a.n.other area before peak demand in the run up to winter.	2	3
		13.2	Staffing rotas for both medical and nursing staff created to enable service provision post 1st August	5	5	25	1) Moving medical and nursing staff to a consolidated site at LCH requires a re-write of rotas and on call arrangements.	Friday, 29 June 2018	Rao Kollipara / Ajay Reddy	5	5	25	"Two sites, one team" approach achieved in the medium and long term.	3	3
		13.3	Pathways and referral processes in place at consolidated site	5	5	25	1) Pathways meeting scheduled for 6th July at Sleaford involving all specialities 2) Pathways to be analysed to ascertain if any changes to existing pathways are required as a result in change to service. 3) Requirement to demonstrate that pathways and processes can be implemented and communicated.	Monday, 9 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	3	3	9	Pathways agreed and in place	2	2
		13.4	Communications plan reflecting emergency	5	5	25	1) New communications strategy and plan to be devised and implemented 2) Key stakeholders, both internal and external, to be engaged 3) Media strategy to patients, families and general public to be initiaated	Monday, 16 July 2018	Anna Richards	3	3	9	1) Comms strategy deployed 2) Patient and staff survey report positive results.	2	2
14	Recruitment and retention of medical staff PHB	14.1	Retention of Consultants to continue to work at PHB if service becomes unattractive	5	5	25	1) Potential of creating a site operating with less pressure than LCH which could facilitate an environment that is conducive to consolidation of learning. 2) Link with ties with Medical school in 2019/20. 3) Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Wednesday, 1 August 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	4	4	16	1) HEEM formally agreeing that the training provided at PHB meets or exceeds training requirement for trainees. 2) Medical school involvement positively incorporated to training.	2	2
		14.2	Recruitment of new staff to PHB may become problematic	4	4	16	Positive recruitment campaign to assure quality training and care provision in non in-patient setting.	Monday, 9 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	4	4	16	1) Positive feedback from HEEM 2) Trainees continue to be allocated to both sites for each new rotation.	2	2
		14.3	HEEM unable to identify trainees who are willing to be placed at PHB, trainees may not wish to select or accept places due to type of service on offer at PHB.	5	5	25	1) HEEM to continue to promote training viability at PHB and assure trainees of viability of the service at PHB in the medium and long term. 2) Potential to reverse the negative view of the placement as being able to experience a "blended" workforce solution to Paediatrics (which is a potential long term outcome of the speciality given continuing decline in numbers of Paediatricians nationally). 3) Resulting service provision could become a vanguard type offering.	Wednesday, 11 July 2018	Rao Kollipara / Ajay Reddy / Paul Hinchliffe / Sue Bennion	3	4	12	1) Positive feedback from HEEM 2) Trainees continue to be allocated to both sites for each new rotation.	2	2
15	Transfer of children and young people from the new (Temporary) Children's Assessment Unit (CAU) at Pilgrim Hospital Boston to Rainforest Ward, Lincoln County Hospital / an Inpatient Ward	15.1	Transfer of children and young people from the new (Temporary) Children's Assessment Unit (CAU) at Pilgrim Hospital Boston to Rainforest Ward, Lincoln County Hospital / an Inpatient Ward	5	5	25	1) Children will not be able to receive care Inpatient care at Pilgrim Hospital as there are no inpatient beds.	Friday, 3 August 2018	Debbie Flatman / Sue Bennion	5	3	15	1) Children with PEWS 5 or less may, following assessment, meet level 1 criteria to be transferred in parents own vehicle as documented within the Safe Transfer of Children and Young People from Emergency Departments and Children's Services-CESC/2014/126 Version 3	2	3
		15.2	There may not be a transport service in place by 01/08/2018 to transfer the children to an inpatient bed which would impact upon patient flow from ED to the assessment unit resulting in extended waits / breaches and the unit remaining as an inpatient ward	5	5	25	1) Extended waits within the Emergency Department and on the assessment unit over 12 hours if patients have to wait for return ambulances.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) EMAS will transport children 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.3	The two proposed dedicated ambulances are for all of Women and Childrens Services i.e.) to transfer pregnant women and children, therefore the demand for transport is currently unknown and there is a risk a vehicle may not be available for a sick child when required.	5	5	25	1) The child may face a longer journey and may deteriorate whilst travelling 2) The family will have to endure longer journeys and may have increased periods of separation from their child.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) Comet will retrieve children requiring level 2 and 3 dependent upon criteria. 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.4	The private ambulance crew may not be trained in the paediatric equipment e.g. Infusion pumps and therefore children will not be able to receive intravenous fluids / drugs throughout the journey from Pilgrim Hospital to Lincoln County Hospital resulting in treatment potentially being stopped prior to the journey resulting in a delay in	5	5	25	1) Treatment being stopped / delayed due to lack of training of private ambulance crew in equipment such as infusion pumps could result in deterioration of child's condition	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	1) Training of Paramedic team in infusion pumps if required. 2) Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.5	The private ambulance may not be equipped with all of the equipment required to treat children during the transfer if their condition should deteriorate on the journey	5	5	25	Paediatric Equipment (Paediatric grab bag) provided to transport team.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	Standard Operating Procedure for Children's Assessment Unit (Draft)	2	3
		15.6	The turnaround time for the transport travelling from Pilgrim Hospital to Lincoln County Hospital is likely to be longer than 3 hours due to poor road networks and vast geographical area and unknown delays on arrival at the destination.	5	5	25	1) Telematic vehicle tracking to enable acute staff to identify optimum transfer time and turnaround. 2) Double up on ambulances availability during the weeks of the interim model to ascertain actual future demand.	Wednesday, 1 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	5	3	15	Policy and Procedure for Patient Transfer Trust Wide CESC/2011/040 Version 4.0.	2	3

16	Change in Directorate Leadership	16.1	The organisation is undergoing a restructure impacting on the existing specialty designation in the directorate.	3	3	9	1) Part of the organisation wide restructure but will come into full effect in the new year by which time, the service model will have been operational for 6 months.	01 June 2019	General Manager	2	2	4	No further mitiagtions	2	2	4
		16.2	Appointment of a Directorate Managing Director and Paediatric Lead Nurse	3	3	9	1) Provision of a strengthened leadership team 2) Ability to focus on the converting the temporary model to a business as usual status. 3) Ensure performance of the unit is incorporated into the assurance and governance process for the Directorate	10 September 2018	Directorate Managing Director	2	2	4	No further mitigations	2	2	4
		16.3	The General Manager has left the organisation	5	4	20	1) Interim Geeral Maager appointed 2) Interim is internal and has a good level of experience and knowledge in Paediatrics and the Directorate	10 September 2018	Directorate Managing Director	3	3	9	The General Manager post is filled on an interim basis.	2	3	6
Financial																		
17	New service may be an unaffordable financial pressure for commissioners	17.1	Change in tariff of assessment based model with no in-patient beds at PHB	4	3	12	Financial model to be delivered and agreed with commissioners to ensure that service remains financially viable.	16 July 2018	Rob Game / Vanessa Treasure	2	2	4	Commissioners agree and commission service with acceptable financial outcome for Trust.	1	1	1
		17.2	Potentially funding travel costs for patients	3	3	9	1) Transport solution to be designed and delivered which remains financially viable.	16 July 2018	Rob Game / Vanessa Treasure	3	3	9	Transport contract / provision in place and operational.	2	2	4
		17.3	Any funding of travel costs for patients could set a precedence which Commissioners are unlikely to create.	4	3	12	1) Locally agreed tariff which incorporates private transport facility. 2) Work with charitable organisations to create a partially funded service.	16 July 2018	Rob Game / Vanessa Treasure	3	3	9	Transport contract / provision in place and operational.	2	2	4
		17.4	ULHT may request funding beyond tariff to implement contingency plan	4	3	12	Mitigation to be identified	16 July 2018	Rob Game / Vanessa Treasure	4	3	12				0
		17.5	Cost of communication to patients and staff in relation to the transfer	5	3	15	Mitigation to be identified	16 July 2018	Rob Game / Vanessa Treasure			0				0
		17.6	Request to underwrite consultant recruitment costs (International)	5	3	15	Mitigation to be identified	16 July 2018	Rob Game / Vanessa Treasure			0				0
		17.7	Implementation of the contingency plan results in stranded costs at PHB	5	5	25	1) Reworking of income based on assessment based model and no in-patient beds for Paediatrics. 2) Potential increased outpatient income 3) Potential for "One stop" approach to some parts of the service via Outpatient clinics.	16 July 2018	Rob Game / Vanessa Treasure	3	3	9	1) If needed, Contingency in place and working providing safe care for patients and staff.	2	2	4
Commercial																		
18	Negative impact on the viability of PHB		Transfer of this service may not align with the long term STP plan	4	4	16	Mitigation to be identified	01 August 2018	Neill Hepburn			0				0
Patients and Stakeholder																		
19	Access		Patients will have inconvenience/change of travelling to a different site.	5	3	15	Mitigation to be identified	31 July 2018	Neill Hepburn			0				0
20	Risk to reputation of NHS bodies	20.1	Reputational as Trust, NHSI have previously stated they would not move the service from PHB to LCH	4	3	12	Mitigation to be identified	31 July 2018	Neill Hepburn			0				0
		20.2	Reputational if the service is not returned to previous model at PHB in 12 months	4	5	20	Mitigation to be identified	31 July 2018	Neill Hepburn			0				0
21	Lack of support from Patient and Public voice	21.1	Patients will not want to see service move from their local hospitals	4	4	16	Communications plan to explain rationale for change	31 July 2018	Neill Hepburn	4	4	16	Communicaton strategy deployed and in place	2	2	4
		21.2	Lack of patient/public engagement about this issue	5	3	15	Develop evidence of case for change and engage with local stakeholders	31 July 2018	Neill Hepburn	3	3	9	Communicaton strategy deployed and in place	2	2	4
22	Increase in young people aged between 14-16 years being cared for within adult wards due to the new temporary Childrens Assessment Unit (CAU) service model on the Pilgrim Hospital Site.	22.1	Due to the change of ward 4A, Pilgrim Hospital, to an Childrens Assessment Unit (CAU) there will be a potential increase in young people aged between 14-16 years being cared for on Adult Wards at Pilgrim Hospital.	5	4	20	1) Children and young people will not be cared for by the appropriately trained nursing staff as Registered Adult Nurses on Adult Wards have not received competency based training in the nursing care of children and young people aged 14-16 years and therefore will not have the knowledge, specialist skills and competencies to care for adolescents including level 3 safeguarding children. 2) Adult nurses have not completed competency assessments and workbooks in Paediatric Early Warning Score (PEWS) or Children's Sepsis 6 and parameters for the recognition of the deteriorating child are different to that of the early warning score for adults (NEWS) 3) Children will also receive treatment in line with Adult guidelines and policies which may be detrimental to their treatment and recovery. 4) Patient experience could potentially be poor due to children and young people being nursed next to sick adults and exposing them to potentially traumatising scenes. 5) RNA's may feel vulnerable and undervalued and this has the potential to eventually impact on morale and staff retention	03 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	4	3	12	1) All staff who work within adult areas who may care for young people aged 14-16 will have received some safeguarding training 2) Policy for the Admission of Young People Aged 14- 18 years into Adult In-Patient Areas- CESC/2011/058 3) Adolescent Admission Risk Assessment Screening Tool completed for all admissions of 14-16 year olds to adult areas 4) Urgent Identification of adolescent area / ward to ensure right staff provide right care in the right area. 5) Communication / notification of when young person admitted to adult areas. 6) Datix completion to help monitor admission rates to adult areas 7) Competency based training could be offered to RNA's	3	2	6
		22.2	As Rainforest Ward will be the only inpatient Childrens ward, there may also be an increase in young people aged between 14-16 years being cared for on Adult Wards at Lincoln County Hospital.	5	4	20		03 August 2018	Rob Game / Paul Hinchliffe / Sue Bennion / Debbie Flatman	4	3	12		2	3	6

United Lincolnshire Hospitals NHS Trust

Contingency Plan



United Lincolnshire Hospitals NHS Trust

APPENDIX C

Health Scrutiny Committee - Questions on Contingency Plan – September 2018

The Committee's questions relate to the contingency plan, previously referred to as Option 3.

Paediatrics

(1) Can the impacts on paediatric services be more clearly set out? *[Pages 39- 40 of the report to the ULHT Board – 25 May 2018]*

It has been possible to retain paediatric services at the Pilgrim Hospital site through extensive work to fill doctor rotas over the next few months. The rota is heavily dependent on the use of agency and locum doctors which does come with a level of risk for these doctors to present for duty when scheduled.

Through this "covered" rota, it has been possible to maintain 97% of services under a temporary service model.

During the first two weeks of operation an average of one paediatric patient per day has been transferred to Lincoln hospital. This is significantly less than the estimation in May 2018.

(2) Throughout Appendix A1 to the 25 May Board paper, there are lists of 'questions to answer'. Have they been fully answered? For reference, some of these questions are listed:

- Numbers of referrals, outpatients, inpatients, births and other activity that will be displaced under each scenario

Each scenario has been modelled, with numbers of patients and activity. The implementation of the temporary paediatric assessment unit solution has seen vastly reduced numbers of patients being displaced.

- What are the workforce and rota implications?

The workforce plans and rotas for the implemented temporary solution are included in the Board paper.

- Which organisation is it proposed will take this activity?

The activity has been contained within UHLT with only two patients being transferred to other hospitals, (these transfers being due to clinical reasons, not capacity issues)

- Have agreements been made with these organisations that they can take this activity?

The Chief Executive and medical Director have written to and contacted all surrounding Trusts to gain support and agreement regarding any transferring patients.

(3) Where children and young people are displaced to other hospitals, is there certainty that these hospitals have the capacity?

The Chief Executive and the Medical Director have written separately to their counterparts in all local hospitals, describing the issues faced at Pilgrim and Lincoln and requesting assistance if required. Those that have replied have given support and where possible, assurance that the predicted small numbers of patients can be accommodated.

(4) How much impact will there be on patient choice?

Patients will of course retain choice with regard to their care and treatment.

Maternity

(5) Does Lincoln County maternity have the capacity to handle an additional 650 births per annum (twelve extra births per week)? *[Page 40 of the report to the ULHT Board – 25 May 2018]*

This refers to the contingency model, the clinical modelling undertaken suggests that a potential additional 800 births per annum could be displaced and managed from Pilgrim to Lincoln.

(6) Do out of county maternity departments have the capacity to handle an additional 1,000 births per year (twenty extra births per week)? [*Page 40 of the report to the ULHT Board – 25 May 2018]*.

The Chief Executive and the Medical Director have written separately to their counterparts in all local hospitals, describing the issues faced at Pilgrim and Lincoln and requesting assistance if required. Whilst the physical capacity exists, it would be dependent upon transfer of some workforce to support.

(7) The figures in Appendix A1 of the report to the ULHT Board (25 May 2018) suggest that 1,150 births (22 per week) might be displaced to Peterborough City Hospital? Does Peterborough City Hospital have the capacity for this? *[The table in Appendix A1 is entitled Obstetric Move – Original STP Calculation.]*

This refers to the contingency model, the clinical modelling undertaken at that time suggested high numbers. Bookings for births at both Lincoln and Pilgrim have stayed stable at previous levels during May, June, July and August 2018.

(8) How much impact will there be on patient choice?

Patients will of course retain choice with regard to their care and treatment.

Transport and Travel

(9) Have all patient transfer arrangements been fully explored? Will private ambulances be used?

The Trust has implemented a dedicated transport solution for paediatric, maternity and paediatric surgical patients that ensures an ultra-safe solution for any patients that may need to be transferred to Lincoln or other local providers.

(10) Have all the impacts on EMAS been fully explored? For example, longer journey times for ambulances taking children to Lincoln instead of Boston.

EMAS have been, and remain, part of the weekly task groups and have been fully involved in the development of the solution, any changes to patient pathways and processes.

Workforce / Organisational

(11) Has ULHT had any discussions with your peers around running the department with a higher number of locum doctors as well as the substantives? Or have you conducted a risk assessment around this option side by side with those displacements that will be caused by option 3?

The temporary solution is reliant on the use of locum and agency doctors, so that we are able to maintain 97% of the service at Pilgrim for patients. The risk register details all appropriate risks associated with the reliance on this mix of workforce.

Estates Plan

(12) There is reference to an estates plan in the ULHT 25 May Board paper, with reference to a start date of June 2018 and a completion date of August 2018. What is the status of the estates plan?

The estates plan is undergoing final planning and agreement, details of the current plan with timelines are included in the 31st August 2018 Board paper.

Communications and Engagement Plan Update

Background

We have been communicating and engaging around the paediatric services for the last three years.

Engagement has taken and will take a number of different forms. We have contacted in excess of 40 groups. Some invite us to attend their meetings to talk about the issues, others ask us to send information to them rather than meeting with them, others have not responded and we will continue to chase them.

The engagement meetings are led using an open forum structure.

At the beginning of the process, we used a series of open questions to help us gather feedback about the service.

Since the introduction of the interim model, we have used the following questions to gather public opinion and inform further service developments and mitigation of concerns:

- What are your concerns about the interim model?
- What would you like to see us do to best provide for the children of Boston and surrounding areas?
- How we can reassure you/ mitigate your concerns about the interim model?

In addition, we have carried out a public online survey, which was promoted in the media, on social media, and shared with community groups and attracted 759 responses.

Engagement response rates and groups

We have visited 16 groups and made contact with further groups to set up future meetings.

Overall, we have listened to 178 people at meetings across the Lincolnshire area, with a main focus on the east coast. All those people were engaged in face to face conversations in a safe environment, where they were encouraged to express their opinion on paediatric services provided in the county.

In addition, we have arranged three engagement meetings at our own sites, which have attracted a total of 25 attendees.

Group	Protected characteristic	Action	Numbers at event
Women and children			
International parents group – Lincoln Children's Centre	Race	Meeting 09.05.2015	20
Black Sluice children's group, Boston	Age, pregnancy and maternity	Meeting 10.07.2016	8
Boston Baptist Church toddler group	Age, pregnancy and maternity, religion	Meeting 10.06.2016	5

Group	Protected characteristic	Action	Numbers at event
Honeypot toddler group	Age, pregnancy and maternity	Meeting 08.06.2016	15
Boston Polish Group	Race, age, pregnancy and maternity	Meeting 04.02.2017	9
Little SNAPs	Age, pregnancy and maternity	Meeting 01.11.2016	6
Norfolk Lodge Children's Centre	Age, pregnancy and maternity	Meeting 01.12.2017	4
Norfolk Lodge Children's Centre	Age, pregnancy and maternity	Meeting 11.01.2018	7
Norfolk Lodge Children's Centre	Age, pregnancy and maternity	Meeting 02.02.2018	12
Sutterton Children's Centre	Age, pregnancy and maternity	Meeting 05.02.2018	11
Sutterton Children's Centre	Age, pregnancy and maternity	Meeting 07.02.2018	8
Skegness Children's Centre	Age, pregnancy and maternity	Meeting 08.03.2018	14
Sibsey Parish Council	Age	Meeting 17.05.2018	11
Spilsby Parish Council0	Age	Meeting 18.06.2018	8
Alford family fun day	Age, pregnancy and maternity	Meeting 14.07.2018	25
Horncastle Children Centre	Age, pregnancy and maternity	Meeting 18.07.2018	15
Paediatric engagement event at Pilgrim Hospital, Boston	Age, pregnancy and maternity	Meeting 31.07.2018	9
Paediatric engagement event at Pilgrim Hospital, Boston	Age, pregnancy and maternity	Meeting 20.08.2018	7
Paediatric engagement event at Pilgrim Hospital, Boston	Age, pregnancy and maternity	Meeting 17.09.2018	9
Total to date			**203**

In addition to the above meetings, on 10 September 2018 time was spent in Boston marketplace raising awareness and seeking views on paediatric services.

In addition to the targeted engagement listed above, we have undertaken extensive engagement over the past 18 months around the development of our 2021 programme. As part of this, various groups and individuals have raised comments, opinions and feedback on paediatric and maternity services. In total we have engaged with over 1,000 people in the last 18 months.

All references to maternity and paediatrics have been incorporated into our reports back into the service, for consideration as part of future service planning.

Communications

Over the past six months we have carried out extensive communication with our staff, public, patients and stakeholders on the subject of paediatrics, maternity services and the interim model. This has been alongside all of the engagement activities which have been taking place and is ongoing.

Staff communication has included:

- Regular team meetings in the department with service leads.
- Briefings and updates via Trustwide email.
- Messaging in weekly, Trustwide e-newsletter and on staff intranet.
- Posters in the department advertising engagement events.
- Verbal cascade.
- Messaging via closed staff Facebook group.

External communication has included:

- Regular briefing newsletters, sent out to all staff, Trust members and stakeholders and published on our website and shared on social media (weekly to begin with, moving to monthly from September), containing updates on the service model, number of transfers and use of the service, recruitment progress. We also use these newsletters to directly address any questions or comments raised by our public, to clarify any rumours.
- Media interviews to explain current circumstances and address concerns.
- Press releases and liaison throughout.
- Advertising of paediatric jobs in monthly digital magazine (now quarterly) and on social media.
- Three columns in Boston Standard published in May, June and September.
- Social media activity- on Facebook and Twitter, describing the service model and encouraging ongoing use of paediatrics at Pilgrim. Also directly addressing any rumour where correction is required.
- Monthly updates at Lincolnshire Health Overview and Scrutiny Committee.
- Monthly updates at ULHT public Trust Board meetings.
- Widely advertising engagement events and reason for them.

We plan to continue with all of these methods of communication over the coming months, and would consider introducing additional channels if required.

Next steps

We are continuing our engagement activities, including contacting other groups to see if we can attend their meetings or send them information.

Other activities we have planned include:

Marketplace – engaging with local community and members of the public – 7.11.2018
Soft play – made contact with Play Towers, indoor *play* area located in *Boston, awaiting response.*

Meetings booked in

Group	Protected characteristic	Action
Lincolnshire parent and carer forum Boston	Age, pregnancy and maternity, Disability	Meeting 05.11.2018
Lincolnshire parent and carer forum Woodhall Spa	Age, pregnancy and maternity, Disability	Meeting 12.11.2018
Lincolnshire parent and carer forum Sleaford	Age, pregnancy and maternity, Disability	Meeting 30.11.2018
Lincolnshire parent and carer forum Bourne	Age, pregnancy and maternity, Disability	Meeting 06.12.2018

Next paediatric engagement event to be held at Pilgrim Hospital, Boston on Tuesday 6 November 2018.

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

Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 November 2018**
Subject:	**Lincolnshire Urgent and Emergency Care – Progress with Developing Urgent Treatment Centres (UTCs) in the county**

Summary:

The purpose of this item is to update the Health Scrutiny Committee on delivery of transformation of Urgent and Emergency Care in Lincolnshire.

Actions Required:

The Health Scrutiny Committee for Lincolnshire is asked to consider the progress set out in the report and to offer its comments.

1. Background

Urgent and Emergency Care (UEC) is one of the NHS's main national service improvement priorities, with focus on improving national A&E performance whilst making access to services clearer for patients.

Across the system staff are working around the clock to deliver the best possible care to more patients than ever before, but it's becoming increasingly difficult as demand continues to rise. Both nationally and in Lincolnshire the current system is under increasing pressure and we need to improve the urgent and emergency care (UEC) system so patients get the right care in the right place, whenever they need it.

Our local ambition mirrors that set out by NHS England which is to transform urgent and emergency care to ensure it better serves those with serious or life threatening emergencies, as well as those with urgent care needs.

In 2013 NHS England published a review that describes joining up A&E, GP out of hours, minor injuries clinics, ambulance services and NHS 111 (the Keogh Review). This vision for change helps patients to understand and recognise where they can get urgent help easily. Primarily the focus is for people with urgent care needs to have access to a more responsive service closer to home.

Nationally the mandate is for the UEC pathway to be increasingly community based, with increasing focus on the use and accessibility of NHS 111 and clinical assessment services (CAS) with the ability to assess patients over the telephone or via directly booked appointments with the service that is right for them. For people dialling 999 we are working with the ambulance service to ensure that patients receive the most appropriate response, whether this is treatment advice given by phone, in person by ambulance staff, or by being taken to hospital. In the future, health records will also be available to clinicians however a patient accesses the health service, whether this is through NHS 111, by ambulance, their GP or A&E.

Importantly, for those with more serious or life-threatening emergency care needs, changes to the current system mean that people will receive treatment in centres with the best expertise and facilities to maximise the chances of survival and good recovery.

