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, 13 July 2022 at 10.00 am in the Council Chamber, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin, T J N Smith, Dr M E Thompson and R Wootten

District Councillors: K Chalmers (Boston Borough Council), J Loffhagen (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council), G P Scalese (South Holland District Council), M A Whittington (South Kesteven District Council) and Mrs A White (West Lindsey District Council)

Healthwatch Lincolnshire: 1 Vacancy

AGENDA

Item	Title	Pages
5	**Cancer Programme Update and Lincolnshire Living with Cancer Programme** *(To receive a report from the Lincolnshire Integrated Care System (ICS), which provides the Committee with an update on the cancer programme and the Lincolnshire living with cancer programme. Clair Raybould, Director for System Delivery, Lincolnshire Integrated Care Board (ICB) Sarah-Jane Gray, Deputy Cancer Programme Manager, Lincolnshire ICB, Kathie McPeake, Macmillan Living with Cancer Programme Manager, Lincolnshire ICB, and Colin Farquharson, Medical Director (ICS Senior Responsible Officer for Cancer – ULHT will be in attendance for this item))*	23 - 44
6	**The Lincolnshire People Board Strategy for Recruiting and Retaining Talent** *(To receive a report from the Lincolnshire People Board, which advises the Committee of the current challenges and opportunities to deliver on the People Plan for Lincolnshire. Maz Fosh, Chief Executive, Lincolnshire Community Health Services NHS Trust and Ceri Lennon, Senior Responsible Officer for the Lincolnshire People Board will be in attendance for this item)*	45 - 122
7	**Humber Acute Services Programme - Update** *(To receive a report from Simon Evans, Health Scrutiny Officer, which provides an update on the progress of the Humber Acute Services Programme. Ivan McConnell, Programme Director, Humber Acute Programme and Linsay Cunningham, Assistant Director Communications and Engagement, Humber Acute Programme will be in attendance for this item)*	123 - 144
8	**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 forthcoming work programme)*	145 - 148

Debbie Barnes OBE
Chief Executive
5 July 2022

Please note: This meeting will be broadcast live on the internet and access can be sought by accessing Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 13th July, 2022, 10.00 am (moderngov.co.uk)

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
15 JUNE 2022

PRESENT:

Lincolnshire County Council

Councillors C S Macey, L Wootten, M G Allan, R J Cleaver, S R Parkin, T J N Smith and R Wootten.

Lincolnshire District Councils

Councillors K Chalmers (Boston Borough Council), J Loffhagen (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), G P Scalese (South Holland District Council), Mrs A White (West Lindsey District Council) and K Rice-Oxley (South Kesteven District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Sarah Brinkworth (Planned Programme Lead, Lincolnshire Clinical Commissioning Group) Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Lucy Gavens (Consultant - Public Health) and Clair Raybould (Director of Operations, NHS Lincolnshire Clinical Commissioning Group).

The following representatives joined the meeting remotely, via Teams:

Peter Burnett (System Strategy and Planning Director, Lincolnshire NHS), Alison Christie (Programme Manager, Strategy and Development), Katrina Cope (Senior Democratic Services Officer), Tom Diamond (Associate Director of Strategy, Lincolnshire Clinical Commissioning Group), Simon Evans (Health Scrutiny Officer), Lucy Gavens (Consultant - Public Health), Jane Green (Primary Care Senior Contract Manager, NHS England / NHS Improvement), Rose Lynch (Commissioning Manager- Primary Care Dental Services), Sarah Brinkworth (Planned Programme Lead, Lincolnshire Clinical Commissioning Group), Kenny Hume (Lincolnshire Local Dental Network Chair), Claire Lloyd (Clinical Transformation Lead, United Lincolnshire Hospitals NHS Trust and Project Lead for Community Diagnostic Centres), Adam Morby (Regional Chief Dentist for the Midlands), Jasmine Murphy (Consultant in Dental Public Health), Clair Raybould (Director of Operations, NHS Lincolnshire Clinical Commissioning Group) and Sandra Williamson (Chief Operating Officer, NHS Lincolnshire Clinical Commissioning Group).

County Councillor C Matthews (Executive Support Councillor NHs Liaison, Community Engagement, Registration and Coroners) attended the meeting as an observer, via Teams. observers.

1 ELECTION OF CHAIRMAN

RESOLVED

That Councillor C S Macey be elected as the Chairman of the Health Scrutiny Committee for Lincolnshire for 2022/23.

COUNCILLOR C S MACEY IN THE CHAIR

2 ELECTION OF VICE-CHAIRMAN

RESOLVED

That Councillor L Wootten be elected as the Vice-Chairman of the Health Scrutiny Committee for Lincolnshire for 2022/23.

3 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors Dr M E Thompson, L Hagues (North Kesteven District Council) and M A Whittington (South Kesteven District Council).

It was noted that Councillor Kaffy Rice-Oxley (South Kesteven District Council) was the replacement member for Councillor M A Whittington (South Kesteven District Council) for this meeting only.

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

4 DECLARATIONS OF MEMBERS' INTEREST

No declaration of members' interest were received at this stage of the proceedings.

5 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 18 MAY 2022

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 18 May 2022 be agreed and signed by the Chairman as a correct record.

6 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcement circulated with the agenda, the Chairman brought to the Committee's attention the supplementary announcements circulated on 14 June 2022. The supplementary announcements referred to:

- Healthwatch Lincolnshire Representative change due to Dr B Wookey retiring as a trustee of Healthwatch Lincolnshire;
- Lakeside Healthcare, Stamford – published report by the Care Quality Commission (CQC) on 1 June 2022 on Lakeside Healthcare, Stamford;
- Non-Emergency Patient Transport in Lincolnshire Update; and
- Specialist Mental Health Support for GP Surgeries.

During discussion, reference was made to the NHS funding for two new mental health practitioners for GP practices in a local area. It was confirmed that the two positions would apply to a Primary Care Network.

The Chairman on behalf of the Committee extended his thanks to Dr B Wookey for his contribution to the Committee over the years and wished him all the very best in his retirement.

RESOLVED

That the Supplementary announcements circulated on 14 June 2022 and the Chairman's announcements as detailed on page 13 of the report pack be noted.

7 RECONFIGURATION OF FOUR NHS SERVICES IN LINCOLNSHIRE: ORTHOPAEDICS; URGENT AND EMERGENCY CARE; ACUTE MEDICINE; AND STROKE SERVICES

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which invited the Committee to consider the Board of Lincolnshire Clinical Commissioning Group's (CCG) decision, and its rationale for making the decision in relation to the reconfiguration of four NHS Services in Lincolnshire: Orthopaedics; Urgent and Emergency Care; Acute Medicine and Stroke Services.

The Chairman highlighted to the Committee the motion agreed at the South Kesteven District Council Extraordinary Council meeting held on 14 June 2022 concerning Grantham and District Hospital. A copy of which had been circulated to all members of the Committee prior to the meeting.

The Chairman invited the following presenters from the NHS Lincolnshire Clinical Commissioning Group: Pete Burnett, System Strategy and Planning Director and Tom Diamond, Associate Director of Strategy, to remotely present the item to the Committee.

In guiding the Committee through the report, reference was made to: the decision of Lincolnshire Clinical Commissioning Group, which approved changes to the four NHS Services

in Lincolnshire; the consultation process; feedback received; assessment by the Clinical Directorate and NHS Lincolnshire Clinical Policies Sub-Group; endorsement by the Quality and Patient Experience Committee; extensive clinical engagement in Lincolnshire and the East Midlands Clinical Senate; and support regionally and nationally for the Board's decision being in-line with best practice.

During consideration of the item, some of the following comments were raised:

- Some opposition was received to the proposed changes for Grantham and District Hospital A & E becoming a 24/7 Urgent Treatment Centre (UTC); and to the fact that 700 people per year would now have to travel to Lincoln. One member provided details of their personal experience of having to waiting thirteen hours in Lincoln County Hospital before being admitted. The Committee was appraised of the situation concerning Grantham A & E and to the services provided by the UTC and to the fact that the services to be provided at Grantham and District Hospital's UTC would be enhanced, compared to other UTC's;
- Some concern was expressed regarding transport plans and who would be responsible for these. A request was made for a copy of the completed document to be shared with the Committee. The Committee noted that engagement was taking place with the county council in this regard, as was looking at voluntary car services and increasing the commissioning capacity of the East Midlands Ambulance Service (EMAS). It was also highlighted that with the rising cost of fuel; some patients would not be able to afford to attend appointments;
- One member queried who the service provider would be for the Grantham UTC. The Committee was advised that the aim was to have an integrated model , including United Lincolnshire NHS Hospitals Trust;
- Problems encountered across all major sites in Lincolnshire when accessing services. It was reported that patients were willing to travel for specialised services and that best practice was to centralise services, as this provided better outcomes and better recovery for patients;
- Staffing shortages. It was noted that there were staffing shortages nationally as well as locally, and that Lincolnshire was taking steps with the Lincoln Medical School, apprenticeships and growing existing staff to help bridge some of the gaps in Lincolnshire;
- Some concern was expressed to ambulance poor response times in Lincolnshire, and to the fact that the Fire Service was being asked to do more in this regard. It was highlighted that joint working arrangements happened in other areas around the country. It was highlighted further that the ambulance service had improved, but the current level of demand was beyond anything ever seen before. Some concern was also raised that (EMAS) were not meeting their Key Performance Indicators (KPIs);
- The need for lifestyle changes to alleviate pressures on the NHS and that more preventative measures needed to be considered;
- Assurance was sought that access to Grantham UTC would be 24/7, when other UTC sites in the county were having to close their doors, for example, due to staff shortages. Reassurance was given that the integrated service being provided at

Grantham would ensure 24/7 opening, as it was not just a community provider. One member stressed that 24/7 healthcare was vital at Grantham;

- The need for a Communication Strategy to ensure that the public were aware of the changes and the conditions that could be treated at the Grantham UTC due to the changes;
- Whether potential housing growth had been factored into the service changes. Reassurance was given that consideration had been taken to future growth. The Committee was advised that every year a detailed plan was compiled concerning service modelling and that the figures provided were nowhere near a critical mass situation;
- The usefulness of UTCs in front of A & E departments and whether they were actually making a difference. Unfortunately, the presenter was unable to comment, as this was a matter for United Lincolnshire NHS Hospitals Trust (ULHT);
- Extended waiting times in A & E departments, it was felt that some of the congestion could be prevented if GPs continued to make contact with specific specialist units, if some action was required;
- Some concern was expressed that despite most respondents living nearest to Grantham Hospital disagreeing with the proposal for Grantham becoming a UTC; the same with those living near to Boston disagreeing with the stroke proposal, the two changes were supported across Lincolnshire as a whole. Clarification was sought as to what was being done to mitigate this; and a question was asked as to whether feedback had been worthwhile. The Committee was advised there had been support for both proposals; and confirmation was given that views were considered and not dismissed and that this could be demonstrated in the evidenced feedback provided; and that there had been overwhelming clinical support for the four proposals and that this had informed the Board's decision;
- Some clarity was sought regarding stroke services, as the report had stated that a third of staff disagreed with the plan for centralisation. It was noted that people locally were concerned what the changes to services would mean for them. It was noted further that ULHT would be having ongoing discussions with staff, as part of the implementation process;
- Clarity was sought regarding the impact of any referral by the Committee to the Secretary of State for Health and Social Care of any proposal, on the overall implementation of the changes. The Committee was advised that the understanding was that the implementation process would not go ahead until after a decision from the Secretary of State had been received. It was highlighted that the delay caused because of this would be detrimental to the health of the population of Lincolnshire. The Committee were reminded of the overwhelming clinical support for the proposal and that referral would be going against this expertise. It was highlighted that the permanent service changes would provide a better future, which would mean staff would be attracted to the area which would help with recruitment, and that there would be certainty in the provision of services. This, however, would not be possible, if there was a Secretary of State action pending. Some members expressed concern regarding the impact a referral would have for Lincolnshire; and that the evidence

provided indicated that a referral might not be successful. Some support was shown for referral for some elements of the decision by the CCG Board; and

- Some clarity was sought regarding the status of Grantham UTC, and whether Grantham would be a 'UTC plus'. The Committee was advised that as part of the modelling prior to consultation, the East Midlands Clinical Senate would not accept the term 'UTC plus', as this was not the accepted terminology. It was however reported that the Grantham UTC was planned to have a stronger clinical base than other UTCs, for example with middle grade A & E doctors, GPs and nurses and the ability to admit patients into hospital, to the 70 community beds to support frail and elderly patients. The level of provision would be higher than other UTCs in the country and that this would provide an excellent service for the population of Lincolnshire.

As a result of the comments raised by the Committee, the Chairman advised the Committee of the options available to them in this regard, to continue to monitor the implementation arrangements; refer all four proposals to the Secretary of State; or just refer one or two elements from the proposals.

It was proposed and seconded that:

(1) To record the Committee's disappointment with the CCG Board's decision on Orthopaedics; Urgent and Emergency Care; and Stroke Services, as these reconfigurations had not been supported by the Committee in its response to the consultation exercise.

(2) To seek further reports on the implementation arrangements for the four NHS services, with particular emphasis on the arrangements for:

(a) staffing, including recruitment and retention;

(b) transport and travel arrangements, including:
- any new local discretions allowed as part of the national non-emergency patient transport arrangements;
- the extent to which the £1m contingency allocated to cover the additional demands on the East Midlands Ambulance Service, and the non-emergency patient service is required;

(c) in relation to Stroke Services:
- any details on securing the capital investment of £7.5 million to increase capacity at Lincoln County Hospital;
- any details on how increased stroke patient numbers are managed by Peterborough City Hospital and Queen Elizabeth's Hospital, King's Lynn;

(d) In relation to the Grantham Urgent Treatment Centre:

- confirmation of the services due to be provided at the Urgent Treatment Centre.

An Amendment was Proposed and Seconded that:

The decision for the accident and emergency department at Grantham and District Hospital becoming an Urgent Treatment Centre be referred to the Secretary of State on the grounds that the decision was based on incorrect population projections.

Upon the Amendment being put to the being put to the vote, it was declared lost.

Upon the substantive motion being put to the vote, it was unanimously carried.

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

RESOLVED

1. To record the Committee's disappointment with the CCG Board's decision on Orthopaedics; Urgent and Emergency Care; and Stroke Services, as these reconfigurations had not been supported by the Committee in its response to the consultation exercise.

2. To seek further reports on the implementation arrangements for the four NHS services, with particular emphasis on the arrangements for:

   (a) staffing, including recruitment and retention;

   (b) transport and travel arrangements, including:
   - any new local discretions allowed as part of the national non-emergency patient transport arrangements;
   - the extent to which the £1m contingency allocated to cover the additional demands on the East Midlands Ambulance Service, and the non-emergency patient service is required;

   (c) in relation to Stroke Services:
   - any details on securing the capital investment of £7.5 million to increase capacity at Lincoln County Hospital;
   - any details on how increased stroke patient numbers are managed by Peterborough City Hospital and Queen Elizabeth's Hospital, King's Lynn;

   (d) In relation to the Grantham Urgent Treatment Centre:
   - confirmation of the services due to be provided at the Urgent Treatment Centre.

8 ENGAGEMENT BY THE NHS IN LINCOLNSHIRE ON LINCOLNSHIRE'S SECOND COMMUNITY DIAGNOSTIC CENTRE

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which invited the Committee to consider a presentation, on community diagnostic centres (CDC) in Lincolnshire, and to express a preference for one of the three options suggested for a second diagnostic centre.

The Chairman welcomed to the meeting the following presenters: Sarah Brinkworth, System Planned Care Programme Lead, NHS Lincolnshire Clinical Commissioning Group, Clair Raybould, Director of Operations, NHS Lincolnshire Clinical Commissioning Group and Claire Lloyd, Clinical Transformation Lead, United Lincolnshire Hospitals NHS Trust and Project Lead for Diagnostic Centres (who was attending via Teams), to present the item to the Committee.

The presentation referred to:

- The background behind CDCs,
- The aims of CDCs;
- The minimum requirements for a CDC;
- Other considerations, which included value for money, longer term impacts, speed of deployment, co-ordination with local and regional priorities and staff and patient engagement;
- National guidance for CDCs;
- Different models of CDCs, which included a standard model, large model and a hub and spoke model;
- Pathways being considered to be included in CDCs;
- Work to date and expansion plans;
- CDC engagement, for phase 1 and 2; and
- Next steps, which advised that it was proposed to expand the Grantham CDC, develop a second CDC and consider the opportunities for future developments for CDCs.

During consideration of this item, the Committee made some of the following comments:

- Some members of the Committee expressed their preference for a large CDC at Louth County Hospital as a hub, with spokes located at Skegness and Mablethorpe. The Committee was advised that North East Lincolnshire CCG was exploring the option of having a CDC in Grimsby. It was felt more needed to be known about this proposal, to see the impact it would have on residents in the north of the county;
- Acceptance of CDCs. Some concern was raised regarding the staffing of the centres when there was already a shortage of staff. It was noted that CDCs provided a new model of care, which offered the opportunity to grow your own, to help mitigate staff shortages;

- Referral to CDCs. The Committee was advised that currently referral was by GP. It was highlighted that it was proposed to expand to health professionals and then it was hoped to start self-referrals. One member enquired whether there was any delay in referrals. The Committee was advised that there were variations in referrals, as some GP practices used pathways in different ways;
- Support was extended to the expansion of the Grantham CDC and to the expansion of provision to a second site. Further clarity was sought as to whether there would be a third site or more in Lincolnshire. The Committee noted that a second site would help with inequalities along the east coast and that it was not definite that funding would be available for other sites at this point;
- The importance of ensuring that the public were aware of the CDCs;
- One member enquired how cover was proposed across the whole of the county, and whether bordering counties had been contacted in this regard. It was reported that the opportunity for the Grantham CDC had been developed during the Covid-19 pandemic, as there was a suitable site immediately available to house a CDC; and that options were now being considered for a second CDC, and that feedback for the phase 2 engagement would help finalise the location for the second CDC;
- Connectivity at CDCs. The Committee was advised that the digital ambition was for the service to be digitalised so that results could be seen on the NHS App; and
- Support was also extended for a community diagnostic centre in Boston as a hub, with spokes at Skegness and Mablethorpe and possibly Spalding.

Upon the Chairman seeking the Committees preference for either the Louth or the Boston option, the Boston option was identified as being the preferred option for the Committee.

RESOLVED

1. That the presentation on Community Diagnostic Centres in Lincolnshire be noted.

2. That the Committee's preferred location of the second Community Diagnostic Centre be option (c) a Community Diagnostic Centre in Boston as a hub, with spokes at Skegness, Mablethorpe and possibly Spalding.

3. That depending on the availability of central NHS funding, plans for further Community Diagnostic Centres being developed in Lincolnshire be noted.

9 NHS DENTAL SERVICES IN LINCOLNSHIRE

Consideration was given to a report from NHS England and NHS Improvement, which invited the Committee to consider and comment on NHS Dental Services in Lincolnshire.

