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, 16 October 2019 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), C J T H Brewis (Vice-Chairman), M T Fido, R J Kendrick, C Matthews, R A Renshaw, M A Whittington and R Wootten

District Councillors: S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), H Matthews (East Lindsey District Council), S Barker-Milan (North Kesteven District Council), G P Scalese (South Holland District Council), Mrs R Kaberry-Brown (South Kesteven District Council) and Mrs A White (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
6	**Healthy Conversation 2019 - Haematology and Oncology, and the Cancer Strategy for Lincolnshire** *(To receive a report from the Lincolnshire Sustainability and Transformation Partnership, which provides the national and local context regarding Lincolnshire's strategy for cancer; and details of the emerging option for oncology and haematology as part of the Lincolnshire Acute Services Review. Senior representatives from the Lincolnshire Sustainability and Transformation Partnership will be in attendance for this item)*	37 - 54
7	**Community Pain Management Service** *(To receive a report from the Lincolnshire Sustainability and Transformation Partnership, which provides the Committee with an overview of the new service model; and a progress update with regard to the implementation of the mobilisation plan. Senior representatives from the Lincolnshire Sustainability and Transformation Partnership will be in attendance for this item)*	55 - 64
8	**Integrated Community Care** *(To receive a report from the Lincolnshire Sustainability and Transformation Partnership, which provides the Committee with an update on the implementation of the Integrated Community Care portfolio. Senior representatives from the Lincolnshire Sustainability and Transformation Partnership will be in attendance for this item)*	65 - 92
LUNCH 1.00 PM TO 2.00 PM		
9	**Impact of Overnight Closure of Grantham and District A & E** *(To receive a joint report from United Lincolnshire Hospitals NHS Trust and the Lincolnshire Sustainability and Transformation Partnership, which provides more information for the Committee on the impact of the overnight closure of Grantham A & E. Senior representatives from United Lincolnshire Hospitals NHS Trust and the Lincolnshire Sustainability and Transformation Partnership will be in attendance for this item)*	93 - 102
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)*	103 - 110

Debbie Barnes OBE
Head of Paid Service
8 October 2019

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
18 SEPTEMBER 2019

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors C J T H Brewis (Vice-Chairman), M T Fido, R J Kendrick, C Matthews, R A Renshaw, M A Whittington and R Wootten.

Lincolnshire District Councils

Councillors B Bilton (City of Lincoln Council), H Matthews (East Lindsey District Council), S Barker-Milan (North Kesteven District Council), G P Scalese (South Holland District Council), Mrs A White (West Lindsey District Council) and L Wootten (South Kesteven District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Dr Dave Baker (GP Chair, South West Lincolnshire Clinical Commissioning Group), Liz Ball (Chief Nurse, Lincolnshire East Clinical Commissioning Group), Katrina Cope (Senior Democratic Services Officer), Ruth Cumbers (Urgent Care Programme Director, Lincolnshire East CCG), Simon Evans (Health Scrutiny Officer), Simon Evans (Director of Operations, United Lincolnshire Hospitals NHS Trust), Sarah Furley (Programme Director, Lincolnshire Sustainability and Transformation Partnership), Dr Neill Hepburn (Medical Director, United Lincolnshire Hospitals NHS Trust), Dr Yvonne Owen (Medical Director, Lincolnshire Community Health Services NHS Trust), Chris Weston (Consultant in Public Health (Wider Determinants)), Dr Catherine O'Dwyer (Consultant Anaesthetist and Clinical Director for Surgery, United Lincolnshire Hospitals NHS Trust) and Kalundaivel Sakthivel (Consultant and Clinical Lead Trauma and Orthopaedic Surgery, United Lincolnshire Hospitals NHS Trust).

County Councillor Dr M E Thompson, Executive Support Councillor for NHS Liaison & Community Engagement had attended the meeting as an observer.

22 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies from absence were received from Councillors Stephen Woodliffe (Boston Borough Council) and Councillor R Kaberry-Brown (South Kesteven District Council).

The Committee was advised that Councillor L Wootten (South Kesteven District Council) had replaced Councillor R Kaberry-Brown (South Kesteven District Council), for this meeting only.

An apology for absence was also received from Councillor Mrs S Woolley (Executive Councillor for NHS Liaison & Community Engagement).

23 DECLARATIONS OF MEMBERS' INTEREST

No declarations of member's interest were received at this stage of the proceedings.

24 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 10 JULY 2019

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 10 July 2019 be agreed and signed by the Chairman as a correct record.

25 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.

The Supplementary Chairman's announcements made reference to:-

- Orthodontic Provision in Lincolnshire;
- Renal Dialysis Services;
- Mental Health Services for Children and Young People;
- Healthy Conversation Workshop Events; and
- Training for New District Councillor Members of the Committee.

Members of the Committee who had attended Clinical Commissioning Group (CCG) meetings, or were planning to attend future meetings were invited to advise the Health Scrutiny Officer of their attendance.

RESOLVED

That the Chairman's announcements presented as part of the agenda on pages 21 to 28; and the supplementary announcements circulated at the meeting be noted.

26 UPDATE FOR HEALTHY CONVERSATION 2019, THE NHS LONG TERM PLAN AND NHS ESTATES

The Committee gave consideration to a report from the Lincolnshire Sustainability and Transformation Partnership (STP), which provided feedback from the Healthy Conversation 2019; advised of the national timetable and local plans to deliver a Long Term Plan for Lincolnshire and provided an update on the position of NHS estate.

The Chairman welcomed to the meeting Sarah Furley, Sustainability and Transformation Partnership Programme Director.

The Committee were reminded of the background behind Healthy Conversation 2019; the number engagement events held, details of which were shown on page 30 of the report.

It was reported that the online survey for the Acute Services Review had closed on 31 August 2019, to enable all data received to be analysed; and that locality road shows were continuing, as were locality workshops. It was reported further that the Healthy Conversation 2019 campaign would be ceasing at the end of October 2019, so that all the information gathered could be used to develop the Long Term Plan for Lincolnshire. Detailed at Appendix A to the report was a copy of Engagement Event Poster Distribution list; and Appendix B provided the Committee with information relating to engagement for Wave 2 and 3 of the Healthy Conversation 2019.

The Committee noted that there were other activities taking place, which comprised of the recruitment of a Citizen's Panel to help with virtual engagement with a representative sample of Lincolnshire's population; that work was continuing with Lincolnshire County Council to collectively address some of the public's concerns regarding transport; and that a local awareness campaign to promote NHS 111 would be starting in October 2019 to support winter resilience.

The Committee were reminded that the NHS Long Term Plan Implementation Framework, published in June had set out the requirements on sustainability and transformation partnerships and integrated care systems to create their five-year strategic plans. It was noted that the framework expected local systems to meet the end goals set out in the Long Term Plan, but also allowed the substantial freedom to respond to local needs and priorities. The expected principles of the system five-year plans were shown on page 32 of the report.

It was highlighted that NHS England had asked each local Healthwatch to support public engagement on the long term plan; and to contribute to the development of a local plan in each area. The report highlighted that Healthwatch Lincolnshire had asked people 'What Would You Do?' to improve local services in Lincolnshire. The Committee noted that 400 people had responded and the common messages received were shown at the bottom of page 32 of the report.

It was reported that Lincolnshire's Long Term Plan would be underpinned by the feedback from Healthwatch and from the public and stakeholders. The plan would

also include the work that had been undertaken on integrated community care and the recent development of Primary Care Networks, as well as plans for Mental Health Services; and prevention and reducing inequalities; and the work of the STP. It was highlighted Lincolnshire's Long Term Plan provided the opportunity to bring everything together in one vision. The Committee noted that the national timescale to produce a draft of the Long Term Plan was 27 September 2019, with the final version being submitted to NHS England on 15 November 2019. The Committee noted further that NHS England would then produce a composite report form all the local plans before Christmas, when it was hoped the Lincolnshire Long Term Plan would be published.

The report also highlighted that there were some outstanding services in Lincolnshire, delivered from well-designed buildings. There were also services that required improvement, in buildings not fit for purpose. It was hoped that the new approach to planning NHS estate in Lincolnshire would unlock innovation and new ways of working. The Committee was advised that feedback on the NHS Lincolnshire Estates Strategy which had been submitted to NHS England was anticipated in October 2019.

The Committee was advised that to deliver a Critical Energy Infrastructure and deliver Urgent Treatment Centre ambitions, a total of £102 million was required. Less the £21 million for the A & E Department at Pilgrim Hospital, Boston announced by the Prime Minister, still left a total of £81 million to find.

It was also highlighted that the back log of maintenance across the hospital sites was £236 million and was rising year on year. It was highlighted further that the backlog maintenance costs of £236million would not achieve all 'new' building standards.

In conclusion, it was highlighted that in order to obtain the necessary capital funding to deliver buildings fit for future health care, significant support was required across the system.

During discussion, the Committee raised the following points:-

- Some concern was expressed that there was a low number of people attending engagement events; and as a result the views obtained might not be representative of the wider population. Reassurance was given that although there had been small numbers attending some of the Healthy Conversation 2019 events, there was evidence that engagement was reaching a wider audience. The Committee was advised that there had been 40,000 hits on the website alone. Reassurance was also given that the petition on Grantham and District A&E had been received and would be included as part of the Healthy Conversation 2019; and that the petition had also been passed to the South West Lincolnshire Clinical Commissioning Group. One member advised that he had found attending a Health Conversation Event very interesting and worthwhile; and encouraged other members to attend an event in their area if they had not already done so. It was further highlighted that there needed to be better publicity of future events. The Committee noted that some of the events planned were going to be held in markets, supermarkets

and other ad hoc places to ensure that everyone had the opportunity to have some input; and that meetings had been planned with voluntary organisations and other groups and stakeholders. One member also highlighted that there was a need to engage with the elderly population;

- The availability of a maintenance plan for NHS Estates. Confirmation was given that a maintenance plan did exist. It was highlighted to the Committee that the investment in building repairs and maintenance had declined, as a result of a lack of overall available funding to the NHS, with priority being on direct patient services rather than buildings. Some concerns were expressed regarding the funding required to recover the back log in maintenance, estimated at £236 million. It was highlighted that the £236 million would not achieve all 'new' building standards. The Committee was advised that an estimate £102 million was required to change some of the buildings, as part of the transformation project. The Committee was reminded that a lot of NHS buildings were over 100 years old. Reassurance was given that every building deemed not to be at a suitable standard was risk assessed; and that risk assessments were conducted on a building by building basis. It was highlighted that estimated maintenance costs were as a result of two decades of under investment in the maintenance budget. It was highlighted further that the solution was this would be addressed by the whole system;
- Joint transport working. The Committee was advised that joint transport work was in progress between the NHS and Lincolnshire County Council to try and address the public's concerns relating to transport. The Committee was advised further that an integrated transport strategy was expected by the end of the year;
- One member enquired how the effectiveness of the 111 system might be solved. The Committee was advised that there was a need to increase public perception; awareness and level of confidence in the service. The Committee noted that awareness would be raised through education campaigns with the public; through the NHS communication plan, and as part of the preparation for winter resilience. The Committee noted further that the communication plan was currently being re-written. Confirmation was also given that further engagement event dates would be shared with the Committee once finalised; as would the local awareness campaign on NHS 111;
- Further suggestions made by the Committee for Appendix B was the inclusion of the Health Scrutiny Committee for Lincolnshire; and Bishop Grosseteste University;
- One member enquired whether there was awareness as to which sites would be reduced (page 33 of the report). A further question asked was whether the Long Term Plan supported a new hospital building for Grantham. Confirmation was given that a new Grantham Hospital was part of feasibility activity, and the Committee noted that as yet no decision has been made with regard to a new Grantham Hospital;
- Citizen's Panel – The Committee was advised that a third party would be recruiting the Citizen's Panel once the Health Conversation 2019 had ceased. It was noted that the purpose of the panel was to allow for further engagement with hard to reach groups to occur. It was noted further that between 3,000 and 5,000 people were to be recruited to the panel; and that members of the panel would be approached two or three times a year to engage in the co-

design of services moving forward. Confirmation was also given that the panel would be comprised of a mix of skills;

- A question was asked whether a general election would affect the Healthy Conversation process. The Committee was advised that the final report was due to be published at the end of the year; and that it was understood that publication of the report on the engagement exercise would not be affected by the pre-election period. It was however highlighted that no consultation would commence during this period;
- One member asked what the £21 million capital announced for Pilgrim Hospital, Boston would be used for. The Committee was advised that the £21 million would be used to refurbish the A & E; up-grade the resuscitation room; and further support for Primary Care Streaming;
- A question was asked if the £81 million required was not available for capital expenditure, whether this would delay the consultation. It was highlighted that £50 million of the £81 million was required to support proposals in the Acute Services Review. It was therefore understood that consultation could be undertaken on those services, where capital funding had been identified, or where no capital funding was required;
- Emerging options from the Healthy Conversation 2019. Confirmation was given that no emerging options had been changed or refined, in the light of comments. The Committee noted that feedback would be reviewed at the end of Healthy Conversation 2019; and then feedback would be presented back to the Health Scrutiny Committee for Lincolnshire to consider; and
- One member asked as to how much involvement the local authority had with regard to the creation of the local plan. The Committee was advised that dialogue was happening between the NHS and Lincolnshire County Council; and for the system to work there needed to be partnership working.

The Chairman extended thanks on behalf of the Committee to the Programme Director, STP for her update.

RESOLVED

That the Chairman on behalf of the Committee be authorised to provide feedback on the Healthy Conversation 2019, the NHS Long Term Plan and NHS Estates; and that a further update be received at either the December 2019 or January 2020 meeting.

27 MEDICAL SERVICES AT GRANTHAM AND DISTRICT HOSPITAL - CASE FOR CHANGE AND EMERGING OPTIONS (HEALTHY CONVERSATION 2019)

Consideration was given to a report from the Lincolnshire Sustainability and Transformation Partnership, which set out the case for change for medical services at Grantham and District Hospital; and the proposed options for future services, as set out within the Acute Services Review; and the feedback to date from the Healthy Conversation 2019.

The Chairman welcomed to the meeting Sarah Furley, Programme Director Lincolnshire Sustainability and Transformation Partnership, Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services, Dr Dave Baker, GP Chair, South West Lincolnshire Clinical Commissioning Group, and Dr Neill Hepburn, Medical Director, United Lincolnshire Hospitals NHS Trust.

The GP Chair, South West LincoInshire Clinical Commissioning Group presented the report and highlighted to the Committee that the report presented only considered the medical services at Grantham and District Hospital.

Page 46 of the report provided information relating to the background of the Acute Service Review. It was noted that the case for change had been established at a Clinical Summit held in February 2018. It was noted further that the case for change had arisen as a result of significant workforce challenges being experienced by United Lincolnshire Hospitals NHS Trust (ULHT), which had impacted the Trust's ability to deliver safe, quality services. It was highlighted that a conclusion had been reached that ULHT was operationally unsustainable in its current form and that a current review of healthcare provision for the Lincolnshire population going forward was required. It was highlighted further that in Grantham there were two primary concerns; the first was the future for the A & E department; and the second, the stability of acute medical services.

Details of the case for change were shown on page 46 of the report. It was reported that at present there were six substantively employed acute care physicians; and that the remaining ten posts were filled by locum consultants. The Committee noted that the service was heavily reliant on locum medical staff.

Paragraph 1.3 of the report provided details of the number of non-planned admissions to the three hospital sites for the first four months of 2019; and a chart on page 47 provided the Committee with activity for the Grantham and District Hospital 'front door' for the period from 1 April 2018 to 31 March 2019.

Details of the two emerging options for Medical Services at Grantham Hospital were shown on page 48 of the report.

It was highlighted that the aim was to have integrated care delivered by the community services, hospital services alongside the recent development of Primary Care Networks. The Vision for 2021 was shown on page 49 of the report.

The Committee was advised that the response to Healthy Conversation 2019 had been significant; and that a review of the feedback provided by stakeholders had been undertaken which was informing the further refinement of the preferred NHS option for the future of not only Medical Services but also A & E services at Grantham. It was highlighted that the resounding feedback with regards to a preferred emerging option for Medical Beds was Option 1, to retain medical beds, but under a new community-focussed model. The table on page 50 provided a summary of the key themes received and the responses published on the Healthy Conversation website.

During discussion, the Committee raised the following issues:-

- Some concern was expressed relating to how much money the proposed option would cost. The Committee was advised that the preferred option had been developed by local senior clinicians; and it would involve a change of mind set and a different way of working by all staff. It was highlighted that the new model would be led by Community Health Services with hospital doctors and hospital services being part of an integrated service with GP services, community health and other local services. It was highlighted further that the preferred model was a patient focussed service, which would meet the needs of the patient, and would also provide a holistic approach to the care of a patient. The Committee was advised that the preferred model presented an exciting opportunity for Grantham and District Hospital. One member felt that it would be useful for the Committee to receive a paper on how the community model of care would work. One member enquired whether the preferred model at Grantham was a model that might be replicated elsewhere. Confirmation was given that Grantham was unique, and that all was being done to ensure that Grantham Hospital had a viable future being more community focussed. It was noted that the model, once trialled might be transferrable to other settings;
- Preferred Service Model –The Committee was advised that the bed cover was 24/7; and that services would be provided seven days a week; as they were already being provided. The Committee noted that it was the intention for staff to be working across urgent care and to be more integrated. Confirmation was given that resuscitation would be offered at Grantham;
- Staffing. The Committee was advised that staffing still remained a local; and a national problem, but the development of a multi-skilled workforce would help the situation;
- Confirmation was sort as to the content of Appendix A – Grantham and District Hospital - Exclusion Protocol – Emergency Care Centre A & E. The Committee was advised that the document as detailed at Appendix A outlined what currently happened at Grantham; and that this version of the protocol had been in place for three to four years;
- Role of Neighbourhood Teams – Confirmation was given that Neighbourhood Teams would be an extension of the hospital and part of the overall system with the integrated working arrangements;
- Step up/Step down – Confirmation was given that this would still happen; and that the provision would be more integrated to provide continuity of care to the patient;
- Page 50 – One member asked for further information relating to the following statement "Options for improved support for children and young people being considered". The Committee advised that this primarily related to the Urgent Care Centre; and that it was hoped that there would be greater scope for poorly children to be seen at Grantham; and
- Reference was made to paragraph 1.3 which listed current urgent care activity at Grantham over a four month period, which clearly showed lower activity at Grantham Hospital than Pilgrim Hospital Boston and Lincoln County Hospital. The Committee noted that the public were aware of the opening hours of the

department; and that medical admissions were still taken 24/7. The Committee was advised that information providing details of activity for the twelve months prior to the overnight closure of the Grantham A & E would be made available to the Committee.

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

RESOLVED

That the Chairman be authorised to provide feedback on behalf of the Committee as part of the Healthy Conversation 2019 engagement exercise on the emerging options for medical beds at Grantham and District Hospital.

28 TRAUMA AND ORTHOPAEDIC SERVICES - CASE FOR CHANGE AND EMERGING OPTION (HEALTHY CONVERSATION 2019)

The Committee gave consideration to a report from the Lincolnshire Sustainability and Transformation Partnership, which provided the national and local context regarding the vision and strategy to deliver an effective and accessible trauma and orthopaedic service for patients in Lincolnshire.

The Chairman welcomed to the meeting Dr Neill Hepburn, Medical Director, United Lincolnshire Hospitals NHS Trust, Mr Kalundaivel Sakthivel, Consultant and Clinical Lead Trauma and Orthopaedic Surgery, United Lincolnshire Hospitals NHS Trust; and Catherine O'Dwyer, Consultant Anaesthetist and Clinical Director for Surgery, United Lincolnshire Hospitals NHS Trust.

The Committee were reminded that the Lincolnshire Acute Services Review had been undertaken to ensure that clinical services at the acute hospitals would be sustainable going forward.

The Committee was advised about a national pilot for trauma and orthopaedics entitled 'Getting it Right First Time' (GIRFT) which was a programme led by a consultant orthopaedic surgeon. It was highlighted that the programme aimed to improve quality of medical and clinical care within the NHS through deeper insight of performance. It was noted that ULHT had volunteered to be involved with the GRIFT pilot due to the high level of patient benefits that could be achieved. The Committee noted further that ULHT had been part of Phase 2, which had included three other hospital trusts (King's College London, East Kent and Cornwall). Details of the orthopaedic pilot arrangements commenced on 20 August 2018 were shown on page 56 of the report. Appendix A to the report provided the Committee with a report of the Getting it Right First Time Pilot trial as at February 2019.

Page 57 of the report provided the Committee with details of elective admissions to the hospital sites for the first four months of 2018, prior to the start of the trauma and orthopaedic pilot. It was highlighted that before the trial, ULHT had experienced extremely high cancellation rates, with up to 43 patients cancelling each month. It was highlighted further that since the orthopaedic project commenced in August

2018, the Trust wide cancellation rate for non-clinical reasons had reduced to 19 cases for the month of February 2019. The Committee was advised that the performance against the 18 week combined Referral to Treatment standard for all providers, for August 2019, the figure was 88.5%, compared to June 2018 when the performance was 85.8%. It was also highlighted that the inpatient waiting list had also reduced to 2,758 at the end of July 2019, compared to 3,197 in June 2018.

The Committee noted that evidence so far had identified a strong case for change to the way in which Trauma and Orthopaedic services were delivered in Lincolnshire. Paragraph eight of the report provided more details to this effect.

It was highlighted to the Committee that there was one emerging option for sustaining general surgery services in Lincolnshire, details of which were shown at paragraph 9 of the report. It was highlighted further that investment was not required to support the proposed option as theatre capacity was sufficient to absorb the proposed changes between hospital sites. The Committee noted that the success of the pilot was down to the dedicated staff at Grantham and District Hospital who had been willing to embrace change.

A summary of the key themes received from the Healthy Conversation 2019 were shown on page 60 of the report for the Committee to consider.

The Committee were invited to comment on the case for change and on the emerging options for Trauma and Orthopaedic Services. The Committee raised the following comments:-

- Cancellation rates – The Committee noted that before the trial, ULHT had extremely high cancellation rates with up to 43 patients cancelling each month. Since the trial, the cancellation rate for non-clinical reasons had reduced to 19 cases for the month of February. It was highlighted that the high cancellation rates had impacted on the cost of the general surgery and orthopaedic service provision. It was reported that for 2017/18, the service had made a loss of £15.67 million. The Committee was advised that the loss for the service for 2018/19 would be made available to the Committee;
- Current service provision – The Committee was advised that the current service delivery provision in operation for the trial provided for all appropriate elective cases to be undertaken at Grantham with dedicated ring fenced beds on Ward 2; all fractured neck of femurs managed by Lincoln and Pilgrim hospitals; and that trauma cases remained at Grantham Hospital for the duration of the trial;
- One member asked whether the success of the pilot would encourage more people to the service. The Committee was advised that the success of the pilot would help with publicity, as ULHT was being seen as a flagship trust; and the pilot was already helping with the recruitment of staff. One member enquired whether the success of the pilot would bring in any additional funding. The Committee was advised that any additional funding would have to be considered by NHS England;
- A question was asked as to what was the lowest realistic level of cancellation rate. The Committee was advised that the cancellation rate of 19 per month

could be reduced further; and that all effort would be made to reduce the rate further;

- The lessons learnt in getting the right level of information to staff concerning the changes and in terms of support needed. The Committee was advised that lots of workshop had taken place, but there was still more to be done, particular reference was made to more time being spent with theatre teams at Grantham Hospital; and that more would be done with the whole team;
- How ULHT was reviewing and monitoring the risks associated with the programme; and a request was made for the Committee to see the necessary documentation. Reassurance was given that robust monitoring was in place, as part of the normal routine business of ULHT. The Committee noted that the management team was now all in one place for all the sites and that monthly incidents and complaints were reviewed;
- Results of the surgical site infection rates – The Committee was advised that these were monitored closely, including by internal audit. The Committee noted that there had been two cases of 'deep infection', in the last six months. Confirmation was given that infection rates were monitored closely; and
- A question was asked as to whether Louth Hospital was now finding that their concerns around orthopaedics had now been addressed. The Committee was advised that it was an evolving process; each patient was assessed as to what was the best place for them to receive care. The Committee noted that more day care surgery was being planned at Louth.