National and Local Context

The health and social care needs of our patients are paramount. In Lincolnshire we are supported by national guidance outlined in 'Next Steps' to deliver our aim over the next two years which is to provide patients with the most appropriate care in the right place, at the right time. The public know where to go when life is in danger. However estimates suggest up to 3 million people who come to A&E each year could have their needs addressed elsewhere in the urgent care system, but patients tell us that the range of alternatives available can be confusing – Walk In Centres, Urgent Care Centres, Minor Injury Units all with differing levels of service. A&E is often the understandable choice for many people unsure where to turn when they need urgent care or advice; this places unnecessary pressure on A&E and other parts of the urgent and emergency care system, and for many patients this results in long waits in the wrong setting.

Following publication of the Keogh Review, NHS England published further guidance to local systems on how to design, implement and deliver new urgent treatment centres. The Lincolnshire UEC system (providers and commissioners), supported by NHS England, have reviewed our current provision against this guidance and have developed plans for each facility and plans will be subject to engagement so the views of patients and the public will be heard.

In response to the Keogh Review, the Lincolnshire Urgent and Emergency Care system introduced an Urgent and Emergency Care Strategy (which was presented to the Committee on 21 March 2018) which sets out the vision for UEC in line with nationally mandated actions and local STP priorities. The Strategy was adopted by the Urgent and Emergency Care Delivery Board and the System Executive Team in January 2018.

The introduction of new urgent treatment centres in the County along with GP access hubs (a GP practice that offers appointments for patients registered with other practices in the area.) will standardise the confusing range of options and simplify the system so patients know where to go and have clarity of services available and where.

Urgent Treatment Centres

The Urgent Treatment Centre Principles and Standards, published by NHS England, set out national core standards for Urgent Treatment Centres (UTCs). This is attached at Appendix A to this report.

The principal aim of creating urgent treatment centres is to increase public confidence in where to go if a patient has urgent, non-emergency care needs by removing different titles such as urgent care centres, minor illness/injury units and walk in centres. A further aim is to extend the remit of urgent treatment centres' clinical and assessment capability so to manage an increased range of lower acuity cases many of which are currently managed in our A&E departments.

The December 2019 national target is for patients and the public to:

- access urgent treatment centres that are open at least 12 hours a day. UTCs will be led and staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.

- have a consistent route to access urgent appointments offered within 4 hours and booked through NHS 111, ambulance services and general practice. (*A walk-in access option will be available, but in line with national direction, receiving advice via telephone triage (via NHS 111) and if required a face to face appointment that has been directly booked in at the UTC will be emphasised via engagement with the public to help reduce unnecessary walk-in presentations.)*

- increasingly have access to routine and same-day appointments and out-of-hours general practice for both urgent and routine appointments at the same facility, where geographically appropriate.

- recognise the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS 111, local GPs, hospital A&E services and other local providers.

Current Provision

In Lincolnshire there are two urgent care centres at Louth and Skegness Hospital sites and Minor Injury/Illness Units at the Gainsborough John Coupland Hospital and Spalding Johnson Hospital. Additionally there is a minor injury service at Sleaford Medical Group (7 days a week) which provides some additional urgent care services evenings and at the weekend; and North West Anglia Foundation Trust (NWAFT) run a Minor Injuries Unit at Stamford Hospital.

Recommended Sites for Urgent Treatment Centres

The national and local vision for UEC is wherever a patient contacts the healthcare system they will have consistent access to all services and will, if necessary, be referred on to necessary services through a process of direct booking whenever possible. Urgent treatment centres will operate as part of a networked model of urgent care, with referral pathways into emergency departments and specialist services as required.

Under national guidance urgent treatment centres will be developed and co-located with existing Emergency Departments (ED) within Lincolnshire. In addition to delivering national standards, UTCs in front of EDs will provide highly effective patient streaming to relevant specialities minimising the requirement for patients to attend the ED or wait to be seen, treated or discharged within the specified timescale for 4 hours. By having urgent treatment centres co-located with EDs, centres will act as an effective filter between urgent and emergency care.

However it is noted in the Strategy document the future of urgent and emergency services at Grantham Hospital has yet to be determined and is out of scope of the Lincolnshire Urgent and Emergency Care Strategy 2018-21 (page 5, section 1.2) which references the work of the East of England Clinical Senate report (December 2017). The future of urgent and emergency care at Grantham Hospital is within the scope of the Acute Services Review being undertaken by the STP, as a system. A full and open public consultation will take place to inform any final decisions on the configuration of services through the Acute Services Review.

In March 2018 in response to requirements and timescales imposed by NHS England CCGs discussed proposed sites for UTCs in the County. Governing Bodies subsequently recommended a service which meets all the UTC core standards be developed at the following sites:

- Louth Hospital (this became a pilot site in March 2018 to test technology and new ways of working but has had no formal re-designation)

- A UTCs will be established at the front door of Pilgrim and Lincoln County Hospitals. The ‘go live’ date is December 2019 and requires capital funding to expand floor space and therefore full capability of a UTC. A capital bid was submitted in July 2017 to NHSE and a response is expected imminently.

- A UTC at Stamford (timescale to be determined in conjunction with Cambridgeshire and Peterborough CCG, with North West Anglia NHS Foundation Trust as the provider).

- A UTC at Skegness

  In the future, all facilities must have in common the offer of booked urgent appointments, accessed through NHS111, General Practice and the ambulance service. In making recommendations to NHS England and the local UEC Delivery Board, commissioners have considered local activity, demand management, and patient flow to ensure that patients are directed to the most convenient service available and that there is consistency of access and that investment is targeted to meet demand.

CCGs recommended the existing Minor Injuries Units at Spalding, Sleaford and Gainsborough will be re-designated as GP Extended Access Hubs (a GP practice that offers appointments for patients registered with other practices in the area) and deliver similar services (but via bookable appointments made to 111/onto the Clinical Assessment Service) or via appointments made through GP In Hours services. CCG commissioners are presently working with NHS England, current providers and GP Federations to determine the final clinical models of care that will operate from these sites. In accordance with recommendations sites will have strong links with other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector in providing an effective and integrated service.

Public engagement is planned for these proposed service changes during spring 2019.

3. Programme Implementation

The implementation of UTCs is fundamental to developing a quality and sustainable urgent and emergency care service in Lincolnshire. The following actions are being taken to achieve successful implementation:

1. engage with the public on proposed changes;

2. design how UTCs will relate and work with other services (in particular with newly developing GP Extended Access Hubs and existing A&E departments);

3. work with all staff and key stakeholders to engage fully in plans and design of UTCs;

4. clarify acuity of patients that can be seen and treated at UTCs and how acuity may be stratified;

5. explore and clinically govern how NHS Pathways (the triage tool used by the NHS 111 service) and the associated Directory of Service (DOS) are adapted to ensure the right patients with the right acuity are directed to UTCs;

6. ensure consistency across the 5 UTCs in the skill mix of staff, prescribing capabilities and access to appropriate investigations;

7. review the opening hours of UTCs (national requirements is as a minimum they must be open twelve hours per day). Currently some minor injuries units operate for less than twelve hours per day and there is inconsistency across the county in provision;

8. review existing issues of inter-departmental transfers between existing m minor injuries units/ urgent care streaming services to A&Es to improve awareness of professionals and the public on what clinical conditions the UTCs can manage

9. to set up the ability for 111 and CAS services to directly book patient appointments into the UTC. This is already in place at Louth and will be rolled out to Stamford and Skegness sites initially before being available at Lincoln County/Boston Pilgrim.

10. review with Lincolnshire County Council Highways for Department for Transport road signage to ensure new national UTC signs are established in place of existing signs

4 Classification of Service Type

Urgent treatment centres will be classed as Type 3 A&E departments. A type 3 department may be doctor led or nurse led and may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment.

The GP Extended Access Hubs will not be classified as Type 3 departments. These services are classified as being appointment based services mainly or entirely accessed via telephone or other referral (for example most out of hours services), or a dedicated primary care service (such as GP practice or GP-led health centre) therefore not classified as a Type 3 service even though it may treat a number of patients with minor illness or injury.

5 Timescale for Implementation

Several underlying projects will knit together through the following transition period (January to end of May 2019) once contractual arrangements are agreed:

- To further develop the communications and engagement planning with the public/key stakeholders and affected staff.

- The mobilisation process for how each site operationally will deliver against the national standards and principles for UTCs (the clinical model).

- To participate in national learning and sharing of information on how other UTCs in the country have been delivered.

- A wider programme of delivery of direct appointment booking capabilities throughout urgent care.

- A wider programme of reviewing shared diagnostic services and any operational efficiency derived.

- To deliver against set timescales for building works at Lincoln and Pilgrim should a positive outcome from capital bidding process occur.

6. Other Transformation Projects

Digital technology is a key enabler to helping to deliver the national and local Urgent and Emergency Care strategy. Local transformation projects include;

ASAPLincs

In September a website and app were launched in Lincolnshire to help people find the most appropriate health care service for their medical needs. The ASAPLincs website and app has been built using the very latest attendance data from Lincolnshire's emergency departments. Detailed behavioural research has also gone in to developing the product allowing our comms and engagement teams to target cohorts of patients we know make inappropriate choices with regard to access to urgent and emergency care. It is designed to allow residents to identify their symptoms or condition from some of the most commonly seen in emergency departments, before displaying the most appropriate treatment service for them. Since its launch the website has had 2,500 individual and new users; 10.2% of users have returned, 30% of users are male, 70% of users are female. The ASAPLincs App has had just 6,356 downloads. ASAPLincs is a finalist in the 2018 Lincolnshire Healthcare Awards in the category of Research, Innovation and Education.

NHS 111 Online

We in Lincolnshire were the first system nationally to introduce NHS111 online. The website forms an integral part of the future service delivery of UEC and will allow patients to book urgent appointments. Our project lead for NHS111 online is also a finalist in the Lincolnshire Healthcare Awards in the category of Rising Star of the Year in recognition of the early and successful implementation of the website and related project work.

Integrated Dashboard

From mid November 2018 the UEC system will have a "live" visible dashboard detailing demand, performance and pressure points across the system. The dashboard will be used across primary, secondary and community care as well as social care to manage the system and its capacity more effectively. The dashboard will help improve quality and patient safety and make issues more transparent to local clinicians and service leaders so they can manage system escalation more rapidly and effectively plus assist reporting to local senior leaders and regulators over the winter.

6. Conclusion

The UTC Programme of work is mandated nationally. We are required as a system to implement changes in line with national requirements in order to streamline services and improve accessibility. We expect reduced attendance at, and conveyance to, A&E as a result of this standardisation and simplified access, as well as improved patient convenience as patients will no longer feel the need to travel and queue at A&E. Attendances at urgent treatment centres will count towards the four hour access and waiting times standard.

The programme of work provides monthly updates to NHS England and there is positive assurance of the considerations being made locally.

7. Appendices

The following Appendix is attached at the end of this report:

Appendix A	Urgent Treatment Centres – Principles and Standards NHS England – July 2017

8. Background Papers

The following background paper was used to a material extent in the compilation of this report:

- Lincolnshire Urgent and Emergency Care Strategy 2018-2021 (This was reported to the Health Scrutiny Committee on 21 March 2018.)

This report was written by Ruth Cumbers, Urgent Care Programme Director who can be contacted via email ruth.cumbers@lincolnshireeastccg.nhs.uk

NHS England

Urgent Treatment Centres – Principles and Standards

July 2017

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**06861**
Document Purpose	Guidance
Document Name	Urgent Treatment Centres – Principles and Standards
Author	NHS England
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Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs , NHS England Regional Directors, Emergency Care Leads, NHS Trust CEs
Additional Circulation List	NHS England Directors of Commissioning Operations
Description	This document sets out the principles and standards which Sustainability and Transformation Partnerships and local commissioners should achieve when establishing Urgent Treatment Centres as part of their local integrated urgent and emergency care system.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Urgent and Emergency Care Review Team NHS England Quarry House Leeds LS2 7UE england.urgentcarereview@nhs.net

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Urgent Treatment Centres

Principles and Standards

Version number: 1.0

First published: 13 July 2017

Prepared by: NHS England

Classification: OFFICIAL

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact england.urgentcarereview@nhs.net

What change are we looking to see?

1. The *"Next Steps on the NHS Five Year Forward View (5YFV)"* was published on 31 March 2017. This plan explains how the 5YFV's goals will be implemented over the next two years. Urgent and Emergency Care (UEC) is one of the NHS' main national service improvement priorities, with focus on improving national A&E performance whilst making access to services clearer for patients.

2. One element of the UEC section of the FYFV is *"Roll-out of standardised new 'Urgent Treatment Centres'".* This document sets out the standards that we want to see implemented by Sustainability and Transformation Partnerships and local commissioners.

3. From the outset of our review of urgent treatment services in the NHS[1], our patients and the public told us of the confusing mix of walk-in centres, minor injuries units and urgent care centres, in addition to numerous GP health centres and surgeries offering varied levels of core and extended service. Within and between these services, there is a confusing variation in opening times, in the types of staff present and what diagnostics may be available.

4. To end this confusion, we have set out a core set of standards for urgent treatment centres (UTC) to establish as much commonality as possible. By December 2019 patients and the public will:
    a. Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
    b. Have a consistent route to access urgent appointments offered within 4hrs and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.
    c. Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.
    d. Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.

5. We expect reduced attendance at, and conveyance to, A&E as a result of this standardisation and simplified access, as well as improved patient convenience as patients will no longer feel the need to travel and queue at A&E. Attendances at urgent treatment centres will count towards the four hour access and waiting times standard.

[1] NHS England (2013) Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report

6. In addition, commissioners will wish to consider if, and how, clinicians working in urgent treatment centres can also provide wider clinical assessment services to patients calling NHS 111.

Alignment with primary care and other urgent care services

7. It is the function of the system to:
    a. guide the patient to the correct level of care and treatment.
    b. provide clarity as to which services are provided where, along with providing pathways to access these services reliably 24/7.

    NHS 111 should be that guiding service for most urgent care needs, in addition to provision of treatment through the clinical assessment service.

8. Wherever a patient contacts the healthcare system they will have consistent access to all services and will, if necessary, be referred on to necessary services through a process of direct booking whenever possible. Urgent treatment centres will operate as part of a networked model of urgent care, with referral pathways into emergency departments and specialist services as required. Commissioners should make sure that all services form part of ambulance services referral pathways as an alternative to conveyance to A&E where appropriate.

9. The General Practice Forward View set out a plan for investment of a further £2.4 billion a year by 2020/21, designed to promote sustainability in general practice, improve patient care and access, and invest in new ways of providing primary care. CCGs are already beginning to commission extra capacity to ensure that, by March 2019, everyone has access to GP services, including sufficient pre-bookable and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care.

10. There is an opportunity for commissioning of a genuine integrated urgent care service, aligning NHS 111, urgent treatment centres, GP out-of-hours and routine and urgent GP appointments with face to face urgent care. Commissioners should align thinking for urgent treatment centres with the core requirements for extended access[2], as well as opportunities with the clinical assessment service that supports NHS 111. There are many opportunities to integrate wider primary care with urgent care, to rationalise the service offer, reduce duplication and flex the workforce to provide urgent and primary care services which meet the needs of the local population.

What are we asking of STPs and local commissioners?

11. There will inevitably be variation in what each urgent treatment centre may provide as the needs will be different for different populations and geographies. But in the future, all facilities must have in common the offer of booked urgent appointments, accessed through NHS111, General Practice

[2] Set out in the NHS Planning Guidance 2017-19.

and the ambulance service. Commissioners will need to consider local activity, demand management, and patient flow and throughput in the final specification of commissioned services. This will ensure that patients are directed to the most convenient service available that can provide the treatment they need, that there is consistency of access and that investment is targeted to meet demand.

12. We know that there will be some exceptions where there will be justification for offering a service that does not meet these standards, most likely in more rural or sparsely populated areas. These exceptions should be agreed on a case by case basis working with NHS England and NHS Improvement regional teams.

13. Commissioners, supported by NHS England, should review current provision, impact and local health needs assessments against the below standards and make a plan for each existing facility, alongside current provision and plans for extended GP access, subject to local consultation and following proper procurement process where appropriate. We know that many services will already offer, or be close to offering, this level of service, and others will need local investment to meet the standards. Other services, that will not meet the new standards, may become an alternative new community service; this may be a GP access hub.

Principles and standards for Urgent Treatment Centres

Principles

1) Urgent treatment centres (UTCs) are community and primary care facilities providing access to urgent care for a local population. They encompass current Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as “Type 3 and Type 4 A&E Departments”. Urgent treatment centres will usually be led by general practitioners, and are ideally co-located with primary care facilities, including GP extended hours / GP Access Hubs or Integrated Urgent Care Clinical Assessment Services (formerly known as “GP out of hours” services).

Co-location with other services

2) Co-location with, and strong links to, other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector will also be beneficial in providing an effective and integrated service. There are advantages if they can be co-located alongside hospital A&E departments to allow the most efficient flow of patients to the service that best serves their need but this will be determined by geographic distribution of urgent care sites and patient flows.

Standards for Urgent Treatment Centres

3) Urgent treatment centres must conform to the following minimum standards. STPs and commissioners may also choose to build upon or add to these, according to their requirements.

(1) Urgent treatment centres should be open for at least 12 hours a day seven days a week, including bank holidays, to maximise their ability to receive streamed patients who would otherwise attend an A&E department. Typically this will be an 8-8 service, but commissioners will wish to tailor to local requirements based on locally determined demand.

(2) Urgent treatment centres should provide both pre-booked same day and "walk-in" appointments, however patients and the public should be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.

(3) Urgent treatment centres, and NHS 111, should support patients to self-care and use community pharmacy whenever it is appropriate to do so. Urgent treatment centres should promote and record the numbers of patients offered self-care management and patient education.

(4) The urgent treatment centre should ensure that there is an effective and consistent approach to primary prioritisation of "walk-in" and pre-booked appointments, and the allocation of pre-booked routine and same day appointment slots.

(5) For patients who require an appointment in the urgent treatment centre this should be booked by a single phone call to NHS 111; locally patients should be encouraged to use NHS 111 as the primary route to access an appointment at an urgent treatment centre.

(6) Patients who "walk-in" to an urgent treatment centre should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary.

(7) Following clinical assessment, patients will be given an appointment slot, which will not be more than two hours after the time of arrival.

(8) Patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time.

(9) Protocols should be in place to manage critically ill and injured adults and children who arrive at an urgent treatment centre unexpectedly. These will usually rely on support from the ambulance service for transport to the correct facility. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance '*Quality standards for cardiopulmonary resuscitation practice and*

training'[3]*, should be immediately available.* At least one member of staff trained in adult and paediatric resuscitation present in the urgent treatment centre at all times. This should all be part of an approach of 'design for the usual, and plan for the unusual'.

(10) An appropriately trained multidisciplinary clinical workforce will be deployed whenever the urgent treatment centre is open. The urgent treatment centre will usually be a GP-led service, which is under the clinical leadership of a GP. There will be an option for bookable appointments with a GP or other members of the multi-disciplinary team. Where the centre is co-located with an emergency department there may be justification for joint clinical leadership from an ED consultant.

(11) The scope of practice in urgent treatment centres must include minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries.

(12) All urgent treatment centres should have access to investigations including swabs, pregnancy tests and urine dipstick and culture. Near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes should be available. Electrocardiograms (ECG) should be available, and in some urgent treatment centres near-patient troponin testing could also be considered.

(13) Bedside diagnostics and plain x-ray facilities, particularly of the chest and limbs, are desirable and considerably increase the assessment capability of an urgent treatment centre, particularly where not co-located with A&E. Where facilities are not available on site, clear access protocols should be in place. Commissioners will need to consider patient throughput in their cost benefit analysis where capital investment will be required.

(14) All urgent treatment centres should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (e-prescribing should be in place in all sites by June 2019).

(15) All urgent treatment centres should be able to provide emergency contraception, where requested.

(16) All urgent treatment centres must have direct access to local mental health advice and services, such as through the on-site provision of 'core' liaison mental health services where services are co-located with acute trusts or links to community-based crisis services.

(17) All urgent treatment centres should have arrangements in place for staff to access an up-to-date electronic patient care record; this may be a summary care record or local equivalent. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient's

[3] https://www.resus.org.uk/quality-standards/acute-care-equipment-and-drug-lists/

best interests in an emergency situation where the patient lacks capacity to consent.

(18) There must be the ability for other services (such as NHS 111) to electronically book appointments at the urgent treatment centre directly, and relevant flags or crisis data should be made available for patients.

(19) A patient's registered GP should always be notified about the clinical outcome of a patient's encounter with an urgent treatment centre via a Post Event Message (PEM), accompanied by a real-time update of the electronic patient care record locally. For children the episode of care should also be communicated to their health visitor or school nurse, where known, within two working days.

(20) Where available, systems interoperability should make use of nationally-defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMED-CT) and nationally-defined record structures.

(21) Urgent treatment centres should make capacity and waiting time data available to the local health economy in as close to real-time as is possible for the purposes of system-wide capacity management; relevant real-time capacity information should also be made available for use across Integrated Urgent Care nationally.

(22) Urgent treatment centres should refer to and align with the Integrated Urgent Care Technical Standards to ensure effective service and technical interoperability.

(23) Urgent treatment centres should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.

(24) Where appropriate, patients attending an urgent treatment centre should be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).

(25) All urgent treatment centres should collect contemporaneous quantitative and qualitative data, including patient experience. From October 2018 all urgent treatment centres must return the data items specified in the Emergency Care Data Set (ECDS). Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.

(26) All healthcare practitioners working in urgent treatment centres should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.

(27) All urgent treatment centres to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.

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

Open Report on behalf of Keith Ireland, Chief Executive

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 November 2018**
Subject:	**Annual Report of Lincolnshire East Clinical Commissioning Group**

Summary:

Each clinical commissioning group (CCG) is required to prepare and publish an annual report and accounts. The purpose of this item is to give consideration to the Annual Report for 2017-18 of Lincolnshire East CCG.

On 17 October 2018 the Committee considered the annual report of Lincolnshire West CCG. The annual reports of South Lincolnshire CCG and South West Lincolnshire CCG are due to be considered at the December meeting of this Committee.

Samantha Milbank, the Accountable Officer, Lincolnshire East CCG, will be in attendance for this item.

Actions Required:

To consider the information in the 2017-18 Annual Report of Lincolnshire East Clinical Commissioning Group, focusing on specific issues in the Lincolnshire East CCG area.

1. Background

Introduction

Each clinical commissioning group has a statutory duty to produce an annual report and accounts. The annual report and accounts are a means in which CCGs set out their main activities of the previous year. The accounts and financial statements aim to demonstrate a CCG's stewardship of its share of the NHS budget.

The form and content of all CCG annual reports and accounts are directed by NHS England and in addition they have to meet requirements set by the Department of Health. As a result of these requirements, annual reports follow a standard pattern. An annual report and accounts typically include:

- an annual report section, including the CCG's performance, for example in reducing health inequalities;
- a governance statement;
- a statement of the accountable officer's responsibilities; and
- financial statements, including a report and opinion from an independent auditor.

It is the responsibility of each CCG's accountable officer to prepare the annual report and accounts. When annual reports and accounts are approved, the governing body must confirm that they are satisfied they present the CCG's year in an appropriate, comprehensive, balanced and coherent way.

Annual Report of Lincolnshire East CCG

Rather than focus on the Annual Report and Accounts of Lincolnshire East CCG in their entirety, it is proposed to focus on the 'annual report' section, in effect pages 1-37 of the report. This is attached as Appendix A to this report. The full Annual Report and Accounts of Lincolnshire East CCG 2017-18 are available at the following link:

https://lincolnshireeastccg.nhs.uk/about-us/key-documents/annual-report-1/2017-18

Annual Reports of Other CCGs.

On 17 October 2018 the Committee considered the annual report of Lincolnshire West CCG. For reference this is available at the following link:

https://www.lincolnshirewestccg.nhs.uk/LibraryDocs/annual-report-2017-2018/

It is proposed to cover the annual reports of South Lincolnshire and South West Lincolnshire CCGs at the December meeting of the Committee. For reference, they are available at the following links:

South Lincolnshire CCG:
http://southlincolnshireccg.nhs.uk/about-us/key-documents/annual-report-1/annual-report-2017-2018

South West Lincolnshire CCG:
http://southwestlincolnshireccg.nhs.uk/about-us/key-documents/annual-report-1/annual-report-2017-2018

2. Consultation

This is not a direct consultation item.

3. Conclusion

The Health Scrutiny Committee is being requested to consider the information in the 2017-18 annual report of Lincolnshire East Clinical Commissioning Group.