The Chairman invited the following representatives from NHS England and NHS Improvement: Rose Lynch, Senior Commissioning Manager, Jane Green, Commissioning Manager, Adam Morby, Regional Chief Dentist for the Midlands, Kenny Hume, Lincolnshire Local Dental Network Chair, Jasmine Murphy, Consultant in Dental Public Health; and from

NHS Lincolnshire Clinical Commissioning Group, Sandra Williamson, Chief Operating Officer to remotely, present the item to the Committee.

Lucy Gavens, Consultant Public Health, was also in attendance for this item.

The presentation referred to:

- The national and local challenges dentistry was facing;
- The locations of services in Lincolnshire;
- The location of local dental surgeries in the county, accessible by car in rush hour and by public transport (not all services were accessible by public transport);
- Details of the 2019 oral health survey of 5 year old children, which showed a wide variation in both the prevalence and severity of dental decay among young children across Lincolnshire. Areas highlighted as being significantly worse that the England average were Boston and the East Midlands; and
- Water Fluoridation. It was highlighted that fluoridation was an effective and safe public health measure to reduce the frequency and severity of dental decay, and narrow oral health inequalities. It was noted that water fluoridation was lacking on the East Coast. It was noted further that in the next year or so Anglian Water was planning changes to the infrastructure of its water supply, which would lead to the removal of fluoride from the water supply for those parts of the county which currently received fluoridated water.

In conclusion, the Committee were advised of future opportunities and solutions for Lincolnshire which included: the rapid oral health needs assessment being undertaken for the County Council to better understand some of the impacts of the pandemic; the introduction of Integrated Care Systems from 1 July 2022; the 'Golden Hello Scheme' a scheme to encourage practitioners to work within NHS dentistry; the NHS Communications Team to share intelligence on local concerns; the role of Local Dental Network Chairs; and the Secondary Care - Getting it right first time oral surgery hospital dentistry review.

During consideration of this item, the Committee made some of the following comments:

- Concern was expressed to the lack of NHS dentistry provision in Lincolnshire and the impact of this for the east of the county. The Committee was advised that there had been a contract issue with the government, which would be addressed, concerning NHS/private distribution, which was a major problem as each provider was independent. As with other areas of the NHS it was highlighted there was a shortage of practitioners across the county. It was also highlighted that the ongoing impact of the Covid-19 pandemic had considerably impacted dental services and the availability of NHS dental care. The Committee noted that NHS England/Improvement were looking into ways to encourage practitioners to work within dentistry;
- Concern was also expressed to the length of time people were waiting to see a dentist;

(Note Councillor S R Parkin left the meeting at 1.00pm).

- Some concern was expressed regarding the removal of fluoridation. It was felt that fluoridation needed to be retained and supported;
- The impact poor oral health had on a person's wellbeing;
- A question was asked whether children were dependent on their parents arranging for them to see a dentist. Confirmation was given that it was the responsibility of parents/carers to take children and young people to the dentist. It was highlighted that there were several programmes for children to encourage good habits in early years settings; and that toothbrushes and toothpaste were being provided to families living in Boston when their child reached 6-8 weeks of age. Additionally, the Lincolnshire Smiles Programme was delivering a supervised toothbrushing programme in early years and primary education settings to prevent decay and establish good life-long oral health behaviours. Further details of the activities across Lincolnshire led by the Public Health Team were detailed in Appendix 5 on page 385 of the report pack ;
- Whether the oral health needs assessment had access to dental records. It was confirmed that there had been access to some dental records;
- One question asked was how many people were not receiving the care they needed. The Committee was advised that this data was not collated or reported on;
- Dentistry provision for pregnant women, one member enquired whether pregnant women were receiving the care they needed. Reassurance was given that where there was a clinical need, patients were prioritised and that pregnant women fell into that category. One member's personal experience highlighted that this had not been the case. The Committee was advised that there was a specific programme for Boston and that practitioners should be conveying the said health messages;
- The cost of private dentistry;
- The responsibility of all to look after their oral health;
- The Department of Work and Pensions changes to benefits, which included access to dentistry and its effect on dental services. Presenters were not aware of the changes and thanks were extended for drawing their attention to the matter;
- One member enquired what the main reason had been for the lack of interest in securing a new provider for dental services in Mablethorpe and what was being done to make it a more attractive option. The Committee noted that following a procurement exercise in 2019, NHSE/I had been unable to secure a new provider of NHS Dental Services in the Mablethorpe areas. As a result, NHSE/I had commissioned Urgent NHS Dental care sessions until March 2023, whilst longer term commissioning intentions were finalised. The Committee was advised that it was planned that general dental service would be in place for 2022/23 within Mablethorpe;
- Further information was sought as to the areas that had seen NHS contracts handed back and the impact this had seen or will have on patients. The Committee was advised that if a practice was to terminate its contract, the areas of need would be looked at and activity would be dispersed, if there was no expression of interest.

The Chairman on behalf of the Committee extended thanks to the presenters.

RESOLVED

1. That the information presented by NHS England and NHS Improvement (Midlands) on NHS Dental Services in Lincolnshire be noted.

2. That a further update on NHS dental services in Lincolnshire be received in six months' time.

10 LINCOLNSHIRE PHARMACEUTICAL NEEDS ASSESSMENT - RESPONSE OF THE COMMITTEE TO THE CONSULTATION DRAFT

The Chairman invited Simon Evans, Health Scrutiny Officer to present the item, which invited the Committee to consider its response to the consultation draft of the Lincolnshire Pharmaceutical Needs Assessment, which was set out in Appendix A to the report.

RESOLVED

That the response to the consultation draft of the Lincolnshire Pharmaceutical Needs Assessment (as set out in Appendix A to the report) be approved.

11 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

The Chairman invited Simon Evans, Health Scrutiny Officer, to present the report, which invited the Committee to consider and comment on its work programme, as detailed on pages 400 to 402 of the report pack.

During consideration of this item, the following suggestions/comments were put forward:

- It was requested that an item on Lakeside Healthcare Stamford, following the publication of the Care Quality Commission's inspection report on 1 June 2022, be included on either the July or September agenda, with the possibility of a representative from Lakeside being included ion the invitation;
- It was suggested that the update on GP Services in October include information relating to evening and weekend access to GP services following a recent post on social media offering this service;
- Fluoridation – The Committee was advised that the Children and Young People Scrutiny Committee were looking into this matter;
- Suicide Prevention and Mental Health Working Group – The Committee was advised that the group were due to meet on 27 July 2022;
- Public Health – In response to a request for further information on the Public Health initiatives in the county, the Committee was advised that the primary focus of the Health Scrutiny Committee was NHS-funded services, and the County Council's

Adults and Community Wellbeing Scrutiny Committee was the lead committee for public health items; and

- The Committee was urged not to lose sight of its request for information on the unmet demand for dentistry in Lincolnshire.

RESOLVED

That the Committee's work programme as detailed on pages 400 to 402 of the report pack be received, subject to the comments/suggestions made above and the items agreed at minute numbers 7 (2)(a)(b)(c)(d) and 9(2).

The meeting closed at 1.46 pm.

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Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
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Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**13 July 2022**
Subject:	**Chairman's Announcements**

1. Information Requested at Previous Meetings

As part of the Committee's discussion of the work programme (see Minute 11, 15 June 2022), there were several items where further information was requested.

(a) Health Visiting Service

At the last meeting of this Committee reference was made to the health visiting service, which is provided by the County Council. The remit of the Health Scrutiny Committee does not preclude consideration of this topic, in the overall context of health and wellbeing, although this Committee's primary focus is on NHS-funded services.

However, the County Council's Children and Young People Scrutiny Committee is due to receive a report on 2 December 2022 on the impact of the pandemic and post pandemic recovery, which will include the health visiting service and immunisations. Reports for this will be available on the County Council's website at this link:
Browse meetings - Children and Young People Scrutiny Committee (moderngov.co.uk)

(b) Fluoridation

As advised at the last meeting, the Children and Young People Scrutiny Committee is due to programme an item on fluoridation. Hitherto, local authorities have been responsible for proposing, varying or terminating fluoridation schemes. The Health and Care Act 2022 will transfer this power to the Secretary of State for Health and Adult Social Care, when these particular provisions are enacted. This means that the government will assume direct responsibility for all schemes.

(c) Annual Report of the Director of Public Health

The annual report of the Director of Public Health for 2021, entitled *The Impact of Covid-19 on Children and Young People in Lincolnshire*, is available at the following link:

Director of public health Annual Report 2021 (lincolnshire.gov.uk)

This provides some background to the issues in (a) and (b) above.

2. Peterborough City Hospital – Care Quality Commission Report

On 24 June 2022, the Care Quality Commission (CQC) published an inspection report on Peterborough City Hospital following inspections on 28 February and 1 March 2022. The inspection focused on two service areas: medical care (including older people's care); and urgent and emergency services at the hospital, which forms part of North West Anglia NHS Foundation Trust. An update from North West Anglia NHS Foundation Trust has been programmed for the 14 September meeting. The main points in the CQC's summary are set out below:

Medical Care (Including Older People's Care)

The CQC found that shortages of staff meant the service did not always have enough medical, nursing and support staff to keep patients safe from the risk of avoidable harm and to provide the right care and treatment in a timely way. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift.

The CQC also found that although people could access the medical care services when they needed it, they did not always receive the right care promptly due to pressures on bed capacity. Arrangements to admit, treat and discharge patients were impacted due to significant numbers of patients that no longer met the criteria to reside in the hospital but were waiting for access to onward care packages. Patients were being moved, sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment. The CQC identified one 'must do' action; and two 'should do' actions.

Urgent and Emergency Services

The main findings of the CQC on Urgent and Emergency Services were:

- The design, maintenance and use of facilities and premises in the emergency department did not always keep people safe. Staff did not complete risk assessments for each patient comprehensively to remove or minimise risks or update the assessments. Staff did not always keep detailed records of patient care and treatment. The emergency department did not have systems and processes in place to safely prescribe, administer, record and store medicines.

- Within the emergency department, staff were not always discreet or attentive when caring for patients
- People could not always access the emergency care service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Staff described a culture of acceptance given the capacity and lack of movement of patients through and out of the hospital. This led to extended patient waits and patients staying for longer than necessary in the emergency and urgent care environment.

The CQC identified seven 'must do' actions; and three 'should do' actions.

The full report is available at: RGN80 Peterborough City Hospital (cqc.org.uk)

3. Healthwatch Lincolnshire Annual Report 2021/22

On 30 June 2022, Healthwatch Lincolnshire published its annual report for 2021/22. Healthwatch has highlighted the following:

- 5,528 people shared their experiences of Health and Social Care Services with Healthwatch Lincolnshire, helping to raise awareness of issues and improve care.
- 1,702 people sought advice and information from Healthwatch Lincolnshire about topics such as mental health and Covid-19.
- Healthwatch Lincolnshire has seen 35,050 page views on its website and has reached 543,557 people through Facebook.
- Healthwatch Lincolnshire has 40 volunteers, who gave up 1,053 hours to make care better for our community.

The annual report is available at: https://www.healthwatchlincolnshire.co.uk/report/2022-06-30/annual-report-20212022-championing-what-matters-you

4. NHS Lincolnshire Integrated Care Board

The NHS Lincolnshire Integrated Care Board (ICB) was established on 1 July 2022. The ICB, together with the following partners, comprise the Lincolnshire Integrated Care System (ICS):

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

Duties of an ICB

The duties of an ICB include:

- promotion of the NHS Constitution;
- reducing inequalities between patients in relation to access to services and outcomes;
- promoting the integration of health services where this would improve quality;
- reducing inequalities of access and outcomes for individuals;
- promoting the involvement of patients and carers and representatives in decisions on prevention or diagnosis, or their care or treatment; and
- enabling patients to make choices about their health services.

Membership

The first board meeting of the NHS Lincolnshire ICB was held on 1 July 2022, and its membership has been confirmed as:

- Chair – Sir Andrew Cash
- Chief Executive – John Turner
- NHS and NHS Foundation Trust Partner Member – Maz Fosh
- Primary Medical Services Partner Member – Dr Dave Baker
- Local Authority Partner Member – County Councillor Wendy Bowkett
- Five Non-Executive Directors – Dawn Kenson, Dr Gerry McSorley, Pete Moore, Julie Pomeroy and Sir Jonathan Van Tam.
- Director of Finance - Matt Gaunt
- Medical Director – Dr Sunil Hindocha (interim)
- Director of Nursing – vacant
- Executive Mental Health Member – Sarah Connery

Other Participants at Board Meetings

In addition to the members of the Board above, the ICB will have the following regular participants at its Board meetings:

- Chair of the Health and Wellbeing Board – County Councillor Sue Woolley
- Public Health Representative – Professor Derek Ward
- Director of Strategic Planning, Integration and Partnerships – Pete Burnett
- Director for System Delivery – Clair Raybould
- Director for Primary Care and Community and Social Value – Sarah-Jane Mills
- Director for Health Inequalities and Regional Collaboration – Sandra Williamson
- Healthwatch Representative – Sarah Fletcher
- Voluntary and Care Sector Representative – Michelle Jolly

Health Overview and Scrutiny

The ICB's adopted constitution includes the following clause:

"7.4.4 The ICB will comply with local authority health scrutiny requirements."

Further guidance from the Secretary of State for Health and Care is expected for health overview and scrutiny committees in the coming months as part of the new arrangements.

The website for the Lincolnshire ICB is: Lincolnshire ICB - Supporting healthcare for the population of Lincolnshire

5. Lincolnshire Integrated Care Partnership

As a result of the Health and Care Act 2022, Lincolnshire County Council has a duty to establish an Integrated Care Partnership as a statutory joint committee, which also forms part of the ICS arrangements. The decision on the formation of the ICP is due to be confirmed by the County Council's Executive on 5 July 2022. Once the ICP has been established, it can determine its own membership and procedures for meetings.

The ICP's one statutory function is to prepare an Integrated Care Strategy, setting out how assessed needs are to be met by the ICB, NHS England, or the County Council. The Integrated Care Strategy must take account of the Joint Strategic Needs Assessment, which will remain the responsibility of the Health and Wellbeing Board (HWB), and in turn the Joint Local Health and Wellbeing Strategy, also the responsibility of the HWB.

Initial discussions on the Lincolnshire ICP have led to informal support for the following arrangements:

- The ICP should align meeting timings, locations, and frequency to the Health and Wellbeing Board.
- Membership of the ICP should be reviewed annually, with as much alignment as possible with the membership of the Health and Wellbeing Board
- An Executive Councillor of the County Council should be appointed as chair of the ICP to reflect the approach of the Health and Wellbeing Board.

Lincolnshire is one of a small number of health systems (ICSs), which directly aligns with the boundary of an upper tier local authority, which provides an advantage of one ICB, one ICP and one HWB for the county of Lincolnshire.

6. Healthwatch Lincolnshire – Care Quality Commission – Integrated Care System Brief Report

On 4 July 2022, Healthwatch Lincolnshire published: *Care Quality Commission – Integrated Care System Brief Report.* This report sets out the findings of Healthwatch Lincolnshire following an engagement exercise undertaken between April and May 2022. Healthwatch Lincolnshire is presenting the report to the Care Quality Commission, with a view to supporting the CQC in the development of its approach to the regulatory assessment of integrated care systems (ICSs) in England.

The report, which is available in full at Guidance (healthwatchlincolnshire.co.uk), includes the following summary of what matters most to the public:

- People want to be treated holistically. This was a theme that was highlighted repeatedly, one that is important to people for better outcomes.

- People want better communication. Problems with communication is a theme we have consistently heard for a long time. The impact of poor communication on patients and carers should never be ignored.

- Better co-ordination between services. People told us that lack of coordination results in them having to continually repeat themselves, wait longer for additional support services or just not be recognised.

- People want services to meet their healthcare needs, they want to be able to access services and be heard.

7. Lincolnshire Clinical Commissioning Group Annual Report and Accounts: 2021/22

Prior to its dissolution on 30 June 2022, Lincolnshire Clinical Commissioning Group approved its annual report for 2021/22, which may be found at: Documents - Lincolnshire CCG

The document is set out in the usual prescribed format and includes sections on:

- performance overview and performance analysis
- key achievements for 2021/22
- financial report
- improving health, reducing health inequalities and prevention
- sustainable development, including estates
- patient, public and stakeholder engagement

In addition to the above, there are sections on corporate governance and the independent auditor's report.

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:	**13 July 2022**
Subject:	**Cancer Programme Update and Lincolnshire Living with Cancer Programme**

Summary

This item provides an update on the Cancer Care Programme and the Lincolnshire Living with Cancer Programme for the Lincolnshire health system, with the information presented applying to all Lincolnshire. Thus, it is not focused on any particular NHS provider of care services.

There is a presentation is attached to this paper, which is in two parts:

- Cancer Programme Update
- Lincolnshire Living with Cancer Programme

Actions Required:

(1) To consider the information presented on the Cancer Care Programme and the Lincolnshire Living with Cancer Programme.

(2) To identify any requests for further information or the timing of future updates.

1. Cancer Care Programme and Lincolnshire Living with Cancer Programme

Presenters

The following are expected to attend the meeting to present this item:

- Colin Farquharson, Senior Responsible Officer for Cancer Lincolnshire Integrated Care System (Medical Director of United Lincolnshire Hospitals NHS Trust)
- Clair Raybould, Director for System Delivery Lincolnshire Integrated Care Board:
- Sarah-Jane Gray, Deputy Cancer Programme Manager Lincolnshire Integrated Care Board
- Kathie McPeake, Macmillan Living with Cancer Programme Manager

Presentation

A presentation is attached to this paper, which is in two parts:

- Cancer Programme Update
- Lincolnshire Living with Cancer Programme

2. Consultation

This is not a consultation item.

3. Conclusion

The Committee is invited to consider the information presented on the Cancer Care Programme and the Lincolnshire Living with Cancer Programme; and to identify any requests for further information or the timing of future updates.

4. Appendices

These are listed below and attached to this report.