The Chairman extended his thanks on behalf of the Committee to the representatives for their presentation and for their openness. The Chairman welcomed the news concerning the success of the pilot and the positive publicity for Lincolnshire.

RESOLVED

That the Chairman be authorised to provide feedback on behalf of the Committee as part of the Health Conversation 2019 engagement exercise on the emerging option for trauma and orthopaedic services.

29 GENERAL SURGERY SERVICES - CASE FOR CHANGE AND EMERGING OPTION (HEALTHY CONVERSATION 2019)

Consideration was given by the Committee to a report from the Lincolnshire Sustainability and Transformation Partnership, which explained the national and local context regarding the vision and strategy to deliver an effective and accessible general surgery service for the patients of Lincolnshire.

The Chairman welcomed to the Committee Dr Neill Hepburn, Medical Director, United Lincolnshire Hospitals NHS Trust and Catherine O'Dwyer, Consultant Anaesthetist and Clinical Director for Surgery, United Lincolnshire Hospitals NHS Trust.

The report presented provided the Committee with background information relating to the clinical speciality for general surgery and what conditions/treatments that encompassed.

It was highlighted that for general surgery the main concern had been the impact of workforce challenges, which had limited the ability to provide adequate cover across the County; it was felt that ULHT was operationally unsustainable in its current form; and as a result a review of healthcare provision was required.

Details of the elective admissions, non-elective admissions and day cases for the hospital sites were shown on page 80 of the report. It was highlighted that performance against the 18 week Referral to Treatment (RTT) standard for all providers across the region for the month of June 2019 had shown that performance for general surgery was only being achieved by three private providers. This information was presented in a chart on page 81 of the report. Page 82 of the report detailed by provider the median waiting times for patients to access the general surgery outpatient clinics as at June 2019.

The Committee were also provided with details of Incidence and Prevalence of Bowel Cancer, this information was contained on pages 83 to 84 of the report. It was noted that ULHT currently provided general surgery theatre lists on three sites Lincoln County, Boston Pilgrim and Grantham and District (Non-elective surgical provision being much smaller at Grantham than at Lincoln or Boston). It was noted further that outpatient appointments were offered at the three main sites plus peripheral sites.

It was highlighted that there was a strong case for changing the way in which general surgery services were delivered in Lincolnshire, as 15% of elective and day case surgical procedure were cancelled per annum due to bed pressures brought about by medical emergencies each year and the 18 week RTT and national cancer standards were not being met. It was also reported that the service had made a £15.67m loss in 2017/18. It was reported further that the reasons for the loss also covered the losses made for trauma and orthopaedics. The reasons for the loss being as a result of the high level of cancelled elective procedures.

It was highlighted further that there would need to be financial investment at the Grantham Hospital site as the emerging option had indicated that five theatres would be required; and Grantham currently only had four theatres.

The Committee was advised that there had not been any Healthy Conversation 2019 feedback relating to general surgery.

During discussion, the Committee raised the following comments:-

- Performance information relating to cancer standards; and how ULHT compared with other Trusts. The Committee was advised that a more detailed breakdown of information could be provided for the Committee;
- Cancellation Rates – The Committee was advised that once the preferred option was rolled out; cancellation rates would be expected to reduce;
- Day Surgery Unit – The Committee was advised that day surgery was being looked at and that Grantham Hospital would be considered for day surgery cases; as it was the ambition to increase the number of day care surgery facilities;

- The Committee was advised that it was hoped to get new surgical facilities for Grantham Hospital, as the report indicated a fifth theatre to increase activity;
- How much of a factor were delayed discharges in the current cancellation rate of 15%. Confirmation was given that rate of delayed discharges was low; and
- How winter resilience effect planned operations in January and February. The Committee was advised that the new model worked well, as the elective centre was not impacted by large numbers of acute admissions. It was noted that operations at acute sites might be affected.

RESOLVED

That the Chairman be authorised to provide feedback on behalf of the Committee as part of the Healthy Conversation 2019 engagement exercise on the emerging option for general surgery.

30 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 as detailed on pages 98 to 100 of the report presented, and whether specific items as shown on page 97 of the report warranted inclusion on an agenda for a future meeting.

The Committee gave consideration to the merits of including the items listed below on to a future agenda:-

- Grantham A & E Overnight Closure – Impact on Peterborough City Hospital – The Committee agreed to consider this item at the 16 October 2019 meeting;
- Community Pharmacy Contractual Framework (2019/20 – 2023/24) – The Committee agreed that this item was not a matter for the consideration at this time; but would be included in the work programme for a future meeting; and
- Orthodontic Provision in Lincolnshire – That this item should be added to the list of items to be planned for inclusion for future meetings.

The Committee were also invited to consider whether they needed to be involved in discussion relating to the location of renal dialysis services in Boston. The Committee agreed that this was not an item for the Committee to consider at this stage and a suggestion was made that the Committee be advised of the progress with the location for renal services in Boston, with local councillors involved if there continued to be an issue.

The Committee was also advised that the Annual Report of the Director of Public Health was now planned for the November meeting.

RESOLVED

1. That the work programme presented be agreed subject to the inclusion of the item on Grantham A & E – Impact on Peterborough City Hospital at the meeting on 16 October 2019.

2. That items on Orthodontic Provision and Community Pharmacy be provisionally listed in the work programme for future meetings.

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

Additional apologies for absence for the afternoon part of the meeting were received from Councillors M T Fido, B Bilton (City of Lincoln Council) and Dr B Wookey (Healthwatch Lincolnshire).

31 WINTER RESILIENCE

The Committee gave consideration to a report from the Lincolnshire East Clinical Commissioning Group, which provided an update on Winter Planning across the Health and Care Economy in Lincolnshire.

The Chairman welcomed to the meeting Ruth Cumbers, Urgent Care Programme Director and Simon Evans, Director of Operations, United Lincolnshire Hospitals NHS Trust.

The Committee was made aware of the background to winter pressures, the national context, and the local picture for Lincolnshire. It was highlighted that in Lincolnshire there was continued progress to integrate services, with a number of projects being set up under the new care models programme that were starting to deliver prevention and improved care for patients closer to home. It was highlighted further that the development of integrated urgent care services was maintaining and building on this momentum.

Details of the six areas of winter planning were shown on pages 89 and 90 of the report. It was highlighted that despite early preparations, trusts were always concerned about winter pressures.

It was reported that for the winter of 2018/19, the demand for services had increased significantly through December, with the ambulance service having a particularly challenging time attempting to cope with the high level of demands from patients. The Committee noted that as the national situation deteriorated regulators had sought assurance from local systems as to how they were responding. It was reported that Lincolnshire teams were able to demonstrate that a more joined up approach by system leaders had translated into a more joined up system management and resilience.

However, despite the pressures the system had received praise from the regulators for its resilience, grip and management of issues and the ability to recover from periods of unprecedented demand.

The Committee were made aware of who was responsible for the plan; the purpose of a winter plan, how the system aimed to manage the pressures; and who implemented and monitored the winter plan. The plan for Lincolnshire was for Health and Care colleagues from across the system to continue working together with a particular focus on learning and understanding reasons at a system level of what needed to be done to reduce avoidable attendances and admissions to hospital and ambulance conveyances.

Details of the Surge and Escalation Plan, Cold Weather Plan were shown on pages 92 to 93 of the report for the Committee to consider.

Other areas referenced were the Stay Well This Winter Campaign, Flu Prevention, Maximising Capacity some reference was made to the Christmas and New Year; Planned Care Activity over the Winter, Transitional Care; Local Authority Plans; Mental Health and Acute Services.

In conclusion, the Committee was advised that the system had learnt from 2018/19 and there was belief that the winter planning for 2019/20 was robust.

During discussion, the Committee raised the following issues:-

- The percentage of staff who had received a flu jab. The Committee was advised that all organisations had been above target at around 72% and that ULHT had been 83%;
- Black Alert – Clarification was given that the term 'black alert' had in effect been replaced by Operational Pressures Escalation Level 4 (OPEL 4). Reassurance was given that no provider was allowed to go above OPEL 3 without system involvement, with procedures and monitoring in place to provide support;
- The inappropriateness of patients with mental health issues using 111; and the availability of overnight beds for patients with mental health issues. The Committee was advised that there were patients with mental health needs in acute beds out of County;
- Reassurance was given that lots of work was on-going with regard to the provision of transport when patients were discharged. Clarification was given that there were clear processes in place surrounding the discharge of patients;
- Reference was made to GP receptionists, many of whom had received training;
- Reduced planned activity during January and February; and how this approach related to the emerging options for trauma and orthopaedics and general surgery, which aim to reduce operations. The Committee was advised that this year there would be better access this year, as a result of the pilot at Grantham Hospital, the system was less susceptible to the effect of winter pressures;
- The timescale for the wholesale reconfiguration of Lincoln County Hospital for additional physical capacity; and whether funding was in place. The Committee was advised that the reconfiguration would be completed the second week of December 2019; and that the additional capacity had been

designed to use efficiencies to create more capacity, with many patients able to return home on the same day;

- Details of the new care models programme – The Committee was advised that the new care models were part of the integration work of the STP; and that further information would be available from the Programme Director, Lincolnshire STP;
- Pressures on A & E and how they continued to grow year on year. A question was asked whether one way to alleviate the pressure would be to re-open Grantham A & E on a 24/7 basis as the need was clearly exhibited throughout section 1.1 of the report. The Committee was advised that the Acute Service Review was on-going; the outcome of which was still awaited; and
- The dedication of staff in an emergency situation. Confirmation was given that plans were in place to accommodate staff that remained on sites to help out in emergency situations such as the 'Beast from the East in 2018'.

The Chairman extended thanks to representatives for their presentation.

RESOLVED

1. That the Winter Resilience Report presented be received.

2. That an update report on Winter Resilience be received by the Committee in one year's time.

The meeting closed at 2.45 p.m.

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:	**16 October 2019**
Subject:	**Chairman's Announcements**

1. Skellingthorpe Branch Surgery Closure Decision

On 18 September 2019, Lincolnshire West Clinical Commissioning Group's Primary Care Commissioning Committee approved a proposal from the GP partners of the Glebe Practice in Saxilby to close their branch surgery in Skellingthorpe. No date has been agreed for its closure and patients are advised to continue to access appointments as normal.

The report to the Primary Care Commissioning Committee included details on the consultation exercise and Lincolnshire West CCG stated that the consultation feedback had been helpful and the CCG was grateful to those people who had taken part. The CCG has also acknowledged that transport from Skellingthorpe to Saxilby will be difficult for a number of patients and the CCG will support the residents and Skellingthorpe Parish Council to find a solution to this. Frail housebound patients would continue to receive home visits as per the current protocol.

During the consultation, residents had queried whether relocating the surgery to alternative premises in the village was an option. In response, it was stated that the issue of finding alternative premises could be addressed, but it would not solve the challenge of being able to provide adequate staffing at the site.

The Committee will receive updates on developments on any transport arrangements from Skellingthorpe to Saxilby.

2. Lincoln Medical School – Turf Cutting Ceremony

As reported to this Committee last month, 80 students were taking up their places at Lincoln Medical School in September as part of their five-year Bachelor of Medicine Bachelor of Surgery degrees, with a further 19 students undertaking foundation year study in advance of the five-year degree.

On 26 September 2019, a 'turf cutting' ceremony took place involving the donors and charitable organisations supporting the new purpose-built Medical School building. The new building will comprise lecture theatres, laboratories, clinical and anatomy suites equipped with diagnostic tools and a dedicated science library. The building work is scheduled for completion in spring 2021 and once at full capacity it will provide training to around 400 medical students at any one time. Students are being taught in existing buildings at the University.

3. Urgent Treatment Centres – Louth and Skegness

On 15 May 2019, this Committee considered the emerging options for urgent and emergency care in Lincolnshire as part of the *Healthy Conversation 2019*. The paper included plans for the current urgent care centres in Louth and Skegness to become urgent treatment centres.

The NHS is introducing urgent treatment centres throughout the country, so that patients can access urgent treatment or advice. NHS England has developed a national standard for the services provided in urgent treatment centres, to ensure a consistent service to the public. Urgent treatment centres are for patients needing urgent medical attention, where it is not life-threatening. As reported to the Committee in May, urgent treatment centres will support and protect accident and emergency services, so that these accident and emergency services can focus on patients requiring specialist emergency care, for example in life-threatening situations.

The Louth Urgent Centre Care will operate as an urgent treatment centre from 14 October and Skegness Urgent Centre Care will operate as an urgent treatment centre from 15 October, with services at these centres provided by Lincolnshire Community Health Services NHS Trust.

These sites will offer bookable appointments via NHS 111; treat minor illness and injury in adults and children of all ages; and have access to diagnostic facilities that will usually include an x-ray machine. The public will be encouraged to call NHS 111 first to book an appoint, if required. Patients will still be able to walk in to these two centres. However, people with pre-booked appointments will be seen first, unless there is a clinical priority.

Two events are being held for the public to talk about urgent treatment centres:

- **Louth** - Tuesday, 29 October from 2.30pm to 4.30pm at the Thoresby Suite at County Hospital, High Holme Road, Louth, LN11 0EU
- **Skegness** - Wednesday, 30 October from 2.30pm to 4.30pm at the Storehouse, North Parade, Skegness, PE25 1BY.

Members of the public are asked to email lchsecomms@lincs-chs.nhs.uk or call 01522 309751 to book a place at either events.

As the two changes from an urgent care centre to an urgent treatment centre do not constitute a substantial development or variation in health care provision, there is no need for full public consultation on these changes.

Other Urgent Treatment Centres in Lincolnshire

I would like to remind the Committee briefly of the other urgent treatment centre plans, as reported to the Committee in May 2019 as part of the *Healthy Conversation 2019* engagement exercise:

- Lincoln County Hospital, and Pilgrim Hospital Boston - There is a national expectation that urgent treatment centres will be co-located with type 1 accident and emergency departments, so existing urgent care streaming facilities will be absorbed into urgent treatment centres at these two sites.

- Gainsborough, Spalding and Stamford are also being considered as locations for urgent treatment centres.

- Grantham - This forms part of the acute services review, so will be subject to full public consultation. The emerging option in *Healthy Conversation 2019* is to have an urgent treatment centre at Grantham Hospital.

4. Funding for Primary and Community Mental Care

On 29 September 2019, it was announced that the Lincolnshire Sustainability and Transformation Partnership (STP) had been successful in a bid for funding and would share £70 million with eleven other early implementers across England to test new models of primary and community mental health care for young, working age and older adults over the next two years.

Lincolnshire's share of the £70 million is expected to be just over £6 million over the two years and it is has been stated that it would allow Lincolnshire to be 'seriously ambitious' in its approach to community mental health during the two-year testing phase. Lincolnshire would also use the funding to maintain and develop new services for people who have specific or additional needs, including complex mental health difficulties associated with a diagnosis of ‘personality disorder’ and mental health rehabilitation.

The additional funding supports one of the initiatives set out in the NHS Long Term Plan, published in January 2019, which made a commitment to transforming mental health services so that people with severe mental illnesses are able to access better care, closer to home. More specifically, the NHS Mental Health Implementation Plan 2019/20-2023/24 sets out how NHS England and NHS Improvement will work with local systems to develop new integrated models of primary and community mental health care.

The Lincolnshire STP has stated that the successful bid will enable Lincolnshire to achieve a significant shift in how people with severe mental illnesses across the county can access the care they need closer to home. The bid was developed across the NHS in Lincolnshire and also involved the County Council.

5. General Dental Services and Orthodontic Services Procurement

On 18 September 2019, NHS England and NHS Improvement Midlands Regional Office issued a briefing on the procurement of general dental services, with new services due to commence from 1 March 2020. This briefing is set out in the annex to this report.

In the light of the information received on general dental and the information relating to orthodontic procurement shared at the last meeting, I plan to include an item on these two topics at the November meeting.

6. NHS England and NHS Improvement

Since 1 April 2019, NHS England and NHS Improvement have been working as a single organisation.

NHS England was referred to as the 'NHS Commissioning Board' in the Health and Social Care Act 2012 and was established on 1 April 2013. NHS England currently has responsibilities for specialised commissioning; some primary care commissioning; and oversight of clinical commissioning groups. Responsibility for the commissioning of GP practices is undertaken by the primary care commissioning committees of the clinical commissioning groups.

NHS Improvement was established on 1 April 2016, bringing together Monitor (which regulated NHS foundation trusts), the NHS Trust Development Authority (which supported and regulated NHS trusts) and three other national organisations.

NHS England and NHS Improvement now operate with seven regional offices:

- East of England
- London
- Midlands
- North East and Yorkshire
- North West
- South East
- South West

Lincolnshire is located in the Midlands region. As this region extends from Shropshire in the west to Lincolnshire in the east and also includes Birmingham, there is some activity at a 'sub-regional' level, for example the East Midlands Cancer Alliance, and the East Midlands clinical networks.

Bringing together NHS England and NHS Improvement has been viewed as a means supporting system-wide approaches, whereas previously each organisation had tended to focus only on clinical commissioning groups or on provider trusts respectively. The joint regional configuration is also considered an improvement, as for example, Lincolnshire was previously in an NHS England 'Midlands and East – Central' region, which extended from Lincolnshire to Buckinghamshire.

7. Annual Reports of Lincolnshire NHS Organisations

The 2018-19 annual reports of the four Lincolnshire clinical commissioning groups and the main local NHS trusts or NHS foundation trusts have all now been published and considered at their annual public meetings and are listed below. The list also includes the links to the main providers of NHS-funded services to Lincolnshire residents, based outside Lincolnshire.

Organisation	Annual Report Reference
East Midlands Ambulance Service NHS Trust	https://www.emas.nhs.uk/about-us/trust-documents/
Lincolnshire Community Health Services NHS Trust	https://www.lincolnshirecommunityhealthservices.nhs.uk/about-us/our-publications/annual-reports
Lincolnshire East Clinical Commissioning Group	https://lincolnshireeastccg.nhs.uk/about-us/key-documents/annual-report-1
Lincolnshire Partnership NHS Foundation Trust	https://www.lpft.nhs.uk/about-us/accessing-our-information/annual-reports-and-accounts
Lincolnshire West Clinical Commissioning Group	https://www.lincolnshirewestccg.nhs.uk/library/annual-report-and-accounts/
Northern Lincolnshire and Goole NHS Foundation Trust	https://www.nlg.nhs.uk/about/trust/annual-reports/
North West Anglia NHS Foundation Trust	https://www.nwangliaft.nhs.uk/about-us/
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	http://www.qehkl.nhs.uk/annual-report.asp?s=Trust&ss=the.trust&p=reports
South Lincolnshire Clinical Commissioning Group	https://southlincolnshireccg.nhs.uk/about-us/annual-reports
South West Lincolnshire Clinical Commissioning Group	https://southwestlincolnshireccg.nhs.uk/about-us/annual-reports
United Lincolnshire Hospitals NHS Trust	https://www.ulh.nhs.uk/about/trust/annual-reports/#annual-reports

Annex 1

Dental Procurement Briefing
NHS England and Improvement – Midlands Region

Background

NHS England and NHS Improvement is responsible for commissioning NHS dental services. The Midlands regional office has developed commissioning intentions from the Oral Health Needs Assessment and Commissioning Strategy (March 2018, Public Health England) recommendations to improve access to NHS dental services.

A procurement process was undertaken in 2018 and unfortunately preferred bidders were not identified for the Louth and Skegness-Spilsby contracts, owing to low interest and quality. Also, two preferred bidders were unable to mobilise the new contracts in Spalding and Boston due to recruitment issues. In November 2018 and February 2019, one provider served notice to terminate its general dental services contract based in Mablethorpe due to recruitment issues.

The Midlands regional office agreed to procure new services to provide general dental services to improve access in line with the Oral Health Needs Assessment and to recommission services in Spalding and Mablethorpe. Seven of the new general dental services being commissioned will provide extended access over and above core hours Monday to Friday 9am-5pm along with a new 8 to 8 service model based in Spalding. The new services are due to commence on 1 March 2020 and preferred bidders will have a six-month mobilisation period to established new services. The contract consists of a 'Personal Dental Services Plus' agreement with a contracting term of seven years with the option to extend for a further three years (subject to Commercial Executive Group approval).

To address recruitment issues being experienced in Lincolnshire, the Local Dental Network Chair is leading a Lincolnshire project to review and develop plans to address dentists' workforce and recruitment issues.

Dental Procurement Overview

A Prior Information Notice (PIN) was issued to potential providers on 18 February 2019 and closed on 22 March 2019. A joint market event was held on 2 April to inform the market of our commissioning intentions, the process and provide an opportunity to discuss with both commissioners and the market on how to successfully mobilise and deliver new services. The joint market event received a good level of interest from potential providers.

Targeted patient engagement process was undertaken to seek views from patients who had regularly attended the closed practice in Mablethorpe. Wider general public engagement process has been undertaken and results were fed into the development of the service specifications.

8 to 8 Service Model

An 8 to 8 practice will provide services between 8am to 8pm, 7 days a week, 365 days per year. The 8 to 8 service model of care is designed to offer routine as well as urgent care for patients not linked to a dental practice. The services are expected to encourage patients into routine care, either at the site/s or with other local dental practices. The 8 to 8 services will be commissioned in the following area:

- Spalding – location B

Extended Access

Extended access services will provide routine and urgent care between Monday to Friday 9am to 5pm with additional extended access sessions, for example, a minimum of two 1.5 hour sessions per week either early morning or evening and a Saturday morning 3.5 hours per session per week. The extended access services will be commissioned in the following areas:

- Boston
- Spalding – location A
- Louth
- Skegness / Spilsby

Please note the exception to the minimum extended access requirements are Mablethorpe as confined to offering extended access within the opening hours of the practice premises e.g. Monday to Friday 8am to 6.30pm. Spalding A will be operating the same opening hours as the previous contractor to maintain access.

Progress

The dental procurement Invitation To Tender was published on 20 May 2019 to 21 June 2019. The procurement process has concluded and identified preferred bidders for three out of the six lots in Lincolnshire. Set out below is a summary of the outcome of the procurement process: -

Lot Details	No of Units of Dental Activity per annum	Preferred Bidder
Lot 3 Mablethorpe	18,800	No preferred bidder identified
Lot 4 Boston	15,000	Burton Dental Lodge
Lot 5 Spalding A	21,000	No preferred bidder identified
Lot 6 Spalding B	25,000	JDSP Dental Limited
Lot 7 Louth	10,000	Smile Centre (Boston) Limited
Lot 8 Skegness/Spilsby	5,000	No preferred bidder identified

The Midlands regional office will work with the preferred bidders over the next six months to ensure the mobilisation of the new practices are on track to enable services to commence delivery on 1 March 2020.

As the procurement process did not identify preferred bidders for three lots, the regional office will consider how to manage commissioning of General Dental Services to improve access in these areas in the interim and longer term solutions.