4. **Appendices** – Listed below and attached to this report

Appendix A	Annual Report and Accounts 2017-18 of Lincolnshire East Clinical Commissioning Group – **Pages 1-37 only**

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

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

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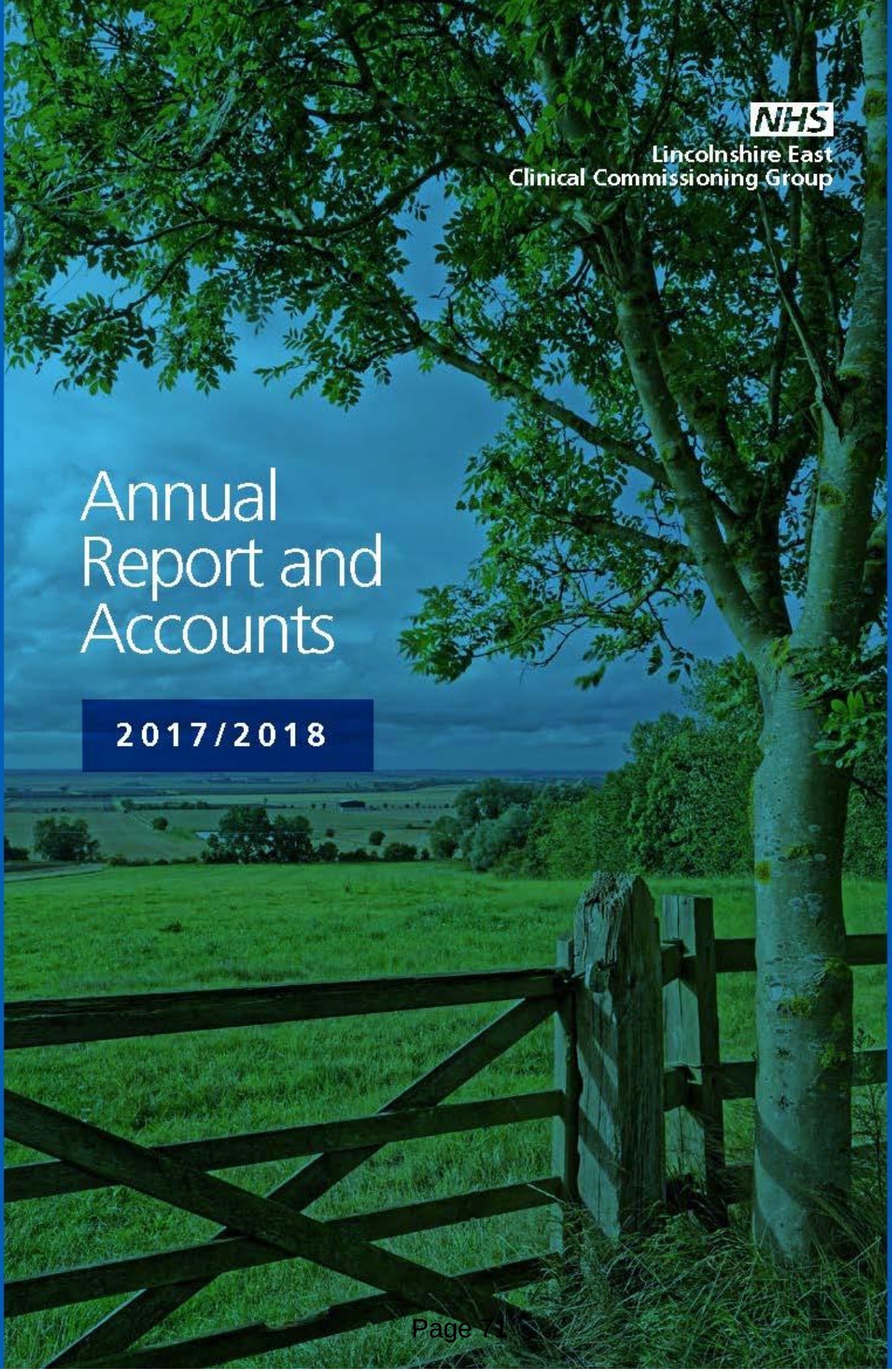

NHS
Lincolnshire East
Clinical Commissioning Group
Annual
Report and
Accounts
2017/2018

Lincolnshire East Clinical Commissioning Group

Annual Report and Accounts 2017/18

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Contents

Introduction

Welcome to our Annual Report

I would like to welcome you to the 2017/18 Annual Report and Accounts for NHS Lincolnshire East Clinical Commissioning Group (LECCG), which covers the period between 1 April 2017 and 31 March 2018. The Annual Report has been prepared in accordance with the National Health Service Act 2006 (as amended 2012) Directions by NHS England, in respect of Clinical Commissioning Groups' annual report.

The information set out within this publication demonstrates our commitment to delivering good quality healthcare to our patients and support to their families and carers. We have faced many challenges over the past twelve months and by working with our partners across the health and care community we have been able to commission some outstanding services and outcomes.

We would not be able to achieve all that we do if it was not for these collaborative working arrangements and strong relationships that we have within Lincolnshire. We have three very vibrant and diverse communities in our localities of Boston, East Lindsey, and Skegness and Coast. Each of these has their own particular challenges and by working closely together we can understand the local differences and what is needed to meet the health and care needs of our population. There is a drive nationally to shift care out of hospital and into the community. We are doing this by supporting closer neighbourhood working so that the healthcare staff and services work together in a more joined up way, with a focus on meeting identified needs within our local populations.

However, that shift away from hospital does not mean we don't value our hospital services. We continue to build strong relationships with our acute provider, United Lincolnshire Hospitals NHS Trust (ULHT), and we are the lead commissioner for all four of the clinical commissioning groups within the county. We have also introduced a number of new initiatives to make access to health and care easier for our patients.

Our GPs across the Lincolnshire East area continue to play a significant role in healthcare in the area. As a clinical commissioning group we seek advice from each of our 27 GP practices on the decisions we make about services. As healthcare providers they regularly see hundreds of patients and provide high quality care and advice to help them to stay healthy and manage their illnesses. Tribute should also be paid to our GPs for their unfailing commitment to opening services and seeing patients during the extreme winter conditions in February 2018. Winter puts pressure on all parts of the health and care services although over recent years the high winter demand scarcely reduces as the season shifts into spring and summer, and the population swells with the influx of holiday makers and temporary residents who come to enjoy the coast and countryside.

As the commissioner for health and care services across East Lincolnshire we need to plan for the levels and different needs of our local population. We do this in response to local demand and needs, and also consistent with national NHS policy and standards. These polides and initiatives play an important role in shaping and challenging how we deliver healthcare to our patients. The GP Forward View is about primary care, so wider than just GPs and their practices, and will allow our patients to access their healthcare needs for longer hours and at weekends. To achieve this will require some innovative ways of working for our practices and their staff and them working more closely and seamlessly with our community, local government, voluntary sector and other providers. We are already seeing the difference that this has started to make with the introduction of an East Lindsey Extended Access Hub pilot which has seen eleven of our practices come together to provide extended opening hours for booked appointments to their registered patients. This new service is delivered at Louth Hospital.

As we move forward into the new financial year we will continue to build on the strong foundations that we have with our patients, their families and carers. We can only develop the future of services in Lincolnshire with strong local engagement and we will continue to build on this during the coming year. There are a wide range of ways that patients can become involved in the workings of the CCG – many of our practices have Patient Participation Groups which are active in keeping patients informed of the many developments as we move forward. In addition, we have a Virtual Patient Council which you can get involved in through our website at www.lincolnshireeastccg.nhs.uk

Finally I would like to thank Gary James, our former Accountable Officer, who retired in December 2017 after leading the organisation since its inception. He has been an inspiration to many and the contribution he has made to the health service both locally and regionally is recognised.

I hope that you find the information contained within this report of interest and if you have any comments please do contact us on 01522 515347.

Samantha Milbank
Accountable Officer
Lincolnshire East CCG
22 May 2018

Performance Report

Performance Overview

We are responsible for commissioning – or buying – high quality healthcare for our patient population across East Lincolnshire, including planned care, emergency care, maternity services, community and mental health services and the majority of GP services for our 250,041 patients registered across our 27 GP practices.

As noted in our Accountable Officer's introduction, whilst we have made significant strides in much of what we do and commission, 2017/18 has been another challenging year for us as a CCG. Like the wider NHS, Lincolnshire's healthcare system manages heightened pressure year-round, particularly during the winter and the partnership working we have undertaken with neighbouring CCGs and our providers has been vital in managing this.

We continue to work with ULHT, who we lead commission on behalf of the Lincolnshire CCGs, to try and address some of the problems faced by the local acute hospital sector, but the standards set by the NHS Constitution remain extremely challenging and we are working hard to mitigate the impact on our patients.

Key issues and risks

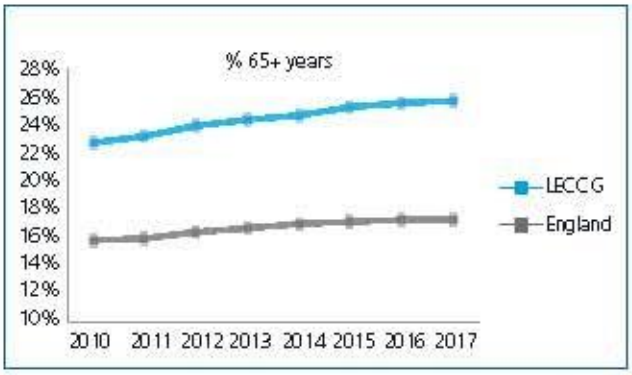
Meeting performance standards has been particularly challenging for the CCG this year, with both national and local factors affecting performance. Our two main hospital providers, ULHT and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), both continued to face major issues, which have led to longer waiting times. Nationally, pressures on A&E and ambulance services continued to increase, which, coupled with pressures on social care, affected flow through hospitals and bed availability.

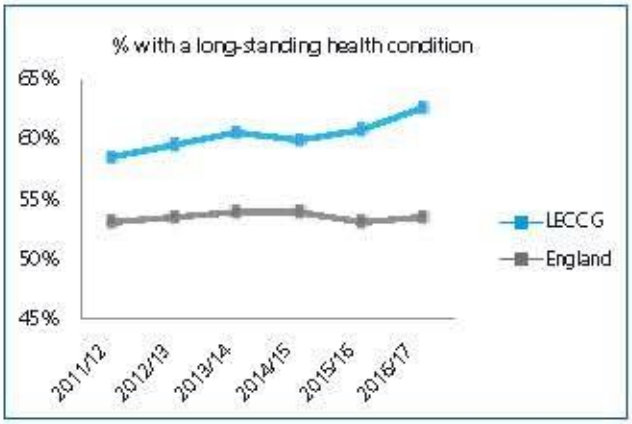
Our commissioning contracts with providers were constructed to ensure that all NHS Constitution standards were met. However, there were specific performance challenges in relation to:

- Waiting times for referrals to treatment in secondary care
- A&E waiting times
- Cancer waiting times
- Diagnostic waiting times for urodynamics, echocardiography and endoscopy tests.

NHS Constitution standards are described later in the report in more detail.

In Lincolnshire East Clinical Commissioning Group, our ageing population has contributed to more complex health issues. The charts below show how the percentage of our population aged 65 and over compares to the England average, and the percentage of LECCG's population with a long-standing health condition. In both cases, there is a widening gap between the England average and that of our local population. This leads to pressures on all our services, induding primary care, community, mental health and secondary care, and means that we have to consider how best to commission the health needs of our older adults and those with complex health issues.





Performance has continued to be affected by increasing numbers of patients requiring health services.

We have a clear and integrated approach to risk management, combined with defined ownership of risk at all levels within the organisation. Identifying and assessing risks at both strategic and organisational level is a well-embedded process within the CCG and we have established a risk sharing group that includes a cross section of members from NHS England, the Care Quality Commission (CQC) and the CCG. Our risk management framework clearly sets out how the organisation will identify, manage and monitor its strategic and organisational risks in a consistent, systematic and coordinated manner. Organisational risks arising from our day-to-day activities are monitored through the risk register and strategic risks are monitored through our Governing Body.

Performance Analysis

How we measure performance

As a CCG we have a duty to improve the quality of services commissioned, to promote the NHS Constitution, to provide information on the safety of services provided and to reduce health inequalities.

Our mechanism for doing this has been the establishment of a performance framework that identifies where we, as commissioners, and our providers do, or do not, meet the standards expected. We meet regularly with our providers to review the achievement of national and jointly agreed local measures to help ensure services perform well and meet the health needs of our population.

In addition, the CCG's quality team undertakes a schedule of visits to our GP practices, secondary care providers and care homes.

NHS England also has a statutory duty to conduct performance assessments of CCGs to assess their capability, ensure that they are complying with statutory responsibilities and are performing in a way that is delivering improvements to patients. For 2017/18, this duty has been enacted through the CCG Improvement and Assurance Framework (CCG IAF) (available at www.england.nhs.uk) and involves a robust and continuous process, using information derived from a variety of sources e.g. local intelligence, self-assessments and CCG produced documents, such as Governing Body papers and audit reports. As part of this process, NHS England monitors us on delivery against four components of assurance:

- Better Health
- Better Care
- Sustainability
- Leadership

The CCG IAF is intended as a focal point for joint work and draws together the NHS Constitution, performance and finance metrics and transformational challenges, and will play an important part in the delivery of the Five Year Forward View. The Forward View and the planning guidance set out national ambitions for transformation in a number of key clinical priorities - mental health, dementia, learning disability, cancer, maternity and diabetes. NHS England publishes a rating for each of these six clinical areas for each CCG. The 2017/18 year end assessments will be available from July 2018 on https://www.nhs.uk/service-search/Performance/Search

Key performance indicators (KPIs)

The key areas of performance for which the CCG is accountable are:

- Delivery of NHS Constitution requirements
- Delivery of the CCG Improvement and Assessment Framework

The CCG IAF is intended as a focal point for joint work and draws together the NHS Constitution, performance and finance metrics and transformational challenges and will play an important part in the delivery of the Five Year Forward View. The Forward View and the planning guidance set out national ambitions for transformation in a number of vital clinical priorities such as mental health, dementia, learning disabilities, cancer, maternity and diabetes. NHS England publishes a rating for each of these six clinical areas for each CCG. The 2017/18 year end assessments will be available from July 2018 on My NHS.

Responsibility for performance management across the CCG ultimately sits with our Governing Body, and performance against key NHS Constitution standards and other indicators is reviewed on a monthly basis. Similarly, financial performance and delivery of the CCG's Quality, Innovation, Productivity and Prevention programme is also reviewed monthly. The Governing Body has delegated aspects of its performance management responsibilities to its Quality & Patient Experience Committee (QPEC), Primary Care Co-Commissioning Committee and Finance & Performance Committee. *Further information on the role of each of these committees and highlights of their work over the year can be found in the Annual Governance Statement contained within this report.*

On an annual basis the CCG is assessed by NHS England for its compliance with Emergency Preparedness Resilience and Response (EPRR) Core Standards. In 2017/18 Lincolnshire East CCG was assessed as being 'Substantially Compliant' with these standards.

NHS Constitution performance summary

NHS Constitution metric	National standard	2017/18 performance	Performance narrative
Planned care			
Patients on non-emergency pathways should wait no more than 18 weeks from referral to start treatment	92%	86%	Our two main providers, ULHT & NLAG, remained in CQC special measures during 2017/18. In line with national guidance, both trusts postponed elective and routine outpatient care over the winter period and continued to experience high vacancy rates and on-going bed pressures. Pressures with patient flow are largely due to delayed patient discharge, therefore, the CCG works closely with providers to improve patient flow.
Patients referred for diagnostic tests should wait no more than six weeks from referral	1%	2.9%	Performance was particulary affected in endoscopy tests at NLAG, caused by a combination of equipment failures and consultant capacity.
Patients whose operations are cancelled on or after the day of admission, for non-clinical reasons, to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice (ULHT)	0%	6.56%	2017/18 has seen continued improvement at ULHT and performance is now in line with the national average.
No patient's urgent operation should be cancelled for a second time (ULHT)	0	0	There have been no breaches of this standard in 2017/18
No patient should wait more than 52 weeks for non-urgent consultant-led treatment to commence	0	191	There was a sharp rise in the number of patients waiting in excess of 52 weeks for their planned care at NLAG. NLAG is implementing new procedures to address this issue. The CCG receives a full analysis of each event from the relevant provider.
A&E waits			
Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	95%	86.3%	Performance is slightly lower than the national average of 88.7%. In line with national experience, A&E pressures have continued in 2017/18. A range of improvement measures are being implemented at both ULHT and NLAG which should see achievement of this standard by March 2019.
No patient should wait over 12 hours from decision to admit to admission (trolley waits) (ULHT)	0	3	There have been three breaches of this standard in 2017/18
Ambulance times			
New, provisional, ambulance response times were adopted by EMAS (East Midlands Ambulance Service) in August 2017 which will not be formally monitored against until April 2018.			
Cancer waiting times - 14 days			
Patients referred urgently with suspected cancer by a GP should wait a maximum of two-weeks for first outpatient appointment	93%	89.1%	Performance is slightly lower than last year, but pathway redesigns should improve performance over the next twelve months.
Patients referred urgently with breast symptoms (where cancer was not initially suspected) should wait a maximum of two weeks for first outpatient appointment	93%	76.4%	Performance is an improvement from last year but breast cancer services were affected by shortages of radiologists, which is a national issue as well as local.
Cancer waiting times - 31 days			
Patients should receive their first definitive treatment within 31 days of a cancer diagnosis	96%	96.6%	Performance remains above the national standard
Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	93.8%	Performance is slightly lower than the national standard
Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	99.4%	Performance has improved from last year and remains above the national standard
Maximum 31 day wait for subsequent treatment where that treatment is radiotherapy	94%	95.7%	Performance has improved from last year and is now above the national standard.
Cancer waiting times - 62 days			
Patients should receive their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	85%	68.3%	Although significant effort has been made in all areas on 62 day performance improvement work, a lot of this effort has been absorbed by the higher levels of patients being referred in on a suspect cancer pathway.
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	88.4%	Performance has improved from last year but is below the national standard
Maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	85% Local	85.1%	Performance has improved from last year and is now above the local standard.
Mental health			
People under adult mental illness specialties on the Care Programme Approach should be followed up within seven days of discharge from psychiatric in-patient care	95%	93.8%	Performance is slightly lower than the national standard, but performance did improve greatly and was higher than the national standard in quarter four.
Mixed sex accommodation breaches			
Minimise breaches	0	137	There has been a significant increase in breaches in 2017/18, mainly due to the way they are recorded at NLAG. Two breaches were at ULHT, all others at NLAG.

CCG Improvement and Assessment Framework performance summary

The framework covers indicators in four domains:

Better Health: how the CCG is contributing towards improving the health and wellbeing of its population and bending the demand curve;

Better Care: focuses on care redesign, performance of constitutional standards and outcomes, including in important clinical areas;

Sustainability: how the CCG is remaining in financial balance and is securing good value for patients and the public from the money it spends;

Leadership: assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

NHS England assesses the CCG's overall performance against the CCG IAF criteria. At the time of writing this report the latest information we have is the 2016/17 year end rating, which for Lincolnshire East CCG is 'requires improvement'.

We also acknowledge that the following areas are where improvements are required, and work is ongoing as follows:

- Antimicrobial resistance - appropriate prescribing of antibiotics in primary care

The work plan for 2018/19 is focused on quality improvement and value for money:

- To reduce unwarranted prescribing practice variation in both primary and secondary care (including switching to lower cost alternatives, reviewing and optimising dosage)
- To increase access to pharmacists as the correct health professional to assist patients in managing conditions by supporting the development of new roles.
- To reduce the volume of prescribing and mismanagement of patients' medications in the community and care homes (polypharmacy).
- To support the GP workforce to provide the best care to patients, releasing GP time with new clinical pharmacy roles, providing education via these new recruits and reducing follow up burden and unplanned admissions due to medication errors.

- People with an urgent GP referral who have their first definitive treatment for cancer within 62 days of referral

The CCG continues to support the system-wide plans to improve cancer treatment times:

- Completed a deep dive within ULHT to understand the issues that are negatively impacting on performance.
- Developed and implemented an agreed action plan to drive improvement
- Secured funding from the Lincolnshire system and national team to deliver the programme of improvement

- Cancer patients' experience
  - At a recent cancer summit the health and care system committed to support a work programme for 2018/19 and determine the key areas of intervention that will ensure that by 2021 we have improved patient experience.
- People with a learning disability who have an annual health check
  - It is a key priority for LECCG, working with the lead countywide commissioning teams, to achieve the ambitions under the Five Year Forward View for Mental Health. To ensure we are improving outcomes for people with mental health, learning disabilities and autism, maximising the opportunities to deliver care and support across the whole health and social care system, thus reducing health inequalities. This includes working with primary care to improve interactions with physical, behavioural and mental health issues, increasing identification, review and ongoing support (i.e. increase annual health checks for people with learning disabilities).

Areas in which the CCG performs well compared to the national average are:

Better Health:

- Newly diagnosed diabetes patients who attend a structured education course (top 10%)
- The number of personal health budgets in place (top 10%)
- Diabetes patients achieving all the NICE-recommended treatment targets (top 20%)
- Emergency hospital admissions for injuries from falls in people aged 65 and over (top 25%)

Better Care:

- Completeness of the GP learning disability register (top 5%)
- Hospital bed use following emergency admission (top 10%)
- Women's experience of maternity services (top 15%)
- People experiencing a first episode of psychosis who start a recommended treatment within two weeks (top 20%)
- Choices in maternity services (top 25%)

- Patients waiting 18 weeks or less from referral to hospital treatment
  - The CCG has supported some of the challenged specialties improve waiting times from over 18 weeks to under (i.e. Cardiology and Neurology) and implemented advice and guidance facilities for our GPs, to save patients from unnecessary referrals to secondary care.

- Patients' overall experience of GP services
  - The CCG regularly holds listening clinics at all surgeries in order to hear patients' views first hand which are fed back to practices. Our practices have also implemented new services, including extended hours and have recently been commissioned to provide more essential services closer to patients' homes, induding ear irrigation, 24 hour ECGs and 24 hour ambulatory blood pressure monitoring.

The Resources, Principal Risk and Uncertainties and Relationships that may affect the CCG's long-term performance

The annual accounts of Lincolnshire East CCG for the year 31st March 2018 have been prepared in accordance with the National Health Service Act 2006 (as amended) Directions by the NHS Commissioning Board, in respect of Clinical Commissioning Groups' annual accounts.

The accounts have been prepared on a going concern basis. Lincolnshire East CCG has achieved its financial targets for 2017/18 as follows:

Remain within Revenue Resource Limit (RRL)	Yes
Achieve 1% planned surplus on RRL	No
Remain within Running Costs Allowance	Yes
Contain cash payments within Maximum Cash Drawdown limit	Yes

The fifth year of the CCG has been financially challenging. The Revenue Resource Limit (RRL) allocated to Lincolnshire East CCG was £386.698m, with a requirement to increase the surplus by £0.8m during the year from £2.125m to £2.925m. As set out in the 2017/18 NHS Planning guidance, CCGs were required to hold a 0.5% national system risk reserve uncommitted from the start of the year, created by setting aside the monies that the CCG would have otherwise spent non recurrently. NHSE confirmed in March 2018 that the full amount of the risk reserve can be released as additional underspend in year. This additional contribution has been used to offset against other cost pressures to achieve a breakeven position in year, therefore meeting our statutory requirement. The CCG has achieved a cumulative net surplus of £2.125m.

The CCG managed its administration functions within the allocated Running Costs Allowance of £5.170m.

Cash payments were also managed within the Maximum Cash Drawdown limit as allocated by the Department of Health.

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in note 6 to the accounts.

The CCG is an approved signatory to the Prompt Payments Code. This initiative was devised by the Government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses. The code gives suppliers confidence that they will be paid within clearly defined terms, and that there is a robust process for dealing with any payments that are in dispute.

Approved signatories undertake to:

- pay suppliers on time;
- give clear guidance to suppliers and resolve disputes as quickly as possible; and,
- encourage suppliers and customers to sign up to the code.

The CCG set financial plans at the beginning of the year which were approved by the Governing Body in July 2017. These plans provide the benchmark for monitoring the financial position throughout the year.