Appendix A	Presentation on Cancer Programme Update and the Lincolnshire Living with Cancer Programme

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

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

Lincolnshire NHS

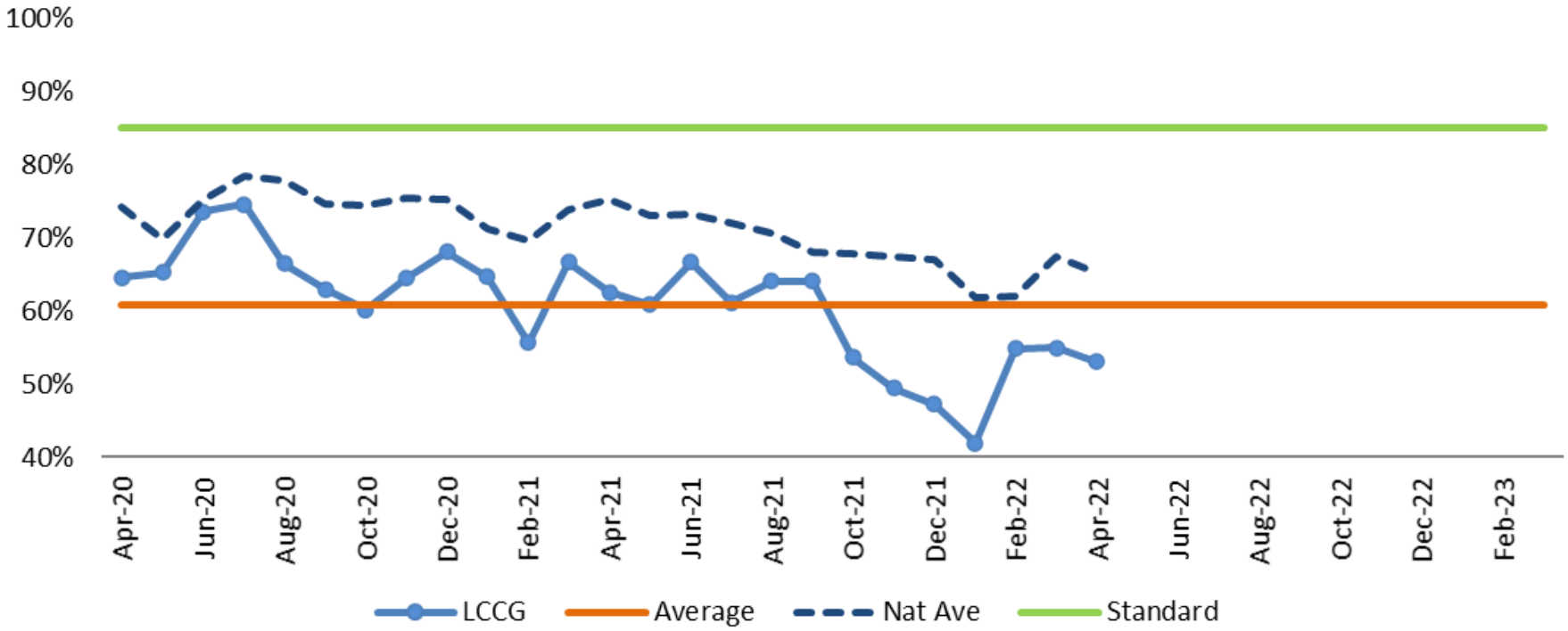
Cancer Programme Update

Health Scrutiny Committee 13.07.22

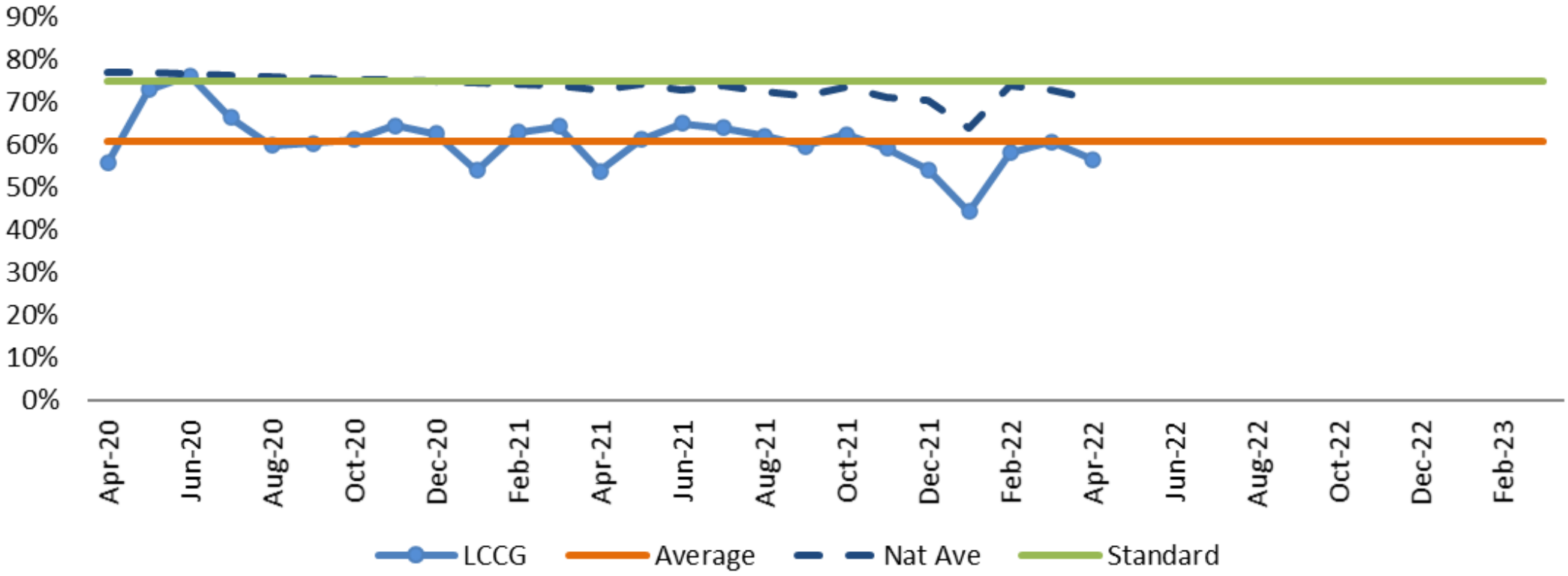
Agenda

- System Performance
- Benchmarking
- Support from the Alliances
- Governance structure for ICB
- Risk and issues
- Improvements – NLAG / NWAFT/ ULHT
- Future work
- Living with Cancer Programme

Patients receiving treatment for cancer within 62 days of an urgent GP referral – Lincolnshire ICB



28 Day Faster diagnosis standard- % of patients told cancer diagnosis outcome within 28 days



62+ & 104+ Backlog – May 2022*

	ULHT	NWAFT	NLAG
Patients waiting over 104 days	139	109	43
Patients waiting over 62 days	516	374	190

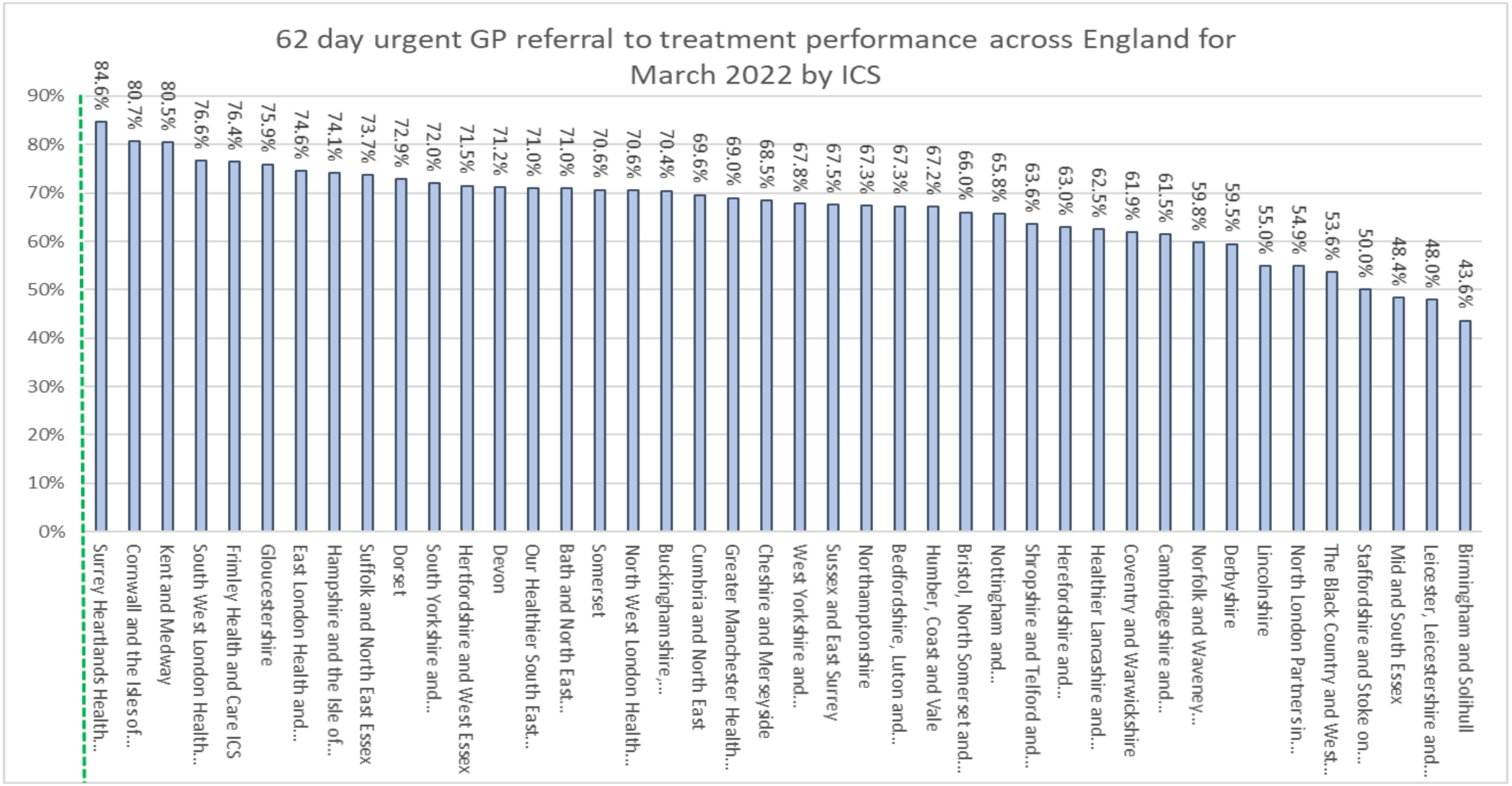
ULHT – United Lincolnshire Hospital Trust

NWAFT – North West Anglia Foundation Trust

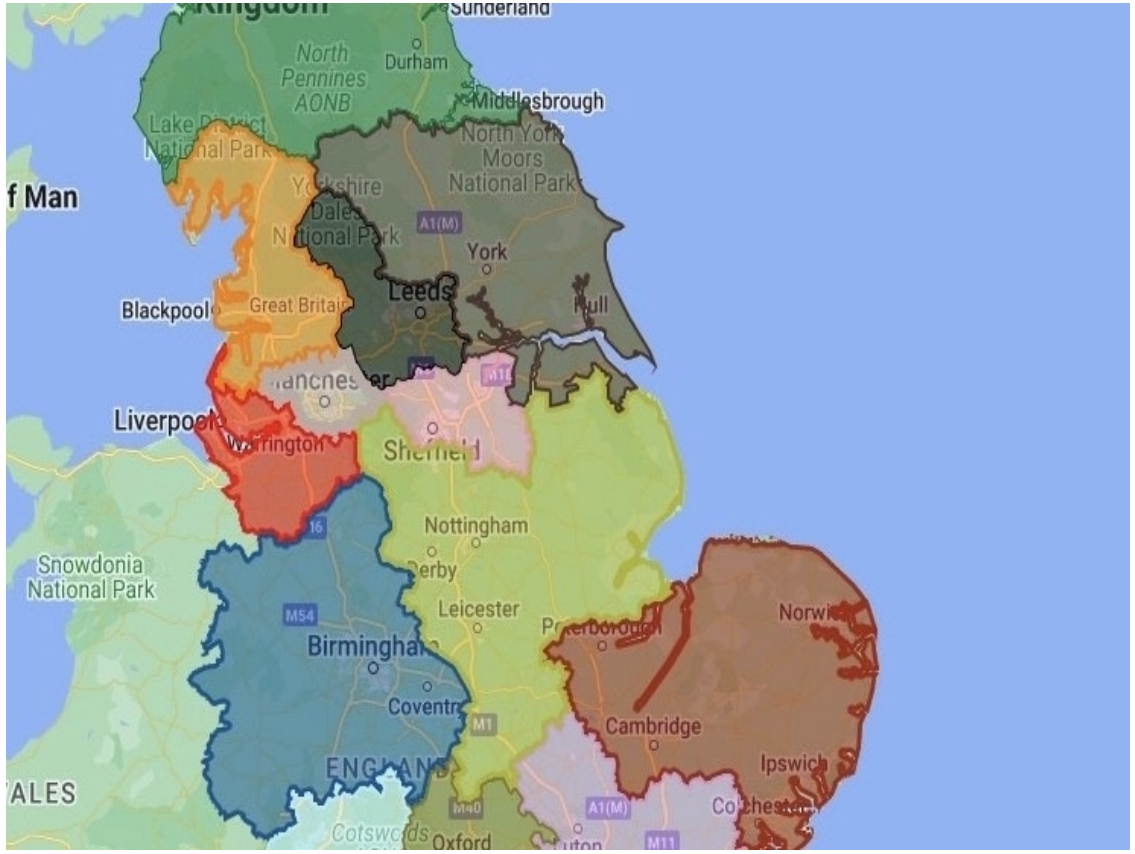
NLAG – North Lincolnshire and Goole Foundation Trust.

*May 2022 – most recent validated performance

Benchmarking Lincolnshire's performance



Cancer **Alliance** support in Lincolnshire



- East Midlands Cancer Alliance
- Cambridge & Peterborough Cancer Alliance
- Humber and North Yorkshire Cancer Alliance
- Finance for Lincolnshire ICB allocated via East Midlands Cancer Alliance – System Development Funding and Rapid Diagnostic Service Funding.

Governance Structure

- ICB oversight of performance through monthly Lincolnshire Cancer Board.
- Monthly meetings with NLAG & NHS Humber and North Yorkshire ICB
- Fortnightly meetings with NWAFT & Cambridgeshire and Peterborough Integrated Care Board
- Lincolnshire ICB attendance at NWAFTs monthly cancer board.
- Lincolnshire ICB oversight and implementation of improvement work at ULHT.

Challenges & Opportunities

Challenges

- Urgent and Emergency Care pressures
- Covid 19 impact both current and future
- Workforce challenges to recruit nationally and locally
- Increased demand post Covid

Opportunities

- Good system working to avoid and or alleviate pressure on UEC pathways and improve discharges
- Further vaccine rollout in September
- Increased health & wellbeing offer to staff
- Alternative pathways for low risk patients i.e. Breast pain pathway
- Utilisation of new simulation tool to demonstrate impact of additional finance

Improvements - NWAFT

- Implementation of neck lump clinics
- Implementation of TPLA (transperineal biopsy under local anaesthetic)
- Roll out of RDS (Rapid Diagnostic Service) virtual assessment service
- Phase 1 of the Galleri Trial (new blood test to see if it can help the NHS to detect cancer early)
- Additional clinical support for skin pathway and endoscopy
- Cancer recovery plan in place following COVID

Improvements - NLAG

- Dedicated cancer transformation team appointed
- Service Improvement plans are being developed
- Implementation of Best Practice Timed Pathways in Lung, Upper GI, Head & Neck
- Lower Gastrointestinal RDS pathway in place since June 21.
- Non Site Specific pathway implemented mid May 22.
- Implementation of single MDTs (multi disciplinary team meetings) across the Humber
- More CNS (Cancer Nurse Specialists) recruited through funding from Macmillan Cancer.

Improvements - ULHT

- Implementation of the Non-site specific pathway – July 2021
- Surgical robot purchased January 2022
- BPTP (Best Practice Timed Pathway) analysis of 4 key tumour sites
- Galleri Trial Phase 1 – completed.
- Development of a simulation tool to model the backlog and interventions
- Recruitment to roles to improve performance utilising SDF funding
- Increase in cervical screening uptake using video text trial
- Implementation of the 90 minute standard
- Roll out of breast pain pathway and Spot clinics

Future work

- Colorectal deep dive
- Implementation of Best Practice Timed Pathways across all tumour sites
- Supporting GPs to recognise early signs and symptoms of cancer
- Work locally and regionally to roll out initiatives to support early diagnosis to improve survival rates
- Galleri Trial Phase 2
- Roll out TLHCs trial (Targeted Lung Health Checks)

Lincolnshire NHS

Lincolnshire Living with Cancer Programme

Lincolnshire Living with Cancer Overview

Lincolnshire NHS

Aim:

- Develop person-centred, local support for people living with cancer, their carers and significant others in Lincolnshire.

By March 2023 implement seven Personalised Follow up Pathways (PFUP) in breast, prostate, colorectal, endometrial, thyroid, lymphoma and skin, including remote monitoring.

To do this we will:

- Implement PFUP including remote monitoring in breast, prostate, colorectal and endometrial by 30th June 2022, thyroid and lymphoma by 30th September 2022 and skin by 31st March 2022
- Implement the Lincolnshire Personalisation Model (Triage/Record/Refer/Navigate) at end of treatment in priority tumour sites by 31st March 2023.

Lincolnshire Living with Cancer Priorities set by NHSE

By March 2023 implement the four living with cancer elements:

- holistic needs assessment and personalised care and support planning
- end of treatment summary
- cancer care review
- access to health and wellbeing interventions.

To do this we will:

- Implement the Lincolnshire Personalisation Model (Triage/Record/Refer/Navigate) at end of treatment.
- Work with PCNs and Primary Care teams to improve the quality of cancer care reviews.
- Integrate Community Cancer Care Co-ordinators in all Neighbourhood Working Teams (NWTs).
- Implement model for different levels of support for all health & wellbeing/quality of life elements
- Map health and wellbeing assets in Lincolnshire to understand available support and identify gaps.
- Launch Lincolnshire Cancer Support website.

Lincolnshire Living with Cancer Priorities set by NHSE

Lincolnshire NHS

Address the finding of the National Cancer Patients Experience Survey (NCPES) and the U16 Cancer Patient Experience Survey (U16CPES)

To do this we will:

- Each year work with the Lead Cancer Nurse at ULHT and her team to analyse the results of the National Cancer Patient Experience Survey.
- Draw up an action plan to inform the focus of our work.

Address the finding of the Cancer Quality of life survey.

To do this we will:

- Promote uptake of the Cancer Quality of Life Survey
- Analyse the results of the survey.
- Act of the results of the survey in the future when available at Trust level.

Lincolnshire Living with Cancer Programme

To support the delivery of the Lincolnshire Living with Cancer Programme, we have carried out work within enabler workstreams:

We have:

- Developed and are delivering the Lincolnshire Living with Cancer strategies, and Digital and Workforce Development strategies.
- Commissioned a formative evaluation to understand the changes brought about by the programme.
- Used quantitative and qualitative data to measure impact.
- Established and supported Co-Production Groups in Sleaford and Mablethorpe.
- In collaboration with ULHT established the Lincolnshire Cancer Patient Panel.