In addition, the dental workforce project is exploring options to support dental recruitment into the Lincolnshire area.

Further stakeholder briefings will be issued to update on future commissioning intentions to secure additional services and to update on the mobilisation of new contracts awarded.

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 East Midlands Ambulance Service NHS Trust Lincolnshire Division

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 October 2019**
Subject:	**East Midlands Ambulance Service NHS Trust - Lincolnshire Division Update**

Summary:

The purpose of the presentation is to update the Committee in respect to the progress being achieved in the following areas within the Lincolnshire Division of the East Midlands Ambulance Service (EMAS). The presentation covers the following topics:

1. Quality
2. Culture Change / Leadership
3. Strategy / Clinical Model
4. Workforce / Recruitment
5. Performance – Revised Trajectories
6. Collaboration
7. Productivity
8. Seasonal Planning / Resilience
9. Transformation
10. Divisional Work Plan
11. Summary

Actions Required:

The Health Scrutiny Committee is recommended to consider and comment on the items discussed during the presentation.

1. Background

Attached at Appendix A to this report are the slides with detailed tables from a presentation from the Lincolnshire Division of the East Midlands Ambulance Service (EMAS). The Health scrutiny Committee is requested to consider this, together with information presented at the meeting.

2. Consultation

This is not a direct consultation item.

3. Conclusion

The Committee is requested to note and consider the information presented by the East Midlands Ambulance Service NHS Trust.

4. Appendices – These are listed below and attached at the end of the report.

Appendix A	Slides with Detailed Tables from the Presentation from the Lincolnshire Division of the East Midlands Ambulance Service NHS Trust

5. Background Papers – No background papers within the meaning of Part VA of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Sue Cousland,
Lincolnshire Divisional Manager of the East Midlands Ambulance Service NHS Trust.

APPENDIX A

KEY SLIDES FROM EMAS PRESENTATION

ARP Ambulance Response Programme

Category	What it means	Target
C1	Calls from people with life-threatening illnesses or injuries	7 mins average response 15mins (90th percentile)
C2	Emergency calls	18 mins average response 40 mins (90th percentile)
C3	Urgent calls	120 mins (90th percentile)
C4	Less urgent calls	180 mins (90th percentile)

Lincolnshire Trajectories 2019-20

	Category 1	Category 1 90th	Category 2	Category 2 90th	Category 3 90th	Category 4 90th
Jul-19	08:00:00	0016:30	00:32:00	01:05:00	03:00:00	03:00:00
Aug-19	07:45:00	00:15:00	00:31:00	01:00:00	02:45:00	03:00:00
Sep-19	07:30:00	00:15:00	00:29:00	00:53:00	02:30:00	03:00:00
Oct-19	07:20:00	00:15:00	00:27:00	00:50:00	02:15:00	03:00:00
Nov-19	07:20:00	00:15:30	00:25:00	00:50:00	02:20:00	03:00:00
Dec-19	07:45:00	00:16:00	00:29:00	01:05:00	02:45:00	03:00:00
Jan-20	07:45:00	00:16:00	00:29:00	01:05:00	02:45:00	03:00:00
Feb-20	07:20:00	00:15:30	00:25:00	00:50:00	02:20:00	03:00:00
Mar-20	07:00:00	00:15:00	00:22:30	00:45:00	02:00:00	03:00:00
Apr-20	07:00:00	00:15:00	00:18:00	00:40:00	02:00:00	03:00:00

Performance by CCG – Quarter 1 2019

CCG	Cat Code Only	Mean	Median	75th Centile	90th Centile	95th Centile
NHS Lincolnshire East CCG	Category 1	00:09:41	00:07:52	00:12:51	00:19:04	00:23:42
	Category 2	00:40:59	00:32:22	00:54:23	01:23:17	01:45:10
	Category 3		00:57:28	02:05:10	03:47:11	04:45:11
	Category 4		01:14:35	01:54:30	02:57:52	04:13:52
NHS Lincolnshire West CCG	Category 1	00:07:35	00:06:23	00:09:15	00:14:05	00:17:05
	Category 2	00:30:44	00:22:43	00:41:11	01:05:13	01:25:31
	Category 3		00:43:02	01:35:08	03:03:36	04:01:25
	Category 4		01:04:47	01:49:53	02:52:52	03:20:54
NHS South Lincolnshire CCG	Category 1	00:10:41	00:09:31	00:14:35	00:19:55	00:22:47
	Category 2	00:35:49	00:28:42	00:46:43	01:11:16	01:33:05
	Category 3		00:45:30	01:32:29	02:53:45	03:37:07
	Category 4		00:55:51	01:38:51	02:05:56	02:36:11
NHS South West Lincolnshire CCG	Category 1	00:08:17	00:06:44	00:11:05	00:16:17	00:18:44
	Category 2	00:31:55	00:25:48	00:42:34	01:04:55	01:20:54
	Category 3		00:39:52	01:21:18	02:20:15	03:20:59
	Category 4		01:05:48	01:54:51	02:23:28	02:38:01

Performance by CCG – Quarter 2 2019

CCG	Cat Code Only	Mean	Median	75th Centile	90th Centile	95th Centile
NHS Lincolnshire East CCG	Category 1	00:10:28	00:08:25	00:13:42	00:20:33	00:24:32
	Category 2	00:44:00	00:33:50	00:58:29	01:30:16	01:55:21
	Category 3		01:04:08	02:18:33	04:11:52	05:08:31
	Category 4		01:28:12	02:44:25	03:49:30	04:10:14
NHS Lincolnshire West CCG	Category 1	00:07:15	00:06:17	00:08:44	00:13:18	00:16:47
	Category 2	00:30:02	00:21:33	00:39:41	01:06:06	01:24:03
	Category 3		00:43:40	01:32:17	02:53:37	04:08:22
	Category 4		00:58:53	01:36:24	02:16:15	03:12:24
NHS South Lincolnshire CCG	Category 1	00:11:19	00:10:24	00:15:42	00:20:16	00:22:30
	Category 2	00:39:36	00:30:44	00:51:57	01:19:39	01:41:59
	Category 3		00:53:30	01:44:40	03:28:07	04:51:08
	Category 4		01:21:07	02:59:31	03:39:56	03:54:31
NHS South West Lincolnshire CCG	Category 1	00:09:10	00:07:43	00:12:18	00:18:17	00:20:48
	Category 2	00:34:21	00:27:24	00:44:37	01:11:39	01:30:15
	Category 3		00:45:11	01:40:33	03:18:16	04:39:48
	Category 4		01:20:04	02:22:12	02:58:07	04:01:06

Conveyance to ED by CCG

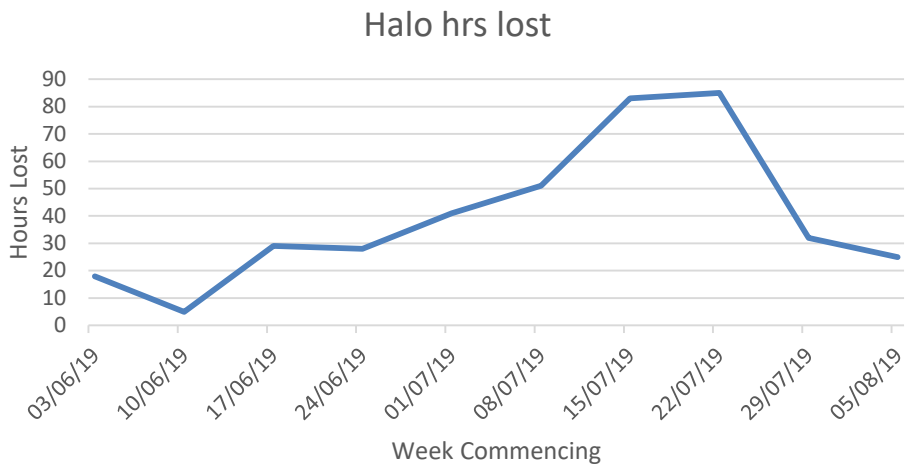
QUARTER 1 2019 CONVEYANCE

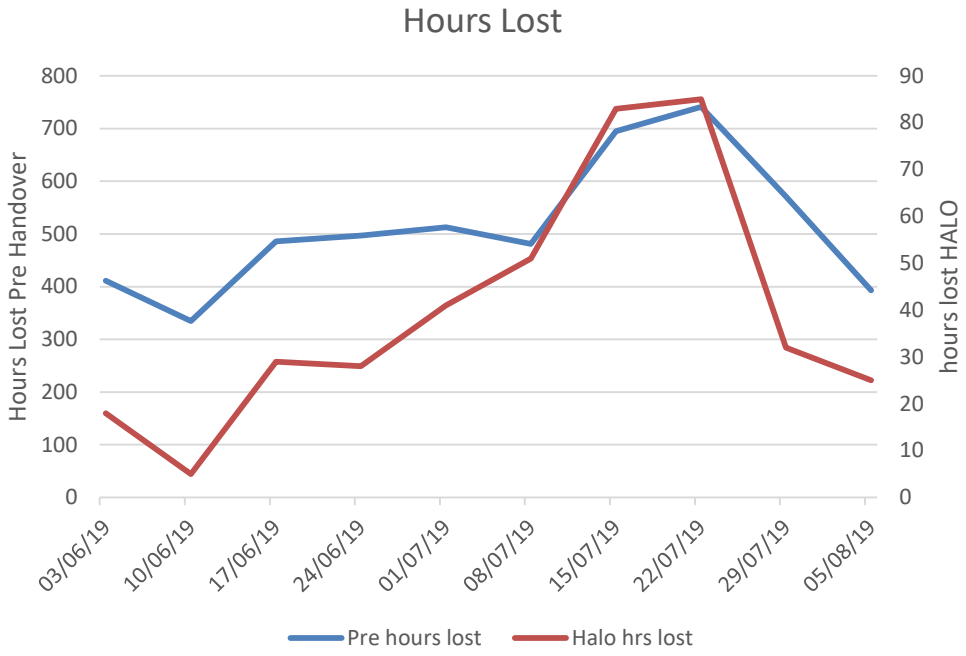
Division	Calls	ASI Hear And Treat	See And Treat	See Treat & Convey Emergency Dept	See Treat & Convey Non Emergency Dept	% ED Conveyance To Incident
Lincolnshire	48,724	3,923	9,930	27,681	914	65.21%
NHS Lincolnshire East CCG	13,352	1,212	2,657	7,516	265	64.52%
NHS Lincolnshire West CCG	9,677	962	2,338	5,154	248	59.23%
NHS South Lincolnshire CCG	5,871	513	1,412	3,239	33	62.32%
NHS South West Lincolnshire CCG	4,933	416	1,298	2,652	272	57.18%

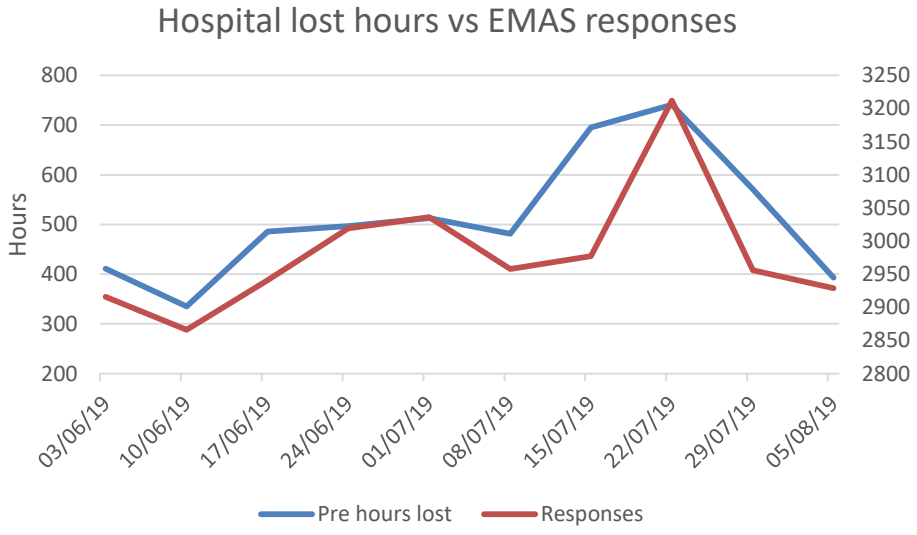
QUARTER 2 2019 CONVEYANCE

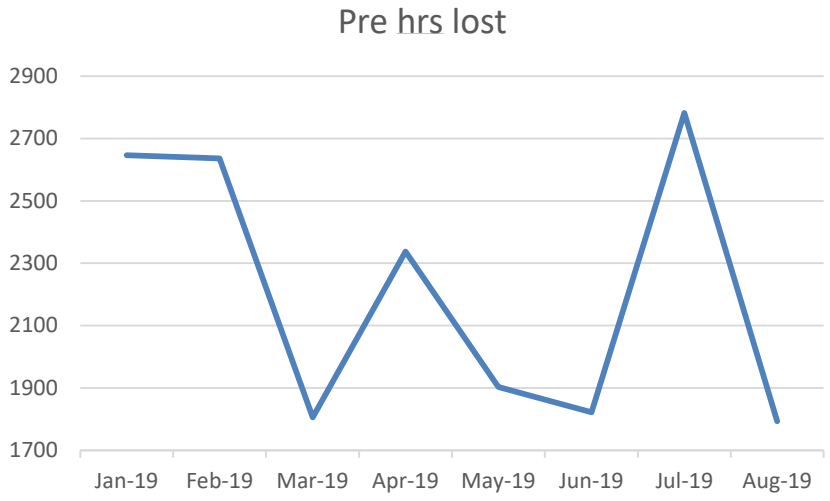
Division	Calls	ASI Hear And Treat	See And Treat	See Treat & Convey Emergency Dept	See Treat & Convey Non Emergency Dept	% ED Conveyance To Incident
Lincolnshire	51,015	3,682	10,220	28,418	916	65.73%
NHS Lincolnshire East CCG	14,327	1,087	2,715	8,000	288	66.17%
NHS Lincolnshire West CCG	10,458	923	2,613	5,383	262	58.63%
NHS South Lincolnshire CCG	6,029	488	1,340	3,269	44	63.59%
NHS South West Lincolnshire CCG	5,408	395	1,395	2,803	230	58.12%

Hospital Impact July Peak

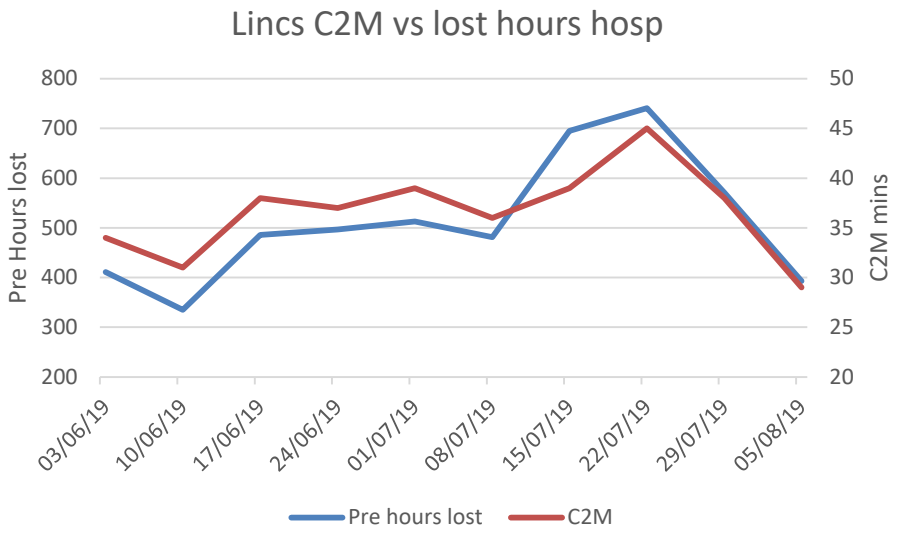


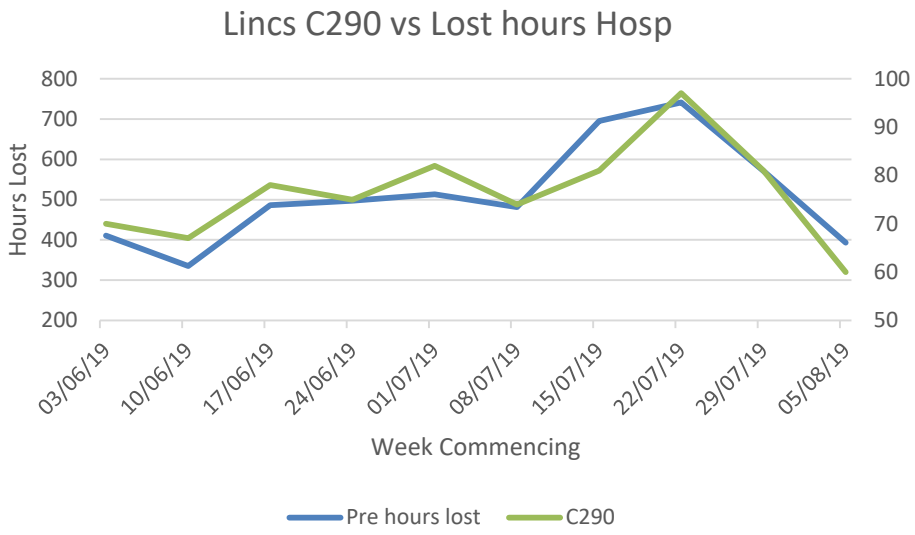


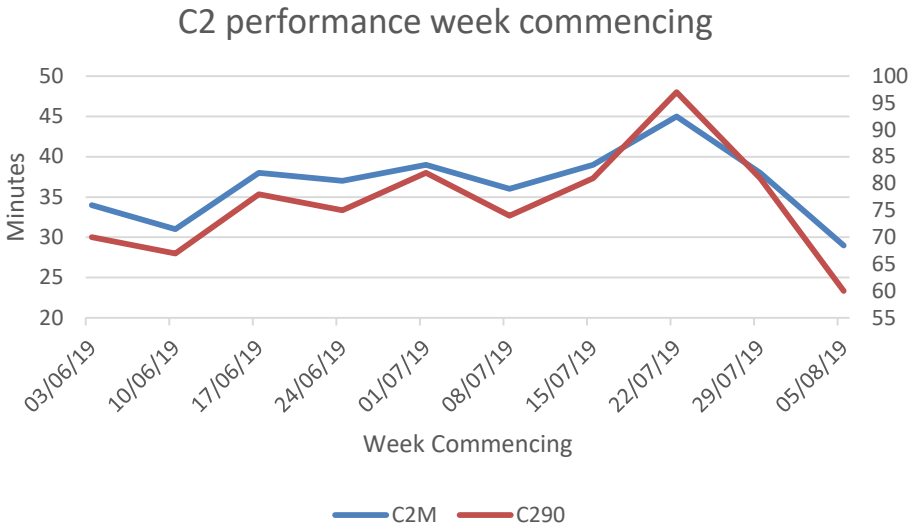




Hospital Impact vs Performance in July



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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:	**16 October 2019**
Subject:	**Healthy Conversation 2019 – Haematology and Oncology, and the Cancer Strategy for Lincolnshire**

Summary:

This report is in two parts:

- Section One: Cancer Lincolnshire's Long Term Plan 2019-24, which describes the national and local context regarding Lincolnshire's strategy for cancer; and the vision and strategy that will deliver effective and accessible haematology and oncology services for patients in Lincolnshire.

- Section Two: Haematology and Oncology, which sets out the emerging option for oncology and haematology as part of the Lincolnshire Acute Services Review.

Actions Required:

(1) Committee members are asked to note and comment on the report.

Section One: Cancer - Lincolnshire's Long Term Plan 2019-24

1. Vision

Ensuring optimal provision of diagnosis, treatment, care and quality of life outcomes for all cancer patients in Lincolnshire by increasing early diagnosis, improving clinical outcomes, developing universal personalised care for people living with cancer, improving patient experience by reducing variation and inequalities, providing high quality services to patients in their local areas.

2. Case for Change

The long term plan sets out bold ambitions for improving cancer outcomes. These build on and accelerate the progress made through the delivery of recommendations of the Independent Cancer Taskforce - Achieving World Class Cancer Outcomes; improving 5 year survival rates and people being diagnosed at an earlier stage.

Cancer survival is the highest it has ever been; with thousands more people surviving cancer each year. More cancers are being diagnosed early and patients' reported experience of care is slowly improving. However despite this very real progress, there is more to be done to narrow the gap between the UK and comparable countries to deliver the very best survival outcomes for patients in England. In 2017 a case for change was developed for cancer.

- In Lincolnshire alone, with our ageing population and with improvements in diagnosis, treatment and aftercare there are currently 27500 people living with cancer and this is expected to rise to 45400 by 2030.
- Cancer is the most common cause of premature death (<75 years old) in England, and incidence rates for all cancers combined have increased by 30% across Great Britain since the late 1970s. Whilst there is a rising trend in the number of cancer diagnoses, there is a positive trend in rates of survival for the majority of cancers. Early diagnosis is crucial for increasing rates of survival and reducing the burden on specialist services.
- Cancer prevalence across the four locality areas (Clinical Commissioning Groups) 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 & 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
- The one year survival (all cancers) for patients diagnosed in 2015 in Lincolnshire (Sustainability and Transformation Partnership) 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
- Whereas survival has improved for most cancers, 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

- 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.
- Demand on cancer services is increasing due to the steady rise of both new diagnoses and the number of patients who survive. Whilst the workforce has absorbed these increases so far, service quality has dropped.
- Increasing public awareness of cancer and earlier presentation of symptoms, demographic changes, increasing use of diagnostics and increasing possibilities of care are increasing significantly the demand for elective cancer care
- Urgent GP two-week wait cancer referrals increased by 7.5% in 2017/18 compared to 2016/17 and conversion rates continue to fall.
- Implementation of optimal earlier diagnosis and speedier diagnostics cancer pathways are adding additional pressure to the existing system and are driving productivity and efficiency improvements.
- Compliance against the nine national cancer standards has been variable for many years as the system struggle to meet this demand and we have particular challenges in a number of tumour sites: lung, skin, breast, urology/prostate, upper/lower gastrointestinal and gynaecology.
- The cancer patients wait longer to be seen and treated than the England average.

3. Benefits

3.1 Acute

- Diagnosis will be achieved earlier in the pathway
- Patients diagnosed early at Stages 1 or 2 will have an improved chance of having curative treatment and long term survival
- Improve five year survival rates
- Earlier detection rates by lowering the threshold for referral by GP
- Accelerate the access to diagnosis and treatment and maximise the number of cancer we identify through screening
- Improved patient experience
- Patients will have greater knowledge of disease
- Upskilling of staff to provide an extended roles
- Reduction in emergency admission diagnosed in Emergency Departments
- Remote monitoring will reduce follow up outpatient activity
- Remote monitoring will increase capacity for clinicians to see greater need/ new patients

3.2 Living with Cancer

- Opportunity to identify their needs and concerns through a supportive conversation with a skilled and competent member of staff and to develop a personalised care plan
- Responsive, timely and co-ordinated support to address the needs that matter most in their life.
- Continuity of care through their cancer journey

- Improved wellbeing and quality of life
- Greater participation in the design of services and their own package of support.
- Involvement as equal partners in designing their own care and support
- Improved feeling and ability to exercise choice and control
- Being treated equally and fairly with a focus on individual strengths and community assets
- Access to a variety of channels and ways to interact with Macmillan to suit individual needs and preferences

3.3 Workforce

- Stronger partnerships and relationships with colleagues and other members of the workforce
- Stronger partnerships and relationships with communities and community assets and East Midlands Cancer Alliance
- Greater skill mix, and learning and development enabling individuals to work at the top of their licence/role
- Increased ability to do the right thing for people with cancer, leading to greater job satisfaction
- Reduced duplication

3.4 System

- Asset based approach utilises existing resources to best ability
- Data collection from health needs assessments will identify areas of need in county to better use resources to meet needs of specific populations
- Learning what works to deliver fully integrated support for people living with cancer from acute to community to primary and back again.
- Building evidence of gaps in holistic support to influence national strategy and planning.
- Testing template for development of support for people with other long term conditions

4. What needs to happen, by when?

Over the next 5 years Lincolnshire STP will work with the East Midland Cancer Alliance, Provider trusts and Macmillan towards building on progress and improvements already made on Cancer Programme. The System will continue to work collaboratively and will continue with its approach to improving outcomes for patients with cancer.