Summary Headline Financial

Total Resources	£386.698m
Operating Expenditure	£384.573m
Cumulative Surplus	£2.125m
Current assets (receivables and cash)	£3.5m

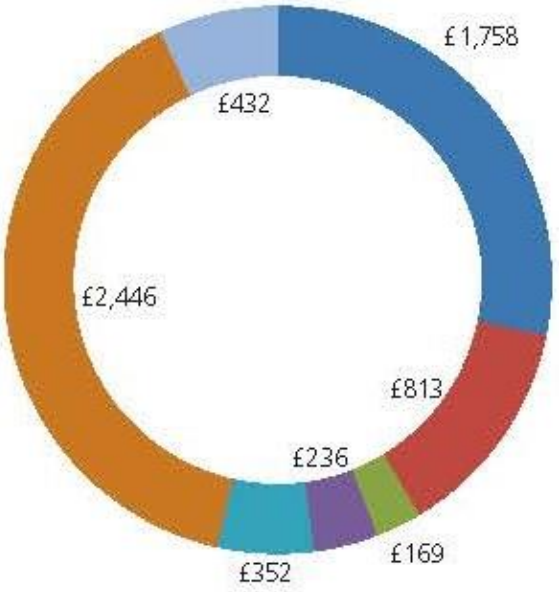
Our operating expenditure of the CCG can be split into two types.

- Programme expenditure: this is for the purchase of healthcare (equates to £379.5m). We spent 98.7% of our resources on healthcare. Around 55% of our programme expenditure is with NHS organisations. Prescribing costs accounted for just under 13% of the total; and,
- Administration expenditure: costs that are not for the purchase of healthcare, but relate to the direct running costs of the CCG equates to £5.1m.

Analysis of Gross Admin Expenditure

- Services from other CCGs and NHS England
- Establishment
- Premises
- Supplies and services – general
- Other
- Employee benefits
- Executive Governing Body members

* Figures shown represent £'000



Analysis of Gross Programme Expenditure

- Services from other CCGs and NHS England
- Services from foundation trusts
- Services from other NHS trusts
- Purchase of healthcare from non-NHS bodies
- Premises
- Prescribing costs
- GPMS/APMS and PCTMS
- CHC Risk Pool contributions
- Other
- Employee benefits
- Executive Governing Body members

* Figures shown represent £'000

Sustainable Development

As part of the NHS, Public Health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020.

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012).

Sustainability has been recognised at a national level as an integral part of delivering high quality healthcare, efficiently. Adopting smarter working practices can make a significant contribution to much of what we do, including patient experience, clinical effectiveness and reducing carbon and waste, and we acknowledge our responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

Being sustainable is about meeting the needs of today without compromising the needs of tomorrow. With this in mind we promote sustainability in the way we commission services from our providers. Sustainability processes are checked in all procurements ensuring providers are aware of their responsibilities to the environment.

Commissioning sustainably means:

- Planning services that are efficient and effective
- Buying services which provide the highest quality at best value and which have least impact on the environment
- Avoiding duplication and waste
- Stopping services not meeting these criteria

We have offices in NHS premises in Bracebridge Health, Lincoln (Cross O'Cliff Court), Boston (Endeavour House), Louth (Louth Hospital) and Skegness (Cecil Avenue Health Centre). Our waste and utilities impact has been calculated on the basis of percentage occupancy and impact on each site.

During 2017/18 we have worked towards:

- Reducing the amount of miles we travel by increasing our use of telephone conferences
- Retaining a corporate day so that staff only need to travel to our offices one day a week for the majority of corporate meetings
- Encouraging all of our staff to reduce their use of paper and to move towards electronic documents where possible. Many of our staff and all of our Governing Body members have iPads, which means we have been able to significantly cut the use and cost of both paper and printing for our Governing Body meetings, as well as for many internal meetings. We have also introduced a significantly more efficient range of printers for those documents that must be printed.

Improve quality

The Health and Social Care Act (2012) places statutory duties on the Secretary of State, NHS England and CCGs to promote continuous improvements in the quality of health services.

Patient safety and quality care remain a priority for the CCG. We are committed to ensuring patients remain the central focus in any commissioning decisions and have a positive experience when using the services we commission. To do this the CCG takes into consideration the three dimensions of quality, clinical effectiveness, safety and patient experience, to provide opportunities to share lessons, working collaboratively as a healthcare system, and continuously improve the quality of care provided to individuals.

The services we commission are monitored against essential standards of quality and the CCG has worked closely with organisations to provide both support and challenge, as required, to ensure we continuously drive quality improvement and patient outcomes.

Throughout 2017/18 there are many examples of how we are working with providers to improve the quality of services for the population of Lincolnshire and we have utilised a range of methods to develop a clear picture of current performance.

Quality Monitoring Framework

We have further developed our approach to commissioning high quality services throughout 2017/18, including a review of our Quality Monitoring Framework (QMF). The framework is based on making efficient use of arrangements already in place within provider organisations, whilst also allowing for commissioner led flexibility both in terms of the level of review required and the subject area.

The CCG has worked closely with providers and federated quality teams to adjust the programme of quality assurance visits to ensure they are providing the appropriate level of detail to support provider organisations and secure the required level assurance for commissioners. This programme of visits is aimed at specific patient care environments, providing the CCG with the opportunity to directly engage patients in the environments, where they receive their care. The revised visit schedule provides the opportunity for the Engagement Manager to support the visits to ensure we are able to capture the views of the patients.

The CCG reviews data and analyses key indicators from various sources, such as harm free care, individual quality metrics, case note analysis, complaints and compliments, incidents, infection prevention and control, and ward and individual department governance to ensure the three dimensions of quality are considered and guide our decision making.

Quality schedules are in place with organisations commissioned in Lincolnshire and there is a requirement for providers to report against a range of patient safety indicators. Providers are required to achieve 95% harm free care for patients, and are monitored at individual ward and department level. The CCG meets with providers quarterly to review progress against the quality schedule and the defined Commissioning for Quality and Innovation (CQUINs) to provide assurance to the CCG in relation to the quality of care delivered to patients in each of these different environments. Concerns in relation to progress against these are escalated to the appropriate boards in the CCG and the provider trusts.

The CCG has further developed the monthly Patient Safety and Quality Meetings (PSQM) with United Lincolnshire Hospitals NHS Trust (ULHT) which has good clinical representation from both the trust and the CCG, supporting the opportunity for challenge, scrutiny and assurance of current issues relating to patient safety in addition to monitoring compliance against the quality schedule and CQUIN achievement. A Chairs' exception report is provided and is designed to report any areas of concern that are currently being managed within the PSQM and escalate any issues as required to the Contract Operational Group and the Contract Assurance Board. In addition, the CCG attends ULHT committees to further support the ongoing quality improvement of the organisation.

Other CCGs have now introduced monthly meetings to improve the level of assurance from other providers in Lincolnshire. Quarterly patient safety meetings are held with the remaining providers in addition to a quarterly formal review that is undertaken with reports submitted to the Quality and Patient Experience Committee, with escalation to Governing Body and the Contract Operational Group and the Contract Assurance Board.

All serious incidents are analysed and reviewed by Chief Nurses from all four Lincolnshire CCGs at the Serious Investigation Review Group, with support from the federated risk and quality team. The CCG and the federated quality team have been working closely with ULHT to support the new process in place to manage the outstanding serious incidents reported.

The System Improvement Board for Lincolnshire continues to monitor progress against the Quality Improvement Programme developed by ULHT in collaboration with the CCG and NHS Improvement. Progress against this is reported to CCGs

Patient Safety

We have a robust system in place for continuing to drive improvement in patient safety for the population of Lincolnshire. All safety incidents are monitored and themed for trends across the health community and reported using the National Reporting and Learning System. The CCG assesses Individual organisations for their level of reporting which provides the opportunity to monitor both the trends of incidents occurring within the organisation, and assess their reporting culture.

The CCG receives notification of incidents, related to Lincolnshire East CCG residents, from provider organisations and ensures that all appropriate action has been undertaken by the notifying organisation, to learn and share lessons, and promote public safety and confidence. Lessons learnt as a result of serious incidents are proactively discussed within the contract review meetings to ensure actions have been embedded into practice and where appropriate lessons learnt from serious incidents are utilised to inform commissioning decisions.

Providers attend the Serious Incident Review Group meeting (SIRG), where all serious incidents are reviewed and closed once appropriate assurance has been received. SIRG is attended by all Lincolnshire CCGs and the addition of the providers at this meeting has created the opportunity to support learning and provide greater, timelier assurance. In addition, the CCG is able to gain further assurance in relation to the individual and collective actions taken by organisations at individual patient safety and quality meetings and risk management meetings where further scrutiny is undertaken.

All serious incidents are subject to a root cause analysis which is reviewed at executive level within the provider and then by the Chief Nurses within the CCG prior to closing. Action plans are identified to address any gaps in care and are monitored through the quality assurance framework, commissioner-led quality assurance visits and quality review meetings to ensure that they are embedded in practice with providers. The Duty of Candour in relation to these incidents is embedded within provider quality schedules and monitored as part of quality review meetings and patient safety meetings.

Never events that occur within an organisation are subject to an enhanced level of scrutiny including quality assurance visits and never event summits. There is representation at the never event summits from the CCG and clinicians from the trust. This process supports an appropriate forum to ensure that lessons are learnt, as well as creating opportunities to share those lessons across the health and social care community.

The CCG continues to monitor a range of mortality indicators and work proactively with providers to drive improvement in patient mortality and avoidable deaths. We provide dinical representation at the Mortality Review Action Group at ULHT to provide challenge and to support opportunities for continued learning. The CCG also supports the collaborative Lincolnshire Mortality Review Group which has been established to provide a forum for secondary care and primary care to review case notes of a selected cohort of patients. This creates the opportunity to work collaboratively to better understand mortality in the patients within our community and create a further opportunity to drive improvement in patient mortality as a healthcare system.

In addition the Strategic Mortality Review Summit is held between Lincolnshire providers and CCGs to:

- ensure a high level strategic focus on hospital/provider mortality rates, the underlying factors and the quality and progress of associated action plans to reduce mortality rates;
- consider the current position with regard to hospital/provider mortality rates;
- provide assurance of the governance arrangements supporting the oversight of hospital/provider mortality;
- review and assure provider and/or commissioner action plans re mortality;
- consider and initiate next steps including necessity for any independent expert reviews.
- a forum to provide commissioner assurance for the four Lincolnshire CCGs, NHS England and Public Health on health economy action

Valuing Patient Experience

The CCG values the opportunity to hear what people think about the services we commission and we use feedback to support decisions about services. We analyse complaints and monitor the themes and trends to promote learning. This information is reviewed in conjunction with other quality metrics to drive quality improvement and is used to further support the schedule of quality assurance visits which improves patient experience and patient outcomes.

The CCG continues to use the Principles for Remedy for NHS Complaints, as set out by the Parliamentary and Health Service Ombudsman (https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy). This identifies good practice with regards to providing remedies for patients wishing to make a complaint and these are supported by the CCG;

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right

Breakdown of all Complaints 2017/18	By Resident Population
Quarter 1	3
Quarter 2	7
Quarter 3	7
Quarter 4	6
Totals	23

During 2017/18 we received 23 formal complaints, both directly from patients and the public, and from Members of Parliament on behalf of their constituents. This compares to 19 received in 2016/17. There has been an increase in the number of complaints received this year, particularly in relation to retrospective review claims for Continuing Healthcare (CHC) funding. The main themes highlighted from the complaints have been communication and commissioning. In light of the complaints received and as part of lessons learnt, new processes have been developed to ensure communication is improved within the relevant services.

The CCG views compliments, concerns and complaints as a valuable source of information, and we act on all feedback received for services we commission, making sure that any concern or complaint raised is dealt with compassionately, effectively and in a timely manner. Our responses to concerns and complaints are administered in line with the Local Authority Social Services and National Health Service (England) Regulations 2009.

Friends and Family Test

The CCG receives The Friends and Family Test (FFT) report at provider, individual ward and department level monthly. This is an essential tool providing information to enable the CCG to assess patient experience across all NHS providers. FFT gives every patient the opportunity to comment on the care they have received and provides an excellent opportunity for providers to learn what they are doing well and what they need to change. This information can be used to develop improvements that will enhance the experience for patients and improve outcomes.

The CCG use this data in conjunction with other patient experience indicators, to drive improvements to services at clinical and ward level, and to support the quality assurance visit schedule.

Assuring Quality in Primary Care

In line with national guidance on delegated commissioning, LECCG has a shared responsibility, along with NHS England, for commissioning most GP services. This includes a statutory responsibility for the continuous improvement and monitoring of the quality, safety and effectiveness of those commissioned primary care services. During 2017/2018 we have continued to work closely with our 27 member practices to support quality improvement, ensuring that high quality services are at the heart of the commissioning process.

The Primary Care Co-Commissioning Committee (PCCC) meets monthly, in accordance with statutory provisions to enable members to make collective decisions on the review, planning and procurement of primary care services in Lincolnshire East, under delegated authority from NHS England. Co- Commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the needs of local populations.

The monthly Risk Sharing Meeting has representation from NHS England, CQC and the CCG and captures information from key performance indicators relating to the experience of patients visiting our member practices and CQC inspection reports and ratings. This information and any other relevant intelligence support discussion within the Risk Sharing meeting and identify the level of risk for each practice. Using a RAG risk matrix the CCG is able to demonstrate the level of surveillance appropriate for each practice and develop a quality assurance visit schedule. Reports are submitted to the PCCC for scrutiny and assurance.

Routine quality surveillance of our member practices is undertaken as part of the GP Practice Support and Quality Visits Schedule. In order to gain further assurance the visiting team may include representation from different specialities.

Listening Clinics have been undertaken as part of the quality visit schedule, enabling the CCG to listen directly to patients registered at their member practices.

Each Listening Clinic is promoted in the practice and via social media, to encourage as many patients as possible to attend and share their experiences of healthcare, which in turn develops actions to improve quality and service delivery.

Summary of the CQC inspection results for Lincolnshire East CCG compared to National ratings 2016/17

Ratings	National from 2016/17 CQC Annual report	LECCG
Outstanding	4%	0%
Good	82%	25 (86.2%)
Requires improvement	10%	3 (10.3%)
Inadequate	4%	0%
Awaiting Report		1(3.4%)
Not inspected		0%

During the past year we have had one practice rated as inadequate following its first Care Quality Commission (CQC) inspection. The CCG provided support and guidance in the development and completion of relevant action plans regarding the issues identified. Together, with the hard work and dedication of the practice in improving systems and processes, the practice was able to improve its ratings on re-inspection by the CQC.

Our quality team continues to attend and support the Practice Nurse Forums, within each of our three localities, which were established in 2014. The forums include education sessions, peer reviews and the opportunity for revalidation support and provide excellent support and development both professionally and personally for our general practice nurse workforce.

Communication, networking and peer support amongst the practice nurses, healthcare support workers and Allied Health Professionals (AHPs) has been further improved with the introduction of a closed Facebook group and WhatsApp page.

CQC Ratings for Provider Organisations

We also work with our provider organisations to ensure they have the support they need following CQC inspections. Outcomes of CQC inspections are as detailed below:-

	Date Report Published	Safe	Effective	Caring	Responsive	Well Led	Overall
United Lincolnshire Hospitals NHS Trust	11/04/17	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Lincolnshire Community Health services NHS Trust	10/12/14	Requires Improvement	Good	Good	Good	Good	Good
Lincolnshire Foundation Partnership NHS Trust	9/06/17	Good	Requires Improvement	Good	Good	Good	Good
Northern Lincolnshire and Goole NHS Foundation Trust	06/04/17	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

As the Lead Commissioner for ULHT, LECCG is leading and co-ordinating the local support and offer to the organisation. We are continuing to support the trust with members of staff from infection prevention and control, safeguarding, risk management and the quality team to provide additional support to the trust.

The System Improvement Board has been established to provide the oversight on the delivery of the Trust's Improvement Plan. Its principal purpose is to support continued improvement in the trust, provide appropriate challenge to ensure that the most robust approaches are being considered, unblock system issues where these cannot be resolved in other forums and provide the system with a collective oversight of the progress against improvement within the trust and wider system. This will ensure progression towards safer patient care.

The System Improvement Board is accountable for gaining assurance directly from the trust and, where appropriate, the wider system, for the delivery of the improvement programme. The Board is made aware of current and emerging risks to the delivery of the improvement plan.

Assuring Quality in the Care Home Sector

During 2017/18 we established robust mechanisms for the quality monitoring and assurance of care homes in Lincolnshire East. We began a series of quality assurance visits alongside the Local Authority contracting officers. We supported a number of homes with quality and performance improvements. Further development is required in 2018/19 to include working with home agencies supporting NHS funded individuals and further discussion with our partners in order to enhance contractual quality monitoring.

During the year multi-agency working has been embedded in the monitoring of the care home sector in Lincolnshire. Lincolnshire County Council (LCC) monitors the risk matrix generated for the care home sector and provides information for discussion at the LCC Safety Quality Review meeting on which CCG's are represented. Action plans for the risks identified are formulated and quality visits are undertaken to provide additional assurance.

Over 2017/18 the CCG have been involved in a number of projects involving the care sector; they have contributed to the collaborative writing of a medication policy for care homes, supported the re-launch of a health professional feedback form for care homes to report incidents of harm and potential harm for investigation, we have worked collaboratively with the Lincolnshire Care Association at local events. The CCG are planning to work further with partners in the development of Lincolnshire polices, supporting a registered nurse in social care competency framework and working with partners in the development of a transfer pathway.

The CCG is an active member of the Enhanced Health in Care Group led by the Lincolnshire Sustainability and Transformation Partnership (STP). Further development is required over the next year to develop a multi-agency quality improvement group for social care settings this group would focus on key issues to support social care settings in improving quality and safety to those accessing the services.

CQC ratings for Registered Nursing Homes

Ratings	LECCG Overall % (Total Number)	Safe % (Total Number)	Effective % (Total Number)	Caring % (Total Number)	Responsive % (Total Number)	Well Led % (Total Number)
Good	63.6%(14)	63.6%(14)	68.2%(15)	86.4%(19)	72.7%(16)	50%(11)
Requires Improvement	36.4%(8)	36.4%(8)	31.8%(7)	13.6%(3)	27.3%(6)	50%(11)

N.B There are three homes that are waiting for a rating due to being newly registered.

Transforming Care

The Transforming Care Partnership (TCP) is established and comprises the four Lincolnshire CCGs and Lincolnshire County Council, enabling the organisations to work together and create a plan to transform services for people with a learning disability and/or autism who are also at risk of developing a mental health condition or challenging behaviors, including people of all ages and those with Autistic Spectrum Disorder (ASD) who do not also have a learning disability.

Lincolnshire has made significant progress during 2017/18. In September 2015 the number of Learning Disability/ASD inpatients was 24 in CCG commissioned beds. As of 17/05/2018 we have a total of 15 in CCG commissioned beds (decrease of 37.5%). During the course of the programme we had a total of 45 new admissions/step downs into CCG inpatient care and 38 discharges.

During the next 10 months there will be a real focus on discharging the final complex cohort of patients to enable us to achieve the trajectory of 9.

Safeguarding

We have access to a Federated Safeguarding Team (FST) shared across the four Lincolnshire CCGs, providing us with the capability to meet the requirements of the accountability and assurance framework for protecting vulnerable people. There is representation from all Lincolnshire CCGs at the Safeguarding Strategy Group.

During 2017/18 the FST has provided support with provider assurance and contractual monitoring in addition to;

- Mental Capacity Act training to CCG and Care home staff facilitated by a Best Interests Assessor and a social worker
- PREVENT Workshop. The FST has assurance that all Tier 1 providers are compliant with PREVENT training
- Contribution to the new Safeguarding Adults Multi-Agency Policies and Procedures
- The newly appointed Named Doctor is reviewing policies and procedures and producing a sample safeguarding children policy for GP surgeries

Infection Prevention & Control

Preventing Healthcare Associated Infections (HCAI) remains a priority for the CCG. We have an infection prevention plan delivered by the federated Health Protection team which supports the four Lincolnshire CCGs. The Lincolnshire Whole Health Economy (Health and Social Care Infection Prevention and Control Group) has been established with representation from providers and commissioners, supporting a system-wide approach.

The Whole Health Economy has worked together to produce a countywide action plan to reduce Gram Negative blood stream infections, which will be ratified at the next Whole Health Economy meeting and implemented within all provider organisations. This work will take place over the next couple of years and there is good engagement from providers to date.

Every provider has an indicator relating to antimicrobial stewardship, which for the larger providers forms part of the Infection Prevention and Control quality indicators (based on the national indicators from NHS England) and performance is assessed and monitored through the quality review process. Smaller providers are expected to provide evidence of assurance relating to Criterion 3 of the code of practice for infection prevention and control as part of the Health and Social Act 2008 – this directly relates to antibiotic prescribing and challenges organisations to ensure that appropriate prescribing takes place.

We also monitor antimicrobial prescribing in primary care, especially high risk antibiotics that can lead to greater resistance if not used appropriately. Our Health Protection team is working collaboratively with other CCGs across the East Midlands on strategies to raise awareness of the emerging threat of resistance and to challenge where necessary.

Quality Surveillance Group

We remain an active member of the Lincolnshire Quality Surveillance Group which brings together health and care organisations within a geographical footprint to share information regarding the quality of all providers, including secondary care, primary care and care homes.

The Quality Surveillance Group (QSG) provides the opportunity for a whole system approach to shared learning through sharing intelligence, an early warning mechanism of risk and poor quality, and coordinated actions to drive improvement whilst respecting statutory responsibilities of and ongoing collaboration between organisations.

Lincolnshire Quality Forum

The Lincolnshire Quality Forum (LQF) brings together key partners from Lincolnshire health providers and commissioners on a three monthly basis. The primary role of the LQF is to monitor, review, support and promote the continuous improvement of the quality of health services and the effectiveness of care and treatment received by patients, across Lincolnshire.

During 2017/2018 the forum has continued to bring together professionals from across the health economy to allow a whole system approach to quality and to drive improvement. This system wide learning is integral to ensuring a shared and broader understanding of quality issues across the county.

During the last year the members of the forum have focused upon Lincolnshire wide policies and the collaborative working across services, in particular between hospital and community settings in the improvement of tissue viability, falls and catheter management.

What do we need to do more of?

We are committed to supporting transformation of services driving the improvements required within Lincolnshire to meet the demands of the future healthcare system and are working closely with the Sustainable Transformation Programme to achieve this.

Engaging people and communities

Opening Statement from the CCG's PPI Lay Member, Brenda Owen

As the CCG's Lay Member and Chair of the Patient Council, it has been a privilege over the last year to work with both patients and CCG staff to strengthen the patient voice. This has been achieved through the continuous development of the listening model and developing links to the equality agenda, where we have continued to work towards achieving a representative voice from each of the nine protected characteristics identified in the Equality Act. This will ensure that our commissioned services meet the diverse health needs of our population.

During the year, we have continued to strengthen and develop the CCG's Patient Council through increasing the two-way flow of information, as well as continuing the development of the patient feedback process into the meeting, via the patient feedback form; this has allowed us to hear the voices of different groups of people. We are now working to establish an additional two PPG Chairs meetings in Boston and East Lindsey, to complement the already well established Skegness & Coast PPG chairs meeting to ensure that we are better connected to all of our practices, located across our large geographical area.

Over the past year we have made excellent progress in co-producing better maternity services for women and families under the Better Births initiative, and the CCG has received national recognition of this work. It has been a busy year for engagement across the CCG, and I would like to congratulate the team on its hard work and efforts in successfully increasing the patient voice.

Engagement function

Our Patient and Public Involvement Lay member is a key member of our Governing Body, Quality and Patient Experience Committee (QPEC) and Patient Council, and champions engagement and equalities, at many levels of the organisaton, The PPI lay member offers advice and challenge to the CCG from a patient perspective to influence commissioning decisions. We have an embedded engagement function which is part of the CCG's Quality Team and led by the Chief Nurse, which ensures that patients and the public are at the heart of CCG decision making. Strategic consultation and engagement advice and development is provided by the Optum Commissioning Support Service.

This year the CCG has continued to deliver the aims as set out in our Patient and Public Engagement and Experience Strategy 2016-19 to:

1. Ensure that the CCG is fully equipped to deliver its mission, values and aims in relation to ensuring the views of patients, carers, staff, stakeholders, partners and the community are fully engaged and represented in decisions about how services are proposed, planned and delivered as well as how they can be improved
2. Undertake effective consultation and engagement
3. Ensure that we work with our whole population and groups who may be under represented.
4. Commissioning high quality care based on evidence of effectiveness
5. Improving access to services, and providing care close to home where possible
6. Reducing inequalities in health, access and patient experience
7. Improving health by focusing on prevention and reaching out to those in greatest need
8. Bringing a local focus to health services and influencing the health system to recognise the needs of the patients in East Lincolnshire
9. Have clinicians at the centre leading innovative service change
10. Increasing service integration and cooperation

Good communications is important for effective engagement; where service users are engaged, satisfaction with health services rises. Therefore, first class communications that fosters engagement is fundamental to the CCG's performance and its ability to deliver first class healthcare for our patients.