Lincolnshire Living with Cancer Programme Key Risks

- Future funding requirement
  - Mitigation developing a business case to request funding for 7 roles to support LWC programme from the ICB

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Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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Open Report on behalf of the Lincolnshire People Board

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**13 July 2022**
Subject:	**The Lincolnshire People Board Strategy for Recruiting and Retaining Talent**

Summary:

Challenges in securing and retaining good people to live and work in the NHS in Lincolnshire are well known and documented, such as:

- Vacancies within medical and nursing roles across the NHS Trusts and Primary Care alike. Although the vacancies are gradually decreasing, there is still work to do in attracting people to live and work in the County.
- Staff turnover has seen a rise – particularly within the last 12-18 months as some colleagues have retired following the pandemic or left their roles / even leaving the NHS.
- A decline in the number of GP partners in primary care – with a rise in salaried GPs and GP Nursing staff
- The age profile of the health workforce in Lincolnshire being higher than many of our counterparts i.e., 22% of our workforce are over 55 years.
- The rurality of the County and geographical challenges therein.

The Lincolnshire People Board is seeking to address these challenges and is continuing to build a team of senior people leaders within Lincolnshire to deliver the *Lincolnshire People Plan* (see Appendix A) and are committed to working across organisational boundaries to achieve a sustainable pipeline of health and care practitioners to serve our population in Lincolnshire. Examples of programmes underway include:

- the *Be Lincolnshire* Campaign
- international recruitment (including refugee doctor programme)
- primary care workforce strategy

- rural and coastal transformation programme
- retention exemplar programme
- workforce planning Lincolnshire solution

This paper and the People Plan 2022/23 attached, will describe in further detail, the nature of the current challenges and the opportunities to deliver the people priorities in Lincolnshire.

Actions Requested:

The Committee is being asked to note the report.

1. Background

National Context

The NHS is the largest employer in England, with 1.2 million whole-time equivalent (WTE) staff working in hospital and community services. However, workforce shortages across all staffing groups in the health and care system are putting NHS hospitals, mental health services, community providers and general practice under significant strain. These vacancies do not affect only clinical staff but also the roles required to keep the NHS running, including leaders and managers.

Unfilled vacancies increase the pressure on staff, leading to high levels of stress and absenteeism, and high staff turnover. The Covid-19 pandemic has also exacerbated long-term issues such as chronic excessive workload, burnout and inequalities experienced by staff from ethnic minority backgrounds. While there are signs that shortages have started to improve, levels of nursing and allied health professional vacancies remain high, recruiting and retaining GPs continues to be difficult and there are significant shortages in some specialties, such as radiology.

There are some encouraging signs of increased numbers in training, with record numbers of medical (University and College Admissions Service (UCAS) figures show that 28,690 students applied to medicine in 2021, a rise of 21% on last year) and nursing students in 2021, and evidence of progress towards the manifesto commitment to 50,000 more nurses working in the NHS by 2024/25. However, the size and complexity of the workforce challenge means it will require concerted and sustained action across the system on workforce planning, pay, training, retention and job roles.

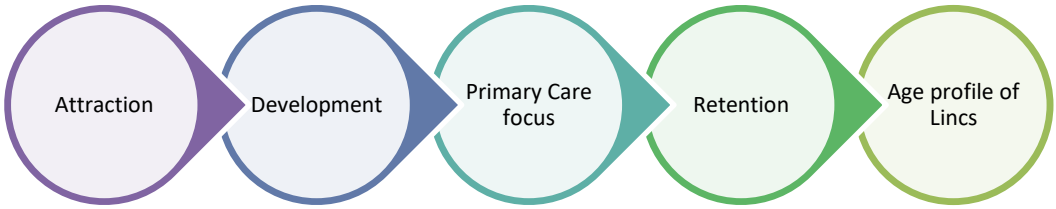
Lincolnshire Context

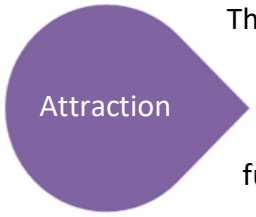
There are no quick solutions to some of our more long-standing workforce issues here in Lincolnshire, however we are committed to working together to find long-term sustainable solutions and to make Lincolnshire the best place to work, so that all our colleagues can feel they belong and thrive. - Maz Fosh, previous chair of Lincolnshire People Board
(taken from the previous Lincolnshire People Plan 2020-21)

Challenges in securing and retaining good people to live and work in Lincolnshire is well known. Within the Health and Social Care Sector this presents an ongoing challenge to providers, with some particularly challenging services and geographies within the County. Covid-19 presented opportunities to really develop relationships across health and care, particularly as we responded collectively to the pandemic in Lincolnshire. Partnership working, collaboration and shared endeavours certainly moved forward.

The Lincolnshire People Board and the associated working groups (the People Team, People Hub, Primary Care People Group and Adult Social Care External Workforce Strategy Group) are becoming much more aligned in seeking to address this challenge and seize opportunities to work better together. We are building a team of senior people leaders within Lincolnshire to deliver the Lincolnshire People Plan (see Appendix A) and are committed to working across organisational boundaries to achieve a sustainable pipeline of health and care practitioners to serve our population in Lincolnshire.

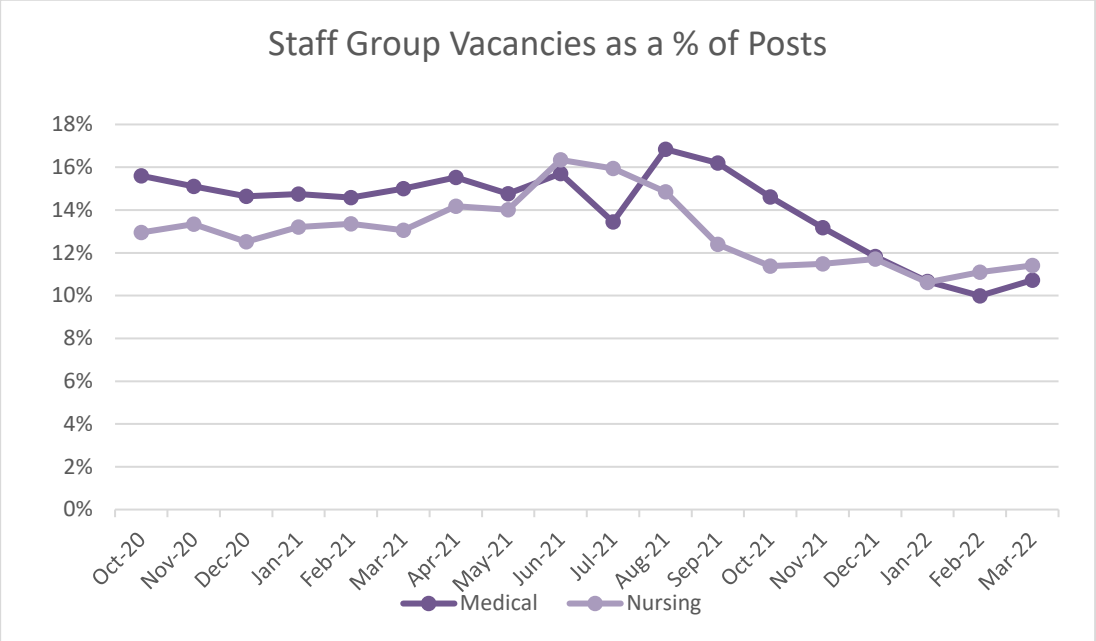
2. Workforce Challenges





There is no quick fix to the attraction and recruitment challenge faced by us in Lincolnshire. Sustainable, long-term solutions need to be put in place to ensure local health and care partners are effectively staffed. This means ensuring careers in the Lincolnshire health and care system are attractive and fulfilling, and that staff are adequately supported, funded, paid and valued.

The chart below demonstrates that Lincolnshire NHS Trusts are continuing to show a downward trend in medical and nursing vacancies. This is against a regional backdrop of rising or static vacancies. For nursing vacancies, we are faring better than some of our regional counterparts who are seeing a rise in vacancies for this staff group. Lincolnshire are, however, still experiencing challenges in attracting and retaining talent into Lincolnshire. Some signs of an improving picture but a long way to go.



Vacancies by professional group (NHS Trusts) - Oct 20 to Mar22

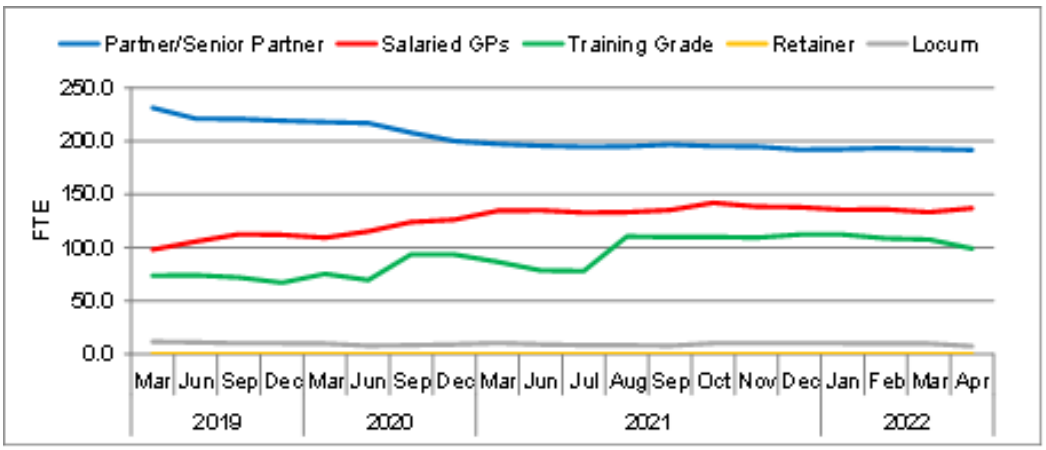
Development

Access to relevant training and continuing professional development (CPD) opportunities has never been more vital – as is the necessary funding and time to undertake training.

A report published by the British Medical Association (BMA) in 2021 (Medical staffing in England: a defining moment for doctors and patients), highlights that today's clinical practice is multi-disciplinary, with patient care demands being more varied and complex than ever. As such, more and varied skills are needed across the board, from nurses and doctors to healthcare assistants. Some of the measures in Lincolnshire to help fill the supply gap include the Lincoln medical school, rural and coastal transformation programme, an expansion of teaching programmes targeted at nursing roles with Lincoln University, partnership with Boston College and increased student clinical placement options through the Talent Academy.

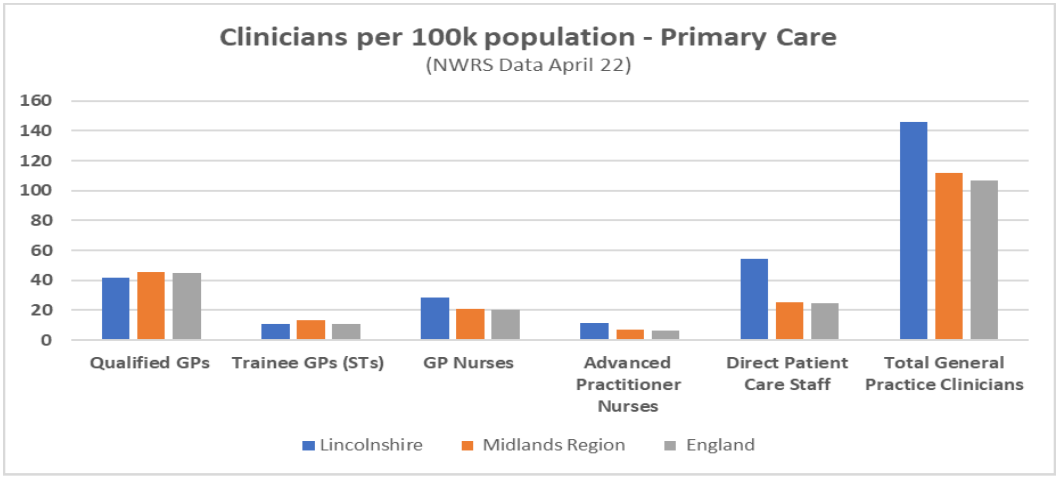
Primary Care Focus

Whilst the last 3 years have shown a steady decline in Partner/Senior partners in Primary Care in Lincolnshire, Salaried GPs and Training Grade GPs are seeing a healthy increase. This is representative of the trend regionally and nationally. There are 48% more 'doctors in training' in Lincolnshire as of March 2022 than in March 2019.



Primary Care <u>Medical</u> Workforce: Mar 19 – Apr 22

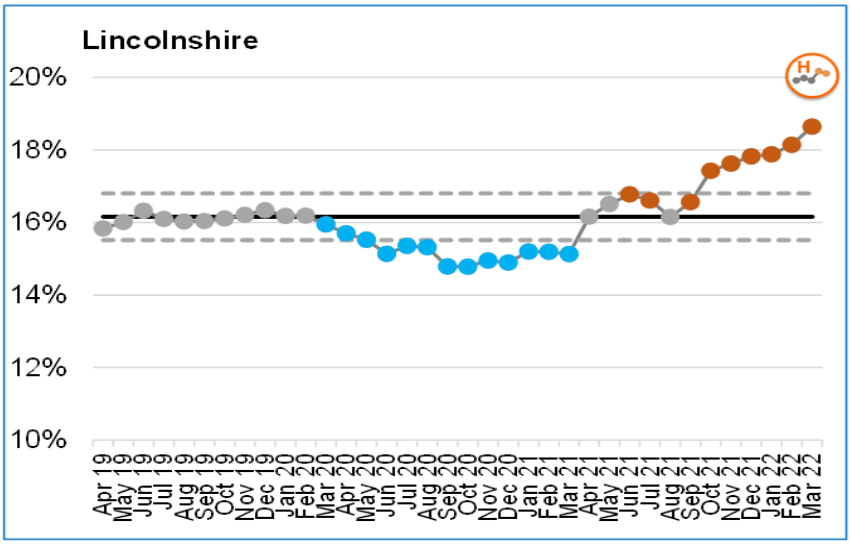
Interesting to note also is the emphasis in Lincolnshire practices of the growing nursing workforce to mitigate the gaps and complement the medical workforce. The overall workforce ratio per 100k population is a favourable picture as at April 2022.



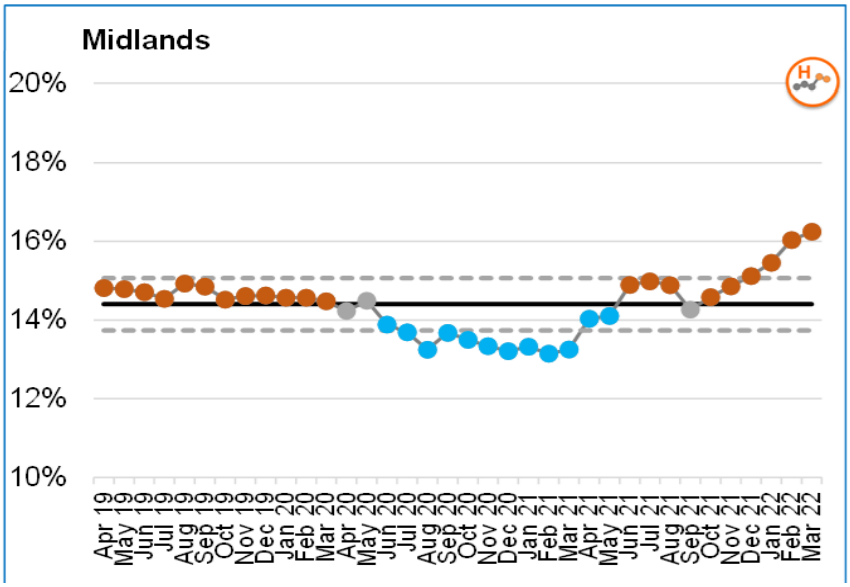
Skill-mix of the Primary Care workforce in Lincolnshire compared to regional and national average

Retention

As the response to the pandemic started to ease, the staff turnover rates in the NHS Trusts in Lincolnshire started to increase following a stable and even declining picture over the previous two years. A proportion of the leavers have retired from NHS service although some of these 'retire and return'. United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services NHS Trust (LCHS) are part of the National NHS People Promise Exemplar programme which has seen resource brought into the County to focus entirely on retaining our workforce.



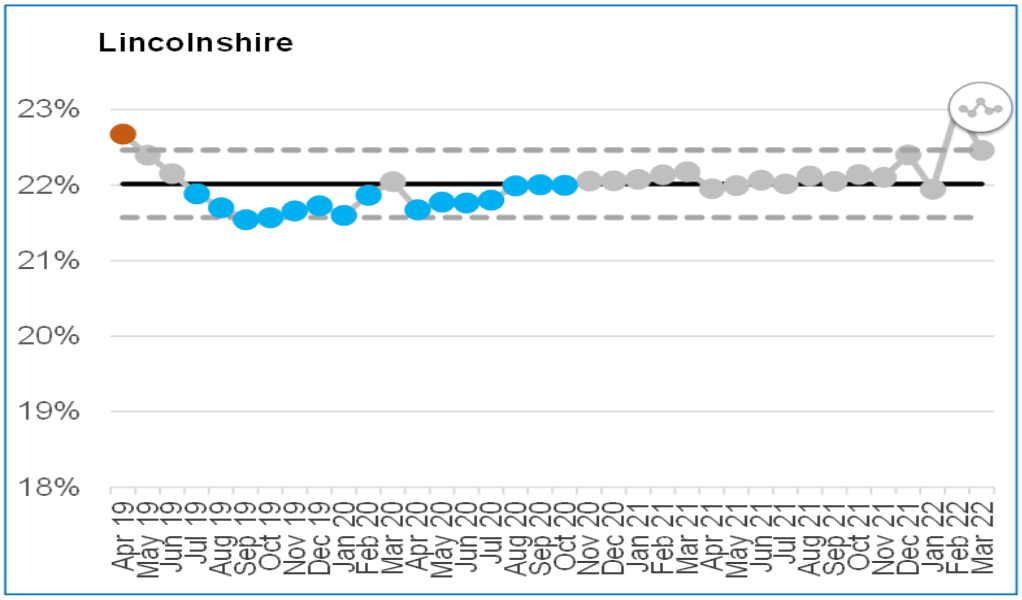
Staff Turnover rates (NHS Trusts) in Lincolnshire - Apr 19 to Mar22



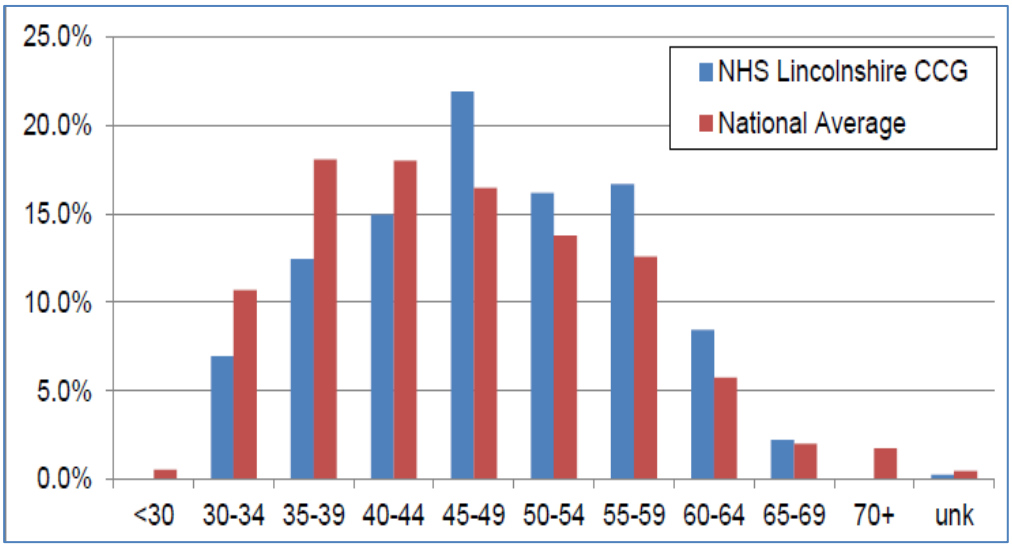
Staff Turnover rates (NHS Trusts) in the Midlands - Apr 19 to Mar22

Age profile

The age demographic of NHS staff in Lincolnshire suggests the age profile is continuing to rise with over 22% of the workforce more than 55 years old. For NHS provider trusts this has been a relatively static percentage over the past two years. Individual providers have several initiatives in place to address the specific challenges that arise out of an aging workforce. An emphasis on 'retire and return', menopause friendly work practices, flexible working etc.