4.1 Ambitions

Survival - *Improve one year survival rates, achieving 79% target by 2023/24.* By 2023/24 - *Diagnose more cancers earlier improving survival rates over five years*

- Reduce variation in diagnosis and treatment
  - Work with the Alliance to understand and identify the variation in outcomes
  - Build consensus including clinically on the approaches to tackling variation
- Ensure Faster translation of innovation and research in practice

- Support the testing, evaluation and spread of promising approaches and interventions that are likely to have the biggest impact

Screening - *By 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients.*

- Increase prevention uptake for patients in Lincolnshire- Preventing Cancer by addressing risk factors, especially smoking.
- Improved uptake of national Bowel, Breast and Cervical screening programmes
- This can be achieved by addressing inequalities, improving access to services and reducing variation so that providers consistently meet the national standard.

Early Diagnosis - *Speed up diagnosis- Earlier Diagnosis increasing % of cancers diagnosed at stage 1/2, reducing emergency presentations, leading to improved survival rates*

- Defining the areas in which the greatest impact can be made
- Population based service and pathway transformation that responds to the challenge
- Directing research, innovation and technology development to address those areas.
- Implementing best practice pathways.
- Sustained investment in equipment and workforce.

Treatment - *Improve the experience of patients with a cancer diagnosis and living with the disease*

- Patients will receive the most effective, precise and safe treatments, with fewer side effects and shorter treatment times.
- Deliver all NHS Constitutional cancer waiting time standards in 2019/20 and annually
- Achieve the new 28 day referral to diagnosis target being introduced by April 2020

Personalised Care - *The Lincolnshire Living with Cancer (LWC) Programme aims to develop person-centred, local support for people living with cancer, their carers and significant others in Lincolnshire. We will do this by implementing the comprehensive model of Universal Personalised Care for people living with cancer*

- Every person living with cancer has access to optimal clinical pathways, personalised treatment, needs assessment, care plan and effective follow up including health and wellbeing information advice and support by fully implementing the Universal Model of Personalised Care for people living with cancer by 2023
- Improve patient experience and satisfaction of services and pathways
- From 2021 the new Quality of Life Metric will be used locally
- Patients on the breast pathway by 2020 will move towards a personalised (stratified) remote monitoring follow up pathway after treatment, and all prostate and colorectal patients by 2021

Workforce - *The Long Term Plan sets out ambitions for improving cancer treatment and care in England. However, unless we have sufficient staff with the right skills and support and give consideration to the workforce impact of future service models these ambitions will not be realised.*

- Work with the Alliance / Health Education England to understand the gaps in workforce and develop a Phase 1 workforce plan
- Continue to deliver improvements and changes to ensure a sustainable workforce and excellent cancer services
- All patients, including those with secondary cancers, will have access to the right expertise and support, including a clinical nurse specialist or other support workers.
- Consider future commissioning implications following the end of the Alliance and Macmillan funding.

5. Current State

Interventions to be implemented for 19/20 onwards

- Improving screening uptake
- Roll-out of Faecal Immunochemical Testing (FIT)
- Rapid Diagnostic Centre - Vague Symptom pathway
- Reducing variation
- Improving GP referral practice
- Faster Diagnosis standard is enforced April 2020

Screening - Public Health Education led

- From September 2019, all boys aged 12 and 13 will be offered the HPV [human papilloma virus] vaccination.
- By 2020, HPV primary screening for cervical cancer will be implemented across England.
- From summer 2019, the Faecal Immunochemical Test (FIT) will be used in the bowel screening programme.

Treatment

Eleven radiotherapy networks will be established across England by 2019/20 to fully implement new service specifications by 2021/22.

6. Future State

The living with programme has engaged with patients and their cares about their care, treatments and experience

People Living With Cancer have told us that:

- **Information governance** – they get frustrated with having to give their information time and time again, and practitioners would welcome access to a centralised electronic record system.
- **Pathways** – pathways into and through diagnosis and treatment, and the transition back into primary care do not work as well as they could. We also have been told that sometimes patients are missing appointments and there are sometimes waits which could be avoided. People would like to have a Holistic Needs Assessment to identify their individual needs and people have told us that there is a lack of regular follow ups and aftercare.

- **Integration** – services do not work in an integrated way, and the transition between services, and different stages of a patient's experience are disjointed. They have also told us that sometimes organisations do not communicate very well between themselves.
- **Workforce** – the workforce in Lincolnshire is professional, skilled and dedicated, but we have also been told that they are under significant pressure and there are gaps in services. Our workforce has told us that they would welcome additional support and access to information and advice. The volunteer and peer support services are well thought of and useful in supporting people, but coverage across the county is patchy.
- **Communications and conversations –** sometimes the communication between professionals and patients, carers and loved ones could be clearer.
- **Information, advice and support** – they just do not know what is out there to support patients, carers and loved ones. Furthermore, they do not know where to go to get information, advice and support,
- **Support services** – there are a lot of amazing support services in Lincolnshire, but we also know that coverage is patchy, there are significant gaps and sustainable funding for services is fragile. There is a particular lack of psychological and emotional support, and support for the physical side effects of treatment is needed.
- **Equity** – at the moment, where you live can have an impact on the support you can get and support services vary from location to location within the county.

7. Interventions to be implemented 2021 onwards

Screening – Public Health England led

- By 2023/24, significant improvements will be made on uptake of the screening programmes.
- Development of the lung health checks by 2022

Earlier and Faster Diagnosis

- Possible implementation of Lung Health Check Programme following evaluation from the Alliance
- Rapid Diagnostic Pathway – to support the implementation of vague symptom pathway
- Working with primary care networks to deliver national specification for early diagnosis of cancer
- By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.
- One year survival in line with 2028 ambition for 55,000 more people to survive cancer for five years or more each year

Treatment

- Genomics: Equity of access to cancer genomic testing as set out in the National Genomic Test Directory, so that during the next ten years all people with cancer who could benefit from genomic testing are able to do so.

Interventions that require further planning with the Alliance as part of the Long Term Plan delivery

- Targeted lung health checks

- Rapid Diagnostic Centres (implementation plan for expansion)
- Familial genetic testing
- Accelerating the translation of innovation and research into routine clinical practice

Comprehensive model of universal personalised care implemented for people living with cancer. This will result in:

- Integrated support pathways across the statutory and voluntary sectors which will improve outcomes and support people living with cancer.
- People living with cancer are active participants in supported self- management.
- People delivering health and social care, work in partnership to facilitate supported self-management.
- Access to universal personalised support and personalised follow up pathways of care and support for all people living with cancer.
- A tested and flexible service delivery model is operational in Lincolnshire.
- A partnership across all stakeholders is established to transform cancer care into a whole systems approach which becomes everyday business.
- The programme is co-designed with patients, the public and stakeholders.
- The programme is fully evaluated to measure the impact and outcomes on the experience of patients, carers and significant others, and the workforce, and recommendations for future evaluation and measurement of the programme are delivered.
- There are the right people in the right place with the right skills to provide timely support for people living with cancer across the county.
- The programme aligns and integrates with other strategic, organisational and operational developments locally.
- People living with cancer experience seamless and co-ordinated pathways of support.

8. What patients said following the Healthy Conversation events

Throughout the feedback gathered we have consistently heard that the main themes/ concerns relating to breast services are**:**

- Poor infrastructure and road networks causing implications to patients and families who need to get to Lincoln.
- Lack of confidence in Lincoln hospital
- Favour of keeping services at Pilgrim

Haematology and Oncology

Throughout the feedback gathered we have consistently heard that the main themes/ concerns relating to Haematology and Oncology services are:

- Capacity/ issues of over burden on Lincoln hospital – overcrowded and poorly staffed, not enough beds
- Costly travel and parking that could cause hardship for both patients and their families when having to visit on such a regular basis
- Frequent cancellations and delays to appointments

Key priorities/areas of focus

We will continue to transform cancer care so that from 2028:

- Three in four cancers (75%) will be diagnosed at an early stage.

We will get there by:

Screening

- Reinvigorating our action to reduce or eliminate preventable cancers before they appear:
- Introduce HPV vaccination programme for boys.
- Taking more action to tackle smoking, obesity and excessive alcohol use.
- Finding more cancers before symptoms appear through the most comprehensive screening programme in the world
- Adopt faster, easier and more effective tests, starting with FIT for bowel cancer screening and HPV for cervical cancer screening.
- Lower screening age for bowel cancer screening
- Maximise the potential of AI, data and genomic testing to find more targeted ways to identify cancer
- Increase uptake of screening programmes, starting with a review led by Sir Mike Richards.

Diagnosing cancers earlier and faster:

- Ensure all nine constitutional standards are met so as to enhance earlier diagnosis, survival rates and reduce the proportion of cancers diagnosed at emergency admissions;
- Targeted case finding, starting with the expansion of lung health checks and low dose CT scans for earlier diagnosis of lung cancer.
- Rapid Diagnosis Centres that bring together modernised kit, expertise and cutting edge innovation to transform diagnostic provision and deliver equitable and fast access.
- Introduce the 28 day faster diagnosis standard and national timed pathways to reduce variation in access to diagnostics.
- Support the development and implementation of best practice timed clinical pathways to include lung, colorectal, prostate and oesophageal;

Ensuring universal access to optimal treatment and adopting faster, safer and more precise treatments:

- Continually improve the systems processes and policies so as to facilitate the pro-active management of patients on their cancer pathway;
- Improve length of stay for acute cancer patients, enabling timely discharge and appropriate care plans to minimise risk of admissions;
- Cutting edge radiotherapy that targets cancer more effectively and reduces side effects and appointment times.
- Greater access to promising new treatments such as immunotherapy.
- Increased use of genomics to target treatments and interventions more effectively.

- Improve survival outcomes and reduce variation through greater networking of specialised expertise, starting with radiotherapy and services for children and young people.
- Work with tertiary centres to provide the best practice pathway for patients accessing specialist centres for diagnostic tests and treatments

Offering personalised care for all patients and transforming follow-up care:

- Surveillance and aftercare that is tailored to individual needs – supported self-management, shared care or complex case management.
- Personalised care to address holistic needs from diagnosis onwards, including needs assessment, care plan and health and wellbeing support.
- Quality of life metric to demonstrate how well people are living beyond treatment.
- Develop Digital solutions to support the delivery of Cancer services across Lincolnshire
- Enhanced recovery programme (Pre-habilitation)
- Roll out of urine protein creatinine testing in acute
- Roll out of urine protein creatinine testing in community
- Personalisation and navigation project (delivery arm)
- Personalised follow up (remote monitoring)
- Shared decision making
- Personal budgets
- Consequences of treatment colorectal

Harness the collaboration of academia, the NHS and industry to develop and rapidly translate into practice the screening, early detection and targeted treatment models of the future:

- Direct and support the acceleration of innovative techniques for early detection and treatment of cancer.
- Greater 'real-world' testing of innovation through Cancer Alliances and Rapid Diagnosis Centres, to speed up transition from development to mainstream use.
- Focus will be needed over the next five years on interventions such as psychological support, healthy lifestyle choices and preventing/managing consequences of treatment

These interventions rely on fit for purpose workforce, infrastructure and leadership:

- Cancer Alliances will continue to lead cancer transformation across their geographies, bringing together local health and care partners to accelerate improvements in cancer service delivery across providers.
- Workforce
- Develop the system workforce to ensure delivery of the long-term plan and National Cancer Strategy. Focus on the challenged areas such as diagnostics, histopathology and oncology.

Planned initiatives/interventions

- Visual management system- manage demand and capacity within United Lincolnshire Hospitals NHS Trust (ULHT) to support constitutional standards by Jan 2020
- Symptomatic Faecal Immunochemical Testing (FIT) – Implementation of the FIT pathway for Colorectal Cancers by March 2020

- Vague symptoms pathway - Rapid Diagnostic pathway development – Model to be developed by 2020 to benefit patients with vague symptoms
- Improving outcomes for patients following treatment for colorectal cancer- 2020- 2023
- Prostate, lung, breast, colorectal, gynaecology, upper gastrointestinal – best practice pathway implementation
- Tertiary focus on head and neck, prostate and lung pathways
- Improving holistic needs assessment in secondary care
- Developing end of treatment summary for improving communication to primary care
- Improving the quality of cancer care reviews in primary care
- Access to health and wellbeing interventions
- Living with Cancer Delivery Arm

Headline investment, including use of transformation funding

- Lincolnshire has received over the past 2 years 18/19- 19/20- 2.2 million from the East Midland Cancer Alliance.
    - Focus is on 62 day performance improvement, 28 day diagnosis, stream lining of pathways and Living with cancer programme

- Macmillan Cancer Support 2016 – 2019 £2.1m. 2020 - 2022 £1.1m
    - Focus has been on the Living with cancer programme

Headline trajectory for key access/outcome measures

1 year survival by 2023/24 will be 79% see below for trajectory for Lincolnshire

Cancer Survival Rate (1 Yr) Persons 15 to 99

Year	Lincolnshire	East	West	South	South West
2016 (Baseline)	71.3%	70.7%	70.4%	72.4%	71.4%
2017	72.4%	71.9%	71.6%	73.3%	72.5%
2018	73.5%	73.1%	72.9%	74.3%	73.6%
2019	74.6%	74.3%	74.1%	75.2%	74.7%
2020	75.7%	75.4%	75.3%	76.2%	75.7%
2021	76.8%	76.6%	76.5%	77.1%	76.8%
2022	77.9%	77.8%	77.8%	78.1%	77.9%
2023	79.0%	79.0%	79.0%	79.0%	79.0%

Gap	7.70%	8.30%	8.60%	6.60%	7.60%
Additional per Year	1.1%	1.2%	1.2%	0.9%	1.1%

By 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients.

Baseline for Lincs in 2017 was 23% at stage 1 16% at stage 2 so slightly less than half.

Cancer Diagnosis at Stage 1 & 2

Year	Lincolnshire	East	West	South	South West
2017 (Baseline)	39.0%	37.6%	36.4%	44.7%	40.3%
2018	45.0%	43.9%	42.8%	49.7%	46.1%
2019	51.0%	50.1%	49.3%	54.8%	51.8%
2020	57.0%	56.3%	55.7%	59.8%	57.6%
2021	63.0%	62.5%	62.1%	64.9%	63.4%
2022	69.0%	68.8%	68.6%	69.9%	69.2%
2023	75.0%	75.0%	75.0%	75.0%	75.0%

Gap	35.98%	37.38%	38.60%	30.32%	34.73%
Additional per Year	6.0%	6.2%	6.4%	5.1%	5.8%

Stage 1	1107	371	291	256	189
Stage 2	795	284	220	147	144
Total	4874	1741	1404	902	827

Local agreed trajectory for 62 day Classic performance for ULHT. This is a trajectory that is closely monitored.

Cancer	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	80.10%	82.28%	82.59%	83.86%	87.27%	86.59%	82.81%	83.38%	86.59%

Section Two: Haematology and Oncology

1. Background

The clinical specialty for haematology and oncology includes treatment for a range of conditions both for patients with or without cancer. For example, the haematology service will diagnose and treat blood cancer conditions including leukaemia, lymphoma and myeloma, and they will also diagnose and treat non-cancer conditions such as haemophilia, and a range of different types of anaemia.

The oncology service treats patients with diagnosed cancer. Oncology provides treatment for a large number of different types of cancer including breast, colorectal, lung, Gynaecology, urology to name just a few. Oncology treatment is non-surgical treatment. Oncology treatment can involve the use of chemotherapy and/or radiotherapy, hormone therapy, and biological therapy. Chemotherapy and/or radiotherapy, and/or hormone therapy are prescribed before or after surgical treatment.

2. The Acute Services Review

The Lincolnshire Acute Services Review was undertaken to ensure that clinical services at the acute hospitals would be sustainable for the future. The case for change was established at a Clinical Summit held in February 2018, and it was determined that due to significant workforce challenges experienced by United Lincolnshire Hospitals NHS Trust (ULHT), this was impacting on their ability to deliver safe, quality services. For haematology and oncology, the key concern was the impact of workforce challenges limiting the ability to provide adequate cover across the county; this manifested itself in the failure to meet performance against national waiting time standards for cancer and non-cancer. There was an agreement that ULHT was operationally unsustainable in its current form and that a review of healthcare provision for the Lincolnshire population into the future was required.

3. Haematology and Oncology Statistics for Lincolnshire

The tables below show the number of admissions to the three hospital sites for the first four months of this year (2019/20) for elective admissions, non-elective admissions and for day case procedures. The tables also include outpatient activity.

Haematology					
Hospital	**Outpatient Activity**		**Day Case**	**Elective**	**Non-elective**
	First	**Follow up**			
Grantham	328	2,644	1,062	29	4
Lincoln	1,267	7,673	3,742	174	222
Pilgrim	585	4,051	2,723	44	167

Oncology					
Hospital	**Outpatient Activity**		**Day Case**	**Elective**	**Non-elective**
	First	**Follow up**			
Grantham	3	54	521	22	0
Lincoln	4,607	20,918	6,405	326	435
Pilgrim	893	4,400	4,539	66	290

4. Current performance

The chart below shows the performance against the cancer waiting time standard for haematology and oncology.

Haematology				
Standard	**April '19**	**May '19**	**June '19**	**National Standard**
14 day	70.4%	89.5%	100%	**93%**
62 day	69.2%	58.3%	50%	**85%**
31 day	96.2%	100%	100%	**96%**

Oncology				
Standard	**April '19**	**May '19**	**June '19**	**National Standard**
31 day subsequent treatment: Radiotherapy	97.3%	95%	94.4%	**94%**
31 day subsequent treatment: chemotherapy	96.9%	100%	98.6%	**98%**

5. Current Service Provision for Haematology and Oncology

ULHT provides inpatient, day-case and outpatient services for a range of tumour sites, sharing the care pathway with regional centres in some specialist tumour sites such as brain or bile duct. The inpatient bed base is currently shared between haematology and oncology at the Lincoln County Hospital, and Pilgrim Hospital, Boston sites, where outpatient services are also provided. Grantham Hospital provides outpatient care where possible.

ULHT offers inpatient services at Pilgrim, Boston and Lincoln County Hospitals. However patients requiring higher intensity treatments are transferred from Pilgrim Hospital to Lincoln County to continue their care.

Lincoln Hospital has 32 haematology/oncology beds, and Pilgrim Hospital, Boston has 17 haematology/oncology beds.

A description of the levels of care delivered is as follows, taken from Nice Guidance:

Level 1 (Outpatient care, day case chemotherapy, limited inpatient chemotherapy for non-Hodgkin's lymphoma (NHL), management of neutropenic sepsis) is provided at: Pilgrim Hospital, Boston (Ward 7A); Lincoln County Hospital (Waddington Unit) and at Grantham and District Hospital outpatient facilities only (and without facilities for neutropenic sepsis)

Level 2 (Facilities for acute leukaemia, using intensive chemotherapy regimens, and aggressive lymphoma) is provided at Lincoln County Hospital

Level 3 (Autologous transplantation) is referred to Nottingham City Hospital

Level 4 (Autologous and allogeneic transplantation) is referred to Nottingham City Hospital

Radiotherapy is provided at the Lincoln County Hospital. Chemotherapy treatments are provided at Lincoln County Hospital, Pilgrim Hospital, Boston, and at Grantham and District Hospital. ULHT also operates a mobile chemotherapy unit, which travels around the county to provide chemotherapy treatment.

6. The Case for Change in Lincolnshire

There is a heavy reliance on agency staff to support the delivery of haematology and oncology in Lincolnshire, and this presents a service sustainability issue. In addition, it presents challenges to provide a service that complies with national waiting time's standards.

Below is a summary of the key challenges for the haematology and oncology services in Lincolnshire:

Lack of compliance with clinical standards and guidelines	**Unable to deliver safe, quality care at the appropriate scale**	**Lack of sustainable and resilient working patterns**
Oncology: • 62-day cancer Referral to Treatment performance is poor • Service does not currently meet NICE guidelines on the provision of acute oncology services Haematology: • Insufficient dedicated side rooms on Waddington Ward (Lincoln County Hospital) • CQC (2017) found outpatient facilities at Lincoln inadequate	• Medical recruitment challenges leading to heavy reliance on locums. 2 out of 8 haematology consultant vacancies; • 8 out of 12 substantive consultant oncologists in post • Only 1 out of 3 haematology posts filled at middle grades • Position set to worsen with imminently retiring consultants	• Outpatient appointments are heavily oversubscribed trust-wide; often double- or triple-booked. Excess activity above capacity is up to 62.4% for haematology. • Unsustainable levels of pressure on clinicians and other staff

7. The Emerging Options for Haematology and Oncology in Lincolnshire

There is one emerging option for sustaining haematology and oncology services in Lincolnshire and this can be summarised as follows:

- Consolidation of haematology and oncology inpatient activity at the Lincoln Hospital. This includes elective inpatient chemotherapy and non-elective emergency admissions, which in the new model will all be admitted to the Lincoln County Hospital

- Pilgrim Hospital Boston and Lincoln County Hospital will provide an acute Oncology service for the immediate assessment and treatment of patients with cancer who need urgent and emergency attention, thus avoiding the need to access care and treatment via a busy A&E department

- Day Case chemotherapy will continue at both Pilgrim Hospital, Boston, and at Lincoln Hospital, for all patients suitable for day case chemotherapy (all regimens currently delivered)

- Day case chemotherapy will continue at Grantham and may increase due to increased utilisation of the mobile chemotherapy service

- The mobile chemotherapy service will provide chemotherapy at other locations across the county

- Outpatient appointments (new and follow up) will continue at Lincoln County Hospital, Pilgrim hospital Boston and at Grantham Hospital.

Consolidating Haematology and Oncology inpatient care at Lincoln County Hospital will provide an opportunity for more consistent achievement of clinical standards e.g. 62-day referral to first treatment for Haematology patients. It will also support the ability to manage immunosuppressed patients in an appropriate setting (side rooms), addressing concerns raised by the CQC in April 2017. This change will provide an opportunity to ‘right size’ the service, and improve facilities as part of a wider change on the Lincoln hospital site, thus meeting the NICE guidelines for management of neutropenic sepsis patients. It will also provide an opportunity to accommodate the increase in outpatient activity.

In addition, consolidating these services at Lincoln Hospital will improve the services ability to attract and retain talented and substantive staff through building a strong and successful service that offers opportunities to work in a centre of excellence model. This would aim to solve current medical recruitment issues, and relieve pressure associated with cancer tumour site coverage (recently where a substantive or agency locum consultant has retired or left their role, the services have needed to shuffle consultants around to ensure all cancer Multi-Disciplinary Teams have an oncologist with an interest in the relevant tumour site).