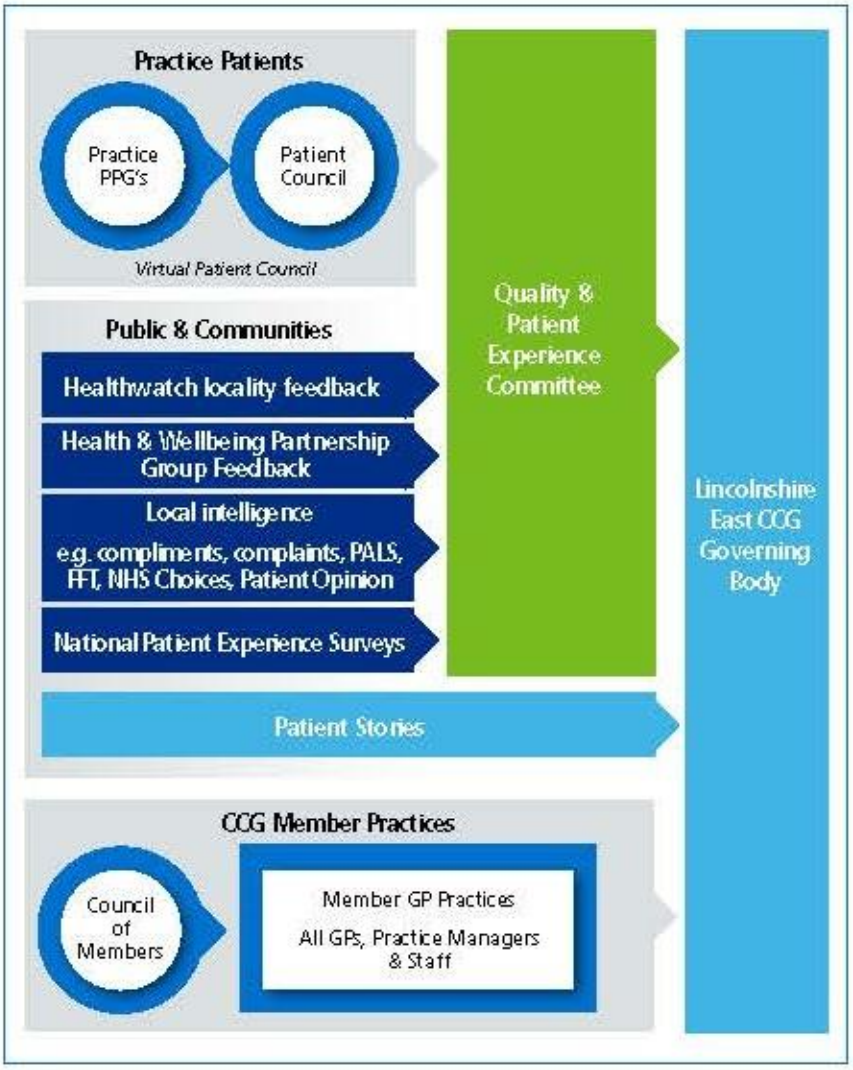
The full Patient and Public Engagement and Experience Strategy 2016-19 can be reviewed on our website, alongside our PPI Annual report.

Governance and assurance

The CCG has continued to develop its Continuous Listening Model, which clearly demonstrates the processes in place to ensure that we put patients and the public at the heart of our decisions and everything we do. We have continued to ensure that robust systems and processes are in place to enable the reporting of patient feedback into the CCG via our committee structures, as well as through our get involved and direct contact channels into the CCG.

Though these mechanisms were are able to ensure relevant action takes place and ultimately ensure patients and stakeholders are kept informed about the resulting action or service change. Throughout 2017/18, increasing emphasis has been placed on ensuring we capture information about patients' experience across all of our providers and Listening Clinics held in GP practices which report back to QPEC. The CCG uses a variety of mechanisms to review and listen to how patients, carers and service users experience our commissioned services, including local patient experience intelligence reports, which include complaints, national patient experience survey results as well as feedback from other sources, for example Healthwatch Lincolnshire, Patient Participation Groups (PPGS), Listening Clinics, Friends and Family Tests across our providers at Trust and ward level.

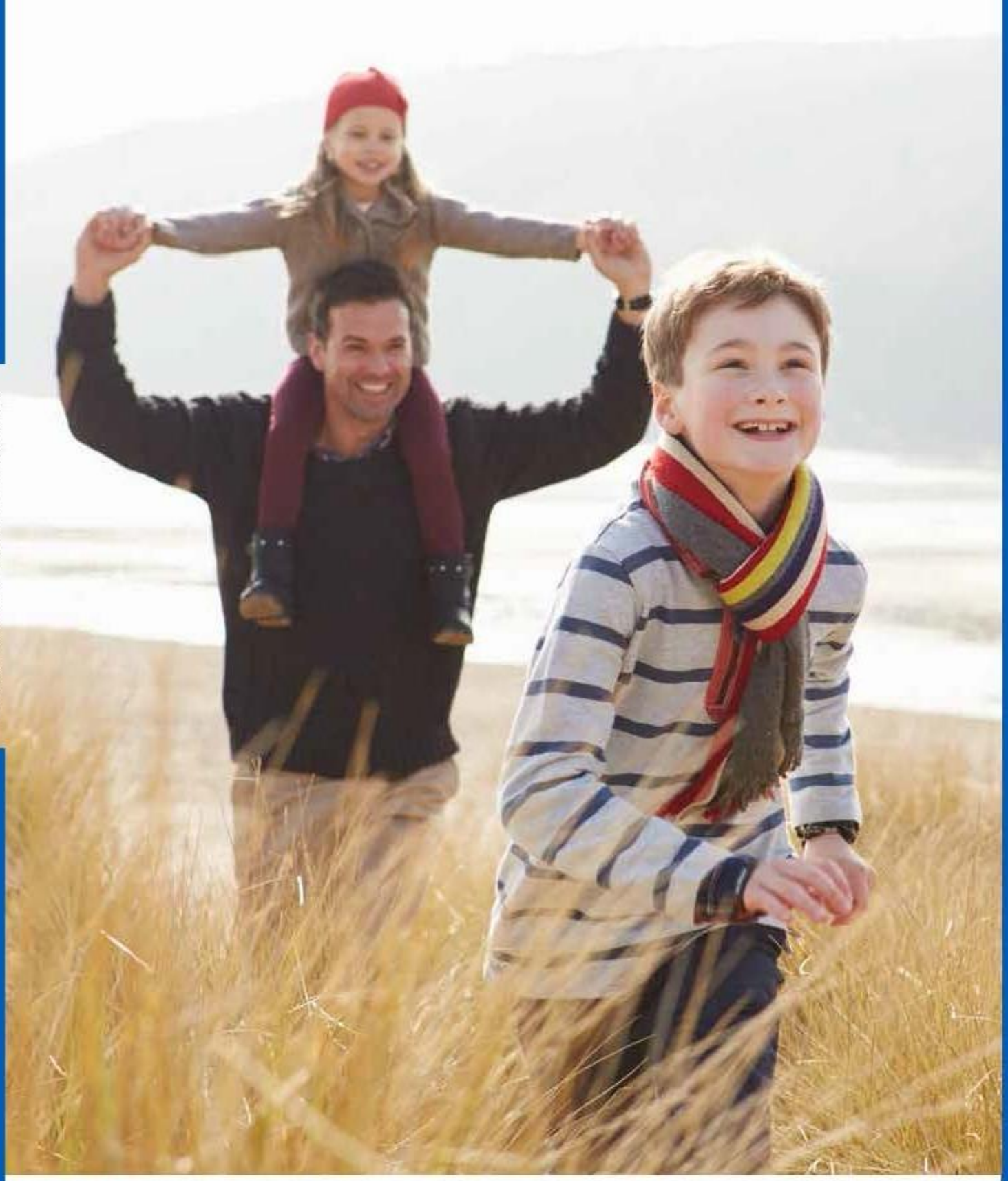
All of this information is triangulated with quality and safety data via the CCG's Quality and Patient Experience Committee (QPEC) to ensure an accurate assessment of the quality of services can be made. The QPEC meeting is a subcommittee of the Governing Body and exists to monitor and review the quality of services commissioned by the CCG, and promote a culture of continuous improvement and innovation in the safety of treatment and care provided to patients, the effectiveness of treatment and care received by patients and the experience patients and their carers have of treatment and care received.



PPG Chairs Meetings

We have made strides to improve our engagement with our PPGs over the last year and are in the process of developing PPG chairs meetings in the Boston and East Lindsey localities to mirror the already well established and functioning Skegness and Coast Locality PPG chairs meetings. Having a meeting in each of the localities will ensure that the CCG is better connected to all PPGs across the CCG's large geographical area which will further strengthen the patient voice in 2018.

One of our aims is to get patients involved in our commissioning cycle. How we will do this is demonstrated by the Department of Health Engagement Cycle that illustrates how engagement fits with the commissioning cyde and how involvement at a stage of the commissioning cycle enables more successful involvement at subsequent stages.



Principles for Engagement

Lincolnshire East CCG will follow the below values for engagement based on the principles for participation identified in the NHS England best practice document "Transforming Participation in health and care". These principles were reviewed and updated at the CCG's Patient's Council on 23 March 2016:

Details of the principles can be found at the following website address: https://www.england.nhs.uk/2013/09/trans-part/

How we enable and support those who want to get involved

During 2017/18 the CCG has worked hard to ensure that people of all backgrounds are supported to get involved. Some of the ways we have supported those who want to get involved are shown below.

- **PPG Toolkit** - We have developed a PPG Toolkit to support PPGs to establish new, or re-energize their existing PPG meetings. The toolkit has received excellent feedback from PPG members
- **Virtual Patient Council** Our Virtual Patient Council continues to be available on the "get involved" section of our website and is inclusive and open to all of our patients, stakeholders and members of the public who want to get involved but are unable to attend our meetings. During 2017/18 we continue to use this forum to display our Patient Council meeting papers, minutes and opportunities to get involved. Also online resources are displayed which support people to get involved.
- **Stakeholder Database** During 2017-18, we have further developed our stakeholder database which is an extensive contacts database of local stakeholder groups, including community, groups from the voluntary sector, and organisations representing people with protected characteristics. The CCG ensures that the database is maintained and utilised to ensure that relevant key stakeholders and groups can be involved in developing CCG projects and influencing our decisions.
- **Readers Panel** - The Readers Panel comment and make suggestions on the language and layout of various leaflets and documents which is crucial in ensuring we provide a consistent approach to the production of patient information, and that it is written in uncomplicated and straightforward language.
- **Viewpoint Panel** The Viewpoint Panel actively involves patients and members of the public in the development, planning and delivery of local services, encouraging members to respond to questionnaires and surveys, attend public meetings, takes part in discussion groups and be the voice of patients in developing services. Over the course of the year members and stakeholders have been given the opportunity to have their say on a number of plans, such as the Equality Delivery System 2, the Better Births Community Hub and some of our practice merger public consultations that have taken place as part of our implementation of the General Practice Forward View work on developing resilience in primary care.
- **Lincolnshire Wide PPI event** – in conjunction with the East Midlands Health Academic Science Network, and NHS partner organizations, we hosted a Lincolnshire Patient, Carer and Public Networking Event. The event was for patients, carers and the public and aimed to inform and inspire patient and public activation to get involved across Lincolnshire health services. The event was for people who were already actively involved or thinking about getting involved and making a difference to their local health and care services. Delegates were able to select up to three of the following workshops run by healthcare staff and patients how to get involved with Patient and Participation Groups, NHS Hospitals and Healthcare Trusts, Research, Sustainability and Transformation Partnerships and Empowering Patient Participation.
- **Promote PPI training opportunities** – We have worked closely with the East Midlands Health Academic Science Network (EMHASN) this year and have made a number of their PPI training events open to our PPG representatives, for example the EMHASN has held a number of training days as part of its East Midlands Patient Leadership Programme aimed at developing skills, confidence and effectiveness of patient leaders across local healthcare systems

The CCG recognises that there is no 'one size fits all' approach to engagement and involvement. We use a variety of ways to review and listen to how patients, carers and service users feel about the health services they have used. This patient experience data is monitored via the CCG's Quality and Patient Experience Committee (QPEC), and is used to influence the CCG's commissioning plans and decisions.

Some of the ways we listen to and involve patients, carers, stakeholders, partners and our community are outlined below.

- Local and national patient experience surveys
- Listening events
- Patient stories
- Patient and Public Council
- Patient experience dashboards
- Quality visits
- The utilization of complaints, concerns and compliments
- Results of the national 360 stakeholder survey
- Specific engagement projects

Some examples of these are explained in more detail below.

Listening Clinics

To support the continuous listening model, we have undertaken listening clinics in primary and secondary care over the past year, to enable the CCG to listen directly to patients registered at their member practices, and patients who use services of the providers, where we are the lead commissioner. The engagement team encourages patients to feedback their experiences of local health services in their own words and feedback is given to the appropriate staff to assist with quality improvement.

Social Media

NHS Lincolnshire East Clinical Commissioning Group strongly supports the use of social media as a positive communication channel to provide members of the public, GP practices and other stakeholders with information about what we do and the services we commission.

We use social media to provide opportunities for genuine, open, honest and transparent engagement with stakeholders; giving them a chance to participate and influence decision making. Social media is a great opportunity for us to listen and have conversations with the people we wish to influence. It not only allows us to make announcements e.g. health news, service information, up-coming events, it allows people to respond to whatever we post and encourages conversation and feedback. Unlike other methods of promotion, social media encourages two-way communications in real time.

Our ongoing interactive content strategy is focused on increasing proactive staff input and public engagement, supporting both national campaigns and CCG priorities. Our purpose across stakeholder groups is to inform, engage, educate and inspire.

Facebook

Facebook allows us to share news, pictures and videos, and also have two-way discussions with the public. By 'liking' our page, users will see our updates in their news feed and can engage with us by reacting to the post, commenting or sharing posts with their friends and family.

We currently have 325 (March 2018) followers which is an increase of 378% on this time last year (March 2017). Many of our GP practices are using Facebook as a way of communicating with their patients and keeping them up-to-date on practice news.

Twitter

We use Twitter to share snippets of health news and local information, or to have a direct conversation with our partners and other Twitter users. We currently have 1,849 followers (March 2018) which is an increase of 22% on this time last year (March 2017). We are always looking to increase our number of followers and encourage people to follow and tweet us and to help spread our messages to their friends and family.

Website

Our website is a portal to communicate and engage with members of the public. We want to ensure that people can easily access information on the CCG and the services available to them. We carry out regular content reviews and continue to develop the site to make it informative, user friendly, easy to navigate and to promote campaigns, events and CCG priorities.

Patient Stories

A regular and diverse programme of patient stories is presented to the CCG's Governing Body to ensure that we are able to listen to and connect with the patient experience across the health services we commission. Patient stories are a powerful way of bringing experiences to life and enable us to focus on the patients overall experience as a whole person, helping us to understand what is important to people, what works well and what can be improved.

Examples of the impact of participation

Focussed STP engagement

During the year, we have continued to talk to and engage with members of the public, staff, volunteers and other key stakeholders across the county to hear their views and inform the development of our five year health plan, the STP. This is a national requirement and since April 2016 we have been working alongside other health organisations in the county, with input from Lincolnshire County Council and other key local partners, to develop a plan to improve the quality of care that we provide, improve health and wellbeing, and ensure that we bring the health system back into financial balance by 2021. We built our STP on the basis of the work already undertaken through Lincolnshire Health and Care, which started work in 2014 to develop a new model of care for Lincolnshire, where we reached over 18,000 residents.

We have developed our vision and proposals for change by working closely with the public, patients, staff, volunteers, local health professionals and other key stakeholders, such as our local politicians and local high interest groups. We believe that our new plan to transform health and care services will only be successful if we worked with the people of Lincolnshire to understand how they wish to access care and what we can do to support them to stay well and healthy.

Since the publication of the STP in December 2016, we have embarked on a countywide round of engagement in order to raise awareness of the five year plan and seek people's views.

We have:

- Participated in over 200 events, briefings and engagement sessions to hear from groups and communities, to feed into the development of the STP
- Held an options appraisal event in January 2017 attended by 150 local healthcare professionals
- Engaged specifically with over 4,000 patients and stakeholders in response to the five year plan being published, including Patient Councils, attending patient groups and support networks, Lincolnshire Healthwatch meetings, and drop in sessions in GP surgeries and children's centres
- Carried out a survey with United Lincolnshire Hospitals NHS Trust, which received more than 800 responses from the public, staff, volunteers, trust members and members of the public
- Public launch of three maternity hubs across the county, including Lincoln, Skegness and Grantham and associated engagement by the Better Births group.
- Held a Lincolnshire Patient Carer and Public networking event in partnership with East Midlands Health Academic Science network.

We continue to engage with patients, carers, members of the public, staff and volunteers to raise awareness about the future plans for health and care in Lincolnshire and to gather feedback.

Engagement with young people and parents with Special Educational Needs and Disability (SEND)

The SEND reforms mean that professionals from education, health and social care services have to work more closely together to give children and young people from 0-25 with special educational needs or a disability the support they need. Over the last year the CCG has led on the engagement project for SEND, developing a process for SEND engagement to ensure that the voices from this group are heard and health needs are addressed.

The CCG has worked closely with the Lincolnshire Parent Carer Forum to strengthen the voice of young people and their parents/ carers. The Designated Clinical Officer (DCO) for SEND, who works across all CCGs, has been working in association with the Local Authority to discuss a joint plan for widening participation to include the voices of the young people who use Lincolnshire SEND services. This included the creation of a group called "Lincolnshire Young Voices" who meet regularly to review and provide commentary on services and activities designed to support this community. This work has also included the set of a closed virtual group via a Facebook, which is being administered by the DCO.

Community Pain Management Service

The CCG has used the "Right Care" approach on the development of the services last year; which is a national NHS England supported programme, committed to delivering the best care and outcomes to patients, and making the NHS's money go as far as possible. Right care methodology identified opportunities for the four Lincolnshire CCGs to improve the Musculoskeletal, and in particular, pain services across Lincolnshire. Previous engagement feedback and the Healthwatch Lincolnshire Pain reports informed the development of a draft proposed Community Pain Management Service and pathway of care. Engagement was undertaken to gather service user and public views using a number of methods including an event held with service users on 20th September 2017, and an online survey was also promoted to service users via the pain clinics, Facebook, Twitter and NHS organisation websites to gather views and sense check the proposed service. Following this feedback, some changes were made to the proposed pathway in line with patient views.

In March 2018, the Lincolnshire Shadow Joint Committee approved the Business Case to procure a Community Pain Management Service. Work is underway for the new service to be up and running by April 2019.

CCG Engagement on the Equality Delivery System 2

This year we have undertaken engagement with our population on our EDS2 self-assessment return, enabling the CCG, in discussion with our local partners and population, to review and continually improve our performance for people with characteristics protected by the Equality Act 2010. Our EDS2 engagement has involved:

- In depth discussions with our Patient Council about how this work should be approached and ways to engage different groups
- An EDS2 public survey that received a response of 120
- A CCG staff EDS2 survey that received a response of 29
- An EDS2 Assessors Group that has helped the CCG to assess our progress against the EDS2 statements, and agree our Equality Objectives for the next year. The assessors group was made up of CCG officers, including staff from the Quality, Engagement and Equalities team, Patient Representatives, and staff from Healthwatch.

Carer Quality Award

During a presentation on Monday 12th March, we received the Lincolnshire Carers Quality Award from Lincolnshire based organisation, Every-One. Every-One works to support unpaid carers and those they care for and the Carers Quality Award is funded by the Lincolnshire County Council. Lincolnshire East CCG has worked with Every-One for the last few months to gain the accreditation, recognising its commitment to identifying and supporting unpaid carers both within the workplace and through commissioned services.

Whilst working towards the award, we have ensured that the invaluable and essential contribution carers make is recognised, which better enables people to live fulfilling lives combined with their caring roles. As part of the award, we demonstrated how we support staff with caring responsibilities to work flexibly around their caring needs, provided carers training and demonstrated how we listen and act on the patient voice of our patient carers, via patient stories, listening clinics and attending carer events. A representative from "Everyone" attends the Patient Council to represent the carer voice, and if they are not able to attend they can submit a patient council feedback form to ensure that the biggest areas of concern by carers can be addressed by the CCG. We also have carers who are key members of our Patient Council. Undertaking the award has been a positive experience and has strengthened our organizational effectiveness. The award has allowed us to achieve recognition for the valuable support we offer to carers and ensures the continuing development of quality approaches for those with caring responsibilities across Lincolnshire East. A number of our practices and providers are working towards or have already achieved this award.

Better Births for Lincolnshire

This countywide project to implement the recommendations identified in the National Maternity review project has been co-produced with women and families from the start and is already seeing the difference it is making to families Lincolnshire wide. The team have undertaken extensive engagement via listening clinics, events and surveys, which have taken place across the whole of Lincolnshire to ensure that new service developments and the commissioning decisions we make are what women families and babies want and need. An example of this has been the development of the Community Hubs where the public and staff have designed the services needed in these hubs across the county and also the information they want to be able to access online and via social media. By listening to this the Better Births website was developed to make information about maternity services more accessible to women and families, and also includes a translation feature which is of particular importance to ensure the website is accessible to all.

The project has involved working with key stakeholders to develop services and share health messaging, an example of this is the team's work with Lincolnshire Police to engage with our migrant community in Boston, and to ensure that families are able to access our full range of maternity services in Lincolnshire. The police have been supporting the project by sharing heath messages around better births on their social media pages and in the meetings they attend to support community cohesion.

A Maternity Voices meeting takes place regularly to ensure local parents and parents-to-be can share their views and experiences of maternity care with the CCG, midwives and staff from the local maternity system, A patient chair has been appointed to this and will chair meetings in 2018.

Work on Dementia to support carers

The CCG is a key partner in the Dementia Action Alliance (DAA), established in each locality to promote awareness and develop dementia friendly communities.

The Skegness locality has held a successful Business and Services event providing dementia friends training across a number of sectors and expanding the stakeholders involved in the dementia friendly communities development. The Skegness DAA is about to commence an application process for working towards dementia friendly community status. The Boston locality is also working towards Dementia Friendly Community status.

Dementia Awareness has been provided to the Boston area primary Care team (both clinical and administrative) and we are looking at rolling this out further. The DAA is also looking to further increase the uptake of Dementia Awareness training.

The CCG is working with GP practices to increase dementia diagnosis rates, these are gradually increasing and the practices have recently undertaken a register validation process. As part of the dementia pathway review, we have been reviewing the diagnosis pathway to look at where we can make improvements. Our practices are also support raising awareness i.e. information stands during Dementia Awareness week.

Migrants rights work

During 2017 the CCG has supported the Migrant's Rights Network who coordinated the Outsider Project in Boston, in response to their majority leave vote in the 2016 EU Referendum, as well as the town's high non-UK born population. The project supported migrants affected by the negative discourse around immigration and promoted a positive narrative demonstrating the benefits of living in an open society where migration is commonplace. The project sought to achieve this by establishing migrant spokespeople to counter the negative narrative around migration, and supporting local migrant communities to organise and build bridges with non-migrant populations. The project included lobbying policy makers and stakeholders to demonstrate the consequences of restrictive immigration policies on their communities. During the course of the year the project undertook research and listening exercises to engage local migrant communities in identifying and highlighting the key issues affecting them, which they then sought to address through the delivery of the project.

The CCG supported the outsider project by attending key meetings in Boston as a key stakeholder, and to better understand issues around access and experience of healthcare for this population. Through attendance at the project's meetings and events, the CCG built strong relationships with the Migrants Rights Network, and we supported and advocated for the project's activities locally. At the project's conclusion, the CCG attended the Migrants' Rights Network roundtable event in Boston, which was aimed at policy makers, decision makers and local stakeholders to attend, present the project's findings and work, and to encourage future ways of working. The CCG has established strong relationships through this which will improve engagement moving forward.

Hearing Lincolnshire's Hidden Voices - Diversity and Inclusion Staff Listening Event

As part of Equality, Diversity and Human Rights Week 2018 (15 to 19 May), the CCG has been planning a Diversity and Inclusion Listening Event, which will take place on 16 May 2018 alongside its largest provider United Lincolnshire Hospitals NHS Trust, to raise awareness of equality, diversity and human rights amongst staff.

During the event members of the public representing protected groups will be asked to share their experience of accessing healthcare services, and also share their views on local NHS plans with NHS staff. The event will help ensure that we are able to meet the diverse health needs of our local population and further strengthen the patient voice from different communities.