The percentage of NHS Trust staff over 55 years in Lincolnshire (Apr19 – Mar22)



The age profile of NHS staff in Lincolnshire (Primary Care)

3. Programmes Underway

The People Board in Lincolnshire meets quarterly and has a very engaged membership across all parts of the sector. The annual Lincolnshire People Plan priorities guide activity for the year and provides oversight of delivery and effectiveness.

The 2022/23 Lincolnshire People Plan (Appendix A) has eight key priorities and the People Board have been successful in securing funding for the 'People Hub' – an innovative programme delivery arm of the People Team who are focused on delivering these key priorities.

Attraction, Retention and Workforce Planning have been identified as high priority and therefore much of this year will be focused on meeting the challenges captured earlier in the report and working in collaboration to meet the needs of the population in Lincolnshire in the delivery of quality patient care. Below are some of the programmes underway:

1 The *Be Lincolnshire* Attraction Campaign

Prior to the Covid-19 pandemic, Lincolnshire commissioned Visit Lincoln to deliver the 'Be Lincolnshire' digital attraction campaign. Due to the pandemic, the launch of www.beinlincolnshire.com campaign in December 2020 was hampered considerably. As the People Board, we are now recruiting a programme lead for the Attraction strategy to reenergise this campaign and promote Lincolnshire as a great place to live and work. Within the Be Lincolnshire research, a small number of demographic groups were considered for the targeted campaign

- Those with young families – due to the excellent schooling in Lincolnshire
- Those 50yrs plus – to come to Lincolnshire for their last career move prior to retirement
- Those with an interest in delivering training – due to the Medical School and growing University opportunities

2 International Recruitment (Including the Refugee Doctor Programme)

In addition to domestic recruitment through various campaigns such as above, international recruitment has seen success in addressing both the medical and nursing vacancies, examples below:

Case Study 1: ULHT Nursing Recruitment

"Over the last two years we have grown our International Recruitment and Onboarding team and offer. To date, we have successfully recruited 404 International Nurses, 320 of whom have already started their journey within ULHT and our OSCE (Objective Structured Clinical Examination) success rate is currently at 100%. We have had only two leavers from this number which pays testament to the positive candidate experience that we pride ourselves on and one of our International Nurses has already been promoted."

Impact of the programme:

- Over 400 roles recruited to
- 100% examination success rate
- 99% retention rate of those recruited over the 2-year period
- Community integration through:
    - job skilling/interview prep workshops for spouses and partners
    - integration into local churches with Sunday mass in Malayalam for the families of Indian nurses from Kerala (church in Boston)
    - direct link into the Lincs Indian Society in Lincoln and Boston through the Hospital BAME network

Case Study 2: Refugee Doctor Programme - Dr Mo's story

"I am Dr Mo. I came to the UK in 2019 looking for refugee status as I was in danger in my own country. I achieved my primary medical qualification at university, something that was ratified by the GMC when I received my registration in September 2021. I struggled to find a role within the UK within medicine in the UK despite lots of applications being completed. At one point I was doing 4 lowly paid roles whilst I was doing my studies. Around November 2021 I became aware of the Lincolnshire Refugee Doctor Project and that they were supporting doctors who were GMC registered looking for roles.

I contacted the project and was contacted quickly by Simon who interviewed me, asking me questions around my CV and the type of role I was looking for, he said he was impressed with my work ethic and that he felt I deserved support and he agreed to introduce me to ULHT for suitable opportunities. Within a short period of time, I was interviewed by the ULHT team, and I was delighted to receive the offer of a FY2 role at Pilgrim Hospital, Boston. The ULHT team and LRDP (Lincolnshire Refugee Doctor Programme) team (with BMA support), helped me find accommodation and were able to support the funding of the first six weeks of my accommodation, this was a massive help for me. I have been in my role for five months now and have been welcomed into and feel a part of the ULHT family."

Impact of the Programme

- 14 doctors attached to the Lincolnshire arm of the programme have relocated to the area with their families and are now settled into the local community. Further three more to follow
- A further 20 doctors have applied for the programme. This is being currently evaluated and progressed.
- The programme scope is being revisited to include other medical/AHP professions

Case Study 3: Mental Health Nursing Recruitment

"Lincolnshire Partnership Foundation Trust (LPFT) have been at the vanguard of international recruitment for Mental Health nurses, with nine recruits currently in the country; three of whom have successfully passed their examinations and are now registered mental health nurses. The International Recruitment Education Team have worked extremely hard under very difficult circumstances to achieve 100% pass rate to date after having only written the first iteration of the training in November 2021. As leaders in the field of Mental Health OSCE (Objective Structured Clinical Examination) preparation training, we are currently scoping out the possibility of running a 'train the trainer' programme where Mental Health International Recruitment staff from other Trusts could attend and be taught how to deliver the programme and be supplied with the outline material to do so. The East Midlands Alliance are keen to support this work and so the first cohort would be to deliver for those organisations within the alliance, although we have also been approached by Trusts from other regions. A proposal is currently being developed with detail around the potential for a train the trainer model and/or the provision of a 'ready-made training pack' of resources."

Ethical Considerations for International Recruitment

- Familiarising ourselves with the World Health Organization Code of Practice on ethical international recruitment.
- There must be no active international recruitment with specific named countries, unless there is an explicit government-to-government agreement with the UK to support managed recruitment activities that are undertaken strictly in compliance with the terms of that agreement.
- There are countries (for example Kenya), or areas of countries, where you cannot undertake direct and targeted recruitment. This is because these countries are receiving government aid and the UK has made a commitment to support their developing health needs.
- Recruitment of international health and social care personnel is closely monitored and reported on to the Cross Whitehall International Recruitment Steering Group.
- Lincolnshire Partnership NHS Foundation Trust is currently in discussion with Caribbean government officials to see how we can give back to the country with the recruitment planned there.

International recruitment in the UK (King's Fund)

3 Primary Care Workforce Strategy

As seen earlier in the report, Lincolnshire is successful in developing pipelines of new doctors, but also keen to skill-mix the workforce, with a focus on GP Nurses practicing at the very top of their licence. Short- and medium-term plans within the Primary Care workforce strategy are as follows:

Short Term

- TERS (Targeted Enhanced Recruitment Scheme) for trainee GPs which offers them a financial incentive to come to Lincolnshire - this has meant that we have attracted between 35 and 45 trainees to Lincolnshire.
- Fellowship Programme to newly qualified GPs to encourage them to stay in Lincolnshire.
- International GP Recruitment Programme for GPs from the EU. Last year six GPs successfully completed the scheme.
- GPN Fellowships (General Practice Nurses) to encourage nurses to come into primary care.
- Funded ACP courses (Advanced Clinical Practitioner) Increased number to enable nursing professionals to work at the top of licence.

Medium Term

- University of Lincoln Medical School - working with them to provide exposure for medical students to primary care from year one with placements - thereby encouraging them to consider a career in general practice.
- ACP Fellowship Programmes – working in partnership with Health Education England to develop an ACP programme in order to address gaps in medical workforce.

4 Rural and Coastal Transformation Programme

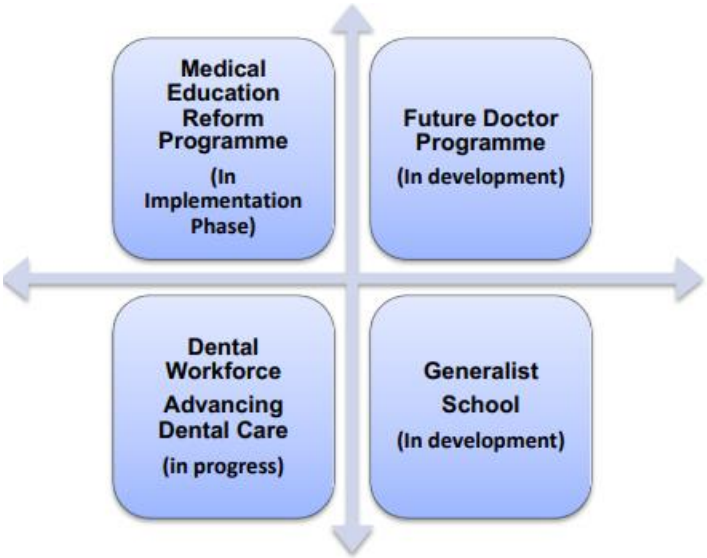
Lincolnshire is a pilot ICS [Integrated Care System] for the newly developed Rural and Coastal Transformation Programme, which sets out addressing health inequalities for public and patients within rural and coastal settings. This new programme sets out an ambition to target a suite of evidence-based programmes within four specific rural-coastal ICSs through a place-based approach. It will be delivered in partnership with Health Education England and the Lincolnshire People Board and will span organisational and service boundaries to address wider determinants of health.

Utilising global and national research, it was identified that patient-related health outcomes in rural communities can be improved through a stable and well-trained local workforce. However, to ensure a sustainable rural healthcare system demands workforce models that have been designed in, and for, these settings. With this in mind, the programme within Lincolnshire acknowledges that workforce planning must reflect unique, rural place-based solutions and successful rural workforce transformation requires:

- Commonality, as rural communities identify more with similar communities in other countries than their own urban centres.
- Delivering education and training within rural communities increases the quality and cultural relevance of services through a lived experience.
- Investing in targeted training of rural residents increases recruitment and stability of services in rural locations.
- Initiatives must be co-produced with the local population to be successful.

(see Appendix B)

The disproportionate rural workforce shortages, especially amongst professionally qualified clinical groups, is being addressed through the programmes below:

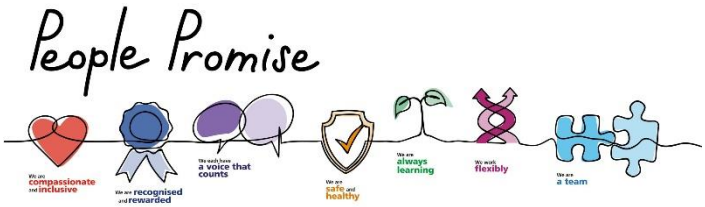


A programme lead has recently been appointed by Health Education England and will sit within the People Hub in Lincolnshire to drive this project over the coming few years.

5 Retaining Our People

The Lincolnshire system has signed up to the People Promise Exemplar Programme in order to address steadily increasing turnover across the region. There are 23 exemplars that have been chosen to be part of this programme and they are a mix of acute, community and mental health organisations. (ULHT and LCHS are exemplar sites participating in the pilot programme).

National teams will work with these sites over the next twelve months to deliver interventions together in one place, at the same time. The exemplars will test the assumption that by delivering the interventions together in one place, we will achieve improved outcomes for staff, organisations and patients, as well as optimum staff satisfaction and retention.



A small team have been funded by NHSEI (NHS England and Improvement) to coordinate and lead this work in Lincolnshire.

6 Workforce Planning

As the Lincolnshire system matures in working in an integrated way, it is important to measure the impact of interventions as stated above. Currently we are working towards a 'One Workforce' dashboard across all health and social care. We have been successful in securing funding for a strategic workforce modelling solution which will, in time, capture and model our workforce across the NHS (including Primary Care) and Adult Social Care.

4. Consultation

This is not a direct consultation item.

5. Key Strategy Documents

The work underway in the Lincolnshire People Board relate to the following national and local drivers**:** (Areas directly relating to this report are in bold print)

NHS Long Term Plan (in particular)**:**

- *A new service model for the 21st Century*
- *More action on prevention and health inequalities*
- *Further progress on care quality and outcomes*
- ***Staff will get the backing they need***
- *Digitally enabled care to go mainstream*
- *Taxpayers' investment used to maximum effect*

https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

NHS People Plan

- *Looking after our people*

1. *Belonging*

- *New ways of working and delivering care*

(i) Growing for the future

https://www.england.nhs.uk/ournhspeople

The National ICS People Framework

- ***Support the health and wellbeing of staff***
- ***Grow the workforce***
- ***Support inclusion and belonging***
- *Value and Support Leadership at all levels*
- *Lead workforce transformation in new ways of working*
- *Educate, train and develop people*
- *Drive and support social and economic development*
- *Transform people services and the people profession*
- *Lead coordinated workforce planning using analysis*
- *Support system design and development*

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0662_Building-strong-integrated-care-systems-everywhere-guidance-on-the-ICS-people-function-August-2021.pdf

Lincolnshire People Plan (See Appendix A)

6. Conclusion

The workforce challenges in the health sector in Lincolnshire are well documented and understood. The solutions are through collaboration, creativity and a passion to work closely with system partners to deliver on the People Plan for Lincolnshire.

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

Appendix A	Lincolnshire People Plan 2022/23 – A One Workforce Approach to Delivering the People Plan as an Integrated Care System (ICS) in Lincolnshire
Appendix B	Rural and Coastal Transformation: Developing Health and Communities Through Workforce, Education, and Training in Small Places

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

This report was written by the Lincolnshire People Board, who can be contacted as follows:

- Ceri Lennon, Senior Responsible Officer for People, Lincolnshire ICS / Chair of Lincolnshire People Board / Director of People & Innovation, LCHS: ceri.lennon@nhs.net
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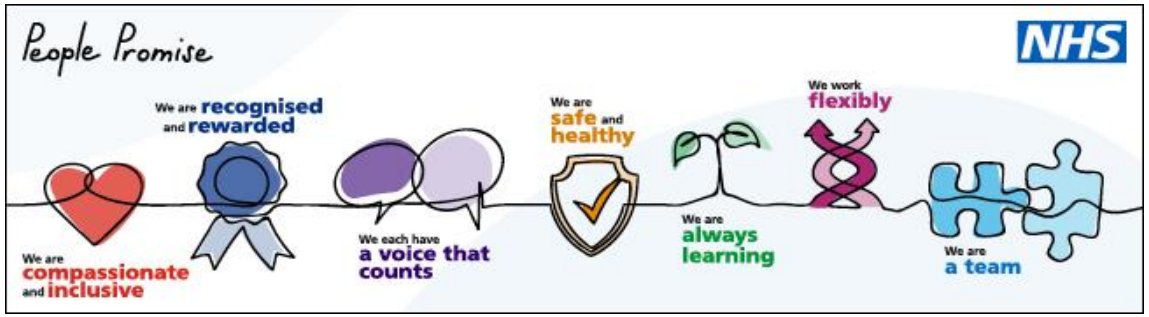
- Claire Low, Strategic Lead for Attraction / Deputy Director of People, ULHT: claire.low@ULH.nhs.uk
- Amy Beeton, Strategic Lead for Retention / Deputy Director of People, LPFT: amy.beeton@nhs.net
- Ade Tams, Strategic Lead for Workforce Planning / Associate Director of People, ULHT adrian.tams@ULH.nhs.uk
- Saumya Hebbar, Lead for the People Hub / Associate Director of People, Lincolnshire ICS: saumya.hebbar@nhs.net

Lincolnshire People Plan 2022-23

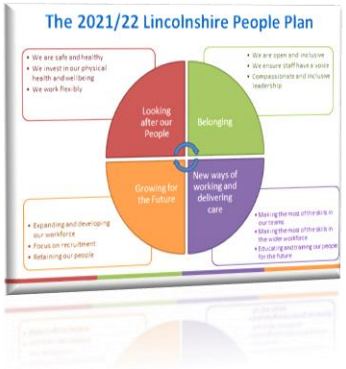
A *One Workforce* approach to delivering the people plan as an Integrated Care System (ICS) in Lincolnshire



Towards 'One Workforce' – timeline for the People Board

2020/21

- *COVID-19 presented opportunities to really develop **relationships** across health and care – particularly as we responded to the pandemic in Lincolnshire*
- ***Partnership working**, collaboration and shared endeavours certainly moved forward*
- ***The first People Plan 20/21** came from this collaboration and set the scene for future working*

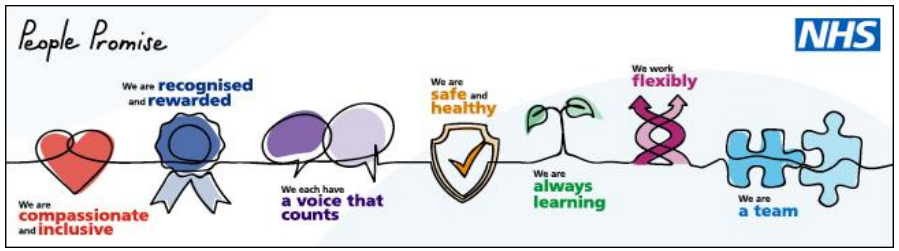


2021/22

- *The workforce cell progressed into the **'People Team'** as a strategic leaders group reporting to the People Board.*
- *Senior people leaders within the People Team provided strategic oversight for the **four pillars of the 21/22 People Plan** in addition to their roles in provider organisations.*
- *Further engagement with wider **system partners** e.g., Lincolnshire Care Association (LinCa), Primary Care and the Voluntary sector has progressed well*

2022/23

- ***There is <u>now</u> the requirement and foundation on which to <u>deliver key people priorities</u>,***
- ***Lincolnshire is looking to build on the strengths of collaboration in delivering the 2022/23 People plan, now incorporating the <u>People Hub – Centre of Innovation</u>.***



Lincolnshire Priorities (where we need to focus):

1. System approach to health and wellbeing – what is our offer to all staff?
2. Promote inclusion and belonging – in seeking to shape a modern employment culture
3. Harnessing new ways of working in the 21st Century Health and Care Sector

4a. Growing for the Future: Workforce Planning and intelligence

4b. Growing for the Future: Attraction into the Lincolnshire Health & Care system

4c. Growing for the Future: Pipeline of our future workforce – widening access into health and care professions in Lincolnshire

4d. Growing for the Future: Retaining our People – a system approach

5. Leadership, Lifelong learning & Talent

Principles of an ICS (ensuring we consider…)