8. Financial Investment Required

Investment will be required to increase the number of beds at the Lincoln Hospital site. There are currently 32 beds at the Lincoln Hospital site, and the modelling of activity for the emerging option has indicated that 17 beds will need to be added to the Lincoln Hospital site to support the transfer of inpatient activity from the Pilgrim Hospital Boston site.

9. Healthy Conversation 2019 Feedback

The response to *Healthy Conversation 2019* has been significant; a summary of all feedback is published on the *Healthy Conversation* website, but nothing specific to haematology and oncology has been raised.

10. Consultation

This is not a direct consultation item. However, the Committee may wish to submit initial comments on the case for change and the emerging options to the Lincolnshire Sustainability and Transformation Partnership as part of *Healthy Conversation 2019*.

11. Conclusion

The *Healthy Conversation 2019* campaign has delivered a recognisable and effective platform to enable our key stakeholder groups to share feedback with Lincolnshire's NHS.

12. Background Papers

No background papers within the meaning of Part VA of the Local Government Act 1972 were used in the preparation of this report. However the following published documents were used to inform this report.

- NHS Long Term Plan published January 2019
- Lincolnshire STP Pre-Consultation Business case version 1.0

This report was written by:
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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:	**16 October 2019**
Subject:	**Community Pain Management Service**

Summary:

During 2018/2019 the Lincolnshire Clinical Commissioning Groups (CCGs) recommissioned the pain service provided to residents throughout the county.

The specification for the new service detailed the requirement for a modern community based service which would deliver clinical services that are in line with NICE [the National Institute for Health and Care Excellence], national and international best practice and the recommendations of the British Pain Society.

The contract was awarded to Connect Health. During the last six months the new service has been established. This has involved establishing a hub and community bases throughout the county, transfer of over 6,000 patients from previous providers to the new service and provision of service for new patients.

This report provides an overview of the new service model and a progress update with regards implementation of the mobilisation plan.

Action:

To note and consider the information presented on the Community Pain Management Service and consider if any further information or action is required.

1. Background

Lincolnshire commissioners had considered changes to the pain management service for over 10 years. The introduction of Right Care in 2016 identified that Lincolnshire was an outlier for musculoskeletal and neurological services and in particular in the management of pain in terms of elective and prescribing activity and spend Multiple projects had scoped options. However, no consensus between all commissioners materialised until April 2018 when a detailed proposal, backed by a number of GPs and supported by patient groups such as the patient councils and , was shared and endorsed across the county.

Best clinical practice as defined by NICE [the National Institute for Health and Care Excellence] and the British Pain Society had reduced the number of recommended interventions with the withdrawal of facet joint injections and acupuncture, both of which were high volume procedures of the local service. At the time of withdrawal Lincolnshire did not deliver the recommended range of support services, the plan was for a new service that would include a multidisciplinary team of specialists offering a wide range of care options including (not limited to) clinical psychology, physiotherapy, occupational therapy, pain medicines review, pain management programmes and spinal injections. The most appropriate care will be informed by clinical need, national guidelines (e.g. British Pain Society; the National Institute for Health and Care Excellence), and shared decision making The new service would bring many additional options for people living with pain in addition to (not instead of) those treatments currently available.

The previous pain service delivered 18,000 appointments annually and 6000 interventions with over 90% delivered by consultants. Clinics were predominantly delivered within an acute setting with over 80% of all interventions medical and or injection based. This service did not represent good value or best clinical practice and was considered to be unsustainable and as such in March 2018, all four CCGs in the Lincolnshire Joint Shadow Committee agreed to:

- decommission the existing pain management service from 31 March 2019 ; and
- procure a new community-based lead provider model to deliver best clinical practice as defined by NICE and the British Pain Society.

Category	Previous Service	New Service	Comment
Acute Setting	yes	no	
Community setting	no	yes	Now wholly community based
Best Clinical Practice	no	yes	NICE and British Pain Society
Psychological Support	no	yes	Less than 3% of patients could access now 100% of patients could access
Medicines Management	no	yes	Now embedded within the CPMS
Rightcare outlier	yes	no	
Off formulary	yes	no	All patient medication is reviewed as part of pathway and aligned to best practice and on formulary
Single point of access	no	yes	Reduced clinical variation

2. Procurement

The Community Pain Management Service for Lincolnshire was procured during 2018/19 in accordance with the Public Contracts Regulations 2015.

Documentation, including specification and questions, was developed in collaboration with Commissioners, subject matter experts and informed stakeholders from the four Lincolnshire CCGs and signed off by the Lincolnshire Joint Shadow Committee and senior responsible officer for the project.

There were six high quality applications received. The bids were assessed and evaluated in relation to specific requirements, using criteria stated in *Document 1 – Process Overview of the Invitation To Tender*. These were a combination of pass/fail and scored questions which covered compliance, technical, quality and commercial criteria. These questions were evaluated by the commissioners, subject matter experts and procurement experts from Arden & GEM (a commissioning support unit).

Following a robust evaluation and moderation process, approval was obtained from the CCG boards prior to the announcement of a preferred bidder and the mandatory 10-day standstill period began. Following successful completion of standstill, the contract was awarded to Connect Health on the 10 November 2018, the commissioner met with Connect Health on the 11 November when mobilisation commenced. The new service was planned to start on the 1 April 2019

3. The Plan

All the main NHS and private providers were given prior notice of the CCGs' intentions to procure a new Community Pain Management Service with the appropriate contractual period of notice of the termination of the contract given (ranging from six months to twelve months based upon contractual requirements). Providers were informed by 16 November 2018 that the contract had been awarded to Connect Health and that the CCG would be in contact to facilitate an introduction with the new provider to instigate the transition arrangement. Table below identified the main providers and the percentage of the activity they deliver.

Provider	Percentage of Activity
United Lincolnshire Hospital NHS Trust	57%
North West Anglia NHS Foundation Trust	17%
Private Providers – Ramsey & St Hughes	14%
Sherwood Forest Hospital NHS Trust	3%
Nottingham University Hospitals NHS Trust	2%
Queen Elizabeth Hospital NHS Trust – Kings Lynn	2%
Doncaster & Bassetlaw NHS Trust	1%
North Lincolnshire and Goole NHS Trust	1%
Other	2%

The plan was to manage the transition of patients from the main providers by the 31 March 2019. 57% of all activity was delivered by United Lincolnshire Hospitals NHS Trust (ULHT), as of the 1 April 2019 they would no longer provide a pain service. Patients from the ULHT service were written to in April 2018 explaining what was going to happen and again in March 2019 with an update of what was going to happen, what to expect and what they need to do. It was important that this cohort of patients had immediate access to the new service.

For patients being treated by other providers the objective was the same, to transfer patients across to the new service by 31 March. However as these providers would continue to deliver pain service for their local commissioners there was no risk that patients would be left without treatment, should the transfer be delayed. This cohort of patients was written to by their provider prior to transition. Each provider had a slightly different approach when working with Connect Health. For example, North West Anglia NHS Foundation Trust (NWAFT), Sherwood Forest Hospital NHS Trust and Nottingham University Hospitals NHS Trust worked with Connect Health and agreed to a phased transition of patients to ensure continuity of care with many patients completing their treatment prior to transition. Despite the agreement and request to work with Connect Health, Queen Elizabeth Hospital NHS Trust completed the patients care episode and discharged back to the GP rather than transition across to the new service.

3.1 Transition of Patients

Providers were encouraged to start the transition of patients by end of February 2019. It was anticipated that the total number of transition patients would be around 6,000. This would be a case mix of active patients, patients waiting for an outpatient appointment (first or follow up) or a procedure and passive patients (not on active treatment but can call on the service if an issue arises). It was agreed with all providers that any patients in receipt of care should transition across to the new service automatically.

Providers were asked to send across the patient's last appointment outcome letter and any other relevant information they felt was appropriate. The transition of medical notes was a combination of electronic record transfer and paper record transfer.

As patients were transitioned across to Connect Health:

- Connect Health registered patients onto their system and created links with the patients' medical records on System One
- Patients were sent a letter welcoming them to Connect Health
- Patients were sent an invite to a workshop – an opportunity to meet the Community Pain Management Service team to understand the new service and answer any questions that they may have.
- The communication to patients emphasised that patients either need to attend a workshop or contact Connect Health to confirm they want to use the service. The service would attempt to contact the patient three times; if no response received the patient would be discharged. This contact would prompt an action from the Community Pain Management Service.
    - The patients notes would be clinical triaged and patients offered:
        - an initial assessment – (the majority) an opportunity to review the patient, understand from the patients perspective their pains needs and to offer the most appropriate treatment

- upgraded to a consultant appointment. – patients whose clinical notes clearly indicate the need for a consultant appointment.

- Following assessment patients a care plan will be agreed, with options for:
  - Pain Physiotherapist
  - GP with extended responsibility
  - Pain Psychologist
  - Pain nurse specialists
  - Pain Management Programme – September 19
  - Medication review
  - Advance physiotherapist practitioner
  - Pain Consultant

3.2 New Referrals

All new referrals from the GP or a consultant would be:

- Administratively triaged – to ensure all relevant information is present
- Clinically triaged – to signpost the patient to the correct clinician (completed within two working days of referral)
- Patients will be contacted (5 workings days from referral) and offered an appointment for an assessment (20 working days from referral)
- Care plan will be jointly agreed, follow up appointments/treatment will be offered (40 working days from assessment)

3.3 Locations

	Physio	Nurse	Psychologist	GPwER	Medication Review	Consultant	Mobile Unit
Lincoln (3)	✓	✓	✓	✓	✓	✓	✓
Boston (2)	✓	✓	✓	✓	✓		✓
Grantham	✓	✓				✓	✓
Skegness	✓	✓					✓
Sleaford	✓	✓					✓
Spalding	✓	✓					✓
Mablethorpe	✓	✓		✓			✓
Louth (Oct)	✓	✓				✓	✓
Market Deeping	✓	✓					✓
Gainsborough	✓	✓					✓

- Service also offers telephone consultations where appropriate and is looking to develop skype style consultations in the future.

3.4 Activity

To the end of September the Community Pain Management Service has delivered:

- 3,867 appointments for transition/back log patients
- 3,014 appointments to new patients

Now that the significant majority of transition patients have been registered Connect Health are working hard to increase capacity further to address the current challenges in the service

4 Challenges

During the mobilisation of the new service model and the introduction of the new provider there have been several key challenges.

4.1 Transition Notes

The response from previous providers has been mixed, from good engagement to no engagement with significant variation on what information was transitioned across.

4.2 Transition Speed

Although all the main providers were given twelve months' notice, many of the providers had not prepared for the transition until followed up in January, with response slow. The majority of patients' notes have now been transitioned. However there are a few smaller providers where work is ongoing to finish the transition. Key challenges:

- ULHT identified an additional 1,200 patients for transition in July
- Some organisation was slow to respond and created barriers to the transition with patients not transitioning across until well into May.
- The transition from some organisation went smoothly, whilst other took more time and created issues for both the service and the patients.

4.3 Provider Co-operation / Support

Some of the previous providers have proved challenging, for example:

- One trust transitioned deceased patients
- One trust had a significant number of patients transitioned across without any records as they did not have any, even though the patient had received treatment
- In the south of the county one trust discharged all their patients back to the patients' GP.
- A number of organisation had issues with the transition documentation which required amending, one organisation required separate agreements for their different sites.
- A number of the previous providers were delivering treatments not recommended by NICE, the British Pain Society or the local *Procedure of Limited Clinical Value* policy. Managing patient expectation has been a huge challenge for Connect Health.

4.4 Locations

Connect Health have established a Community Pain Management Service hub in Lincoln and run 13 clinics across Lincolnshire.

As a new service Connect Health are actively monitoring areas of demand to ensure that they direct their capacity into the areas of demand. This is a long process which cannot be completed until the transition patients have become business as usual patients and true demand can be identified. Issues have been identified in the south of the county.

Stamford

Connect Health have made repeated attempts to establish a pain service in Stamford.

- Initial discussions with NWAFT to work together were positive, but NWAFT withdrew a week before go live date
- Local GP Practice offered some clinical space in their surgery for the Community Pain Management Service. The offer was withdrawn in June/July as they decided to utilise the clinical space in a different way.
- NWAFT indicated that clinical space had become available, negotiations were ongoing with Connect Health but offer withdrawn in August as space had been reallocated to another service

4.5 Referral Management Centre

- Knowledge of area: Patients feel that the people in the Referral Management Centre do not know the geography and infrastructure of Lincolnshire and the challenges the local population face, for example, living in Stamford and being offered an appointment in Mablethorpe
- Information provided: Some of the information provided by the Referral Management Centre has been incorrect and unhelpful.
- Key Messages: From the start of the contract some of the messages from the Referral Management Centre were unhelpful. Connect Health have worked hard to ensure that every patient gets the same positive message.
- Administrative errors are a cause for concern, for example, two letters being sent but containing conflicting and/or incorrect information
- Some of the staff have not shown sufficient empathy for this cohort of patients. A chronic pain patient has significantly different needs from a musculoskeletal patients

4.6 Patient Co-operation / Expectation

- Transition patients were all sent a letter asking them to either book a workshop or contact Connect Health, attendance at the workshop or contacting Connect Health would instigate the service to arrange an assessment appointment. A significant number of patients have not contacted the provider or attended a workshop.
- Patient transferring from previous services providing treatment that were not recommended by NICE or the British Pain Society, have a difficult change pathway to follow. For some, where a procedure is no longer recommended there is no alternative recommended procedure, this can be extremely distressing and frightening for patients who have been receiving treatments for an extended period.

4.7 Capacity

- **Appointments:** Connect Health are offering patients the next available appointment, without regard to location. If patients require a more local appointment, access will depend upon availability which has created delays
- **Consultant appointments:** The service is therapy led, consultant are a key part of the service in particular around assessment for an intervention and the delivery of the intervention. Connect Health has experienced a challenge in providing consultants to assess for an intervention, with limited coverage around the county. This capacity has been a bottle neck in the service.
- **Interventions:** Connect Health has subcontracts in place with BMI for complex patients who require further support and InHealth who provide a mobile theatre which can deliver a range of interventions across the county.
- **Locations:** Connect Health will constantly monitor activity to model capacity against demand. This will accelerate once transition has been completed. Connect Health have highlighted that there is greater demand than anticipated in the Spalding area and are looking at how they can increase capacity.

4.8 Procedures of Limited Clinical Value

The Community Pain Management Service is required to comply with the CCGs' policy on *Procedures of Limited Clinical Value* as recommended by NICE, the British Pain Society, for example, lignocaine infusions, facet joint injection, acupuncture and ketamine prescribing. The CCGs would not support prescription of these procedures or drugs

4.9 Complaints

Connect Health manage the complaints they receive through their Governance Team. The team monitor the complaints they receive, identifying themes and re-occurring issues. To September 2019, Connect Health had received 75 complaints, 74 of which were around the transition process and subsequent patient experience. The outcomes from the first five months have resulted in the following actions.

Theme	Action(s)
Appointment Availability	1) Service manager sourcing additional capacity 2) Actively recruiting to vacant posts 3) Locums 4) Overtime 5) Bank Contracts (coming soon) 6) Referral Management Centre staff provided scripts on information to provide patients to better manage expectations 7) Training members of the senior clinical team to direct list to procedures. This will streamline the current pinch point in the service.

Theme	Action(s)
Referral Management Centre Call Handling	1) Significant investment underway to better resource and improve processes at the Referral Management Centre 2) Director of Patient Experience appointed 3) Referral Management Centre staff provided scripts on information to provide patients to better manage expectations
Procedures of Limited Clinical Value	1) Individual funding requests are being submitted for patients who have genuine exceptionality and there is clinical justification for a *Procedure of Limited Clinical Value.* 2) Requested a position statement for lignocaine infusions from the Commissioners

4.10 Compliments

In addition to the complaints received there have been a number of compliments from patients:

- "I wanted to pass on how kind and helpful you were and how easy you made the whole experience for me. I am absolutely thrilled with you"

- "Before my appointment with _____ I was at my lowest ebb…_____ spent about 2 hours talking to me and my wife….It was like a switch just flipped in my head and I thought "I can do this"! I went home and spoke to my boss and took the month off work. Since then I have been walking every day and I've walked 150 miles at the gym. My wife and I walk every day. I've lost weight. Have regained all my range of movement and my physical and mental health has blossomed"

- "I am writing this email to you because I feel that good results should get to the people that provide this service. I was referred by my wonderful GP, _____, who worked tirelessly to get me the right help I needed. I was referred to Suite B Pain Management; the clinician I saw was _____. The Doctor treated me with respect; he listened and asked me questions. I felt he totally understood my plight. He consequently referred me to see a Pain Psychologist, _____ also at Suite 8 Skegness. I have now seen the psychologist five times and she is using EMDR [eye movement desensitisation and reprocessing treatment] plan. **I wanted to let you know this has transformed my life. The difference is amazing I am totally pain free now. I take no pain relief.** I hope this technique can help other patients with long term chronic pain. Thank you so much to your department for giving me my life back. My sincere thanks to you all"

5 CCG Ongoing Management / Oversight

The CCGs recognise that the introduction of a new service provider and establishment of a new service model is complex and that there are several risks that need to be proactively managed. In order to do this, CCG colleagues undertake the following:

- Fortnightly operational meetings with Connect Health

- Monthly contract meeting with Connect Health
- Support patients who are having difficulties with the transition to the new provider
- Maintain regular contact with Connect Health to ensure that individual patient concerns are being managed / or have been resolved.

In addition

- Connect Health continue to attend the CCGs patient council to obtain feedback and listen to concerns regarding either the management of the service or the new service model.

6. Consultation

This is not a direct consultation item.

7. Conclusion

The Committee is requested to note and consider the information presented on the Community Pain Management Service and consider if any further information or action is required.

8. Background Papers

No background papers within the meaning of Part VA of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Sarah-Jane Mills, who can be contacted on 01522 515381 or 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:	**16 October 2018**
Subject:	**Integrated Community Care**

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
- Introduction of Primary Care Networks
- Use of Technology
- Development of Specialist Community Services.

Actions Required:

The Committee is requested to note and consider the information presented on Integrated Community Care, and to decide whether any feedback should be submitted to the Lincolnshire Sustainability and Transformation Partnership, as part of the *Healthy Conversation 2019* engagement exercise.

1. Background

The NHS nationally and locally faces significant challenges. We all acknowledge the pressures of an aging population, increasing need and cost with an overstretched workforce. These issues seem more acute in our county, particularly with a dispersed semi-rural population with pockets of high deprivation. However, our response to this challenge has not changed since the creation of the NHS over seventy years ago. We are over reliant on a reactive, hospital based, paternalistic model of health care with different sectors of our health and care system working in splendid isolation.

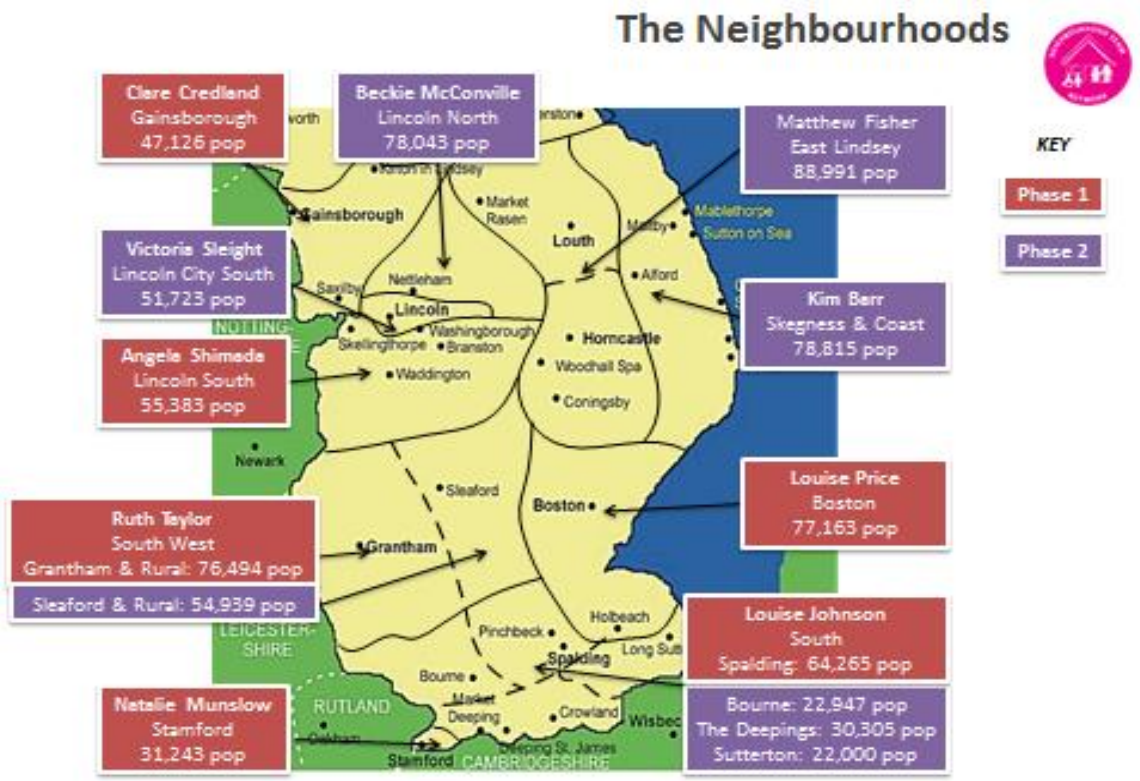
The feedback from the *Healthy Conversation* has confirmed that local people are asking for care close to home, a holistic approach that helps them remain in the bed they bought, to make access a simple process and a high standard of care delivered by compassionate professionals who they trust.

In responding to this, we understand the need to change the way care is delivered in the community, where the majority of care takes place and move away from the hospital focus. The Integrated Community Care portfolio is our proposal to realign care across the county.

We have been working together for some years to develop services that will support and enable us to achieve the task of people from across Lincolnshire. Our local plans will be supported and facilitated by the key actions outlined in the *NHS Long Term Plan*. This national programme sets out the expectation of modern, resilient primary care supported by excellent community care including mental health and an integrated service model which ultimately stops our reliance on hospital based services.

This report describes the progress to date and the work we are doing to maintain the development of Integrated Community Care across the county.

2. Neighbourhood Working



The neighbourhood teams continue to work closely with partners in their local communities. There have been some excellent examples of local initiatives that are supporting the development of holistic care, which reflects patient need and is delivered by a team of professionals from different organisations working as one. Some of these examples include:

- Using IT generated alerts to ensure that patients with complex need who had been discharged from hospital were contacted by the Neighbourhood team on discharge. The team were then able to complete a full assessment in the patient's own home and develop a proactive care plan that reduced the risk of further admissions to hospital.
- Introduction of advance practitioners across the Lincolnshire East teams to support management of complex patients identified by GPs.
- Linking with partner agencies to build a multi-agency team to support patients who are homeless. This has evolved to become 'team around the adult' .
- Ongoing development of a dedicated care home liaison service that has reduced the number of attendances at A & E, reduced the number of emergency admissions, increased the number of patients dying in their preferred place of death and reduced the number of GP visits to care homes.

Neighbourhood working is the foundation of the Integrated Community Care programme. Over the last two years the teams have focused on building the links with partners in their local communities. There is now strong evidence that this joined us working is having a positive impact on the outcome for patients but that there are also some key constraints that are stopping us realising the full benefits.