Specifically, in relation to our obligations under the Equality Act, when identifying stakeholders for engagement we will be sure to seek out the 'seldom heard', looking at the nine protected characteristics plus carers and people who are socioeconomically deprived. These nine protected characteristics are outlined in the Equality Act 2010. To support development of commissioning plans and decision making, it is essential that engagement and communication methods consider the needs of people with a protected characteristic and enables them to fully participate.

Future plans

The CCG will continue to engage with harder to reach communities and will progress its PPI work in line with the organisation's equality objectives. The CCG will consider further training of the Patient Council and development of PPGs.

Freedom of Information

The Freedom of Information Act 2000 (FOI) gives people a general right to access information held by or on behalf of public authorities. It is intended to promote a culture of openness and accountability amongst public sector bodies and to facilitate a better public understanding of how public authorities carry out their duties, why they make the decisions they do and how they spend public money.

Exemptions deal with instances where a public authority may withhold information under the Freedom of Information Act or Environmental Information Regulations. Exemptions mainly apply where releasing the information would not be in the public interest, for example, where it would affect law enforcement or harm commercial interests. Requests are handled in accordance with the terms of the Freedom of Information Act 2000 and, wherever possible, best practice guidelines from the Information Commissioner's Office and the Ministry of Justice are followed to maximise openness and transparency.

In 2017/18 the CCG received 235 individual FOI requests resulting in 1,897 questions being raised.

Equality & Diversity

Over the last year we have developed and implemented various equality and diversity initiatives to meet the aims of the public sector duty (PSED) of the Equality Act 2011. In carrying out our functions, we have given 'due regard', to eliminating discrimination, advancing equality of opportunity and fostering good relations, to those who are defined by the Equality Act as having a protected characteristic and those who are not. Many of the initiatives delivered have also linked to our obligations under the Health and Social Care Act 2012 to address health inequalities, where our main focus has been to ensure that service users, patients and carers, receive the right healthcare which meets their individual needs.

How we have achieved our current objectives

The work we have undertaken has enabled progress to be achieved in line with our equality objectives where we have:-

1. Developed relationships with key minority groups, such as older adults and migrant workers, to get key messages to the CCG on their needs and expectations. For example the CCG attends a workplace health meeting, alongside key stakeholders, to ensure that health concerns can be addressed for factory staff in Boston, where English is not their first language. We also continue to have listening clinics (started in 2015), which enable CCG to listen to patient experiences first hand and understand where things are working and where they are not from the patient perspective. This allows us to take action as necessary that concerns different protected characteristics.
2. Carried out performance management with provider organisations to ensure that patient monitoring is taking place and being used to inform their equality plans. This is achieved through regular Patient Quality and Assurance meetings, where all providers are expected to give feedback on the implications of equality and diversity issues in relation to their work.
3. Developed forums/networks to support disabled staff and promoted mental wellbeing amongst staff. Examples here include providing training in line with annual National Stress Awareness day, being recognized as a 'Mindful Employer' and achieving Disability Confident level 2 (see below). Furthermore we make our equality information available on our website, which is part of our public commitment to meeting the equality duties and will strive to ensure that relevant networks are created to support this work over the coming years

Our objective to develop project work to support people with neurological conditions and their families will continue well into 2018/19. Our focus will be to liaise with key individuals and organizations to identify and address any gaps, where evidence demonstrates that some groups are disadvantaged when accessing services. We will consider the individual health care requirements of people with neurological conditions and provide appropriate support to help people to overcome any disadvantages they may experience.

EDS2 development and implementation

The level at which we have achieved our equality objectives has been assessed through the EDS2 (Equality Delivery System 2). Our objectives have connected to the four equality goals of the EDS2; better health outcomes; improved patient access and experience; a representative and supported workforce and inclusive leadership and the 18 linked outcomes that focus on the issues of most concern to patients, carers, communities, NHS staff and Boards as stated in the framework.

The EDS2 assessment has highlighted the effectiveness of our equality and diversity practice, showing progression in many areas of our work from the developmental level to 'achieving' level. Evidence of this is included on our equality and diversity webpage. It is our intention to set further and more specific objectives for the coming years to ensure that progress continues across all areas, which results in positive outcomes and impact on staff, service users and other stakeholders.

Consultation and engagement

An important aspect of the EDS2 implementation process is to consult and engage with stakeholders, including staff, patients, carers and communities, about the services we provide. We did this, through a short survey, the outcomes of which provided us with information on the areas in which we were doing well and where people felt we could do better. We have taken this on board, and will be working on improving all communications channels internally with staff and externally with our service users and stakeholders in the future. We will also be carrying out more comprehensive consultation and engagement exercises, as required, to ensure we reach different individuals, communities and groups so that the health services we provide are shaped by the diversity of our users.

Equality Impact Assessment process

Our two-stage equality impact assessment process has been an essential tool to enable staff to assess how existing policies or new services, policies and procedures can have equality implications on groups of people from different protected characteristics. We have found this process to be helpful as it gives consideration to equality implications and helps us to mainstream equality and diversity into the work we do.

Training

Training staff on the various equality developments was another important aspect of the progress made around equality and diversity last year. Many staff, with key policy related responsibilities, undertook training on the Equality Act, PSED and how to conduct Equality Impact Assessments. The training was designed to support staff in their work to make equality and diversity part of their 'thinking' process when reviewing existing policies, developing new functions and initiating proposals for commissioning of our services.

Disability Confident

With regards to disability, we reviewed our policies and practices and were assessed at 'Disability Confident level 2'. As part of this work we will continue to:-

- Interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities
- Discuss with disabled employees, at any time, but at least once a year, what we can do to make sure they can develop and use their abilities
- Make every effort when employees become disabled to make sure they stay in employment
- Take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work

We will review these commitments annually and work towards achieving Disability Confident level 3 over the coming year.

The progress we have made in Equality and Diversity over the last year has given us greater incentives to improve our services even further for both our staff and service users. Our intentions now are to set clear objectives for the next three years and indude specific actions which are measurable so that we can report progress on how our equality related health outcomes impact on the different communities we serve.

Reducing health inequality

We work with Public Health to jointly identify and implement the most cost effective, high impact interventions on health inequalities. The value of partnership working as being central to this is demonstrated through the strategic health groups (SHG) in Boston and East Lindsey, which bring together Public Health, LECCG and the local councils, and are supported by the Public Health locality leads. These groups have identified the following local priorities where key indicators require improvement.

In Boston a priority around encouraging healthy lifestyles and behaviours has resulted in the establishment of a Community Alcohol Partnership to tackle issues relating to alcohol misuse, and the development of a 'Get Out, Get Active' project, which has secured funding to improve outdoor leisure facilities across the borough. Reducing the disability employment gap through addressing social and economic determinants has been identified as a key priority in East Lindsey; the SHG is encouraging local employers to achieve Disability Confident Employer Status, and best practice is being shared for use in local organisations.

Both strategic health groups identified a need for improving local housing and financial resilience, this has been progressed in Boston by tackling overcrowding and improving management of houses of multiple occupancy, as well as supporting the Environment Agency in its approved application for a Boston Barrier, which will improve protection from tidal flooding for more than 14,000 properties. In East Lindsey a Housing, Health & Care Delivery Group has convened and supported a successful bid to review options to accommodate older people. The partnership has also worked closely with the LECCG neighbourhood teams on developing a 'Are you ready for Universal Credit?' campaign aimed at improving awareness of the universal credit changes for vulnerable residents across East Lindsey.

A key indicator identified for requiring improvement across all of LECCG was dementia awareness and diagnosis; both SHGs have prioritised working towards achieving dementia friend town status and not only have they improved the training offer for professionals, but have also worked to increase local support provision alongside the third sector.

Health and wellbeing strategy

Local Authorities and CCGs) have an equal and joint duty to prepare a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) through the Lincolnshire Health and Wellbeing Board. The purpose of the JHWS is to set out the strategic commissioning direction for the next five years for all organisations who commission services in order to improve the health and wellbeing of the population and reduce inequalities.

Currently the JHWS produced by the Health and Wellbeing Board for Lincolnshire is due to end 2018 and the Health and Wellbeing Board for Lincolnshire has been engaging on the development of a new JHWS based on the evidence induded within the newly refreshed JSNA for Lincolnshire. There was a high degree of commonality across the different engagement stages and the overall emerging priorities identified from the engagement are: Adult Mental Health, Mental Health and Emotional Wellbeing (Children and Young People), Housing, Carers, Physical Activity, Dementia and Obesity.

Further work will be undertaken on the priorities. This outlined a need for better integration across the health system including:

- Embedding prevention in Integrated Locality Teams across all priority areas
- Building prevention across health, care and education with a particular focus on inequalities through co-commissioning across partners
- Development of joined up intelligence and research to identify needs and target prevention activity where it is most needed to ensure equitable service provision
- Support the workforce through workplace wellbeing and upskilling to recognise opportunities for taking preventive action to improve health, such as through Making Every Contact Count (MECC) and self-care
- Harness digital technology to provide solutions to support self-care across the priority areas

The Health and Wellbeing Board for Lincolnshire will develop a robust delivery plan which will align to JSNA as a continuous process with periodic review, so that priorities will have a longer timescale for delivery, and their delivery plans will be linked to the themes identified. Specific delivery groups will be accountable to the Health and Wellbeing Board for Lincolnshire to ensure their plans are delivered.

Samantha Milbank
Accountable Officer
Lincolnshire East CCG

22 May 2018

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

Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 November 2018**
Subject:	**Delivery of the NHS England National Cancer Strategy in Lincolnshire**

Summary

This report advises the Committee of the progress of the delivery of the *NHS England National Cancer Strategy* across Lincolnshire. As part the Lincolnshire Sustainability and Transformation Partnership, we have been working to implement a cancer improvement plan that will deliver the priorities in the national strategy for the Lincolnshire population.

This report outlines our current work programme and the future priorities that will support improved outcomes for people living in Lincolnshire.

Action Required:

The Health Scrutiny Committee is invited to note the progress on the delivery of the NHS England National Cancer strategy across Lincolnshire.

1. Introduction

Receiving a cancer diagnosis is a life changing event. The NHS England National Cancer Strategy '*Achieving World-Class Cancer Outcomes*' was published in 2015 by the Independent Cancer Taskforce. The key strategic priorities of this strategy are to:

- Radically upgrade prevention and public health
- Lead a national drive for earlier and faster diagnosis

- Put patient experience on a par with clinical effectiveness and safety
- Transform our approach to living with and beyond cancer
- Invest in high quality modern service
- Transform commissioning, provision and accountability.

In Lincolnshire, as part our Sustainability and Transformation Partnership, we have been working to implement a cancer improvement plan that will deliver these strategy priorities for the Lincolnshire population. This report outlines our current work programme and the future priorities that will support improved outcomes for people living in Lincolnshire.

1.1 The Starting Point

In January 2017 we held the first ever Lincolnshire Cancer Summit. This brought colleagues from across the Lincolnshire health and care system together with colleagues from the East Midlands Cancer Alliance, patients and members of the public together to consider a Case for Change. The case for change presented all the available data and information together in one place to provide 'a single version of the truth', allowing everyone to work from the same understanding and evidence base. It introduces the changes that are needed, the benefits that the changes can bring.

Together colleagues at the summit identified areas of successes, areas of challenge and national best practice. This provided the basis from which we have been able to develop a plan to support the transformation of the cancer care system so that it is responsive to local needs, meets mandatory care standards and creates excellent health and wellbeing outcomes for our local population.

A summary of the information considered is set out below:

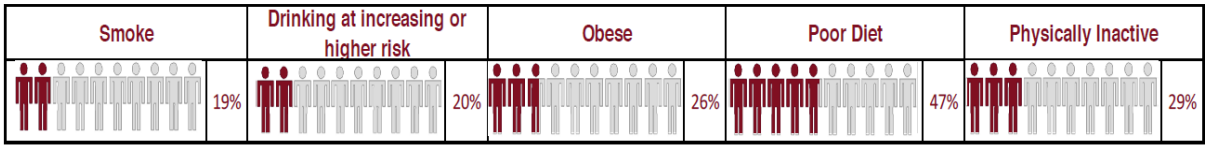
- Cancer is a major cause of premature mortality accounting for more than 1-in-4 of all deaths and between 2012 and 2014, rates due to cancer were higher in Lincolnshire than the national level
- Cancer prevalence across the 4 CCGs ranges from 2.7% to 3.2% (national average = 2.6%) and in 2016/17 there were 25,599 people living with Cancer in Lincolnshire
- The most common cancers are Breast, Lung, Colorectal and Prostate and of these, colorectal is the most common cancer In Lincolnshire
- Smoking prevalence in adults is 21% (2016) which is higher than the England total of 15.5%
- 65% of adults are classed as overweight (2015/16), above the England total of 61%
- People diagnosed with cancer via an emergency route is higher in Lincolnshire than other areas
- Screening programmes are well attended across Lincolnshire, all above the national average.
- There are three Cancers that have Screening programmes currently and include Colorectal, Breast and Cervical.

The Cancer Health Outcome and Inequality Gap

- Life expectancy at birth: the average number of years a male, in Lincolnshire, would expect to live is 77.6 which is below England which is 79.5 and the world leading nation which is Switzerland at 81.3 years. Based on 2013/15 data

- Life expectancy at birth: the average number of years a female, in Lincolnshire, would expect to live is 81.9 which are below England which is 83.1 and the world leading nation which is Japan at 86.8 years .Based on 2013/15 data
- The One year survival (all cancers) for patients diagnosed in 2015 in Lincolnshire (STP) was 71.4%. This was below the England total at 72.3%. This ranged from 70.7% in Lincolnshire East and West to 72.5% in South Lincolnshire
- Whilst survival rates for people diagnosed with cancer have improved, the difference between survival rates for the more survivable cancers and the less survival cancers is significant at 55%. Less survivable cancers account for almost 50% of all deaths from common cancers (see table 2 below)
- All cancers combined are the most common cause of death in the UK, accounting for more than a quarter (28%) all deaths (2016).
- In males in the UK, all cancers combined are the most common cause of death in the UK as a whole (30% of all male deaths). In females in the UK all cancers combined are the most common cause of death in the UK as a whole (26% of all female deaths).
- 53% of deaths for all cancers combined in the UK are in males, and 47% are in females. This reflects the sex differences in cancer incidence (higher in men than women) and survival (higher in women than men).
- For all cancers, the percentage of patients diagnosed at stage 1 & 2 (excluding unknown stages) in Lincolnshire STP was 53.6%. This was slightly below the England total which was 53.7%
- There is wide variations in access to care and treatments across Lincolnshire and across the East Midlands
- The East Midlands and Lincolnshire specifically has relatively low levels of involvement in research trials compared to other parts of the country.

Prevalence in the East Midlands of key lifestyle factors (table 1)



Graph showing cancer 5-year survival in 2015 between 1971 and 2015 (table 2)

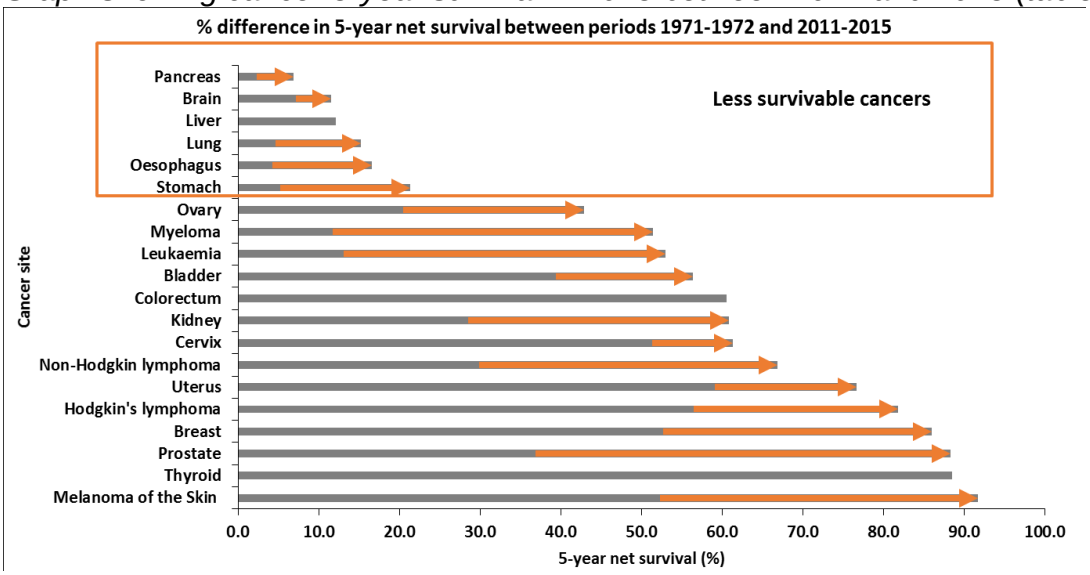


Table 2: Cancer Five Year Survival in 20 common cancers. Graph showing: cancer five-year survival in 2015 (grey bars) in England. Orange arrows highlight the difference in five-year survival between 1971 and 2015.

Data compiled from Quaresma et al, 2014, the Lancet (1971-2001) and ONS (2011-1015). Note that there is no historical data for liver, colorectal and thyroid cancer.

1.2. Current investment in Cancer Services

Four in ten cancers could be prevented by supporting people with lifestyle changes such as not smoking and maintaining a healthy weight, yet the focus and resources continue to be on treatment and follow-up.

It is estimated that currently over 80% of health spend is in the hospital setting and only 12% within the community and even less on prevention.

Many people present late with their cancer symptoms, leading to poorer outcomes and resulting in higher costs and as such the system needs to understand why this is happening.

Lincolnshire has a higher than average late diagnosis figures. One of the key priorities of the Lincolnshire plan is to raise awareness and improve clinical pathways to ensure that patients presenting with vague symptoms are referred promptly and that the diagnostic pathway within secondary care is streamlined to support timely diagnosis. Cancer Research UK actively work with partners across Lincolnshire by raising awareness in Primary care of the importance of recognising the early signs and symptoms of cancer.

A key area of focus during the last twelve months has been to establish faster diagnosis pathways. A number of specialist teams now offer straight to diagnostic test to enable a faster route to diagnosis. United Lincolnshire Hospitals NHS Trust (ULHT) have provided primary care with referral forms that allow the GP to directly refer patients into a diagnostic test these include Breast, Lower Gastro-Intestinal, Upper Gastro-Intestinal, Prostate and Lung this ultimately reduces the number of days a patient is on a pathway with the anticipation that a diagnosis will be identified sooner.

People should be cared for in the right place, at the right time and by the right person. More cancer care could be delivered in the community, ‘closer to home’.

1.3 Patient Experience

Quality of cancer care is inconsistent, despite the best efforts of staff and in Lincolnshire there are longstanding issues with meeting NHS Constitutional Standards. Lincolnshire was rated amongst the lowest by patients who responded to the National Cancer Patient Survey in 2016.

2. Priorities Developed and Agreed at the Lincolnshire Cancer Summit

Whilst everyone who attended the cancer summit agreed there was much to do the following priorities were agreed :

- Improve delivery of the 62 day constitutional standard
- Improve patient experience
- Improve service in the community for people living with and beyond cancer

2.1 Improve Delivery of the 62 day Constitutional Standard

The 62 day treatment standard is a national target included as part of the NHS Constitution. The aim is that a patient should receive their first treatment no later than 62 days from the date that their GP made the initial referral for investigation of symptoms that may suggest a cancer diagnosis. This standard is important because the best outcome for patients are achieved the earlier treatment is commenced. The national standard is that 85% of patients should receive their first treatment within 62 days.

Whilst some tumour sites perform consistently well against the 62 Day standard: Skin & Breast and there has been increased reliability across all cancer pathways in relation to Chemotherapy and Radiotherapy delivery.

Colleagues from across Lincolnshire have come together to focus on the clinical pathway and support transformational change for specific tumour sites including Urology/ Upper Gastro-Intestinal/ Colorectal/ Lung and Breast, more recently Head and Neck and Oncology, where it was none that there was a challenge achieving the 62 day standard.

The methodical approach enabled us to see what was happening at each key point in a patient's journey and where there were delays, which by changing the way we worked we could eradicate or remove. The following are examples of changes that have been made:

- All patients contacted by ULHT to book an appointment to review symptoms that may suggest a cancer are asked whether they understand that they have been referred by their GP on a two week wait pathway.
- Where possible patients are offered choice for their first appointment within seven days of their referral. This enables patients to ask for slightly longer if they want to arrange for someone to come with them but still ensures they are seen within two weeks.
- Nurse triage and straight to test appointments have been introduced for patients with suspected colorectal cancer. This means that when the patient first sees the Consultant the Consultant has access to their results.
- Primary and secondary care clinicians have come together to review and standardise clinical referral forms, the tests they use for diagnosis and implement timed pathways that are in line with the best in the country.
- The Lincolnshire system has invested in new systems and additional resources to ensure that it is possible to track exactly where a patient is on their pathway and to expedite any potential delays.
- Understanding the demand data and patients flows has been integral to the improvements made to the 62 day performance, gaining visibility of the patient numbers referred into or out of county allows the system to provide the capacity to

meet the demand. The system clearly understands the numbers referred into ULHT and the numbers referred to other providers. Both the trust and Commissioners have worked on this together to ensure clarity around each pathway. On average about 80% of Lincolnshire patients flow into ULHT and 20 % flow out of county to other providers that are closer to where they live.

Graph below shows 62 day performance for all specialities at ULHT, the graph indicates a step change in improvement from January 2018 where performance has been maintained over 75% bar June and July peaking in August at 82%. The last time performance achieved over 80% was in 2015.

In addition to the changes we have made we understand that there is further work to do. This work will include working with other trusts to reduce delays associated to:

- Referrals to tertiary cancer centres for onward treatment,
- Diagnostic/pathology delays,
- Specialised CT /staffing levels
- Availability of High Dependency Unit/Intensive Care Unit beds
- Outpatient appointments not attended as planned ('Did Not Attends')
- Use of outdated follow-up models (which means appointments are available for new patients
- Vacancies in key positions: e.g. consultants, GPs radiologists, radiographers, pathologists, cancer nurse specialists, endoscopists, community nurses and many more.
- Use of technology , such as skype and telehealth which could support reduced patient travel

2.2 Review of Patients who had to wait more than 104 days for their Initial Treatment

Although waiting time performance is below average, Lincolnshire is keen to ensure that outcomes remain good for patients. For all patients that have had to wait more than

104 days for their initial treatment a clinical review is completed to determine whether the patient has suffered serious or moderate harm as defined by NHS England.

In April 2018 an independent audit of the trust's review was arranged. The purpose of the audit was to ensure that the processes used by the Trust are robust. Professor Steve Ryder, Deputy Medical Director of the East Midland Cancer Alliance, visited to audit the review of twelve patients who had waited over 104 days.

Key Findings of the independent audit were:

1. No patients suffered serious or moderate harm as defined by NHS England criteria
2. The review agreed with the assessment of the ULHT team as to the root cause of the breach in 62 day pathway with only two minor amendments, for example the potential role of capacity versus patient choice.
3. Five breaches appear to be primarily the responsibility of a tertiary provider with referral being made from ULHT at an appropriately timely place in the pathway (between 18 and 25 days). The remainder sit with ULHT.

2.3 Patient Experience

We have been supported by patients, support groups and health watch to understand how we could improve patient and family experience of their cancer treatments.

Over the last year there have been changes to the way we communicate with and support patients and their families. Some specific changes have included:

- Asking patients whether they understand that they have been referred on a cancer pathway when initial appointments are made
- Arranging for someone to contact them if they hadn't understood this and require additional support
- Reviewing how Clinical Nurse Specialists work with patients
- Identifying patients who are not attending appointments, making their GP aware so that they can provide additional support

Every year there is a national cancer experience survey. Over the last twelve months there has been an improved overall score of 0.3 to 8.6/10. Whilst this is still below the national average is 8.8/10 we understand from the comments and directly from patients and their families that they want to be more involved and active in their care, and that they would like more support to feel confident to be able to self-manage after treatment.

2.4 Living With and Beyond Cancer

Until recently the focus for cancer services has been on providing a prompt diagnosis and treatment for the cancer, but there are currently 2.5 million people in the UK living with cancer; this is expected to rise to 4 million by 2030, with 45,400 living in Lincolnshire alone. Cancer survival is at its highest ever, with improvements made in the last 15 years, and

people are now twice as likely to survive at least 10 years after being diagnosed with cancer as they were at the start of the 1970s.[1]

It is known that people who are offered good support before, during and after a cancer diagnosis and treatment often have better outcomes than people who are not. In Lincolnshire, the support that people can get is patchy and services are sometimes disjointed. The programme aims to change this.