People centred – One workforce approach

Focus on key priorities – ICS People Framework 10 deliverables

Subsidiarity – pushing down accountability to the ICS

Minimum disruption – simplicity

… with reference to the Long-Term Plan LTP here

1. *A new service model for the 21st Century*
2. *More action on prevention and health inequalities*
3. *Further progress on care quality and outcomes*
4. *Staff will get the backing they need*
5. *Digitally-enabled care to go mainstream*
6. *Taxpayers' investment used to maximum effect*

Against the backdrop of the People Plan

People Plan here

1. *Looking after our people*
2. *Belonging*
3. *New ways of working and delivering care*
4. *Growing for the future*
5. *(from 22/23) Leadership and lifelong learning*

… and system strategic delivery plan

1. *Care Closer to Home*
2. *MSK*
3. *Prescribing*
4. *…and more*

…and the ICS People Framework

People guidance here

1. Support the health and wellbeing of staff

2. Grow the workforce

3. Support inclusion and belonging

4. Value and Support Leadership at all levels

5. Lead workforce transformation in new ways of working

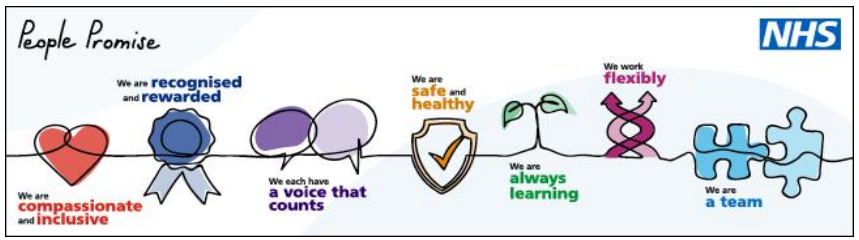
6. Educate, train and develop people

7. Drive and support social and economic development

8. Transform people services and the people profession

9. Lead coordinated workforce planning using analysis

10. Support system design and development



Lincolnshire People Board – Governance Framework

Lincolnshire Integrated Care Board (ICB)

Organisational Boards / Sub Committees

Midlands People Board

Lincolnshire Health & Care Collaborative Exec Delivery Board (LHCC)

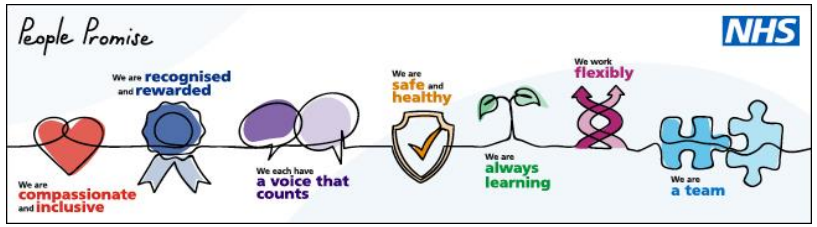
Lincolnshire People Board

Lincolnshire People Hub (Delivery)

- System approach to health and wellbeing
- Workforce Planning and intelligence
- Attraction into the Lincolnshire Health & Care system
- Pipeline of our future workforce
- Support inclusion and belonging
- Harnessing the opportunities in the wider workforce
- Retaining our People
- Leadership, Lifelong learning & Talent

Lincolnshire People Team (Strategic Oversight)

- Looking after our People
- Belonging
- New ways of working
- Growing for the Future
- Leadership, Lifelong learning & Talent (from 22/23)



Lincolnshire Health & Care Collaborative – Governance Framework

Provider Leadership Board (Joint Committee)

Lincolnshire Integrated Care Board

ICB Committees

ICB/Provider Collaborative Joint NED Chaired Committees:

1. Service Delivery and Performance
2. Quality
3. Finance and Resources

Decision making body with authority to delegate

Accountability driven through Monthly Assurance Report to Sovereign Boards and/or sub committees presented by LHCC Managing Director supported by CEO and underpinned by Early Warning Metrics

Lincolnshire Health and Care Collaborative Executive Delivery Board

Joint Committee accountable for the delivery of 3 delegated ICB functions to the ICB and Sovereign Provider Boards:

1. Service Delivery, Redesign and Transformation
2. Data and Digital
3. People and Culture

Membership: CEO's of LHCC Member organisations and LHCC Managing Director

Senior Operational Leaders Group

Drives system operational service delivery, acts as Programme Board for system service redesign and transformation

Membership: COO's, SRO's and CFO's. Programme Leads

Transformation Boards initially:

- Care Closer to Home,
- MSK
- Prescribing

Provider Collaborative Steering Group

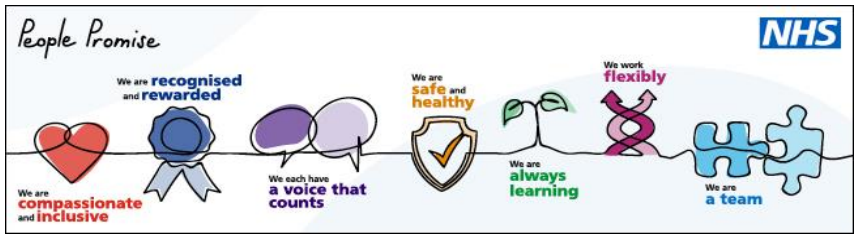
The PCSG supports the LHCC Executive Delivery Board on work that spans the delegated functions. Including:

- Development and implementation of overarching Alliance Agreement;
- Creation of the required culture, relationships and partnerships.
- Development of the necessary governance arrangements.
- An OD programme.
- Communications and Engagement for the collaborative.

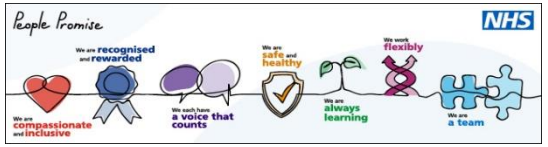
Enabler Boards

- People
- Digital

- LHCC Executive Delivery Board functions as a Joint Committee with CEO membership
- NED Assurance is guaranteed through
  1. **NED Chaired Joint ICB/Provider Committees**
  2. **Monthly Assurance Report from LHCC to sovereign Provider Boards presented by LHCC Managing Director and relevant CE**O
- In scope limited in first instance to those services in scope to Strategic Delivery Plan



The Lincolnshire People Plan – 2022/23 at a glance



The People Plan Pillars 2022/23:

- **Looking after our People**
- **Belonging**
- **New Ways of Working and Delivering Care**
- **Growing for the Future**
- **Leadership, Lifelong Learning & Talent**

The System People Priorities:

1. *System approach to health and wellbeing – what is our offer to all staff?*
2. *Support inclusion and belonging in seeking to shape a modern employment culture*
3. *Harnessing new ways of working in delivering health and care*
4. *4a. Growing for the Future: Workforce Planning and intelligence*
   4b. Growing for the Future: Attraction into the Lincolnshire Health & Care system
   4c. Growing for the Future: Pipeline of our future workforce
   4d. Growing for the Future: Retaining our People – a system approach
5. *Leadership, Lifelong Learning & Talent*

The Deliverables:

- Review the HWB offer
  HWB Conversations
  Ensuring access
- Six high impact actions
  Improve representation
  Deliver the EDI Strategy
- Optimise Capacity
  Wider Workforce
  Support new models of care
- Workforce Planning
  Attracting People
  Pipeline of future workforce
  Retaining People
- Leadership Stocktake
  Leadership/Talent Intent
  Forward plan
  Career Conversations
  Lincs LEAD Group

Priority 1. System approach to health & wellbeing

Looking after our People

...in continuing to ensure the health and wellbeing of our staff:

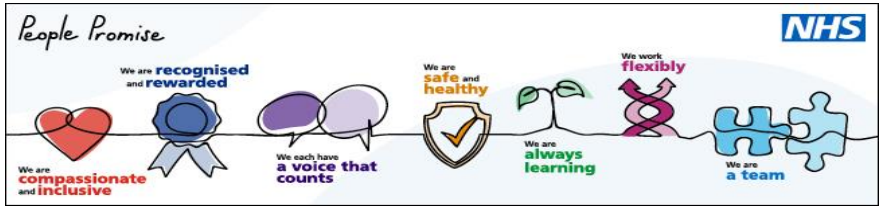
We must:

- Approach Health and Wellbeing as a system – modelled and promoted by leaders to secure 'buy-in'
- Agree the Lincolnshire Health and Wellbeing Strategy at Lincolnshire People Board and align to the Lincolnshire People Plan
- Review the Lincolnshire Health and Wellbeing Offer and rebrand the HWB hub
- Embed health and wellbeing conversations and support leaders in holding them effectively
- Clarify the operating model in ensuring access to the Lincolnshire Health & *Wellbeing Hub* and other initiatives
- Undertake a thorough Occupational Health Review
- Promote flexibility to retain talent (for example, menopause awareness, becoming a *menopause friendly* workplace)
- Collate timely intelligence to inform areas of priority in keeping people safe and well

and as a result:

- Continue in developing a compassionate culture
- Increase uptake of HWB offers
- Improve the People Promise scores in 'we are safe and healthy' and 'we work flexibly'

Strategic lead: Julie Stevens



Priority 2. Promote inclusion & belonging

Belonging

...In seeking to shape a modern employment culture – promoting flexibility, wellbeing and career development, and redoubling our efforts to address discrimination, violence, bullying and harassment:

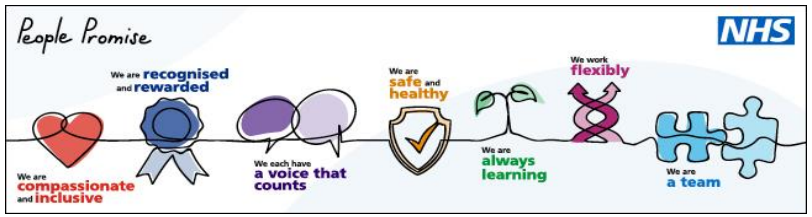
We must:

- Agree the Lincolnshire Equality, Diversity and Inclusion (EDI) strategy at Lincolnshire People Board
- Baseline the reporting requirements for EDI Data across the system (timely and meaningful EDI and staff survey data) across all groups with protected characteristics
- Deliver the six *high impact* actions to overhaul recruitment and promotion practices
- Implement plans to promote equality across all protected characteristics
- Embed staff networks across the system, ensuring they have the support to thrive and have a voice
- Clarify the principles of allyship in promoting wider attendance and engagement with staff networks and forums
- Fully utilise initiatives and guidance as they become available from NHSE/I and the CQC in relation to confidence to speak up initiatives e.g. Just Culture and Civility charter

and as a result:

- Respect, equality and diversity will be central to changing the culture and will be at the heart of the workforce implementation plan
- Improve the BAME disparity ratio and Increase proportion those in senior leadership with protected characteristics
- Improving the People Promise scores in 'we are compassionate and inclusive' and 'we are always learning'

Strategic Lead – Jane McLean



Priority 3. Harness new ways of working in delivering health & care

New Ways of Working and Delivering Care

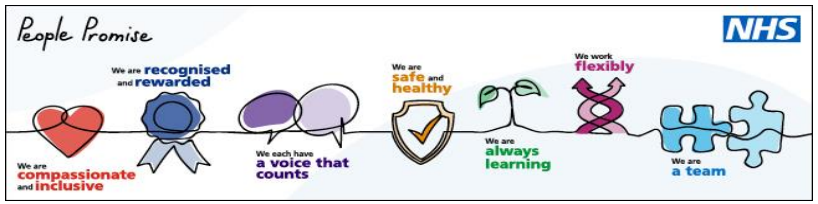
..in delivering 21st Century Care

- Optimise Capacity of Workforce to make sure the right staff with the right skills are in the right place at the right time
- Supporting the Strategic Delivery Plan in clinical redesign of Care Closer to Home
- A clear approach to harness the opportunities within the ICS to promote and expand the volunteer workforce.
- Making the most of the skills in the wider workforce such as bank workers
- Develop a plan for system wide programmes and initiatives such as NHS cadets or reservists in conjunction with the Talent Academy
- Support organisations to harness the effort of the wider workforce – the 3rd sector, other volunteers and carers in developing the workforce in delivering new models of care
- Lead the system collaborative bank programme
- Optimise the capacity of the current workforce by ensuring the highest level of attainment set out by the 'meaningful use standards' for e-job planning and e-rostering

and as a result:

- Staff, patients, service users benefit from well-designed volunteering initiatives
- Higher proportion of clinical staff deployed using e-roster and utilising e-job plan
- Collaborative bank strategy with all system partners engaged
- A result of the Reservist programme will be to have a flexible contingent workforce able to respond during peak times

Strategic Lead – Dusty Millar



Priority 4a. Growing our workforce – planning and modelling...

Growing for the Future

..to gain insight and plan ahead

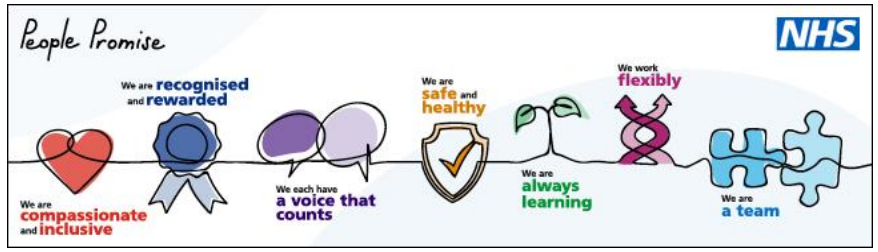
We must

- Create detailed system workforce plan to identify and prioritise current workforce gaps across all system organisations.
- Secure expertise and / or WF planning system to address the planning requirements for modelling future needs
- Identify an effective platform for workforce modelling
- Introduce predictive analytic reporting to inform workforce planning across the system partners (NHS providers in 22/23)
- Agree System metrics to track progress against workforce plans and review to inform priorities.
- Engage with system partners for future wider implementation of workforce planning
- Building capacity and capability to inform workforce planning and modelling across all system partners

and as a result:

- Workforce Modelling capability is increased within the System and the System has a Workforce Plan

Strategic lead: Ade Tams



Priority 4b. Attraction into the Lincolnshire Health & Care System

Growing for the Future

..to grow the workforce in health and care

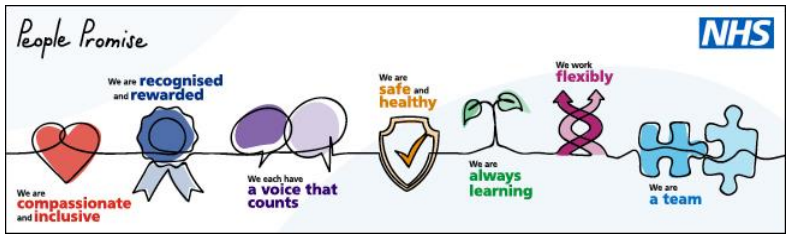
We must:

- Adopt a system-wide approach to attracting staff to Lincolnshire (domestic and International)
- Work with Health and Social Care partners in securing expertise
- Raise the profile of the County and the sector in a creative manner, utilising the skills of other agencies as appropriate
- In conjunction with the Workforce Planning Lead, and using the system-level intelligence on predictive vacancy positions, ensure there is a dynamic attraction and recruitment programme to meet demand
- Oversee the contract for the Digital Attraction Campaign *Be Lincolnshire*
- Attraction strategy stage 1
- Attraction Strategy Stage 2
- International Recruitment
- Oversee the Refugee Doctors programme

and as a result:

- **Lincolnshire will have a joint ambition to attract a workforce to live and work in the County**

Strategic lead: Claire Low



Priority 4c. Pipeline of our future workforce...

Growing for the Future

..to train as health and care professionals for the future

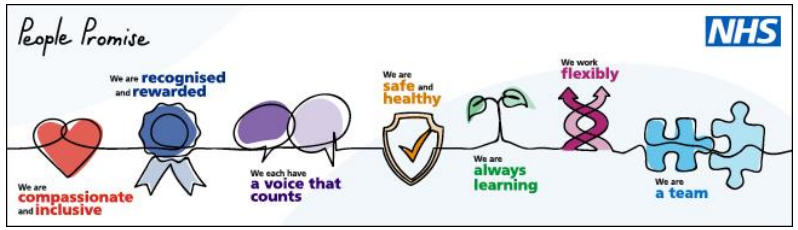
We must:

- Align Talent Academy and Training Hub and ensure priorities and requirements are defined and agreed
- Evaluate the current entry level apprenticeships and scope the opportunities for apprenticeships within Primary Care
- Have oversight of funding to support existing or future workforce recruitment and pipeline – with a system rigour into the utilisation of the apprenticeship levy and other funding
- Enable system collaboration with education providers in order to maximise workforce pipeline, particularly in key roles
- Coordination of joint ventures such as 'new to care HCSW' cohort recruitment
- Ensure sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible
- Working towards a 3-year Apprenticeship plan aligning with the workforce plan from 23/24

and as a result:

- All System organisations to widen participation and create training and employment opportunities, including through expanding apprenticeships as a route into working in health and care; and create training and employment opportunities

Strategic lead: Claire Low



Priority 4d. Retaining our People

Growing for the Future

..a system approach

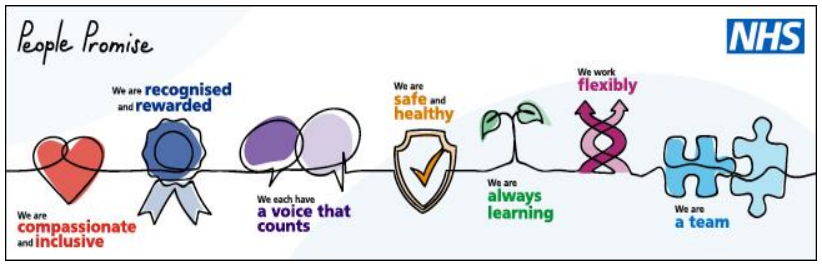
We must:

- Develop a system-wide retention action plan
- Work with People Promise Managers to embed the People Plan and People Promise
- Work with system partners to maximise opportunities to retain staff across the NHS and Social Care
- Be instrumental in supporting the delivery of the ICS' retention priorities
- Ensure feedback, insight and evidence gained is utilised to enhance staff experience and retaining our people
- Deliver a system-wide retention plan, co-ordinate and manage the development and delivery of a specific set of retention outcomes – wider than flexible working alone
- Ensure all aspects of EDI are responded to in any retention activities including but not limited to the system-wide retention plan
- Agree the introduction of Portfolio Careers as a retention measure
- Deliver a scoping document outline portfolio careers concentrating on ACP and PA – fellowship programme
- Accelerate the introduction of expanding advanced clinical practitioners

and as a result:

- Lincolnshire will retain talent within the County and sector

Strategic lead: Amy Beeton



Priority 5. Leadership, Lifelong Learning & Talent

Leadership, Lifelong Learning & Talent

..to lead well in a changing landscape

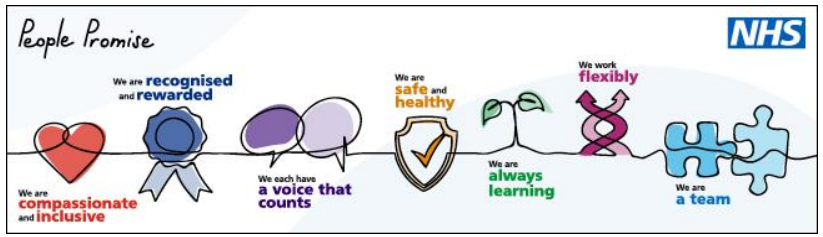
We must:

- Undertake a stocktake of the current offers and programmes
- Understand the national strategic intent
- Create a Lincolnshire Leadership and Talent Forward Plan
- Engage with the national team regarding the launch of the *NHS Leadership Way*
- Engage and support leaders in having Career Conversations
- Establish LEAD (learning, education and development) Group
- Ensuring staff are making the most of their skills and expertise will form a critical component of the NHS workforce implementation plan

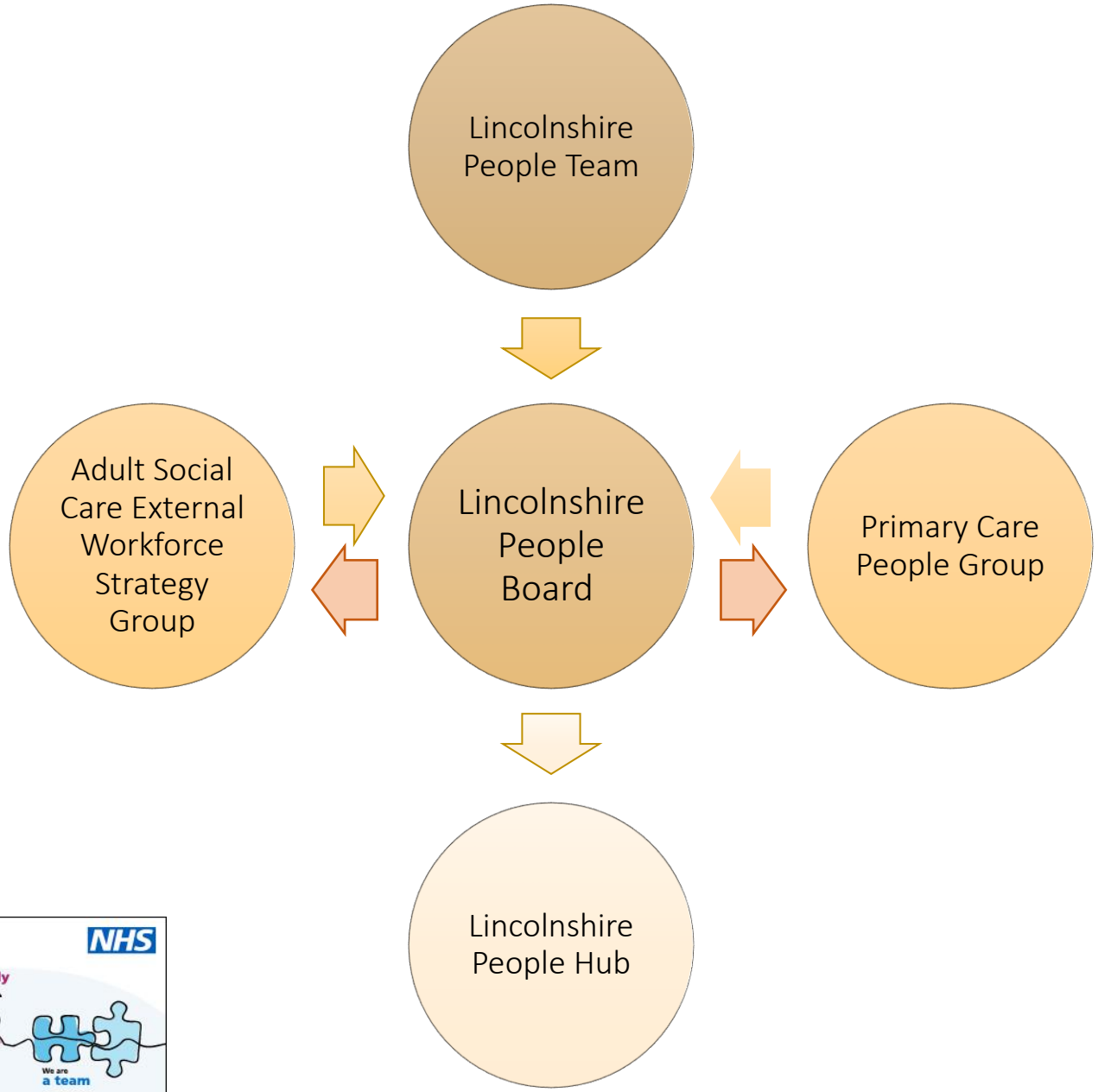
and as a result:

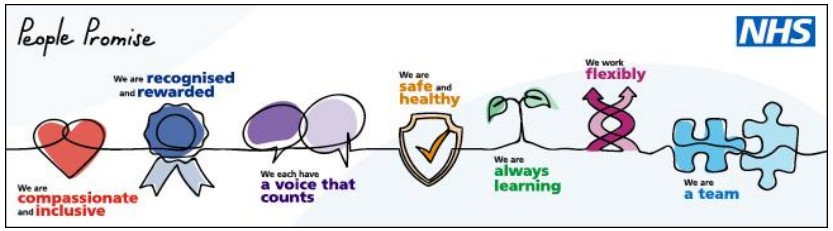
- Lincolnshire will train and retain great leaders in the system
- Improving the people promise scores in 'we are compassionate and inclusive'

Strategic lead: Sarah Akhtar

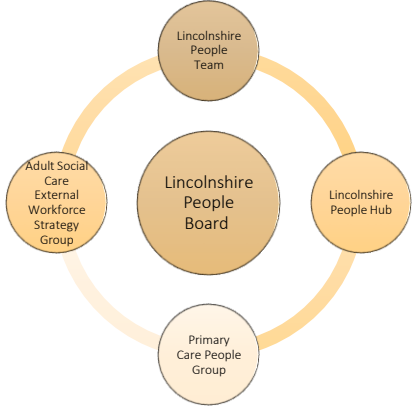


The Lincolnshire People Collaboration





The Lincolnshire People Board



Agenda

- People Plan update
- People Hub Update
- Primary Care People Group Update
- Adult Social Care External WF Strategy Group Update
- *One Workforce* Dashboard
- Funding & HEE
- Midlands People Board

Membership

Ceri Lennon, Chair

People Plan Pillar Leads

- **Looking after our People**: Julie Stevens
- **Belonging**: Jane McLean
- **New Ways of Working**: Dusty Millar
- **Growing for the Future**: Amy Beeton, Claire Low, Ade Tams
- **Leadership, Lifelong Learning & Talent**: Sarah Akhtar

Professional Leads

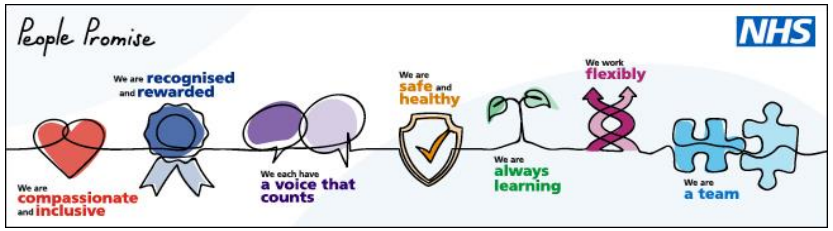
- **Nursing**: Tracy Pilcher
- **Medical**: Dr Colin Farquarson
- **AHP**: Angela Shimada
- **Pharmacy**: Kiran Hewitt
- **System BAME & Allies Chair**: TBC
- **Comms lead**: Charley Blyth

System Partners

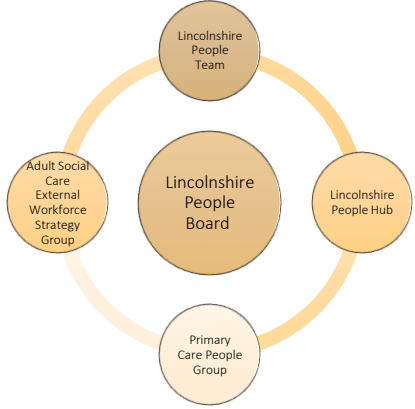
- **Lincolnshire County Council**: Justin Hackney
- **Primary Care**: Dr Kevin Thomas
- **Lincolnshire Care Association**: Melanie Weatherly
- **Voluntary Sector**: Michelle Jolly

People Hub

- **People Hub Lead**: Saumya Hebbar
- **People Board Programme Lead**: Jo Watson
- **People Board Administrator**: Samantha Williams



The Lincolnshire People Team



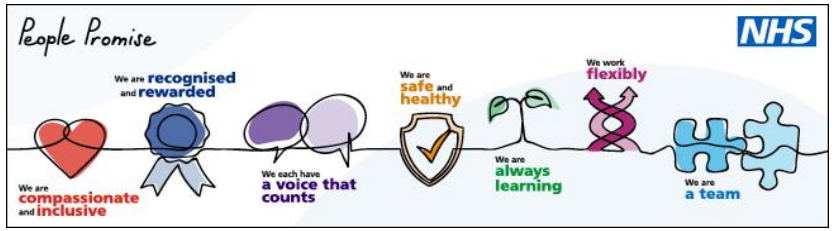
Agenda

- People Plan Pillar Updates
- People Hub Project Updates
- Workforce Issues
- Workforce Development Funding Update
- Risks, Issues and Escalations

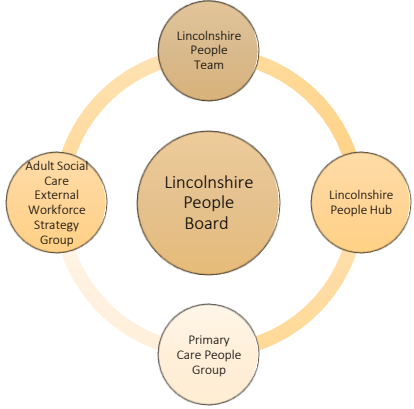
Membership

SRO
Ceri Lennon

- **Looking after Our People** — Julie Stevens
- **Belonging** — Jane McLean
- **New Ways of Working** — Dusty Millar
- **Growing for the Future**
  - **WF Planning** — Ade Tams
  - **Attraction** — Claire Low
  - **Pipeline for Future Workforce** — Claire Low
  - **Retention** — Amy Beeton
- **Leadership, Lifelong Learning & Talent** — Sarah Akhtar
- **System Partners**
  - **Adult Social Care** — Mark Turton, LinCa
  - **Primary Care** — Wendy Cundy
  - **ICB / AGEM** — Simon Collingwood
  - **Talent Academy** — Claire Flavell
  - **Lincs Training Hub** — Runa Saha, Susan McElnea
  - **HEE** — Felicity Begley



The Lincolnshire People Hub

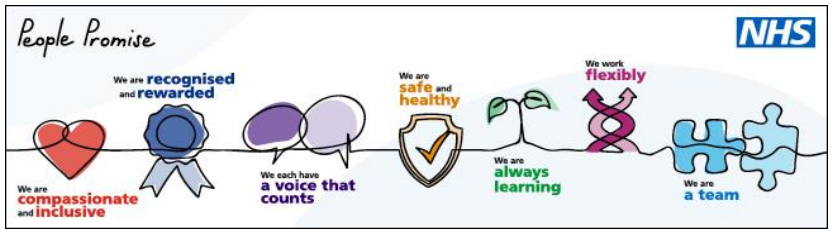


Agenda

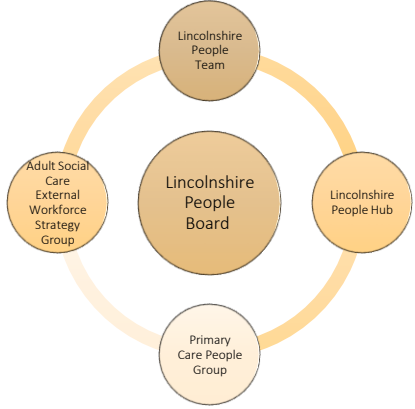
People Team Update → People Hub Project Updates → Risks, Issues and Escalations

Membership

- **Associate Director of People**: Saumya Hebbar
  - **System Workforce Lead & Looking after Our People Lead**: Julie Stevens
  - **Belonging Project Manager**: Angela Stockwood
  - **Wider Workforce Lead**: Chris Scard
  - **WF Planning Project Manager**: TBC
    - **WF Planning Project Support**: TBC
  - **Attraction Lead**: TBC
  - **Retention Lead**: Vicki Lightfoot
    - **People Promise Manager LCHS**: Musiiwa Takavarasha
    - **People Promise Manager ULHT**: Liz Smith
  - **People Plan Programme Lead**: Jo Watson
    - **People Plan Project Support Officer**: Dominika Mroz



The Lincolnshire External Workforce Steering Group

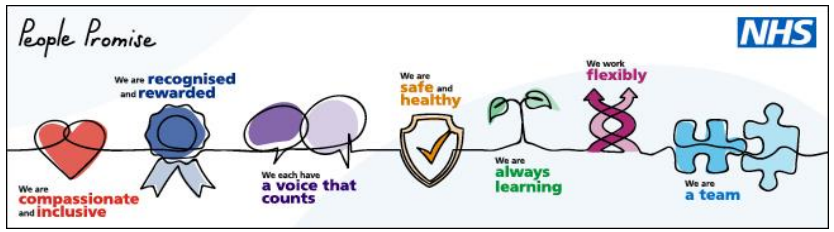


Agenda

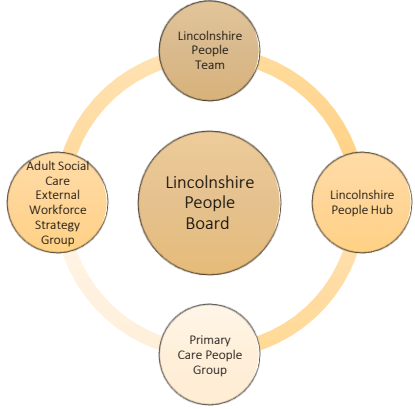
- Welcome and Introductions
- Action Tracker
- External Workforce Dashboard
- Workforce Plan

Membership

- Assistant Director Specialist Adult Services and Safeguarding, LCC Chair
  - Chair - Lincolnshire Care Association
  - Locality Manager Midlands, Skills for Care
  - Lead Professional – Principal Social Worker, LCC
  - Contract Manager, LCC Commercial Team
  - Head of Integration and Transformation, LCC
  - Head of Quality & Information, LCC
  - Strategic Communications Lead, LCC
  - General Manager Service Development, LCC



The Lincolnshire Primary Care People Group



Agenda

- Development of the Primary Care People Plan
- ARRS Recruitment and Retention
- Professional Updates
- Lincolnshire Talent Hub Update
- LMC Update
- Primary Care Workforce Issues

Membership

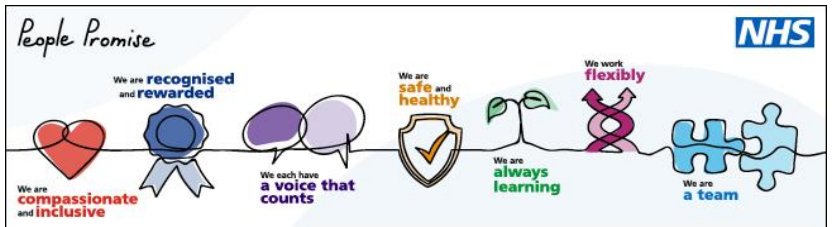
Chair:
Dr Kevin Thomas
GP/PCN Clinical Director/Workforce Lead

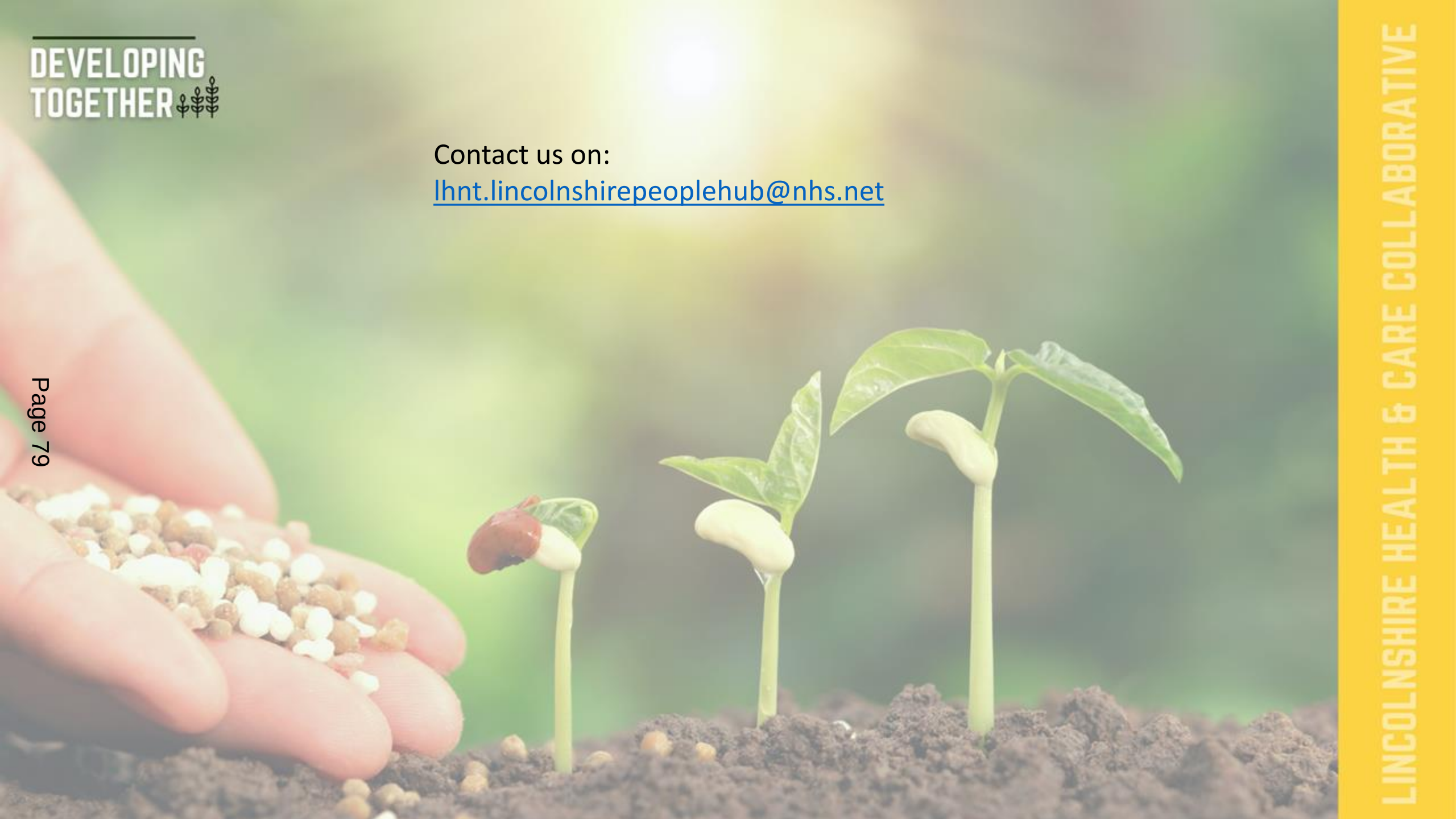
People Plan Pillar Leads
- Belonging Lead (GP)
- New Ways of Working and Delivering Care Lead (PC Senior Digital Business Partner)
- Leadership, Lifelong Learning and Talent Lead