To ensure that we continue to drive the development of Neighbourhood working, Carolyn Nice, Assistant Director, Adult Frailty and Long Term Conditions, Lincolnshire County Council, has agreed to lead the next phase of development. The key objective of this work will be to address the barriers that prevent fully integrated patient care. Early priorities include :

- reviewing the work done to date to identify which core roles should be included in the Neighbourhood team;
- improving access, for all members of the core team, to information that enables them to identify patients that would benefit from holistic interventions;
- identifying bases in local communities where colleagues from different organisations can be collocated; and
- identifying key individuals in each organisation who will support the neighbourhood team to resolve issues that are currently preventing a patient from receiving the care they need.

Alongside this work there is a dedicated programme of work to support the integration of services for patients who are frail. The key priorities for this team are:

- developing the acute frailty unit;
- extending responsive community provision to enable patients taken to hospital to go home as soon as possible;
- developing guidelines to support the review of medications for patients on multiple treatments;

- standardising the assessment tools that will be used in Lincolnshire; and
- reviewing the service provision, systems and processes to support patients who are approaching the end of their life. The aim of this programme of work will be to map the current arrangements in order to reduce duplication and additional administrative processes that can lead to delays in patients receiving the care they need.

3. Introduction of Primary Care Networks

One of the key initiatives of the NHS long term plan is the development of Primary Care Networks. (Appendix A).

Primary Care Networks (PCNs) will create the framework to facilitate greater integration and joint working both across General Practice and with other agencies. Across Lincolnshire there are 13 PCNs. A map showing the boundaries of these is currently in development.

A Clinical Director has been appointed from the practices that are part of the PCN. In some instances this role is shared by two people.

PCNs across Lincolnshire are at different places in their development. Over the next few months the key priorities for the PCNs are:

- Introducing new roles within the PCN :

    - **Clinical Pharmacists:** highly trained health professionals who are specialists in medicines. If you have a long-term condition such as asthma or diabetes, the clinical pharmacist can talk to you about the medicines you are taking to make sure they are working for you.
    - **First Contact Physiotherapists:** are advanced practitioners with extensive expertise in the clinical assessment, diagnosis and management of musculoskeletal (MSK) conditions. They can also refer patients for a course of physiotherapy treatment, order investigations or make referrals into secondary care services,
    - **Social Prescribers:** supporting patients with one or more long-term conditions, who need support with their mental health, who are lonely or isolated, or who have complex social needs which affect their wellbeing. They spend time with patients, focusing on ‘what matters to me’ and taking a holistic approach to people’s health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.

- Preparing for the five new service specifications that will become operational from April 2020 :

    - Medicine reviews
    - Enhanced health in care homes
    - Anticipatory care
    - Personalised care
    - Supporting early cancer diagnosis

4. Use of Technology

Some of the key concerns highlighted as part of the *Healthy Conversation* were in relation to access to GP appointments and the difficulties of travel in rural communities. A recent event celebrated the progress in developing the digital platforms to support health and care across all sectors and throughout Lincolnshire.

One option is to add digital appointments in addition to the traditional face to face appointments provided by GP. By using this approach; people can be seen by a doctor via their smart-phone, tablet or computer.

The use of technology to support General Practice is currently being piloted in 8 practices across Lincolnshire. The use of technology may be described as an e-consultation or by the name of the produce that is being used, for example *Ask My GP* or *Q Doctor*.

E-consultations are also being used by the Clinical Assessment Service as part of the wider development of the counties integrated urgent care service provision.

Our plan is that, by April 2020, 75% of practices will be using this technology and by April 2021 all our GPs will be using e-consultation to support improved access.

The feedback both from patients and clinicians is very positive and has highlighted the following.

- More choice and flexibility when you need it
- The right clinician, first time
- Greater convenience when you need a doctor's advice
- Save unnecessary journeys to your GP practice
- A highly skilled medical team who can provide innovative care via an effective and proven digital consultation service.

5. Specialist Community Services

Alongside the development of existing community based services work has begun to reduce the need for patients to attend an acute hospital. Current initiatives include:

- Diabetes: To introduce a single team approach to support the management of patients with diabetes. The aim being that by April 2021 90% of all diabetes care will be delivered in the community.

- Stroke Rehabilitation: To establish a single team approach to support the management of patients who have had a stroke. The single team will support patients to receive access to acute interventions and facilitate discharge within ten days so that the person may continue their rehabilitation in their own homes

- Dermatology spot clinics: The Spot Clinics are face to face triage clinics, delivered in a community setting, for single lesions. They are 2 hour consultant led clinics that will run out of Lincolnshire GP Practices which also offer Community Surgical Scheme, to allow the clinics to develop into one-stop clinics where lesions can be removed following triage by the consultant.

6. Ongoing Development

The Integrated Community Care programme is the key enabler to delivering sustainable modern health care. The core elements of the programme are the development of Neighbourhoods and PCNs. This work has begun as has the review of current service models these two transformation programmes will support the development of arrangements to enable us to realise the ambitions of both the Lincolnshire and NHS Long Term plans.

At the heart of the Integrated Community Care programme is the ambition to build services that will improve the healthy life expectancy of people living in local communities. In the coming months alongside the development of PCNs, Neighbourhood working and refresh of service models we will increasingly be exploring how technology can help us to enhance local service provision and give us access to data that will enable clinicians to better identify patients who would benefit from proactive interventions.

Underpinning the Integrated Community Care programme is the need to change the relationship between local residents and the NHS. The aim is to ensure that patients, carers and professionals worked together to develop care and treatment plans that are right for the individual. We will need support from local people to help us design services that will achieve this goal.

Whilst the development of Integrated Community Care is consistent with the feedback from our *Healthy Conversation* events, and national best practice we understand that new ways of working are often frightening and confusing. We are keen to support residents and professionals as we develop the Integrated Community Care portfolio and would welcome the opportunity to provide regular updates to the Health Scrutiny Committee.

7. Consultation

This is not a direct consultation item, but the Committee may wish to submit comments to the Lincolnshire Sustainability and Transformation Partnership as part of *Healthy Conversation 2019* engagement exercise.

8. Conclusion

The Committee is requested to note and consider the information presented on Integrated Community Care, and to decide whether any feedback should be submitted to the Lincolnshire Sustainability and Transformation Partnership, as part of the *Healthy Conversation 2019* engagement exercise.

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

Appendix A	Briefing: Understanding Primary Care Networks – Context, Benefits and Risks *(The Health Foundation – July 2019)*

10. Background Papers – No background papers within the meaning of Part VA of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Sarah-Jane Mills, who can be contacted on 01522 515381 or Sarah-Jane.Mills@lincolnshirewestccg.nhs.uk

Briefing:
Understanding primary care networks

Context, benefits and risks

Rebecca Fisher, Ruth Thorlby and Hugh Alderwick

Introduction

From 1 July 2019, all patients in England should be covered by a primary care network (PCN). PCNs are made up from groups of neighbouring general practices. New funding is being channelled through the networks to employ staff to deliver services to patients across the member practices. PCNs are not new legal bodies, but their formation requires existing providers of general practice to work together and to share funds on a scale not previously seen in UK general practice. The hope of national NHS leaders is that PCNs will improve the range and effectiveness of primary care services and boost the status of general practice within the wider NHS.

PCNs are being introduced at a very difficult time for general practice. *The NHS long term plan* acknowledges that investment in general practice declined relative to the rest of the NHS between 2004 and 2014, while both demand and complexity of patient needs were rising. This has contributed to a fall in patient satisfaction and increased pressure on staff, which has exacerbated shortages of GPs and practice nurses, who have left the profession at a faster rate than it has been possible to replace them. Despite a target to increase the number of GPs by 5,000 between 2014 and 2020, the number of full-time GPs was 6% lower in 2018 than in 2015.[1]

PCNs will receive funding to employ additional health professionals such as pharmacists and paramedics. Once they are established, *The NHS long term plan* envisages that the networks will also be a vehicle for improvements in primary care and broader population health, and give primary care more influence within the larger Integrated Care Systems (ICS) – geographically based partnerships of NHS organisations and local authorities – which will be in place across England by 2021.

PCNs are being established rapidly at a time when general practices have limited spare time and energy to invest in creating new networks. Formally announced in *The NHS long term plan* on 7 January 2019,[2] the vision of what PCNs would be, and what they might be expected to do, was outlined in the 2019/20 GP contract published on 31 January 2019.[3] Details of the funding (how much PCNs will receive and what is expected of them in return) were published on 29 March 2019.[4] Practices had to organise themselves into networks and submit signed network agreements to their clinical commissioning group (CCG) by 15 May 2019. NHS England expects the network contract to provide 100% geographical coverage by 1 July 2019.[5]

Joining a PCN is not compulsory for a GP practice. But by channelling a significant proportion of the increased funding for general practice – £1.8bn of the £2.8bn promised over 5 years in *The NHS long term plan* – through the network contract rather than directly to individual practices, NHS England has made it challenging for practices to abstain from joining PCNs.

This briefing places PCNs in the context of previous changes to general practice funding and contracting. It examines the rationale for networks, explores relevant evidence and draws out intended benefits and possible risks for the future of PCNs.

What's happening?

What are PCNs?

PCNs are groupings of local general practices that are a mechanism for sharing staff and collaborating while maintaining the independence of individual practices. NHS England has stipulated that networks should 'typically' cover a population of between 30,000 and 50,000 people (the average practice size is just over 8,000). There are likely to be around 1,300 PCNs across England. A single practice with a list size of over 30,000 can register as a PCN, and networks of over 50,000 will be allowed in some circumstances. Networks are expected to be geographically contiguous and co-terminous with local CCG and ICS footprints.

The networks are part of a set of multi-year changes, supported by the new 5-year GP contract published in January 2019. Neighbouring practices enter network contracts in addition to their core GP contract. Groups of practices collaborating as a network will have a designated single bank account through which all network funding – a significant proportion of future practice income – will flow. NHS England has calculated that by 2023/24 a typical network covering 50,000 people will receive up to £1.47m via the network contract.[5]

What will they do?

The new GP contract is designed to deliver commitments made in *The NHS long term plan*, for example on medicines management, health in care homes, early cancer diagnosis and cardiovascular disease case finding. PCNs are the key vehicle for doing this. Once they are formed, networks will have responsibility for delivering seven national service specifications set out in the contract in return for the new funding (see Table 1).

Table 1: PCN service specifications[3]

Service specification	Introduced from	Examples
Structured medicines review and optimisation	2020/21	• Directly tackling over-medication, including inappropriate use of antibiotics. • Focus on priority groups including the frail elderly.
Enhanced health in care homes	2020/21	• PCN members expected to support the implementation of vanguard models tested between 2014/15 and 2017/18.
Anticipatory care	2020/21	• Practices in PCNs to collaborate to offer more care, and more proactive care to patients at high risk of poor health outcomes.
Personalised care	2020/21	• Implementing aspects of the Comprehensive Model of Personalised Care.[6]
Supporting early cancer diagnosis	2020/21	• Ensuring high and prompt uptake of cancer screening invites.
Cardiovascular disease prevention and diagnosis	2021/22	• The Testbed Programme will test the most promising approaches to detecting undiagnosed patients, with subsequent roll-out across PCNs.
Tackling neighbourhood inequalities	2021/22	• Approaches will be developed through the Testbed Programme and tailored to meet the specific context of PCN neighbourhoods.

The mechanism being used to channel funds to PCNs is the Directed Enhanced Service (DES). These are voluntary add-ons to the core GP contract, and have been used for several years to incentivise specific services, for example vaccination programmes, or care for people with dementia. The specific DES requirements of PCNs are set out in the Network Contract DES Specification[4] and include the provision of extended hours (ie appointments outside the core contracted hours of 08.00–18.30, Monday–Friday).[4] The focus of the Network Contract DES in 2019/20 is on establishing networks, with five of the seven service requirements coming in from 2020/21. Full details of the seven service requirements are yet to be published, but PCNs will be expected to deliver against an agreed set of 'standard national processes, metrics and expected quantified benefits for patients.'[3]

How will they do it?

PCNs will be expected to draw on the expertise of staff already employed by their constituent practices, and will receive funding to employ additional staff under an Additional Roles Reimbursement Scheme (ARRS). The work of the networks will be coordinated by a clinical director, a role that will be funded on a sliding scale depending on network size (equivalent to 0.25 of a whole-time equivalent (WTE) GP post per 50,000 patients).

The ARRS is the most significant financial investment within the Network Contract DES and is designed to provide reimbursement for networks to build the workforce required to deliver the national service specifications.

The five reimbursable roles are:

- clinical pharmacists (from 2019)
- social prescribing link workers (from 2019)
- physician associates (from 2020)
- first contact physiotherapists (from 2020)
- first contact community paramedics (from 2021).

The ARRS is intended to cover 70% of the ongoing salary costs of these posts, except for social prescribing link workers, whose costs will be 100% covered. The remainder of the cost of employing these allied health professionals will be met by member practices within the PCN. The sum invested in the ARRS will rise from £110m in 2019/20 to a maximum of £891m in 2023/24. If a network of 50,000 patients should choose to recruit all possible reimbursable roles, it would be eligible for additional ARRS funding of £92,000 in 2019/20, rising to £726,000 by 2023/24 (see Table 2). Suggested job specifications are provided, but PCNs will have flexibility to choose which staff they want and to write job descriptions tailored to local needs.

Table 2: Projected growth in funding for Additional Role Reimbursement Scheme, 2019–2024

	2019/20 (from July)	2020/21	2021/22	2022/23	2023/24
National total	£110m	£257m	£415m	£634m	£891m
Average maximum per typical network covering 50,000 people	£92,000	£213,000	£342,000	£519,000	£726,000

Source: NHS England and BMA. Investment and evolution: A five-year framework for GP contract reform to implement *The NHS long term plan*. 2019, p.11.

How are PCNs funded?

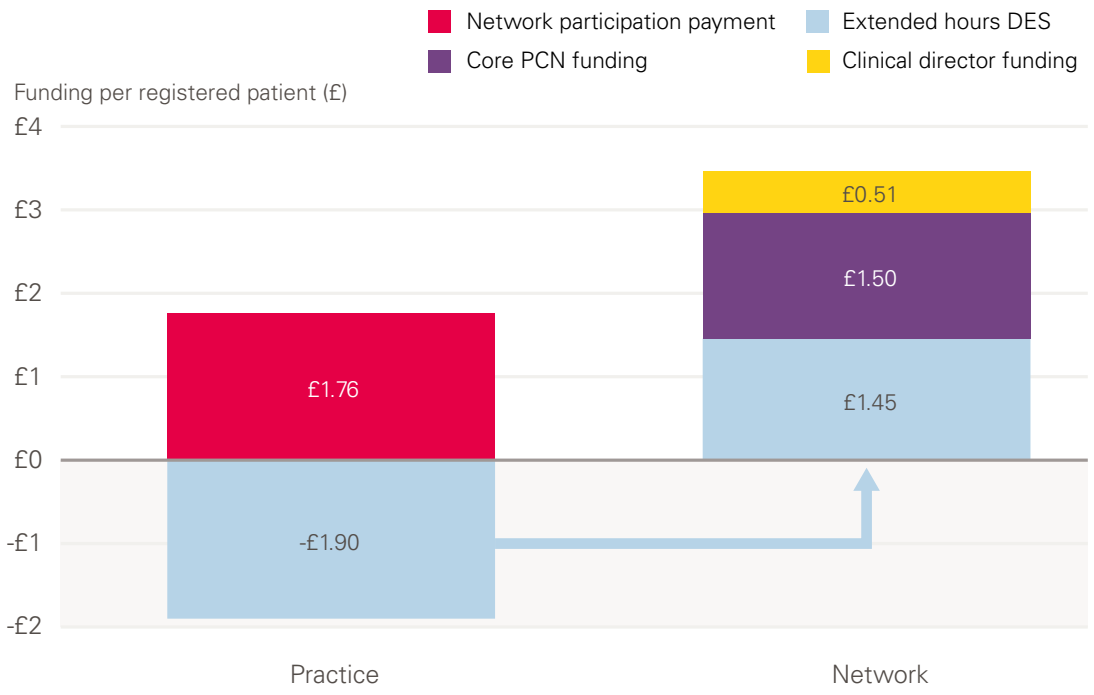
£1.8bn of the promised £2.8bn over 5 years of additional funding for general practice will flow through the Network Contract (see Table 3).

Table 3: Revenue streams for PCNs

Payment	From	Amount	Notes
Clinical director	CCGs to PCNs via Primary Medical Care allocations.	£0.514 per registered patient for the period 1 July 2019 to 31 March 2020.	Calculated on the basis of 0.25 WTE per 50,000 patients, at national average GP salary (including on-costs). This will be provided on a sliding scale based on network size.
Core PCN funding	CCGs to PCNs, from core CCG allocation.	£1.50 per registered patient.	
Extended hours access appointments	CCGs to PCNs via Primary Medical Care allocations.	£1.45 per registered patient.	Pro rata over 12 months (equates to £1.099 per patient from July 2019 to March 2020).
Network participation payment	NHS England to individual practices.	£1.761 per weighted patient per year.	
Additional Roles Reimbursement Scheme	CCGs to PCNs via Primary Medical Care allocations.	PCNs will be entitled to claim a percentage reimbursement of either 70% (or 100% for social prescribing link workers) as set out in the Network Contract DES, and subject to a maximum amount.	The roles for which payment will be made are clearly set out in the Network Contract DES, and payment will only be made once staff have been recruited.

Some of the funding (known as the network participation payment) will be received directly by practices, with the remainder of additional funding directed to the network. In addition, some funding previously received by individual practices (for provision of extended access) will now be allocated to networks instead (see Figure 1).

Figure 1: Funding for practices and networks, excluding new roles reimbursement



Note: Extended hours payments previously received directly by practices will now be paid to PCNs. A variable ARRS sum (not shown in Figure 1) will be added to the network payment, depending on the number of staff employed.

Why this, why now?

Although the plans for nationwide implementation of PCNs seem to have emerged very recently, they build on recent policy to encourage general practices to work at greater scale.

The 2014 *Five year forward view* for the NHS in England set out a vision for greater collaboration between general practices, as well as collaboration between general practices and wider community health services, hospitals and social care.[7] GPs could opt to become involved in developing several new care models, including multispecialty community providers (MCPs) – networks of GPs that would integrate services with other health and care professionals in the community – and primary and acute care systems (PACS), which involved closer integration between primary care and hospital services for a local population.

The 2016 *General practice forward view* continued in a similar vein, promising the introduction of a voluntary MCP contract to integrate general practice services with wider health care services, encouraging GPs to work at scale across practices to collectively provide extended access, and promising additional allied health professionals in extended practice roles within primary care.[8] In 2017, *Next steps on the five year forward view* announced an intention to 'encourage' practices to work together in hubs or networks of between 30,000 and 50,000 patients.[9] The benefits of larger-scale models of general practice were described as allowing the employment and sharing of a greater range of staff (such as community nurses and pharmacists) without closing practices or forcing co-location of services.

Prior to *The NHS long term plan*, the approach had been to emphasise the voluntary nature of any collaboration and offer a variety of different forms through which collaboration might happen. Two elements differentiate PCNs from most pre-existing collaborations in general practice:

1. Practices working in formal collaboration with each other under a **shared network agreement**.
2. A **shared income stream** across practices forming a primary care network.

In most localities this represents a sizeable change to the way that general practice is run and funded. By formalising PCNs, the 2019 GP contract goes further than any previous effort in giving clarity and direction on both form and function of general practice at scale in England. In particular, it is intended that new kinds of staff, including pharmacists, physiotherapists and paramedics, will become 'an integral part of the core general practice model throughout England,' rather than optional add-ons who could be 'redeployed at the discretion of other organisations'.[3]

According to NHS England, the networks will 'enable greater provision of proactive, personalised, coordinated and more integrated health and social care'.[3]

Three key rationales put forward for PCNs in both *The NHS long term plan* and the 2019 GP contract (the latter in conjunction with the British Medical Association (BMA)) are set out below.

1. A pragmatic response to chronic workforce challenges

The GP contract acknowledges that, despite the commitment to increase GP numbers by 5,000, progress in recruiting new doctors has been 'more than offset' by GPs leaving the profession or going part-time. Progress in increasing the number of practice nurses has also been slow and, as a result, many practices had been recruiting to other roles – such as pharmacists – in the wider primary care team faster than had been expected. Hence the decision to give a 'major boost' to recruitment of these roles through the PCN route.[3] The choice of target roles is also pragmatic: NHS England and the BMA estimate that (in contrast to GPs) there is, or soon will be, adequate supply of these roles – pharmacists and link workers immediately, physiotherapists and physician associates by 2020 and paramedics by 2021, to avoid 'net transfer from the ambulance service'.

It is hoped that these wider roles will take some of the pressure off GPs and practice nurses, indirectly helping to ease workforce pressures. Policies already underway to increase the numbers of GPs and practice nurses will continue.

2. Consolidating general practice in the wider health system

PCNs are policymakers' new answer to an important gap in the local organisation of the NHS. Better integration of primary care with secondary and community services has long been a policy goal, but has been held back by several challenges, including how to actively involve general practice – a key provider of services but generally in small units – in wider decisions about how services are organised and delivered across geographical areas.

PCNs are intended to be more than a vehicle for employing additional shared staff between practices. *The NHS long term plan* sets out a vision of care delivered at 'system, place and neighbourhood level', with PCNs representing a new unit of 'neighbourhood' level general practice within the larger units of ICSs. The new clinical directors are expected to provide leadership for PCNs and represent their constituent practices, acting as a conduit between general practice and the ICS. The GP contract makes clear that PCNs and their clinical directors will have access to better data, including predictive risk data, from the network practices and 'robust activity and waiting time data' at both individual practice and PCN level by 2021.

Providers of community services are also being asked to configure their services to match network boundaries by July 2019, although there is no detail yet about how this will be implemented.

3. Improving population health

The NHS long term plan sets out an ambition for all NHS organisations to have more of a proactive focus on improving 'population health'. The term 'population health' is used in various ways in *The NHS long term plan*, but includes action to find and offer services to people at risk of deteriorating ill-health, as well as prevention of illness. NHS England believes that the 30,000–50,000 population size of PCNs breaks population groups in to more manageable chunks for the delivery of interventions to improve population health (single practices being generally too small and CCGs too large). What these interventions look like in practice isn't currently clear, although it is clear that PCNs will be expected to play a role in the prevention of cardiovascular disease and tackling neighbourhood inequalities, as both of these have been singled out as future PCN service specifications.

From 2020, there will also be an Investment and Impact Fund – a savings scheme tied to the development of community-based services that enable reductions in hospital activity – available to networks via their ICS. Guidance has not yet been developed, but the GP contract notes that any monies earned from the Fund are 'intended to increase investment for workforce and services, not boost pay'.[3]

PCNs in their historical context – what's the evidence for where we're going?

There is no directly comparable precursor to PCNs from which to draw evidence, but there has been some evaluation of different forms of networks and collaborations in general practice in the NHS. This section places PCNs in their historical context, considering the evidence related to general practices working at greater scale as both commissioners and providers of services.