In 2016 Lincolnshire West CCG, as lead for cancer in the county, secured substantial funding to develop the Lincolnshire Living with and Beyond Cancer Programme (now re-named the Lincolnshire Living with Cancer Programme) from Macmillan Cancer Support.

The programme aims to transform the way we support people living with cancer. The aim is to ensure there are seamless integrated pathways of care across all care sectors, and to particularly address the current unmet holistic needs reported post treatment. The aim is to transform services to fully support people throughout each phase of illness: from the period between referral and a cancer diagnosis, and through diagnosis and into treatment; improve support for people in their transition from acute care back into primary care and into recovery and survivorship; and for people with advanced disease, support people in their transition from acute care into palliative and end of life care.

Our work has involved speaking directly to patients – below are some of their stories

"Cancer is life-changing and it doesn't stop when the treatment ends. This needs to be better recognised locally in our cancer support pathways."

"I have found the mental side of cancer the hardest to overcome. It changes you completely and makes you question and re-evaluate your whole life. I have struggled with a lack of confidence and it has taken a lot of time for me to accept that I will be never be the same person I was before."

"My husband passed away last April, 1 month after being diagnosed. Since the initial diagnosis he had no quality of life as he was too ill to receive any chemo etc. Although it is now 10 months since he passed I still feel in a state of shock about the speed of everything happening. Obviously all the nurses and doctors etc. were concentrating on him, rightfully so, but I feel once I lost him, I was offered no support and I have even been told I don't qualify for counselling as I am 'just' going through bereavement. So in answer to the question, nothing has 'allowed' either of us to get the most out of life. My husband's life is no more at the age of 55 and I am struggling to have a life without him."

During the last 18 months we have:

- Engaged with 400 healthcare professional, patients, carers and significant others from around the county were asked: what kind of support already exists and what kinds of support are missing? A wide range of information, experiences and stories were gathered, and from these were extracted the kind of support patients would like

[1] Cancer: Then and Now. Diagnosis, treatment and aftercare from 1970 – 2016. Macmillan Cancer Support August 2016.

to receive, what the experience should be like and the changes they would like made.

- Developed a strategy to support patents affected by cancer in Lincolnshire across the whole system, using a collaborative approach with partners from across Lincolnshire. Included were all 4 CCGs, Lincolnshire County Council Public Health, our providers – ULHT, Lincolnshire Community Health Services NHS Trust and Lincolnshire Partnership NHS Foundation Trust, Healthwatch Lincolnshire, Macmillan, Cancer Research UK, University of Lincoln, Patient and Public Involvement groups, Every-one and St Barnabas Hospice.

- Agreed that our aim is "To develop person-centred, local support for people living with and beyond cancer, their carers and significant others in Lincolnshire".

- Agreed the following priorities:

    - **Your information** – people get very fed up with having to give their information time and time again, so looking at ways to stop this happening.

    - **Pathways** – map the way people move through their diagnosis and treatment, and what happens after treatment, aim to make the processes smoother, and also put in support so that people don't miss appointments.

    - **Joining things up** – sometimes different services do not work together very well, so work with other programmes to ensure that everyone works together more readily. They've told us that sometimes organisations don't communicate very well between themselves either.

    - **Workforce** – make sure workforce supported during this programme. Look at volunteer and peer support services, and how they can be involved.

    - **Communication and conversations –** people have said that sometimes the communication between professionals and themselves could be clearer.

    - **Information, advice and support** – many people have said that they do not know what's out there to support them, and don't know where to go to get information, advice and support. Exploring ways that everyone (and this includes health and social care professionals) know where to go for what they need.

    - **Support services** – there are support services in Lincolnshire, but there are gaps. Explore ways to use the services we already have, make them stronger and start new services to help fill the gaps. Many people have said that the psychological and emotional impact of cancer is not well recognised, and more could be done to support this.

    - **Equity across Lincolnshire** – where you live can have an impact on the support you get. Explore ways in which people in all parts of the county can access support more easily.

- Developed a programme framework was developed to build work-streams, projects and enabler work-streams. This programme will link with the neighbourhood working framework being developed through the Integrated Community Care programme.

- Appointed a team to deliver the programme :
    - The current team are all currently funded externally by Macmillan cancer Support, and work closely with a wider team employed by Lincolnshire West CCG and ULHT.

LWC Programme Manager LWCCG		
Acute Project	**Community Project**	**IA&S Project**
Macmillan Lead Cancer Nurse ULHT	LWC Programme Manager LWCCG	Macmillan Lead Cancer Nurse ULHT
Acute Facilitator(s) ULHT	Community Facilitators LWCCG	Acute Project Manager ULHT Community Project Manager LWCCG (TBC)

Our Local Workforce Action Board programme is working to:

- Ensure all cancer patients have access to a holistic needs assessment, treatment summary, cancer care review, and a patient education and support event which comprise The Recovery Package[2]
- Develop and commission risk stratified pathways of post treatment management;
- Promote physical activity;
- Understand and commission for improved management of the consequences of treatment.

The three projects are concentrating on rolling out the four elements of the Recovery Package in secondary care (Holistic Needs Assessments and Treatment Summaries) and the community (Cancer Care Reviews in primary care – currently usually carried out by a GP, and access to Health & Wellbeing), and enhancing the existing Macmillan Cancer Information and Support Service (MCISS) to be the conduit by which we support people at the end of treatment to access all the services in their community which can help them self-manage and continue to enjoy life; albeit their new life.

To test different aspects of the Recovery Package in different areas 'Macmillan Community Facilitators' are running test projects in Gainsborough, Boston, Grantham, Lincoln and Spalding looking at 'navigation' and access to existing services such as the Macmillan Direct Volunteering Service, Social Prescribing, The Wellbeing Service and Healthy Lifestyle services. They are also working with GP practices and patients county-wide to understand what is currently happening around Cancer Care Reviews.

Results of these test projects will be available in November and these will inform the next part of the programme.

[2] http://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/recovery-package

In the meantime, a substantial further bid to Macmillan is being prepared, to greatly enhance the current MCISS, to help more people access the information and support they need.

2.4.1 The Breast Pathway

The focus has been on one pathway to give a sense of what the current experience is like for people who have breast cancer. The pathway has been mapped and details of patient numbers have been gathered and analysed. The aim is to understand the number of people starting and finishing their treatment in ULHT and also out of county trusts – Peterborough, Kings Lynn, Nottingham and Grimsby. It has been difficult to extrapolate the data sets form the pathway due to varying systems that are not aligned or link to each other. This approach to understand the data has been a collaborative in order understanding the current state.

2.4.2 Macmillan GPs

Further funding from Macmillan has been secured to recruit 4 Macmillan GPs in the county. These GPs will not be directly working with patients; rather they will be working with their peers, and also supporting different aspects of the whole Cancer Improvement Programme, and palliative and end of life services. It is expected that the GPs will be in place in the New Year.

2.4.3 Co-production

Co-production is different from engagement with patients, in that it gives people with lived experience the opportunity to shape and influence how services and projects are designed and delivered. It is one of the fundamental principles of our programme, and is an element of work by which we will be measuring our success. External funding from Macmillan is being sourced to develop and establish a Living with Cancer Co-production Group of 8 – 15 people affected by cancer. Experts in this emerging field in the county will be involved to do this effectively, and it is believed that this is the first LWC programme in England to do this.

2.4.4 Evaluation

The Outcomes Framework, which was developed as part of the Strategy development, will be used to self-assess successful outcomes. However, to fully evaluate the programme and projects, Lincolnshire has been chosen by Macmillan as one of four areas in England to measure the impact of the Recovery Package. This is likely to be carried out by an academic or research group and it is anticipated that this will go out to tender in the New Year so that the second year of acute and community projects can be evaluated.

3 Future Plans

Improving cancer services remains a local and national priority. The Lincolnshire Cancer Team is continuing to work with key partners to deliver changes that bring about real benefits for patients that are affordable and sustainable. Our collective focus remains on developing person-centred cancer services for people living in Lincolnshire and ‘making the right things happen’

We are currently refreshing our plan and working to finalise the key priorities for the coming year. These will include:

- Achieving and sustaining the 62 day treatment standard
- Working with partners from the East Midlands Cancer Alliance and Lincoln University to develop arrangements to address workforce gaps.
- Work with partners to develop service delivery models that will support fragile services and reduce the need for patients to travel out of county.
- Build on our experience of working with partners to establish services in Lincolnshire that we cannot currently support for example for some diagnostic tests patients have to travel to other counties
- Continue to implement the Living with and beyond cancer plan – with specific focus on securing additional funding to develop the Macmillan advice and support service.
- Roll out of community based follow up services.
- Working with Cancer UK to understand what needs to happen to improve early diagnostic rates and agree a work plan to address identified gaps.
- Raise awareness of the fact that lifestyle changes can reduce the risk of getting cancer – that is some cancers really are preventable.

4. Conclusion

The Committee is invited to consider the progress with the local delivery of the NHS England National Cancer strategy.

5. Consultation

This is not a consultation item.

6. Background Papers

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

This report was written by Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group on behalf of the Lincolnshire Sustainability and Transformation Partnership (Sarah-Jane.Mills@lincolnshirewestccg.nhs.uk)

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

Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 November 2018**
Subject:	**Integrated Community Care Portfolio**

Summary:

This report updates the Health Scrutiny Committee for Lincolnshire on the implementation of the Integrated Community Care portfolio and the progress that has been made in four of the key programme areas: Neighbourhood Working; GP Forward View; the Integrated Accelerator programme; and the KPMG and Optum commissioned work. The report identifies the key successes and issues.

Actions Required:

To note the progress on the delivery of the Integrated Community Care Portfolio.

1. Background

1.1 National Context

Where once the primary purpose of the health and care system was to provide episodic treatment for acute illness, it now needs to deliver joined-up support for growing numbers of older people and people living with long-term conditions.

To meet this challenge, the NHS and its partners must break down barriers between services and give greater priority to promoting population health and wellbeing.

Integrated care systems (ICSs) have been proposed as the future model for the health and care system in England. Their development represents a fundamental and far-reaching change in how the NHS works across different services and with external partners.

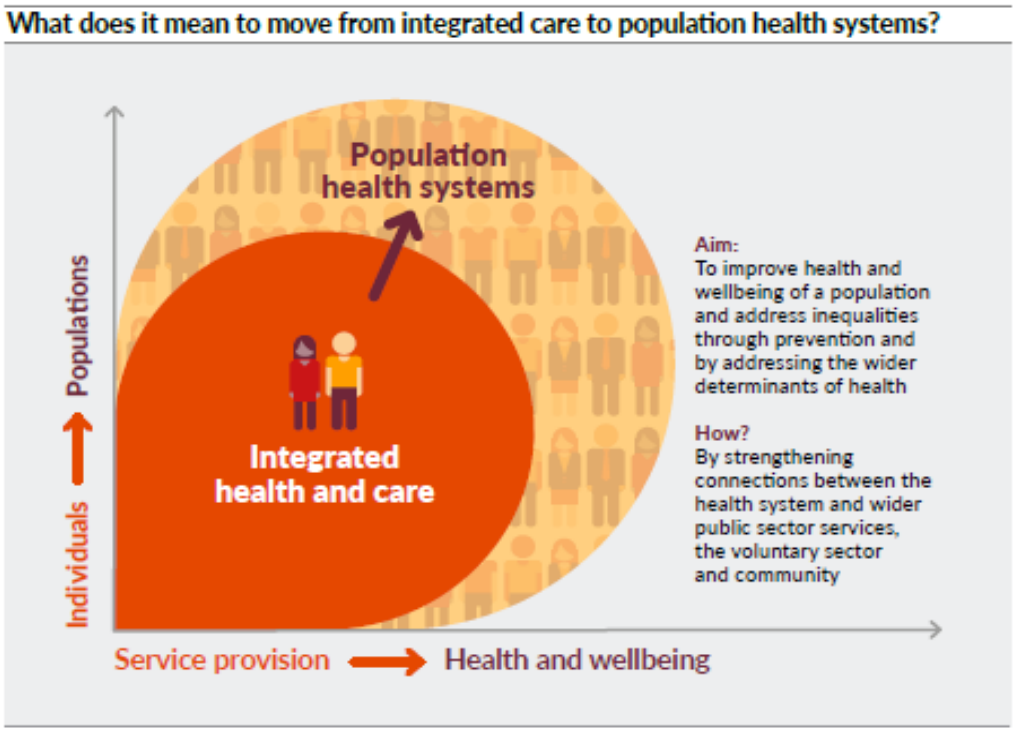
These ‘place-based’ partnerships will be given more control over local funding and services in the hope that they can make better use of resources and improve the health and wellbeing of their populations.

ICSs have no basis in legislation, and rest on the willingness and commitment of organisations and leaders to work collaboratively and there is no national blueprint to guide the way.

In June 2017, NHS England selected ten areas to develop the first ICSs. A further four were announced in May 2018, and others will follow. They are expected to become increasingly important in planning services and managing resources in the future.

Supporting the development of an Integrated Care System remains one of the key areas of focus for Lincolnshire. The aim is that colleagues from across the whole system come together to ensure that the services that are delivered by all partners for people in Lincolnshire work together to promote health and wellbeing.

The illustration below shows the next step from integration at a statutory and service level to population health systems which include the local community assets and the wider determinants of heath.



Ref: Kings Fund: A Year of Integrated Care Systems Sept 2018

The table below illustrates the early learning from the initial ICS sites – the key enablers and barriers to progressing in local systems, and learning for Lincolnshire.

Table 1 Factors that help or hinder progress in local systems

Enablers	Barriers
• Collaborative relationships • Shared vision and purpose • System leadership • Clinical leadership and engagement • Partnerships with local authorities • A meaningful local identity • Established models of integrated working • Stability of local finances and performance • Funding to support transformation • A permissive and supportive national programme	• The legislative context does not support system working • A legacy of competitive behaviours • Regulation and oversight is not aligned behind ICSs • Frequently changing language and the lack of a clear narrative • Leaders face competing demands • Funding pressures can both help and hinder progress

1.2 Lincolnshire Context

In seeking to establish an effective Integrated Care System it is necessary to raise the profile of services that are provided outside the acute hospital (including mental health in-patient settings). Our ambition is that as a Lincolnshire system, our default position is that care will be provided in the community unless there is a clinical need or value for money reason that care and treatment should be provided in an acute hospital setting.

As such the development of care closer to home, Integrated Community Care (ICC), is a priority for the Lincolnshire system as it is the foundation of our ambition to improve the health and wellbeing of our population. The ICC programme will apply to all service areas and for all age groups. Our aim is to develop care and treatment arrangements that promote partnerships not only across General Practice and statutory bodies but with the third sector, independent agencies and specifically with the person themselves.

Care and treatment will be delivered to support the individual needs and promote quality of life. As such a key element of our work will be to work with individuals, communities and the wider population to raise awareness of how to reduce the risk of getting a condition, what changes an individual can make to their life-style to reverse or manage a long term condition, what support they can get from within their local communities and how to make best use of the care and treatment provided by their GP, other health and care professionals and partners in the third sector.

In recognising the need to raise awareness and promote the development of ICC, the Lincolnshire Sustainability and Transformation Partnership (STP) work plan was redefined so that there was alignment of activities to four pillars. One of these pillars is described as Integrated Community Care and includes a range of transformational programmes which focus on the key priorities in terms of impact, deliverables and scalability.

- Neighbourhood Working
- Primary Care
- Integrated Accelerator Programme (NHSE)
- Agreeing a single vision of the Integrated Care System for Lincolnshire
- Building capacity and capability to use data to provide knowledge and intelligence that will enable us to commission and deliver care and treatment that improves outcomes for local residents.

2. Integrated Community Care Board

During recent engagement events people living in Lincolnshire communities have told us that they want high quality services to be provided locally to where they live. Based on this, the Integrated Community Care Board agreed a clear vision and ambition for the future development of services.

All care and treatment will be delivered in the community unless it can be evidenced that the service / function needs to be delivered in an acute setting.

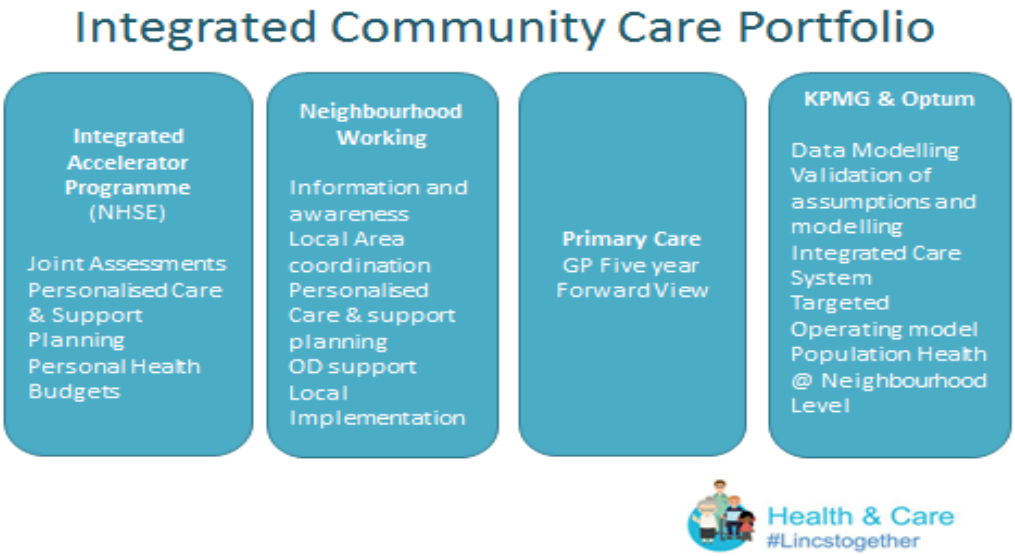
By focusing on our communities we can reserve our hospital services for those who really need it. Integrated Community Care brings together the ambitions of local people and professionals, encourages partnerships, innovation and use of technology to deliver accessible high quality health and care which is easier to access.

To enable us to achieve this the ICC board have also developed a set of principles that will guide our work programme and decision making.

These principles are :

- Engage local people to help us design and develop community services so that these reflect their needs and the things that matter to them;
- Test, analyse and challenge emerging findings, particularly from the data modelling and population health analytics;
- Developing innovative system level solutions which have the required scale of impact;
- Providing solutions that work from an individual's rather than organisational perspective, move from silo working to system thinking;
- Agree and commit the resources necessary for the successful completion of the programme;
- Support and enable, through their organisational and system leadership, rapid testing of potential solutions;

The ICC board have prioritised four key programmes as outlined below. The development of community services is ongoing in other areas such as Mental Health, Elective Care, Cancer and Children and Families as part of these programmes of work. As the ICC board becomes more established these key programmes will be included so that the principles of ICC are aligned to all services across Lincolnshire.



3. Neighbourhood Working

Neighbourhood working is the term used to describe the coming together of all services in a defined geographical area to support the needs of a local population of between 30,000 and 50,000 people. It is an essential element of the Lincolnshire STP as it allows us to ensure that services are delivered to ensure both equity of access and the demographic needs of a local population. For example in Lincoln city there is a greater number of young people and families whilst on the East coast there are more older people living with a number of long term conditions.

The delivery of local services also enables us to recognise the important contribution of other agencies including but not limited to, District councils, the third sector and local independent providers. The development of services for local residents and investment in local assets will encourage partnerships and innovation to address the challenges experienced, for example, investment in high quality technology could enable patients to have access to consultations with clinicians in other areas without having to travel.

The vision for Neighbourhood working is simple:

It is the heart of our Integrated Community Care offer. The person and their support networks are our focus. Health care the voluntary services and other local agencies will work in partnership to empower them to take an active role in their health and wellbeing with greater control and choice.

3.1 The Operating Framework

The five key functions of the operating framework are now clearly identified and defined and are being utilised to support the development of local services.

These are set out below :

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.

3.2 Neighbourhood Working Progress

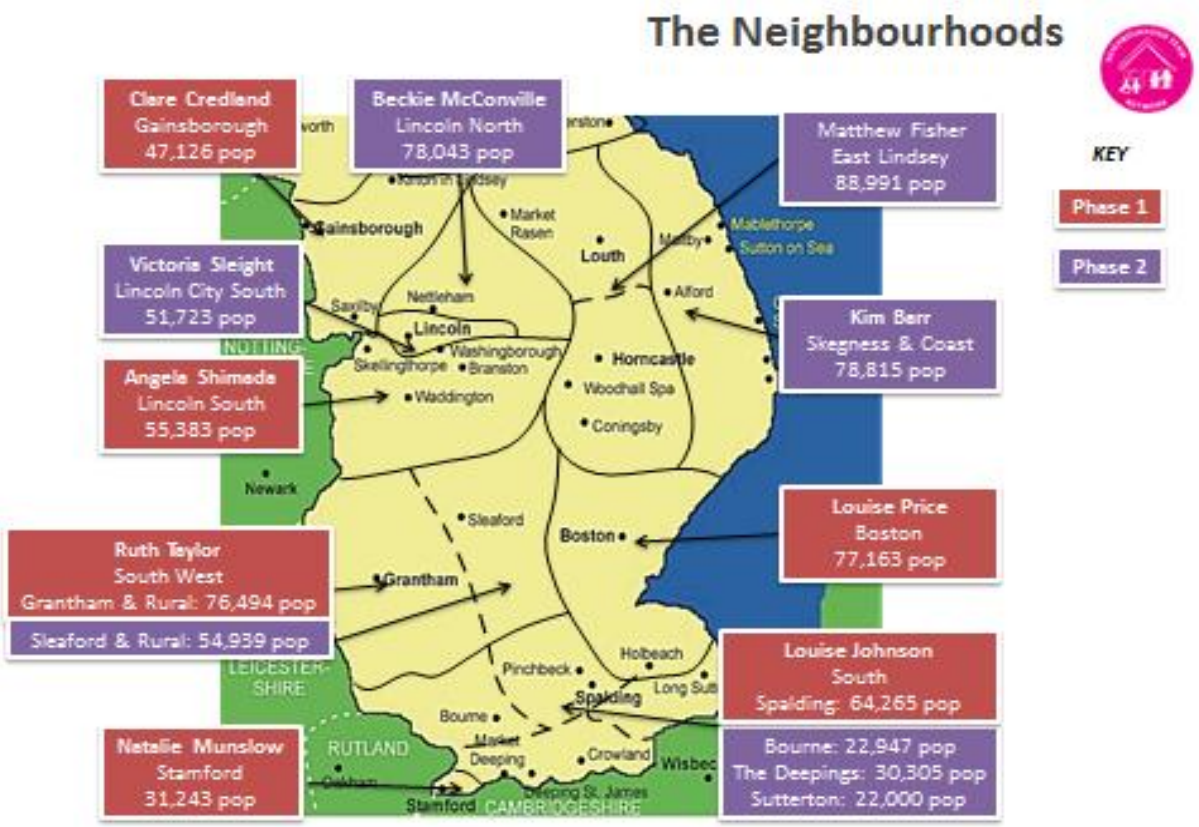
The Neighbourhood Working approach is now being implemented across the whole County with 10 Neighbourhood Leads having been appointed supporting 12 areas. These Neighbourhood Leads come from different professional background including nursing, social work and allied health professionals. They have also worked in a range of clinical settings and with different patient groups including individuals who are frail, children and people with mental illness.

The richness of their combined experience is an asset to Lincolnshire. As a team they will ask the difficult questions, provide the visibility of patient and staff experience, encourage us all to think differently and be the catalyst to supporting new ways of working that will improve outcomes for patients.

Over the last six months the Neighbourhood Leads and GP practices in the local area have been working closely with their communities and staff working in the area, to agree key areas of focus which will have the greatest impact.

The Neighbourhood Lead's role is to provide the local leadership to bring together service users and colleagues in the local area so that they can better understand local needs and identify opportunities to improve services. Early successes have been the reduction in duplication of assessments and the building of links that support people to have quicker access to local expertise.

Neighbourhood	Neighbourhood Lead	Current Focus
Boston	Louise Price	Frailty Personalised Care and Support planning
Gainsborough	Clare Credland	Frequent attenders at Secondary Care Personalised Care and Support planning
Lincoln City South	Victoria Sleight	Mental Health
Lincoln South	Angela Shimada	Care Homes
Lincoln North	Becky McConville	End of Life & palliative Care
Stamford	Natalie Munslow	Frailty and links to Acute services
East Lindsey	Matthew Fisher (comm Jan 19)	Frailty – Home visiting
Skegness and Coastal	Kim Barr	Frailty and Extra Care
South West	Ruth Taylor	Personalised Care and Support planning
South	Louise Johnson	Continence and Carers



3.3 Neighbourhood Working Across Lincolnshire

Whilst Neighbourhood working is key to promoting care for local communities and reducing silo working between organisations it is recognised that there is an inherent risk of creating new silos that result in barriers between neighbourhood areas. For that reason the neighbourhood is considered as one of the building bricks that will come together to support the needs of the wider Lincolnshire population. In essence, local services will be enhanced by additional support / specialism delivered for a wider population – generally 250,000 (current CCG footprint) and then 750,000 (current total Lincolnshire population).