Previous forms of general practice at scale

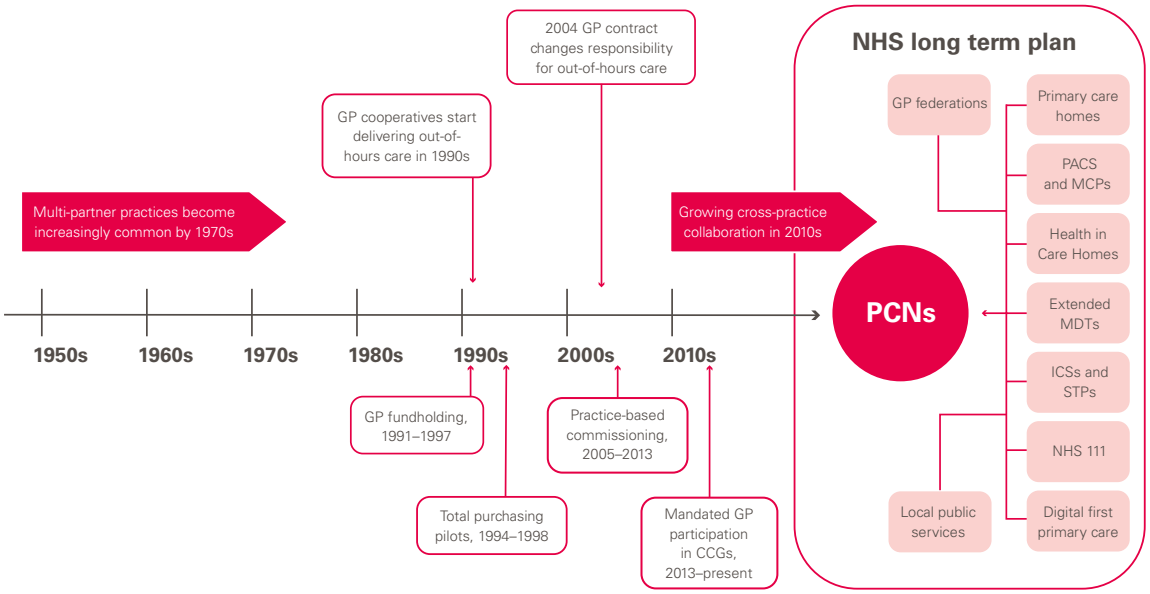
Commissioning

General practice has evolved over time (see Figure 2). From a 1950s model of predominantly single-handed practice, the 1960s and 1970s saw multiple-partner practices become the norm, with falling patient list sizes per GP and improved facilities.

Throughout the 1990s and 2000s, there were opportunities for GP practices both to have greater control over budgets and to collaborate to do so. From 1991, GP fundholding allowed GPs to hold budgets with which to purchase primarily non-urgent elective and community care for patients. GPs had the right to keep any savings, with policymakers hoping that this would financially incentivise GPs to manage costs while applying competitive pressure to acute providers. By 1997/98, 57% of GPs had opted to become fundholders.[10] From 1994, the 'total purchasing pilot scheme' enabled GP practices – either individually or in groups – to commission all services for their patients (although in reality few chose to do so).

Though fundholding was phased out in 1997, from 2005 to 2013 practice-based commissioning (PBC) gave participating practices control over their budgets to purchase secondary care. Practices were given indicative budgets, based on their historic spending, and although they weren't allowed to directly pocket the savings (the key distinction between PBC and fundholding), a proportion of any savings could be recycled into improving patient care. Though both fundholding and PBC were voluntary, the involvement of GPs in CCGs (replacements for primary care trusts created through the Health and Social Care Act) is not. All general practices are required to be members of their local CCG, but only a minority of GPs have a formal role with the CCG.[11]

Figure 2: Trends in the commissioning and provision of general practice in England



Providing services

In the 1990s, practices started working collaboratively to provide out-of-hours care through GP cooperatives – a trend largely reversed when the 2004 GP contract removed the obligation for GPs to provide 24-hour care for their registered patients.

More recently, there has been a trend towards collaboration between GP practices, pushed in part by reductions in practice funding, rising patient and administrative demands, and workforce shortages, and pulled by new funding opportunities for large-scale GP providers (for example from the *Five year forward view*).

In 2016, the Nuffield Trust estimated that almost three-quarters of practices were working in collaboration with other practices, and by 2017 this had risen to 81%.[12,13] The survey reported practices often belonging to multiple collaborations, operating at different levels in the system and for different purposes. A relatively small proportion of practices were working in nationally funded collaborative models (eg as MCP 'vanguards' supported through NHS England's 'new care models' programme) and only half of practices reporting collaboration felt that it had been formalised in any way.[13] Existing forms of collaboration in general practice (for providing services) have varied widely in both form and function.

NHS England state that as of 30 November 2018, 93.4% of practices across England considered themselves to be part of a 'network', but it is likely that the majority of these networks are not working at the level of collaboration required of PCNs.[14] A more recent study (in press) suggests that previous estimates of levels of at-scale working have been much too high, the actual proportion of practices working together in some form (defined as collaborations that serve more than 30,000 patients) is closer to 55%. The same study estimates the proportion of general practices working closely together at scale to be less than 5%.[15]

How are PCNs different from previous forms of general practice at scale?

- **Homogeneity of form:** All practices signing up to PCNs are signing the same network agreement and agreeing to the same contractual terms. While there will be variation in how PCNs choose to operate, how they employ staff and how they deliver services, there will be a common basic operating and funding model for all practices in PCNs across England.
- **Homogeneity of function:** In signing the PCN network agreement, practices will be agreeing to deliver the seven service specifications to be set out by NHS England. Networks are expected to have flexibility to tailor the services they offer to the needs of their neighbourhood, but core contractual obligations will be the same nationwide.
- **Requirements on size and location:** Although the PCN DES allows for a degree of flexibility around PCN size and geographical footprint, existing forms of general practice at scale (such as super-partnerships, primary care homes and existing networks) vary by size and are not all grouped into neighbourhoods.

The advent of PCNs is likely to challenge and potentially disrupt some of these existing forms of collaboration in general practice. GP federations will not usually be allowed to hold the Network Contract DES, and although PCNs may choose to subcontract services to their local federation, the extent to which they do so is likely to vary.

What can the evidence on general practice at scale tell us about PCNs?

Recent examples of scaled-up general practice and networked provision of services provide no clear evidence of impact on quality of care, patient experience or cost-effectiveness.[16] Two studies of networked general practice in one region reported improvement in clinical outcomes and perceived benefits from the perspective of clinicians, but the region in question has had a long track record of using quality improvement approaches to raise standards in primary care.[17,18]

Pettigrew et al's 2018 systematic review searched for evidence of the impact of GP collaborations to explore whether scaled-up general practice can deliver better quality services while generating economies of scale.[16] Their conclusion – that there isn't enough evidence to confidently conclude that the expectations placed on GP collaborations will be met – was accompanied by a warning that further evidence, together with learning from evaluations of current approaches, is needed before large-scale general practice is pursued as national policy. The review is part of a larger report including case reviews of eight at-scale GP providers.[12] Analysis of 15 quality indicators across these providers was unable to detect marked differences in quality of care compared to the national average, and reported mixed views from patients, some of whom valued new forms of access, while others were concerned about the potential loss of a trusted relationship with their own GP.

NHS England have pointed to primary care homes as a successful precursor to PCNs. Launched in October 2015, there are now over 225 primary care homes in England, at various stages of development, serving 10 million patients. The primary care home model brings together general practices with a range of health and social care professionals to deliver care to populations of 30,000–50,000. There are obvious similarities to the new PCN model on network size, a service delivery model based on a multidisciplinary workforce, and an ambition to combine personalised care with improving population health. Evaluation of primary care homes is ongoing, but an early review by the Nuffield Trust found that participation had strengthened inter-professional working and stimulated formation of new services tailored to the needs of different patient groups.[19] There had, however, been a cash injection of £40,000 from NHS England for each of the primary care homes they evaluated, and the report concluded that developing primary care homes requires significant investment of money, time and support.

Without a substantial body of evidence from existing GP-at-scale organisations to guide policymakers, Mays et al sought to understand the lessons that might be learned for large-scale general practice from other inter-organisational health care collaborations.[20] Their findings are relevant to PCNs in three core domains:

- network size
- leadership
- continuity of care.

Network size

No consistent relationship has been found in primary care between the size of health care organisations and their performance. Mays et al identified trade-offs between being small enough to have flexible and inclusive decision-making processes, and large enough to influence the local health economy.[20] This is of direct relevance to PCNs, which are intended, at least in part, to bridge a gap between individual general practices and emergent ICSs.

Leadership

The time and resources required for health service reorganisations are often underestimated.[21] Strong leadership is often cited as essential in overcoming these challenges, but the primary care workforce has historically been relatively unengaged in leadership training and development.[22,23]

Continuity of care

Evidence suggests that continuity of care in general practice is associated with higher quality care for particular patient groups.[24,25,26] Offering extended hours access will be a core requirement of PCNs, but this responsibility will be shared across practices in a network and between different allied health professionals. PCNs can meet their contractual obligations by offering extended hours appointments with nurses, physiotherapists and other multidisciplinary team members. Any evaluation strategy for the networks should include monitoring the effect of PCNs on continuity of care.

How does evidence on GP contracting and commissioning relate to PCNs?

Some studies of previous approaches to GP commissioning have indicated that linking clinical decisions with financial responsibility can deliver improvements in performance, but these have tended to be more modest than had been anticipated.[27] A 1998 evidence review from The King's Fund found that GP fundholding was associated with increased transaction costs and created a two-tier system in access to care for patients of fundholders and non-fundholders.[28]

Health Foundation analysis from 2004 of commissioning changes made in the 1990s did not find any substantive evidence to demonstrate that any approach had made a significant or strategic impact on secondary care services.[29] Neither GP fundholding nor practice-based commissioning showed any significant improvement in outcomes.[30,31]

What can be learned from attempts to scale general practice in other health systems?

Experiences over the past two decades of attempts to deliver networked general practice in New Zealand, Australia and Canada highlight trade-offs between voluntary and mandatory participation. Where joining a network was incentivised but not mandatory, a sizeable minority do not participate, but mandating collaboration is shown to risk clinician disengagement and even resistance.[32] In Scotland, the new GP contract mandated that practices became part of a geographic quality cluster, but early evaluations are mixed and clusters seem to be struggling in areas where practices face different issues and struggle to agree priorities.[33] In Wales, 64 clusters of practices covering between 30,000 and 50,000 patients were set up from 2014 to improve the planning and delivery of local services. An inquiry published in 2017 found that, while there were some impressive examples of collaboration, clusters as a whole were still immature, needed more support with their development, and were finding that financial and demand pressures on primary care were hindering progress in some areas.[34]

Evidence base for the interventions to be used by PCNs

Many of the intended benefits of PCNs hinge on the capacity of the additional staff to free up GPs, using the multidisciplinary team to deliver a range of more effective and personalised services to patients. The BMA's *PCN handbook* offers some evidence of the probable benefits relating to the new roles.[35] We have not reviewed the evidence on the individual roles and interventions that the PCNs are likely to deliver, but the evidence for the impact of some of these roles is not always clear – for example, for social prescribing link workers (and for social prescribing interventions more broadly).[36,37]

The National Association of Link Workers (NALW) highlights that there is currently no research exploring the knowledge, skills, experience and support needs of existing link workers.[38] Ultimately, the success of social prescribing is contingent on the availability of services within communities to effectively address identified needs. Of the link workers who responded to a small NALW survey in 2019, 74% identified 'a lack of resources and/or funding in the community and difficulty in accessing resources in the community/council' as the most challenging aspect of their role.[38]

Risks and challenges

PCNs are a core part of *The NHS long term plan*'s vision of achieving more proactive, coordinated care through greater collaboration between GPs and other services in the community. Drawing on the skills of a wider range of health professionals is a pragmatic response to rising demand and shortages in the GP workforce. PCNs have the potential to improve coordination of services for patients and to support GPs to deliver high-quality care. They may also support GP involvement in wider NHS decision-making.

The decision to direct much-needed additional funding and resource through PCNs rather than direct to practices is a clear signal that policymakers see scaled-up general practice as the best route to a more secure footing for general practice and better care for patients.

But PCNs are not without risks. This section analyses potential barriers and risks to the successful roll-out of PCNs, and what they might mean for general practice.

Speed of implementation

The most immediate challenge is the extremely tight timetable for setting up the networks. Practices across the country have had to understand the policy, form themselves in to networks, appoint clinical directors and agree ways of working sufficient to sign their network agreements, all in very little time.

In their design of the network policy, NHS England and the BMA have attempted to strike a balance between top-down guidance and allowing room for practices to determine what organisational forms are best suited to them. Provided there is a single 'nominated payee' for funding, practices can choose their own models for how that funding flows within the network and their governance arrangements (for example, whether to have a board, how to make sure practices are represented adequately and can hold both the network and each other to account). Five potential options are set out in the BMA's *PCN handbook*.[35] All have different implications for VAT and employment liabilities (for the new staff), and the degree to which practices may or may not be happy to trust a lead practice, federation or third-party organisation to manage the PCN funding on their behalf.

While the freedom to determine what works best locally makes sense, these decisions will have been challenging to make in the limited time available, not least because they have important implications for individual practices. In its guidance, the BMA states that 'in all cases it is essential to take your own legal and financial advice on the potential legal and tax implications'.[35] Mandating that networks form at such speed risks pushing them to make decisions based on what is most possible, or easy to do, rather than allowing time to consider how to best structure themselves to meet the needs of their populations.

For some parts of the country, in particular those with primary care homes or the early MCP vanguard sites, networks are already the norm in primary care. Some will already have strong cross-practice relationships, trust and understanding – all necessary foundations for successful collaboration. But in others, existing collaborations may not match the PCN requirements to be geographically contiguous or within the specified population size, and their service models may not match the requirements of the new network DES. Existing relationships may be strained as a result.

For areas without existing network structures, in the absence of organisational or leadership development support from NHS England, establishing PCNs will have been more challenging. PCNs with data-sharing agreements in place ready to deliver the extended hours requirements of the network specification on 1 July 2019 will receive £1.50 per head of core PCN funding backdated to 1 April 2019. This is a significant incentive to be ready 'on time', but areas with the strongest existing network structures are most likely to capitalise on the offer, while others that face the longest road to network formation might receive less funding for the start of the journey.

Getting organisational forms right will be necessary, but not sufficient, to produce high-functioning PCNs. Lessons from the Health Foundation's improvement programmes have included the importance of teams having the time and skills to design, implement and sustain new ways of working. NHS England has been keen to leave the choice of which professionals to employ, and their remits, up to individual networks, but without careful implementation the benefits of expanded clinical teams are not guaranteed. The speed of implementation means that NHS England has not yet made any comprehensive organisational development support available to networks, and there is no leadership development offer for clinical directors (who may have been selected from a relatively small pool of available and willing GPs within a network). These resources are in development, but are large omissions that need to be rectified quickly.

PCNs are being developed within a context of wider changes in NHS structures. Sustainability and Transformation Partnerships (STPs), themselves relatively new, are rapidly evolving into ICSs, and the wider architecture of the NHS is shifting quickly. These overlapping initiatives, which must eventually work seamlessly together if their ambition is to be realised, add to the complexity of implementation.

Funding

Although the majority of practices stand to benefit financially from network participation, there are concerns that this will not universally be the case. PCNs will self-determine the distribution of network funds across member practices, making it hard to generalise about the implications for individual practices. Possible risks include:

- The removal of other sources of income for practices. To cover the cost of providing core PCN funding (which must come from CCG core allocation) CCGs may remove other payments available to practices (for example, some locally incentivised schemes). If income available to individual practices from enhanced services is reduced in order for CCGs to afford to pay networks, it is possible that funding to individual practices may fall.
- Payment for the clinical director role is being made on a whole-of-England average – but GP salaries vary by locality. PCNs in areas with high salary costs may find themselves out of pocket in reimbursing clinical director time, particularly if they face a 'double whammy' of needing to employ additional GP cover to fill clinical sessions vacated by the clinical director.
- Under the ARRS, NHS England has promised to meet 70% of the costs of employing most additional staff, but networks will be expected to meet the remaining 30%. This may be more feasible for some networks than others, and therefore ability to unlock the potential benefits of additional staff may vary between networks depending on their underlying financial positions. Financial liability for the new roles, for example in the case of redundancy, will also sit with the practices in the network.

Workforce and workload

Increasing the skills mix in primary care is intended to relieve pressure on GPs. Although NHS England recognises that more GPs need to be recruited and has put plans in place to accelerate this, progress is slow. There is an additional risk that PCNs might *decrease* the amount of GP time available for direct patient-facing activity.

Clinical directors are being funded at 0.25 WTE (on the basis of an average network size of 50,000). If this would otherwise have been patient-facing time for the clinical director, then the loss to a practice of over 1 day of consulting time each week is not insignificant. New staff such as pharmacists and physiotherapists will also need to be supervised by GPs. This is both a contractual obligation and a requirement for patient safety, but supervision, particularly with new staff, is an additional draw on GP time. Perversely, areas with the fewest GPs – where there may be greatest reliance on allied health professionals – will require proportionately more of the GPs' scarce time to be spent on supervision.

There are also unanswered questions about how realistic the PCN workforce plan is. NHS England is confident that 20,000 additional allied health professionals will be available in time, but there are no data available in the public domain to allow us to model or verify these projections. NHS England has not stated how many of each type ofprofessional is expected, but the scale of the increases required will be large. In September 2018, there were only 55 physiotherapists, 99 physician associates and 428 paramedics working in general practice in England.[39]

Increasing the primary care workforce means more then just increasing headcount. Appropriate workspace must be found to accommodate the new workforce, and this is likely to be a challenge in some GP surgeries. It is not yet clear whether additional funding will be made available to ensure that practice premises are fit for their expanded purpose, but is likely to be needed.

Inequalities

The inclusion of a PCN service specification on inequality is a welcome signal that networks will be a core part of the increased efforts to tackle health inequalities, as set out in *The NHS long term plan*. But aspects of the way PCNs are currently designed risks exacerbating existing inequalities in the provision of primary care.

The Carr-Hill formula – used to weight funding for GP practices – has been criticised for not sufficiently taking the effects of deprivation into account.[40] Despite promises from NHS England and the BMA to address this, the new GP contract has not done so. As a result, the weighted component of per capita funding for PCNs is based on a formula that may systematically under-fund practices with the most need. Furthermore, some PCN payments are not weighted at all, such as the annual uplift of £1.50 per patient from CCGs for networks and funding for extended hours.

There is a commitment that in future PCNs will be able to unlock extra funding from an Investment and Impact Fund – essentially a savings scheme accessible to networks able to achieve specific targets. Examples of what these targets might be include reductions in A&E attendances and delayed discharges, but these are likely to be systematically

easier to achieve in some populations. There might be ways to mitigate this (by offering more money per unit of achievement in deprived areas, for example) but this will require action from policymakers.

It is already clear that the workforce crisis in general practice is disproportionately affecting deprived areas. Between 2008 and 2017, the number of GPs working in areas containing the most deprived quintile of the population fell by 511, while 134 additional GPs were recruited to the areas containing the most affluent quintile.[41] The ability of PCNs to deliver the services that will eventually be required of them is contingent on the successful recruitment of allied health professionals. NHS England is confident that there will be enough staff, and that this can be achieved without pulling staff away from secondary care. But even assuming that the promised 20,000 additional staff will be available to PCNs, there are no mechanisms to level the playing field for recruitment. We calculate that the number of pharmacists working in general practice is already lower in more deprived areas.[42] Although some professionals will choose to work in areas of greater need (and often greater workload) there's a risk of perpetuating a situation in which PCNs serving the most deprived populations (with the greatest health needs) are least able to recruit. Funding through the ARRS is only unlocked when staff are in post: if networks in deprived areas are systematically less able to recruit, there will be a corresponding reduction in network funding. Where a PCN doesn't use its full ARRS allowance to recruit into posts, the money will be retained by the CCG. This risks creating a perverse incentive for CCGs – themselves under significant financial pressure – to favour under-recruitment into PCNs.

Although the intention of PCNs is that working at increased scale will increase practice resilience, there is no evidence to suggest that this will necessarily or universally be the case. The number of practices closing has risen rapidly in recent years and the most affected areas have strikingly similar profiles.[43] Areas with older populations and older GPs (often rural and coastal locations where attracting new staff has been particularly difficult) have borne the brunt of practice closures, often leading to increased pressure on remaining local practices. Geographically grouping practices might allow PCNs to offer more attractive and diverse job roles and to reduce workload by streamlining back-office functions. But where the entire geography of a PCN is an area of high deprivation, increasing inter-dependence between neighbouring practices that are already vulnerable risks a domino effect, where the failure of a single practice drags others down with it.

In networks with only small pockets of deprivation within more affluent areas, or where a very small area has a defined need (such as a practice specifically providing care to homeless people), a single practice serving that group may find itself and its specific needs isolated within a larger network of practices.

Evaluation and monitoring

CCGs (or NHS England local teams, where there are CCGs without delegated primary care commissioning) are responsible for overseeing the Network Contract DES registration process and assuring that PCNs deliver against the requirements of the DES. A Primary Care Network Dashboard is being developed to support this and should be introduced from April 2020.

This monitoring should set a baseline for delivery against contractual requirements, and should provide some accountability and transparency on what the new investment has produced in terms of services delivered and, ideally, outcomes. But comprehensive evaluation of PCNs is also needed. NHS England is working on an evaluation framework, and this must include metrics to capture process as well as performance, recognising the difficulty of evaluating a complex intervention within a complex system. The opportunity to design PCNs with evaluation in mind, and to commence evaluation at the outset, has already been missed.

The formation of PCNs also raises questions regarding the regulation of general practice. The Care Quality Commission has been considering how to approach the regulation of larger providers of general practice, and the current model of inspecting and regulating general practice based on assessment of individual practices may need adjusting to reflect monitoring and regulation of services being delivered at network level, as well as the extent to which practice engagement in network activity is viewed as a marker of quality.

Where next for PCNs?

The ambition of policymakers to scale up general practice is not new, but the scale and pace of the change required to deliver PCNs is. Implementing the networks in the context of major pressures in general practice represents a risk for NHS England. For PCNs to meet the broader objectives of policymakers for primary care, they are likely to require:

- funding – which must represent a genuine increase, distributed equitably
- the promised workforce – distributed equitably
- improved recruitment and retention of GPs
- time and support for implementation, including organisational development and leadership support
- meaningful monitoring, and a support offer for struggling networks
- the ability of the wider system – including nascent ICSs and established secondary care, community care and social care providers – to work collaboratively with PCNs.

Underpinning all of this is the importance of building relationships to create meaningful collaboration. PCNs require practices to move beyond their traditional boundaries. Sharing financial resources can both generate and strain relationships, and practices will have to trust each other if sharing both staff and data is to benefit patients.

From a policymaking perspective, PCNs may have evolved partly as a pragmatic solution to the difficulties in recruiting and retaining GPs – but the networks also contain a bold vision for the future of general practice and primary care. They are simultaneously a vehicle for stabilising general practice, and one through which significant change and service improvement is expected if the pledges of *The NHS long term plan* are to be met.

For patients and the public, much will depend on what happens once the agreements are in place and contracts put in motion. If PCNs meet national expectations, patients stand to benefit from access to a wider range of services through a stabilised general practice. Better use of medications, less reliance on hospital care and improved links with other services in the community are among the prizes on offer.

There is no one version of what success for PCNs will look like – and neither is it clear what failure would entail. It is patients who will feel the effects of either scenario. PCNs are a significant change within a complex system – and general practice isn't embarking on it from a position of strength. The same need that has in part driven the formation of PCNs means that there will be little resilience left in general practice should they falter or fail.

It is vital that a safety net is created to identify and support PCNs that struggle, and to ensure that resources are distributed equitably, in proportion with deprivation and health need. The challenge of implementing PCNs must not be underestimated. Sufficient time and support must be given for genuinely collaborative relationships to develop in a part of the health system that has historically placed great value on its independence and close relationships with its patient population. Otherwise the breakneck pace of PCN implementation risks undermining the ambitions of the policy.

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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 United Lincolnshire Hospitals NHS Trust and the Sustainability and Transformation Partnership

Report to:	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 October 2019**
Subject:	**Impact of Overnight Closure of Grantham A&E**

Summary:

Following the inclusion of a reference in the 2018-19 annual report of North West Anglia NHS Foundation Trust (NWAFT), the Health Scrutiny Committee has requested more information on the impact of the overnight closure of Grantham A&E, in the first instance, on Peterborough City Hospital.

The purpose of this request for information is to inform the Committee, when it considers the consultation on the future of Grantham A&E, which is expected in 2020.

Actions Required:

(1) The Committee is requested to consider and note the information presented in the report, including the assurance from the NHS in Lincolnshire that the impact of the overnight closure of Grantham A&E has been and will continue to be managed until such time as the outcome of the public consultation on Grantham A&E is implemented.

(2) The Committee is requested to specify any additional information required to inform its response to the consultation on the future of Grantham A&E in 2020.

1. Background

Annual Report of North West Anglia NHS Foundation Trust

As reported to this Committee on 18 September, the 2018/19 annual report of North West Anglia NHS Foundation Trust (NWAFT) included the following extract (page 19):

> In addition, the Trust continues to see an increase in the number of emergency patients from Lincolnshire in the evenings, following the reduction of opening hours at Grantham Hospital A&E department, which was implemented in 2016/17.
>
> **The increase in PCH A&E Attendances from the Grantham patch is as follows:**

	Arrived by Ambulance = No	Arrived by Ambulance = Yes	Total
2017/18	832	385	**1,217**
2018/19	906	475	**1,381**

Analysis of the Figures from North West Anglia NHS Foundation Trust

There are four specific questions that need to be answered by NWAFT relating to the above figures, which have been forwarded directly to them:

(1) What is the NWAFT definition of 'the Grantham patch'? Does it refer to the area covered by South West Lincolnshire Clinical Commissioning Group? Or does it refer to certain NG postcodes only?

(2) Do the figures above apply to attendances at Peterborough City Hospital A&E between 6pm and 8am, when Grantham A&E is closed? Or do the figures apply to attendances throughout the whole day? (Noting that 'walk in' patients can choose to attend Peterborough City Hospital rather than Grantham).

(3) How many patients attending Peterborough City Hospital from 'the Grantham patch' could not have attended Grantham A&E in any event, as they required treatment which is not available at Grantham, as it is not covered by the exclusion protocol? (There is more information on the exclusion protocol below.)

(4) What was the number of patients from ‘the Grantham patch’ for the two years prior to the closure of Grantham A&E overnight?

The answers to these questions have been sought from NWAFT and will be reported to the Committee when they are available.

Overall Context

To provide overall context, NWAFT had 150,180 A&E attendances in 2017/18 and 160,915 A&E attendances in 2018/19. In 2017/18 46,395 of the attendances arrived by ambulance, with 48,100 arriving by ambulance in 2018/19. However, the 'Grantham patch' is defined; irrespective of the time of arrival; and patient need and choice, each figure quoted by NWAFT in its annual report represents less than 1% of its A&E activity in each of the two years, 2017/18 and 2018/19.

Predictions at the Time of the Grantham A&E Overnight Closure (August 2016)

When United Lincolnshire Hospitals NHS Trust (ULHT) made the decision to close Grantham A&E overnight on the grounds of patient safety, its risk assessment predicted the following:

> "Between 18:00 and 08:00 Grantham receives on average 30 attendances (85th centile = 35 attendances). Of these 24 self-present (85th centile = 28) and six (85th centile = 7) are conveyed by EMAS. Analysis suggests that based upon the self-presenters' home postcode their next nearest A&E would be as follows (based on 28 [85th centile]):
>
> | | | |
> |---|---|---|
> | Lincoln | 50% | (14) |
> | Pilgrim | 25% | (7) |
> | Peterborough | 8% | (2) |
> | Others | 17% | (5) |
>
> "The above assumes:
>
> 1) Patients do not change their self-presenting behaviours which they may do to access a local service. This would limit the impact of the other providers. The staffing model will be able to absorb some increases in hourly presentations above the current levels.
> 2) Out of hours services at Grantham does not expand its presence onsite.
> 3) Additional patients are not absorbed within urgent care services within the South West Lincolnshire CCG footprint.
>
> "Analysis suggests that based upon the patients conveyed by EMAS by their pick up postcode their next nearest A&E would be as follows (based on 7 – 85th centile):
>
> | | | |
> |---|---|---|
> | Lincoln | 50% | (3) |
> | Nottingham | 25% | (2) |
> | Leicester | 25% | (2)" |

The risk assessment included the following statement:

> "The following distribution of patients may present to alternative emergency departments:
>
> - Lincoln 6,178 = 17 additional patients per day
> - Pilgrim 2,851 = 8 additional patients per day
> - Peterborough 891 = 2 additional patients per day
> - Grimsby & Leicester 166 each = 0.5 additional patients per day
> - Leicester, Lincoln or Nottingham 1,545 = 4 additional patients per day"

Reports to ULHT Board on Impact of Closure

The Board of United Lincolnshire Hospitals NHS Trust (ULHT) received regular monitoring reports on Grantham A&E. These reports often included the statement from NWAFT on Peterborough City Hospital: "No specific concerns have been raised."

A report to the ULHT Board on 4 October 2016 stated:

> "The agreed daily monitoring process remains in place. Based on the data collected up to and including Tuesday 27 September is as follows:
>
> - Daily average attendances at Grantham remains on average c.60 per day. This demonstrates a reduction of 20 attendances a day on the average attendances (80) seen between 1 August and 16 August. This is less than 25 reduction predicted.
> - Attendances at Lincoln and Pilgrim remain within normal variation. However Lincoln has seen a spike in general attendances since 12 September. There is no evidence to suggest that this is caused by patients from the Grantham area.
> - Analysis of attendances at Lincoln A&E from the Grantham postcodes NG31, NG32 and NG33 suggest that on average an additional four people per day are attending Lincoln. Of these four, two on average arrive by ambulance. This has resulted on average of one additional admission per night at Lincoln from a Grantham resident.
> - Daily average admissions at Grantham remain at around twelve compared to a previous average admission rate of 14. This suggests a daily reduction of two admissions a day. This is less than the six predicted. There has been no increase in admissions at Lincoln or Pilgrim.
> - No material change in Out of Hours presentations.
> - No change in ambulance conveyance rates at Lincoln or Pilgrim. The data, covering a 41 day period since the change, continues to demonstrate that the expected numerical impact is lower than originally thought. However this will remain under close scrutiny."

East of England Clinical Senate Report

In November 2017, at the request of United Lincolnshire Hospitals NHS Trust, the East of England Clinical Senate published its *Review of Accident and Emergency Services at Grantham & District Hospital.* This report included the following statement:

"4.23 The panel agreed that there was insufficient evidence to form an opinion on whether the closure had had an impact on hospitals outside of the area e.g. Nottingham Queens Medical Centre, Leicester Hospitals and Peterborough City Hospital."

It should be noted that the East of England Clinical Senate's report recommended that ULHT should continue to provide an Accident and Emergency Service at Grantham and District Hospital on the current opening hours of 08.00-18.30, seven days a week until a more definitive long term urgent and emergency care plan was developed and agreed. All the recommendations in the report were adopted by ULHT. As a result of this decision, no change can take place with the opening hours at Grantham until a full public consultation has taken place and been implemented.

Emerging options for Grantham A&E are included in the *Healthy Conversation 2019* pre-consultation exercise, and a full consultation is expected in early 2020.

Context for Grantham A&E

Grantham A&E, as a type 3 A&E, operates an 'exclusion protocol', which sets out the conditions which can and cannot be treated at its A&E. This exclusion protocol pre-dates the overnight closure in August 2016 and has led to patients from the Grantham area attending other A&Es for treatment of more serious health needs, as defined in the protocol, irrespective of the overnight closure. This is attached at Appendix A for reference.

Position of the Health Scrutiny Committee

The Health Scrutiny Committee for Lincolnshire has previously recorded its opposition to the overnight closure of Grantham A&E, and it is understood that this position is unchanged.

The Committee's most recent consideration of Grantham A&E was on 15 May 2019, when the Committee considered the urgent and emergency care strand of *Healthy Conversation 2019*, which included emerging options for urgent treatment centres, including Grantham. Following the Committee's consideration, the Chairman's letter included the following statement as the Committee's initial view on the emerging option for Grantham A&E:

> "Grantham A&E has been closed between 6.30 pm and 8.00 am since August 2016 and recently passed the threshold of 1,000 nights of closure. I would again like to emphasise that this closure was originally made on a temporary basis. The Committee has previously recorded its opposition to the way this

temporary closure has become 'permanent' and its concerns over the absence of A&E facilities in the Grantham and surrounding area overnight.

"Given that the four urgent treatment centres in Lincolnshire listed above [Boston, Lincoln, Louth and Skegness] will be accessible on a 24/7 'walk in' basis, the Committee would like to see the urgent treatment centre proposed for Grantham also to be based on 24/7 'walk-in' access. As Grantham is larger than Louth or Skegness, it would seem logical and equitable for its urgent treatment centre to be accessible on a 24/7 walk-in basis. We would like to see more supporting information for the Lincolnshire NHS's preference for the urgent treatment centre at Grantham to be accessed via 111 between 8.00 pm and 8.00 am.

"The Grantham A&E department is sometimes described as type 3. The Committee is aware of the 'exclusions protocol' which lists conditions which cannot be treated at Grantham A&E. For the purposes of clarity, the Committee would like to see a list of conditions which can currently be treated in Grantham; and a list of the treatments and services which are planned for the Grantham urgent treatment centre. This would enable the Committee and members of the public to be able to compare what services are provided and would be provided in the future.

Position of the NHS in Lincolnshire

The NHS in Lincolnshire reiterates its position that Grantham A&E was closed overnight on the grounds of patient safety. This position was confirmed by the report of the East of England Clinical Senate.

The NHS in Lincolnshire has always acknowledged that there would be an impact on other A&Es arising from the overnight closure, but believes that the extent of the impact is in line with expectations; has been managed; and will continue to be managed by other A&E departments and NHS services, until the outcome of the consultation on Grantham A&E.

Some patients from Lincolnshire have always accessed Peterborough City Hospital even prior to the changes at Grantham.

Lincolnshire's NHS has;

- considered demographic growth at South Holland of 1% and South Kesteven populations 1.1% year on year - http://www.research-lincs.org.uk/idoc-Population-Trends-Lincolnshire.aspx)
- noted that there has been a general trend of increases in A&E attendances locally and nationally.
- noted that there has been an increase in the use of NWAFT A&E from the Grantham area which is above population growth and this is more evident in the hours Grantham A&E is closed; however the trend line is comparable to the increase when Grantham A&E is open.
- noted that when Grantham A&E is closed the mode of arrival at NWAFT is pointing to walk-ins / self referrals as the main driver for A&E activity increases.

- agrees that there has been increased activity at NWAFT, although it is not as high as the level of activity that has decreased from Grantham. Much of the other activity has gone to Lincoln County Hospital or Pilgrim Hospital Boston.

Given population increases, Lincolnshire NHS has concluded this is not unusual and could be considered within the parameters of increases seen generally in A&E nationally.

2. Consultation

This is not a direct consultation item. On 15 May 2019 the Committee considered the emerging option for Grantham A&E, and submitted its initial views on this (set out above). Full public consultation on Grantham A&E is expected in 2020 and the Committee can make a full response to this.

3. Conclusion

The Health Scrutiny Committee is requested to consider and note the information presented in the report, including any additional information made available at the meeting from NWAFT. This report includes an assurance from the NHS in Lincolnshire that the impact of the overnight closure of Grantham A&E has been and will continue to be managed until such time as the outcome of the public consultation on Grantham A&E is implemented.

The Committee is requested to specify any additional information required to inform its response to the consultation on the future of Grantham A&E in 2020.

4. Appendices

These are listed below and attached at the end of the report: -

Appendix A	Grantham and District Hospital – Exclusion Protocol – Emergency Care Centre / A&E (United Lincolnshire Hospitals NHS Trust)

5. Background Papers

No background papers within the meaning of Part VA of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Sarah Furley, Lincolnshire STP Programme Director, Lincolnshire Sustainability and Transformation Partnership

APPENDIX A

United Lincolnshire Hospitals NHS
NHS Trust

GRANTHAM AND DISTRICT HOSPITAL

EXCLUSION PROTOCOL

Emergency Care Centre / A&E

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital A&E department, and Emergency Assessment Unit

The following Specific Patient Groups

- Fast Positive Stroke
- ST MI
- Gastro-intestinal haemorrhage (fresh blood or melaena).
- Severe abdominal pain and acute abdomen (refer patient directly to Lincoln County.)
- A female of childbearing age with lower abdominal pain.
- A male under 30 years of age with testicular pain.
- A patient with suspected AAA or ischaemic limb needs admission to the on-call Vascular Unit (Pilgrim Hospital)
- All Obstetric and Gynaecological patients except those expecting a normal delivery in the Midwife Managed Unit.
- Head injury – Glasgow Coma Score **< 15**
- Neutropenic sepsis
- Patients requiring dialysis
- Patients with renal transplants
- Ophthalmological emergencies (e.g. acute glaucoma, Trauma)

Patients with Major Injuries

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

Patients with Significant Mechanism of Injury who need Admission or Assessment

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

Paediatric Exclusions

Ambulances / GP's SHOULD NOT bring / send these patients to Grantham and District Hospital A&E department, and Emergency Assessment Unit

- Children requiring Paediatric assessment / Review
- Children with severe Breathing difficulties
- Children with severe asthma
- Children with Severe Bronchiolitis
- Children with biphases stridor
- Children with Severe Croup
- Children with DKA
- Children with Status epilepsy
- Children who have self-harmed
- Children requiring Mental health assessment

ADMISSION PROTOCOL

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

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

For example:

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

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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 Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 October 2019**
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. Since May 2019, the Committee's focus has been the consideration of cases for change and emerging options as part of the *Healthy Conversation 2019* engagement exercise, which is due to close on 31 October 2019.

Actions Required

To review, consider and comment on the work programme set out in the report.

1. Today's Work Programme

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

16 October 2019 – 10 am	
Item	*Contributor*
East Midlands Ambulance Service NHS Trust - Lincolnshire Division Update	Mike Naylor, Director of Finance, East Midlands Ambulance Service NHS Trust Sue Cousland, General Manager – Lincolnshire Division - East Midlands Ambulance Service NHS Trust
Healthy Conversation 2019 – Haematology and Oncology, and the Cancer Strategy for Lincolnshire	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group

16 October 2019 – 10 am	
Item	*Contributor*
Community Pain Management Service	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group
Integrated Community Care	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group
Impact of Overnight Closure of Grantham A&E	Sarah Furley, Programme Director, Lincolnshire Sustainability and Transformation Partnership Mark Brassington, Chief Operating Officer, United Lincolnshire Hospitals NHS Trust

Healthy Conversation 2019

Since May 2019, the focus for the Committee has been the consideration of the cases for change and emerging options, as part of the *Healthy Conversation 2019* engagement exercise, which was launched in March 2019 and will continue until 31 October 2019. To date the Committee has considered the following elements (with acute services review items highlighted in bold): -

- **Urgent and Emergency Care (15 May)**
- **Women's and Children's Services (12 June)**
- **Breast Services (12 June)**
- **Stroke Services (12 June)**
- Mental Health, Learning Disability and Autism Services (10 July)
- **Grantham Medical Beds (18 September)**
- **Trauma and Orthopaedics (18 September)**
- **General Surgery Services (18 September)**

There are two further items on today's agenda:

- **Haematology and Oncology**
- Integrated Community Care

Role of the Committee

The Committee's role at this stage has been to provide initial comments on the emerging options, without prejudging its response to the formal consultation on the acute services review items, which is expected early in 2020.

2. Future Work Programme

Planned items for the Health Scrutiny Committee for Lincolnshire are set out below. Currently there are no items programmed for 2020, but the Committee may wish to consider items for these meetings, bearing in mind that time may need to be set aside for consultation items arising from the acute services review.

13 November 2019 – 10 am	
Item	*Contributor*
United Lincolnshire Hospitals NHS Trust: Care Quality Commission Update	Senior Management Representatives from United Lincolnshire Hospitals NHS Trust
Community Pharmacy Contractual Framework (2019/20 - 2023/24)	Contributors to be confirmed
General Dental Services and Orthodontic Services Update	Contributors to be confirmed
Mental Health Update: (a) Older Adult Services (b) Child and Adolescent Mental Health Services (To be confirmed)	Jane Marshall, Director of Strategy, Lincolnshire Partnership NHS Foundation Trust

18 December 2019 – 10 am	
Item	*Contributor*
United Lincolnshire Hospitals NHS Trust: Children and Young People Services Update	Senior Management Representatives from United Lincolnshire Hospitals NHS Trust
NHS Long Term Plan – Local Implementation	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Non-Emergency Patient Transport	Representatives from Lincolnshire West Clinical Commissioning Group
Annual Report of the Director of Public Health	Derek Ward, Director of Public Health, Lincolnshire County Council

22 January 2020 – 10 am	
Item	*Contributor*

19 February 2020 – 10 am	
Item	*Contributor*

25 March 2020 – 10 am	
Item	*Contributor*

Items to be Programmed

- Developer and Planning Contributions for NHS Provision
- CCG Role in Prevention
- Lincolnshire Acute Services Review – Formal Consultation Elements: -
  - Breast Services
  - General Surgery Services
  - Haematology and Oncology Services
  - Medical Services / Acute Medicine (Grantham and District Hospital)
  - Stroke Services
  - Trauma and Orthopaedic Services
  - Urgent and Emergency Care Services
  - Women's and Children's Services
- Lincoln Medical School – Impact on NHS in Lincolnshire

3. Previous Committee Activity

Appendix A to the report sets out the previous work undertaken by the Committee in a table format.

4. 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

	2017						2018										2019										2020			
KEY ✓ Substantive Item α Chairman's Announcement Planned Item	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	23 Jan	20 Feb	20 Mar	17 Apr	15 May	12 June	10 July	18 Sept	16 Oct	13 Nov	18 Dec	22 Jan	19 Feb	25 Mar	22 Apr
Meeting Length - Minutes	170	225	185	170	205	230	276	280	270	230	244	233	188	280	160	275	185	200	150	265	130	130	220	244	245							
Cancer Care																																
General Provision																✓																
Head and Neck Cancers														α					α				α									
Care Quality Commission																																
General																			α													
Children's Social Care																								α								
Clinical Commissioning Groups																																
Annual Assessment														α																		
Lincolnshire East																✓																
Lincolnshire West															✓																	
South Lincolnshire																	✓															
South West Lincolnshire																	✓															
Community Maternity Hubs								α																								
Community Pain Management												α								α												
Dental Services							✓		α								α	α		✓												
GPs and Primary Care:																																
Boston – The Sidings																					α											
Cleveland Health Centre Gainsborough																							α									
Extended GP Opening Hours								α			α				α																	
GP Provision Overall			α		α																			✓								
Lincoln GP Surgeries		α		α																												
Lincoln Walk-in Centre		✓	α	✓		✓		✓			✓																						
Louth GP Surgeries		α	α																													
Out of Hours Service														α																		
Skellingthorpe Health Centre																						α	α	✓								
Sleaford Medical Group									α																							
Spalding GP Provision														α																		
Grantham Minor Injuries Service												α	✓	α																		

	2017						2018											2019											2020			
KEY ✓ Substantive Item α Chairman's Announcement Planned Item	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	23 Jan	20 Feb	20 Mar	17 Apr	15 May	12 June	10 July	18 Sept	16 Oct	13 Nov	18 Dec	22 Jan	19 Feb	25 Mar	22 Apr
Health and Wellbeing Board:																															
Annual Report												α																			
Joint Health and Wellbeing Strategy		✓						✓																							
Pharmaceutical Needs Assessment					✓		✓																								
Health Scrutiny Committee Role	✓																														
Healthwatch Lincolnshire											α		α		α									α							
Lincolnshire Community Health Services NHS Trust																															
Big Conversation																								α							
Care Quality Commission													α		α																
Healthcare Awards																								α							
Learning Disability Specialist Care				✓									✓																		
Lincolnshire Sustainability & Transformation Partnership / Healthy Conversation 2019																															
General / Strategic Items				✓			✓				α	✓	α	✓			✓		✓	✓		✓		α	✓						
Breast Services																							✓								
General Surgery																									✓						
GP Forward View										✓																					
Grantham Acute Medicine																									✓						
Haematology																															
Integrated Community Care										✓						✓															
Mental Health								✓							✓	α								✓							
NHS Long Term Plan																α	✓	✓	✓					α							
Oncology																															
Operational Efficiency									✓																						
Stroke Services																							✓								
Trauma and Orthopaedics																									✓						
Urgent and Emergency Care									✓							✓						✓									
Women and Children Services																							✓								

	2017						2018											2019											2020			
KEY ✓ Substantive Item α Chairman's Announcement Planned Item	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	23 Jan	20 Feb	20 Mar	17 Apr	15 May	12 June	10 July	18 Sept	16 Oct	13 Nov	18 Dec	22 Jan	19 Feb	25 Mar	22 Apr
Lincolnshire Partnership NHS Foundation Trust:																															
General Update / CQC		✓																α													
Older Adults Services																					✓										
Psychiatric Clinical Decisions Unit							α																								
Lincolnshire Reablement & Assessment Service																	α														
Local Government Elections																			α												
Louth County Hospital														α	✓		α														
Northern Lincolnshire and Goole NHS Foundation Trust			α												α			α													
North West Anglia NHS Foundation Trust							✓									α				✓												
Organisational Developments:																															
CCG Joint Working Arrangements													✓	α				α			α	✓									
Integrated Care Provider Contract														α	✓																
National Centre for Rural Care													α					α													
NHSE and NHSI Joint Working												α						α													
Lincoln Medical School			α														α														
Patient Transport:																															
Ambulance Commissioning			✓																												
East Midlands Ambulance Service			✓		α					✓	α	α	α	✓		α	α				✓										
Non-Emergency Patient Transport						✓	α	✓	✓	✓		✓	α	✓	α	α	✓	✓	✓	✓			✓									
Sleaford Ambulance & Fire Station											α		α																		
Public Health:																															
Child Obesity												α	α																		
Director of Public Health Report												✓																			
Immunisation					✓																										
Influenza Vaccination Programme																	α														
Pharmacy			α																												
Renal Dialysis Services														✓								α									
Quality Accounts	✓								✓											✓		α	α								

	2017						2018											2019											2020			
KEY ✓ Substantive Item α Chairman's Announcement Planned Item	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	23 Jan	20 Feb	20 Mar	17 Apr	15 May	12 June	10 July	18 Sept	16 Oct	13 Nov	18 Dec	22 Jan	19 Feb	25 Mar	22 Apr
United Lincolnshire Hospitals NHS Trust:																															
A&E Funding		α																													
Introduction	✓																														
Care Quality Commission		✓										α	α	✓				✓	α	✓				✓							
Children/Young People Services											✓	✓	✓	✓		✓	α	✓		✓				✓							
Financial Special Measures			α		✓					✓																					
Five Year Strategy																						α									
Grantham A&E			✓				✓	α						α	α	α		✓	✓		α										
Orthopaedics and Trauma												α		α					α												
Stroke Services																		α													
Winter Resilience					α	✓	α	α			✓				✓										✓						