The level of resource required will again be determined by local need, for example, dedicated palliative and end of life teams or specialist diabetic nurses will work across a number of neighbourhoods.

To enable this, the Lincolnshire community will develop standardised pathways that will be adopted throughout the county although they may be delivered differently in a local area. The framework is currently being applied for Frailty, Diabetes and End of Life. The development of pathways will be supported by Clinical experts from our clinical cabinet. As pathways are developed it will be possible to review resource allocation and realign funding to support local service delivery.

During the last year other key pieces of work have been progressed to provide the foundation for integrated community care these include :

a. **Library of Information and Services** – has been developed in partnership with LCC and the STP, and will offer the public and staff a central repository of services and functions across the county.

The service will also offer both 'live webchat' and telephone contact for advice and guidance.

The service will be 'soft launched' in November 2018.

b. **Local Area Coordination** – Care Navigation and Social Prescribing is now being piloted across the County – with partnership working between the Lincolnshire Voluntary Sector infrastructure, primary care and the voluntary and third sector organisations, including a connection into the Wellbeing service.

Individuals who have been offered a non–medical solution have had a different and alternative experience and in one case the individual has built up enough confidence to start volunteering at a local group, having not been able to leave their property due to anxiety.

c. **Personalised Care and Support Planning –** now forms part of the Integrated Accelerator programme being led by NHS England. This has given the Neighbourhood working project the impetus and momentum to really start to drive this forward. See section 5.

In order that we can evaluate and monitor our progress a number of working measures have been agreed. These will evolve and develop as we begin to understand how we can bring together the data held in different settings to help us understand what is happening at a local level.

Outcome Measures for Neighbourhood Working (April 2018-March 2019) Finalised Version 8.3 13/09/18

	Outcome	Measure	Expected Direction of Travel	Baseline	Target
1.	People are supported by an integrated approach to assessment and care and support planning	Number of integrated Personalised Care and Support Plans completed	↑	Will commence as part of the accelerator programme	
2.	People are enabled to die in their preferred place of death	Percentage of people who die in their preferred place of death	↑		
3.	People access a range of non-statutory services to support their health and wellbeing needs	Increase the availability of non-statutory as an alternative to statutory services.	↑		
4.	People are supported to live as independently as possible at home	Number of long term residential and nursing home placements.	↓		
		Number of NEL admissions to Secondary Care *	↓		
		Number of A&E attendances. (Secondary Care Data)*	↓		
		Number of people accessing crisis services (mental health)*	↓		
5.	People, and their carers, have a positive experience when they access care and support.	Service user and carers satisfaction survey			
6.	People are supported to return home quickly and safely, after a hospital admission	Number of individuals who are still at home 91 days after a hospital discharge.*	↑		
		25% reduction in length of stay in hospital for individuals with one or more of the frailty syndromes	↓		
		Achieve 3.5% DTOC - secondary care (Secondary Care Data) *	↓		

3.4 Enablers

Organisational Development and behaviour change

This continues to be a key enabler for the Neighbourhood Working programme with the focus of the conversation 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.

There is also a growing consensus across Lincolnshire of the value of rapid testing which has been used across a range of programmes recently. It has been recognised that when done well, this approach can quickly deliver tangible changes such as improving a clinical pathway, whilst also increasing motivation, engagement and communication across organisational boundaries.

With this in mind we have been developing a comprehensive OD (organisational development) programme with funding support from the Integrated Accelerator Programme (IAP) and Lincolnshire workforce advisory board (LWAB) and has personalisation and rapid testing at the heart of it – this has been and is being made available to all Neighbourhoods and across the wider portfolio.

3.5 Information and Technology

The roll out of the Care Portal into the Neighbourhoods and into GP practices across Lincolnshire is starting to have a positive impact for example being able to see appropriate information regarding an individual's stay in hospital.

16 GP practices are currently accessing the portal with a target of 60 by March 2019. United Lincolnshire Hospitals NHS Trust (ULHT) are rolling out across their organisation, with 170 users from ULHT, Lincolnshire Community Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and St Barnabas actively using it. There is a target of 2500 users across provider organisations by end of Mar 19 - this will include Lincolnshire County Council Adult Social Care.

Digital technology is now high on the agenda for the system and is starting to be tested at Neighbourhood Level. For example, Stamford are currently running a pilot with a small number of individuals who have been identified as having a moderate level of frailty and using Apps on their phones and iPads tracking how they are on a day to day basis.

3.6 Engaging Local People

The success of neighbourhood working and integrated community care will be influenced by our ability to engage local people to help us shape local services and understand what we are seeking to achieve and how they can contribute and support us. Whilst our discussions thus far have been on self-care in relation to treating minor illness, we will be seeking to work with colleagues in public health to raise awareness and encourage everyone , irrespective of age and current health, to understand how they are a key partner in managing their health and well-being. Our focus will be in helping local people understand how they can reduce the risk of them becoming unwell, what they can do to either reverse or manage a condition, providing information and signposting people to the support available to help them and asking them to consider in advance what they can do that can enable us to treat them effectively should they become unwell. One example will be for patients to give consent that their records can be shared across key teams that may be involved in future treatment.

3.7 Neighbourhood Working – The Impact

Starting in early October an initial pilot was ran with one GP practice to review a number of patients who frequently attended A & E and had a high frailty score when using a nationally recognised assessment tool.

One patient who was identified through this review had attended A & E on 31 occasions during the last twelve months for treatment of problems associated to a catheter.

Working together the local teams completed a review to understand the nature of the catheter issues. An advanced care plan was developed with the patient and the care home team so that they knew what to do if they notice changes thus avoiding a

problem developing. The team have remained in regular contact with the care home team and after 20 days the patient had not had any further problems that had required attendance at A & E.

This simple intervention not only provided a much better experience for the individual concerned but meant that the ambulance that would have been called was available for someone else and that there was one less person attending A & E.

New Role developed as part of Neighbourhood Working – the Primary Care Coordinator.

Primary Care Coordinators are working across the South and South West of Lincolnshire as the link between Primary Care and the neighbourhood. They proactively support individuals who have a high level of frailty, offering clinical expertise but also linking up and coordinating support with colleagues from across the locality.

"I just wanted to drop you an e mail to inform you that recent changes within the Deepings practice are having a positive impact here at Rose lodge.

"The primary care co-ordinator has been working closely with resident RM and the GP. This has resulted in his falls reducing from 10 per month to zero; this is just one example of many. The weekly visit by the GP is working exceptionally well; improving patient care and reducing crisis situations and our work load so that we can spend more time with our clients."

James story

James was living with diabetes and working as a graphic designer when he permanently lost his sight. James is 30 and the loss of his sight has had a profound effect on his physical and emotional wellbeing.

Partners from across health, care and the third sector working together have supported James to:

- Receive the physical care he needed
- Understand and manage his mental health needs
- Access housing support through his local authority
- Join local support groups with other people living with a disability
- Complete a training course to maintain his independence
- Adapt and manage his disability, including using technology he is passionate about
- Seek support for his father, who is his full time carer

4. General Practice

“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.” GP Forward View (GPFV) 2016.

The Integrated Community Care Programme will build on the work that has been ongoing across Lincolnshire to progress the GPFV recommendations. This programme has been progressed at a local level by individual practices, by groups of practices who have come together to form a network / federation, by CCGs working with local GPs and by the STP GPFV steering group. The work programme has been facilitated and enabled by the LMC and NHS England.

During the last year there have been many successful initiatives that have made a tangible difference to patients and the professionals working within general practice. Some examples include :

- International recruitment
- Introduction of workflow optimisation
- Local pilots delivered in partnership with colleagues in the neighbourhood including Care home support , ECP home visiting schemes
- Being selected as one of only two pilots to establish a practice nurse programme that will enable newly qualified nurses to take their first jobs in GP
- Extending the GP team to include other professionals such as Clinical Pharmacists, First contact physios.
- Neighbourhood leads and GPs working together to identify patients who would benefit from a personalised care package which includes support from other agencies
- Roll out of extended access across Lincolnshire – enabling everyone to have the opportunity to see a GP in an evening during the week and on both Saturday and Sunday.

The strength of GP is the links it has with its local community and as such as the ICC programme develops GP will be central to ensuring that services are delivered in a way that reflects the needs of local residents.

4.1 Workforce

One of the key areas of concern with regards providing a resilient GP service for the local community is workforce availability.

Our aim is that by September 2020 we will have 2,020 patient facing staff in primary care. The trajectory for September 2018 was 1,983, and we are slightly ahead of this with 1,985 people in post. In addition to this, Lincolnshire has been successful in bidding for £225k to support 10 nursing posts new to general practice in a new approach to nursing education, working with BGU.

There is a supporting programme to increase both retention and recruitment. These include national support to repeat our international recruitment initiatives and initiatives to encourage registrars who have trained in Lincolnshire to remain here when they qualify. Practices throughout the county are keen to support the new medical school and have already signed up to provide placements for medical students

Focused projects are being supported with two of the Federations. These programmes will facilitate practices to understand the skills and competences required to best meet the needs of local people and then look to extend the GP team to include other professional groups thus allowing GPs to focus specifically on those patients with complex needs. In addition to the examples referred to earlier models to provide improved access to mental health support in primary care are being developed.

Our aim is to ensure that we develop a rolling workforce plan that reflects the changing demands and needs highlighted through the development of our ICC programme.

4.2 Working differently

A number of practices are due to commence a pilot to test out on-line consultation. Two different approaches to on-line consultation will be tested out across a number of practices covering both urban and rural areas.

A number of events are planned to support practices in gaining understanding and experience of how to use quality improvement methodology to support continuous improvement of local services.

4.3 Primary Care at Scale

Primary care at scale describes the opportunity for GPs to work together to support the needs of people living in a neighbourhood. There are different arrangements across Lincolnshire but in essence they are all working to deliver the same objectives. Namely :

- Provide increased resilience to GP.
- Provide improved access to specific services that would be unaffordable if delivered by a single practice.
- Provide 100% coverage of extended services.
- Build opportunities for GP to work in partnership with other agencies to enhance Integrated community care e.g. specialists working in GP for example a pilot is being arranged in one Neighbourhood that will provide patients with ongoing mental illness direct access to a CPN who works across the practices in a Federation.

As the range of services available in GP increases then it is important that patients can be supported to get an appointment with the right person first time. In the coming months, receptions will be provided with enhanced training to enable them to gather

some basic information from patients so that they can book them an appointment with the right person. The infrastructure to enable patients to be booked into GP practices other than their own have been tested through the introduction of extended access and are working well.

Extended access has been rolled out across Lincolnshire since the 1st October although some services were operational from September. The models and delivery arrangements have been developed locally. Although it is early days there is good usage of the service and patients have been happy to travel to other places to be seen.

4.4 Building practice resilience

Additional funding has been provided to support practices develop greater resilience by working together to provide care for their patients. Both of these programmes were developed by groups of practices to mitigate their specific risks but will provide valuable learning which can be shared across the county.

One programme is focussing on releasing time for patient care by developing people and changing processes that are more efficient. Processes will be standardised, as a precursor to sharing these tasks between practices. In this way, processes will be done once for multiple practices rather than multiple times in each practice, there are added benefits of this programme as it creates the opportunity for staff to cover for gaps or even develop rotational posts across a number of practices.

The second programme covers 5 east coast practices and is to develop an acute care home visiting service utilising specialist paramedics. Cases will be triaged by the practice with specialist paramedics actually carrying out visits following medical triage.

The specialist paramedic programme follows on from work currently underway in partnership with Health Education England as part of a national pilot evaluating the benefit of keeping patients differently and keeping them in their community.

Both programmes are being run for 12 months and involve end of programme evaluation.

5. Integrated Accelerator Programme

On 20 March 2018, Jeremy Hunt announced three pilots integrating health and social care assessments, to take place over two years in Gloucestershire, Nottinghamshire and Lincolnshire.

5.1 Purpose and scope

NHS England will support the sites to implement a pro-active and joined-up approach to needs assessment, personalised care and support planning, and (where beneficial) integrated personal budgets. This builds on the work already underway as part of the Integrated Personal Commissioning and the personalised care demonstrator programmes.

The objectives of the pilots are:

- better health and wellbeing outcomes
- reduced demand on health and care services
- better experience for people and their families.

The scope of the pilots includes anyone who receives a needs assessment under the Care Act 2014 from the local authority, including carers and regardless of financial circumstances. The initial focus will be decided with each site based on local priorities.

5.2 Local Response

In Lincolnshire this programme is being embedded into Neighbourhood Working and is building on the progress that has already been made.

NHS England are specifically working in three Neighbourhoods;

- Grantham (South West)
- Boston
- Gainsborough

The initial phase of the project commenced in October, and will focus on using the skills and expertise learnt through the Helen Sanderson and Associates project and test out a co-produced and designed care and support plan template.

Each Neighbourhood will use rapid testing / plan, do, study, act (PDSA) models to test out the template in their area with different cohorts of individuals to get a really good cross section of the population.

The next steps will be to develop an electronic solution to enable individuals and workforce the appropriate visibility of their plans, including emergency services.

From a governance perspective the programme will have its own Board and will report directly into the Integrated Community Care Board.

6. Building the infrastructure to support ICC

The Lincolnshire Health and Care system is working with two nationally renowned organisations (KPMG & Optum) to develop a model of an Integrated Care System, through using data analytics, designing an operating model and building on the work of neighbourhood programme.

This programme consists of a number of separate but related initiatives:

a. **Modelling and data analytics** – looking at data across the STP including adult care to understand where best to put resources, and how many and which services will be needed in the near future

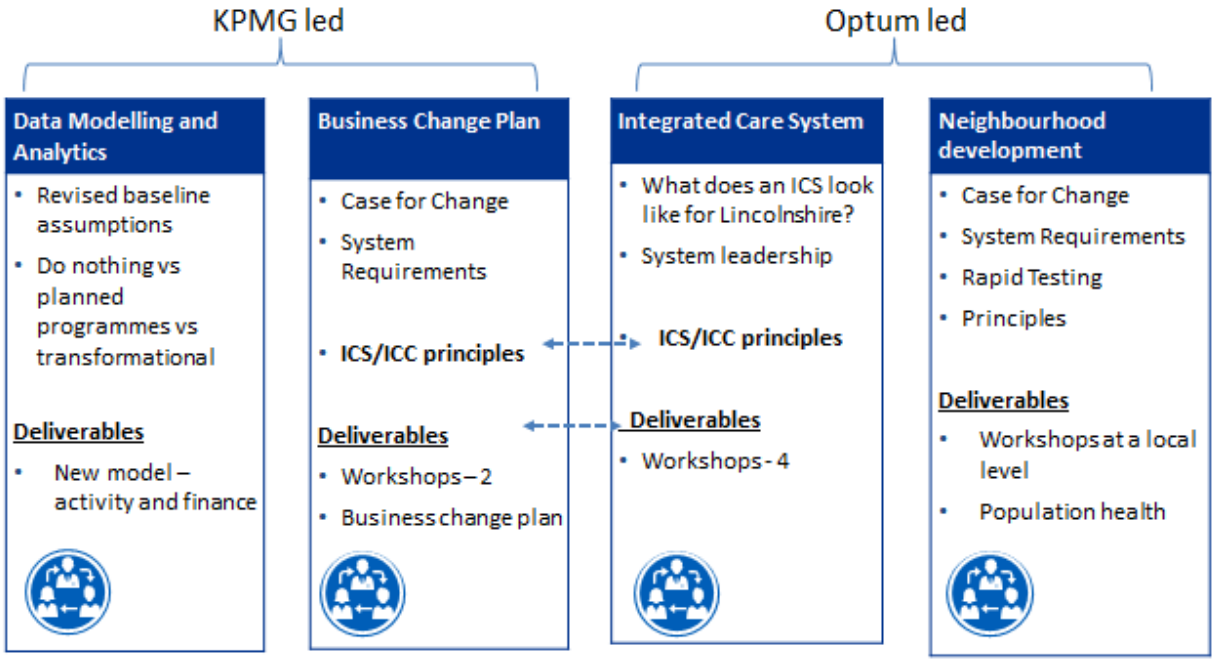
b. **Whole system engagement** – leaders from all organisations in the STP including Lincolnshire County Council are working together to develop a shared vision and model for integrated care in Lincolnshire. The current system is no longer fit for purpose and a radical redesign is needed that focuses on prevention, self-care and ensuring care is closer to home.

c. **Locality activities** – neighbourhood working is a step in the right direction. Now, the focus is to ensure that it is working well and focusing their efforts and prioritising as well as they can.

   It is important to ensure that the neighbourhoods understand the system changes that will be determined by system leaders and have a say in those changes, based on their local knowledge.

   Optum are working with East Lindsey, Lincoln South and South Lincolnshire Neighbourhoods.

The illustration below outlines the high level plan and deliverables and demonstrates how the two business are working together to meet the objectives set.



6.1 Progress to date

The first ICS workshop has been held and has started to identify some of the key principles that the system leaders want to focus on in the development and design of an ICS.

A number of workshops are being held over the next 3 months which will focus on the ICS model and being clear about the operating model for such a transformational change.

Data modelling is underway with the Optum assumptions of 3 years ago being reworked with current and future planning activity being fed in. This will then be revalidated and utilised as part of the whole system modelling piece KPMG are leading on which will include local, national and international data and evidence.

Key Milestones

- End Oct – second ICS workshop
- During Nov – stakeholder engagement and task and finish groups
- Mid Nov – Data Modelling piece complete
- Nov & Dec – Neighbourhood testing
- Mid Dec – Operating model workshop – including data piece
- End Jan – Development of business case for an Integrated Care System for Lincolnshire

7. Conclusion

This report outlines the background to the evolution of the Integrated Community Care portfolio and its links to both national and local priorities. It describes the four main programmes and their progress to date including the ongoing requirement for Organisational Development and behaviour change.

It is presented to inform the Health Scrutiny Committee of the current progress in development of the Integrated Community Care Portfolio for Lincolnshire.

8. Background Papers

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

Document title	Where the document can be viewed
GP Forward View 2016	https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

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

Open Report on behalf of Keith Ireland, the Chief Executive

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**14 November 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:

To review, consider and comment on the work programme set out in the report and 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: -

14 November 2018 – 10 am	
Item	*Contributor*
Children and Young Persons Services at United Lincolnshire Hospitals NHS Trust - Update	Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust
Lincolnshire Urgent and Emergency Care – Progress in Developing Urgent Treatment Centres	Ruth Cumbers, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group

14 November 2018 – 10 am	
Item	*Contributor*
Children and Young Persons Services at United Lincolnshire Hospitals NHS Trust - Update	Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust
Lincolnshire Urgent and Emergency Care – Progress in Developing Urgent Treatment Centres	Ruth Cumbers, Urgent Care Programme Director, Lincolnshire East Clinical Commissioning Group
Lincolnshire East Clinical Commissioning Group Annual Report	Samantha Milbank, Accountable Officer, Lincolnshire East Clinical Commissioning Group
Delivery of the NHS England National Cancer Strategy in Lincolnshire	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group
Lincolnshire Sustainability and Transformation Partnership: Integrated Community Care Portfolio	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group

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

12 December 2018 – 10 am	
Item	*Contributor*
NHS Long Term Plan	John Turner, Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership
South Lincolnshire Clinical Commissioning Group Annual Report 2017-18	John Turner, Accountable Officer, South Lincolnshire Clinical Commissioning Group
South West Lincolnshire Clinical Commissioning Group Annual Report 2017-18	John Turner, Interim Accountable Officer, South West Lincolnshire Clinical Commissioning Group
Non-Emergency Patient Transport	Mike Casey, Director of Operations, Thames Ambulance Service

23 January 2019 – 10 am	
Item	*Contributor*
United Lincolnshire Hospitals NHS Trust – Care Quality Commission	To be confirmed.

20 February 2019 – 10 am	
Item	*Contributor*

20 March 2019 – 10 am	
Item	*Contributor*
Quality Accounts - Arrangements for 2019	Simon Evans, Health Scrutiny Officer

17 April 2019 – 10 am	
Item	*Contributor*
East Midlands Ambulance Service Update	Sue Cousland, East Midlands Ambulance Service Divisional Manager, Lincolnshire

Items to be Programmed

- Louth County Hospital Inpatient Services Engagement - Outcomes
- Adult Immunisations
- Developer and Planning Contributions for NHS Provision
- North West Anglia NHS Foundation Trust Update
- Joint Health and Wellbeing Strategy Update
- CCG Role in Prevention
- Dental Services in Lincolnshire

Items to be Programmed – No earlier than March 2019

- Lincolnshire Sustainability and Transformation Plan Consultation Elements:
  - Women's and Children's Services
  - Emergency and Urgent Care

Appendix A to the report contains the work programme in a table format.

3. 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.

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

APPENDIX A

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
AT-A-GLANCE WORK PROGRAMME

KEY
✓ = Substantive Item Considered
ca = Chairman's Announcement
= Planned Substantive Item

	2017						2018									
	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec
Meeting Length - Minutes	170	225	185	170	205	230	276	280	270	230	244	233	188	280	160		
Cancer Care																	
General Provision																	
Head and Neck Cancers														ca			
Clinical Commissioning Groups																	
Annual Assessment														ca			
Lincolnshire East																	
Lincolnshire West															✓		
South Lincolnshire																	
South West Lincolnshire																	
Community Maternity Hubs								ca									
Community Pain Management												ca					
Dental Services							✓		ca								
GPs and Primary Care:																	
Extended GP Opening Hours								ca			ca				ca		
GP Recruitment			ca		ca												
Lincoln GP Surgeries		ca		ca													
Lincoln Walk-in Centre		✓	ca	✓		✓		✓			✓						
Louth GP Surgeries		ca	ca														
Out of Hours Service														ca			
Sleaford Medical Group									ca								
Spalding GP Provision														ca			
Grantham Minor Injuries Service												ca	✓	ca			
Health and Wellbeing Board:																	
Annual Report												ca					
Joint Health and Wellbeing Strategy		✓						✓									
Pharmaceutical Needs Assessment					✓		✓										
Health Scrutiny Committee Role	✓																
Healthwatch Lincolnshire											ca		ca		ca		
Lincolnshire Community Health Services NHS Trust																	
Care Quality Commission													ca		ca		
Learning Disability Specialist Care				✓									✓				
Lincolnshire Sustainability and Transformation Partnership																	
General / Acute Services Review				✓			✓				ca	✓	ca	✓			
GP Forward View										✓							
Integrated Community Care																	
Integrated Neighbourhood Working										✓							
Mental Health								✓							✓		
NHS Long Term Plan																	
Operational Efficiency									✓								
Urgent and Emergency Care									✓								
Lincolnshire Partnership NHS Foundation Trust:																	
General Update / CQC		✓															
Psychiatric Clinical Decisions Unit							ca										
Louth County Hospital														ca	✓		
Northern Lincolnshire and Goole NHS Foundation Trust			ca												ca		
North West Anglia NHS Foundation Trust							✓										

KEY

✓ = Substantive Item Considered

ca = Chairman's Announcement

= Planned Substantive Item

	2017						2018										
	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec
Organisational Developments:																	
CCG Joint Working Arrangements													✓	ca			
Integrated Care Provider Contract														ca	✓		
National Centre for Rural Care													ca				
NHSE and NHSI Joint Working												ca					
Undergraduate Medical Education			ca														
Patient Transport:																	
Ambulance Commissioning			✓														
East Midlands Ambulance Service			✓		ca					✓	ca	ca	ca	✓			
Non-Emergency Patient Transport						✓	ca	✓	✓	✓		✓	ca	✓	ca		
Sleaford Joint Ambulance & Fire Station											ca		ca				
Public Health:																	
Child Obesity													ca				
Director of Public Health Report												✓					
Immunisation					✓												
Pharmacy			ca														
Renal Dialysis Services														✓			
Quality Accounts	✓								✓								
United Lincolnshire Hospitals NHS Trust:																	
A&E Funding		ca															
Introduction	✓																
Care Quality Commission		✓										ca	ca	✓			
Children/Young People Services											✓	✓	✓	✓			
Financial Special Measures			ca		✓					✓							
Grantham A&E			✓				✓	ca						ca	ca		
Orthopaedics and Trauma												ca		ca			
Winter Resilience					ca	✓	ca	ca			✓				✓		

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