Professional Representatives
- GP/ First 5 Representative
- GPN Representative
- LMC Medical Director
- Deputy Chief Nurse
- Primary Care AHP Representative

Workforce Team
- PCN Business Manager Workforce Lead
- Primary Care Workforce Lead
- Primary Care Programme Lead
- Senior Workforce Lead – System Transformation

System Partners
- Primary Care Head of Transformation
- HEE Workforce Transformation Manager – Lincolnshire
- Senior Communications and Engagement Manager
- Lincolnshire Talent Hub Business Director




DEVELOPING TOGETHER
Contact us on:
lhnt.lincolnshirepeoplehub@nhs.net
LINCOLNSHIRE HEALTH & CARE COLLABORATIVE

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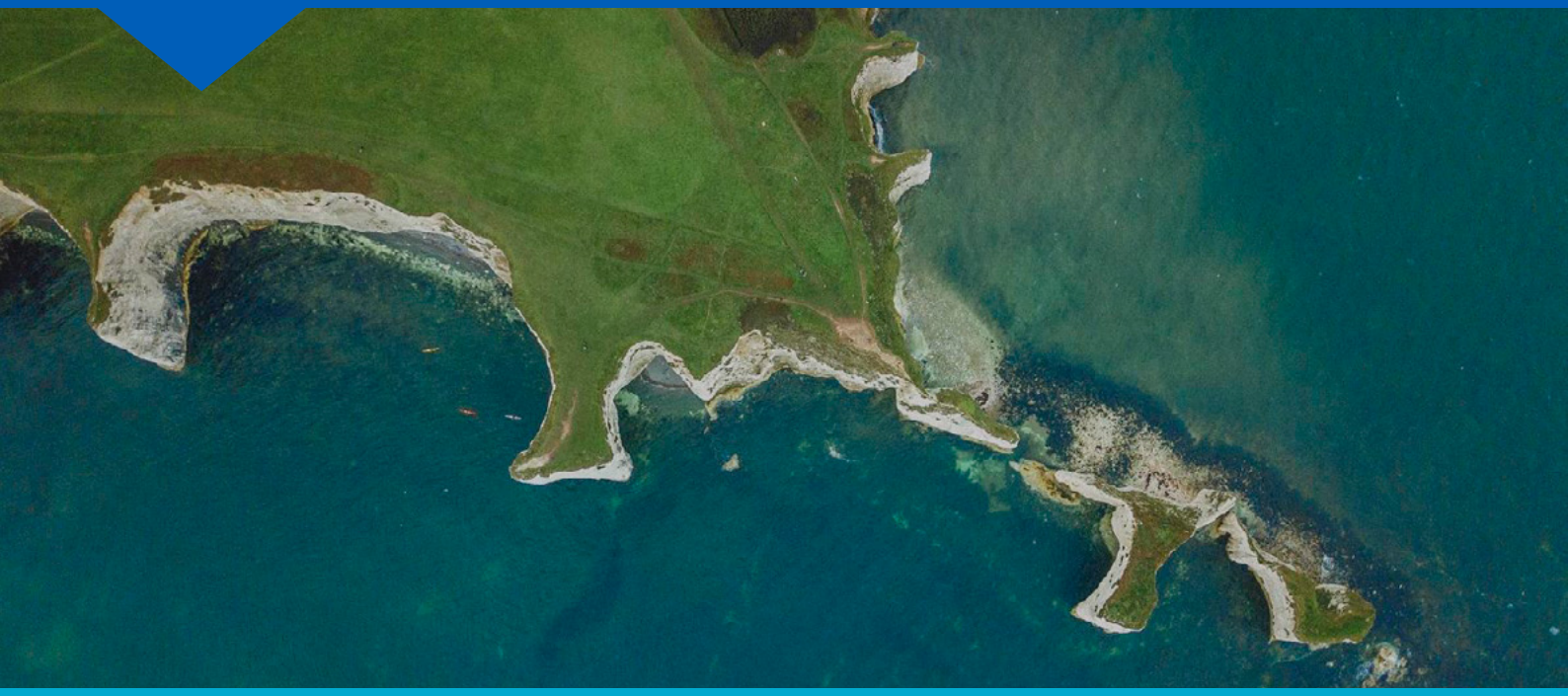
Health Education England

Rural & Coastal Transformation:

Developing health, care and communities through workforce, education, and training in small places.



A discussion paper for NHS Health Education England

Authors: Adrian Tams, Patrick Mitchell & Andrew Dickenson

Report date: September 2021

Contents

Executive summary

> "The most successful model of education and training for local comprehensive Public Health Care is socially accountable, immersive community-engaged education woven into a facilitated education and training pathway starting with recruiting local students from rural and underserved communities."
>
> Strasser, Roger; Strasser, Sarah. 2020. Reimaging Primary Health Care Workforce in Rural and Underserved Settings. Health, Nutrition and Population Discussion Paper; World Bank, Washington, DC.

- This report is about addressing health inequalities for public and patients within rural and coastal settings.
- Patient-related health outcomes in rural communities can be improved through a stable and well-trained local workforce. However, to ensure a sustainable rural healthcare system demands workforce models that have been designed in, and for, these settings.
- Regional workforce planning must reflect unique rural place-based solutions.
- Successful rural workforce transformation requires:
  - Commonality, as rural communities identify more with similar communities in other countries than their own urban centres.
  - Delivering education and training within rural communities increases the quality and cultural relevance of services through a lived experience.
  - Investing in targeted training of rural residents increases recruitment and stability of services in rural locations.
  - Initiatives must be co-produced with the local population to be successful.
- The disproportionate rural workforce shortages, especially amongst professionally qualified clinical groups, is being addressed within the Medical Education Reform Programme, Future Doctor Programme, Generalist Schools and Dental Programmes, but requires more creative place-based solutions.
- This paper sets out an ambition to target a suite of evidence-based programmes within four specific rural-coastal ICSs (laid out in page 17). While these pilots will be place-based, HEE will take the good practice and learning emerging from them to inform future HEE investment and direction.
- This will require HEE to continue to work with partners and span organisational and service boundaries to address wider determinants of health.

Introduction

This discussion paper highlights global, national, and local research on workforce, education, and training in rural and coastal communities. In line with HEE Business Plans, it sets out an ambition to build a defined programme offer in these areas, helping to reduce ill health and health inequalities in rural areas through educating, training and digitally enabling the health and care workforces.

The aim of this paper is to open a conversation within HEE about interventions that could drive more positive outcomes for rural and coastal communities. It builds on what HEE is already developing rather than containing a formed or finalised set of recommendations.

The paper sets out:

1. Global health research on workforce and digital approaches in rural and coastal areas and the learning and practice that can be taken from global initiatives.
2. To define the challenges to rural and coastal areas, through exploring data on the wider determinants of health and workforce levels and why these communities are often overlooked within UK health policy.
3. To identify HEE programmes that can support rural and coastal ICSs.
4. A case for increasing the proportion of medical students who come from a rural background, providing positive rural learning experiences in medical schools and creating specific rural training programmes to increase the number of doctors with the interest, knowledge and skills for rural practice[1].
5. A proposal to pilot transformation programmes across four ICS areas (Lincolnshire, Norfolk & Waveney, Suffolk & North East Essex, and Kent & Medway). The learning from these pilots will be shared with other ICS / rural and coastal areas in England and with our global partners.

This paper aligns to the same issues highlighted in the Chief Medical Officer's Annual Report 2021[2] which concentrated on health in coastal communities. The central argument of the report is that the health challenges of coastal towns, cities and other communities are serious and that if we do not tackle their health problems vigorously and systematically there will be a long tail of preventable ill health which will get worse as current populations age. HEE contributed a chapter to this report, which included analysis on the medical workforce and how HEE programmes could support a programme of reform to overcome some of these challenges.

Defining rural and coastal places is core to workforce design. The Rural Urban Classification is a national statistic used to distinguish between urban and rural areas. The Centre for Subnational Analysis at the Office for National Statistics (ONS) has produced a series of articles on towns, and the 2021 CMO's 'Health in Coastal Communities' report, has focussed on coastal areas although rural remains overlooked within UK health policy.

Deprivation indices have been widely used in health care planning. Existing indices, however, are dominated by characteristics of urban populations that may be less relevant in capturing the nature of rural and coastal deprivation. Combining 4 of the domains in the Index of Multiple Deprivation (IMD) with access to services and demography data reveals how rural and coastal areas have concentrations of deprivation and ill health.

Local NHS organisations are seen as 'anchor institutions[3]' as they are unlikely to relocate and have a significant stake in a geographical area. They have assets that can be used to reduce widening health inequalities and pressures on health care services including workforce and training. HEE is already supporting this work in seeking to build enhanced training, education, and digital learning opportunities in rural and coastal areas.

Attracting graduates into rural areas is critical. Compelling data from Canada, North America and Australia highlight the need to train and retain medical students who have followed a rural track programme. Strasser demonstrated that 30% of students from the Northern Ontario School of Medicine continue into speciality training[4], making training in rural areas an essential aspect of this offer. It is necessary to establish a pathway preferencing students from rural backgrounds onto medical courses[5].

In terms of current policy that are opportunities to position solutions within the Levelling Up agenda as well as in relation to mainstream health funding. As part of the Government's plan to level-up regions, the Towns Fund[6] is a £3.6 billion fund investing in selected towns across England. Each Town establishes a Board and produces a Town Investment Plan of priorities and projects to unlock the investment. Many of these Plans are considering how their interventions will impact and improve the health and wellbeing of the population. For example, Skegness and Mablethorpe secured their Town Deals in March 2021 – and their Plan includes the development of a 'Campus for Future Living'. HEE has identified several workforce transformation programmes which could be piloted from the Campus.

Global Context

HEE supports the NHS to engage in global activity to attract and retain staff and strengthen workforce development. While examples from other countries are always context, place, and community specific; they offer insights into the factors related to workforce and digital approaches in other rural and coastal areas.

Globally, the population density of medical practitioners tends to be higher in urban areas compared to rural and remote settings (Organisation for Economic Co-operation and Development 2019[7]). Recruiting and retaining a skilled health workforce is a recurrent global challenge for remote and rural communities, negatively impacting access to services and directly on health. The research literature demonstrates how different factors facilitate or hinder recruitment and retention of healthcare workers in remote and rural areas; however, there are few practical tools to guide local healthcare organisations in their issues. It was highlighted in a Nuffield Trust (2018) report that smaller hospitals are burdened with workforce shortages, spiralling costs, and increasingly complex models of care for acutely ill patients[8]. Detailed examples of global good practice and insights are set out at Annex 1.

The development of a rural and coastal programme will allow HEE to explore innovative solutions to identified chronic issues by learning from global research. There are three globally identified factors that are viewed as crucial in securing the right workforce in rural areas: (1) a rural upbringing, (2) positive clinical and educational experiences in rural settings as part of undergraduate medical & clinical education and (3) targeted training for rural practice at the postgraduate level.

Classifying rural and coastal communities

The Rural Urban Classification[9] is a national statistic used to distinguish between urban and rural areas. Using this classification, 9.6 million people, or 17.1% of the population, lived in rural areas in 2019[10].

- Rural areas have a higher proportion of older people compared with urban areas. In 2019, the most prominent age groups in rural areas were 50-54 years and 55-59 years (comprising 7.9% of the rural population); while the most prominent age groups in urban areas were those aged 25-29 years and 30-34 years (comprising 7.2% of the population).
- The average age in rural areas has increased faster than in urban areas. In 2019, the average age in rural areas was 44.9 years, 5.7 years older than in urban areas. The average age in England increased by 1.5 years between 2002 and 2019, but by 3.1 years in Rural Town and Fringe areas and 3.8 years in Rural Villages.
- Generally, people living in rural settlements have lower overall levels of accessibility to key services compared to people living in urban areas. 80.9% of people living in rural areas have access to a GP within half an hour's travel using public transport and walking, compared to 99.5% of people living in urban areas.

- Rural communities are ageing more rapidly than urban areas.
- Younger population tends to decline the more rural the settlement type.
- Older people experience worse health and have greater need of health and care services.
- Access to health and care services is often poorer than in urban settings.

- One of the key contributors to health disparities in rural areas is inadequate staffing of rural health services (Malatzy et al. 2020[11]).
- A recent review prepared for the Cavendish Coalition (NIESR 2018[12]), identified that of the 44 Sustainability and Transformation Partnerships in England (ICS), 22 have a rural population greater than or equal to the national average (17%).
- The review highlighted how connections between 'rural' issues and 'workforce' were lacking across ICS's. It is an ambition of the rural and coastal programme within HEE to bring together these issues.
- Within the review, data revealed an overall difference of 45% in the ratio of NHS staff per head of population in the 11 most rural ICS areas compared to England as a whole, meaning that compared to the national average rural areas have 45% fewer workers per head of population.
- The review identified key staff groups with significant workforce shortages: professionally qualified clinical staff, doctors, consultants, staff grade, specialty registrar, core training, foundation doctor year 1, dentists, midwives and AHP's.

Health outcomes are also poorer in coastal areas. The pleasant environment attracts older, retired citizens to settle, who inevitably have more and increasing health problems. An oversupply of guest housing has led to Houses of Multiple Occupation which led to concentrations of deprivation and ill health.

There is no nationally agreed upon definition on what constitutes a 'coastal community'. The CMO's Annual Report (2021) takes a broad definition, with the term applied to any settlement along the coast (including villages, towns, and cities). PHE[13] defines a coastal area as 'any coastal settlement within a local authority area whose boundaries include UK foreshore – including local authorities whose boundaries only include estuarine foreshore'. The Centre for Subnational Analysis at the Office for National Statistics (ONS) has identified 169 Coastal Towns in England and Wales[14], and categorises them by size, and according to whether they are seaside or non-seaside towns.

Except for seaside resorts and coastal cities, there has been very little focus on other rural and coastal areas which often remain overlooked within health policy.

Deprivation

A joint PHE LGA case study report[15] unpicked a widely held assumption that people living in rural places are better off, both in monetary terms and in terms of health and wellbeing. The report was prepared against a backdrop of a growing realisation that broad brush indicators can mask pockets of significant deprivation and poorer health outcomes. More Information is provided in Appendix 2. The development of a new index (RDI) by Professor Andy Jones and Amanda Burke at the University of East Anglia set out in more detail in Appendix 2 is particularly important in this context.

Deprivation may take different forms in different contexts:

- The IMD measures relative deprivation and not prevalence.
- The RDI provides a basis for developing and/or weighting deprivation by applying three domains: (1) relative deprivation – IMD domains for income, employment education, health, and disability; (2) locality related deprivation – IMD domain for housing in poor condition and DfT data on average time to travel to 8 essential services; and (3) population – people aged 75 years and over.
- Applying the RDI increases the number of LSOAs in rural and coastal areas that are deprived.

Workforce Agenda

Taking account of deprivation factors, HEE has combined data on rural and coastal workforce distribution with the IMD (Appendix 3). This identified four areas with low workforce levels (doctors less than 0.3/1000; nursing 2.5/1000) with high deprivation levels (>22):

Table 1: Pilot geography IMD Score and workforce/1000 population

Geography	IMD Score	Rank	Drs/1000 capita	Rank	Nurses/ 1000 capita	Rank
Lincolnshire	29.6	6	0.23	2	3.26	14
Norfolk – Kings Lynn	27.1	8	0.25	5	3.17	13
Suffolk – James Paget	27.2	7	0.23	1	2.57	5
East Kent	22.8	15	0.37	13	2.7	6
Medway	22.5	16	0.23	4	2.17	1

The WHO[16] published 16 evidence-based policy recommendations for the design, implementation, and evaluation of initiatives to attract and retain health workers in rural areas, grouped around education, regulation, financial incentives (eg TERS)[17], personal and professional support. It has identified that rural exposure during undergraduate medical training contributes to recruitment and retention in nonurban settings, which should be included in strategies addressing shortage of rural practitioners. International evidence has identified that rural placements during medical education are particularly effective for rural-entry students, indicating that Universities should be encouraging applications from rural students within a widening access and participation initiative[18].

- Rural and coastal areas often struggle to attract, recruit, and retain the right workforce.
- HEE workforce analysis has identified rural and coastal areas that are under-served and highly deprived. Four of these areas are good places to start if we are to reduce disparities.

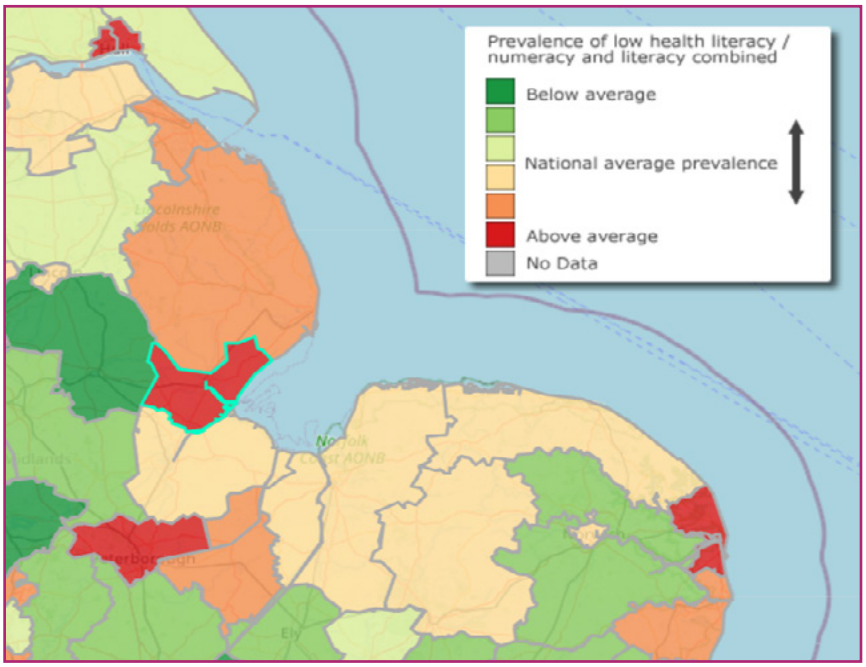
Digital Literacy

The data available on digital literacy suggests that all four pilot areas face considerable challenges with adoption of digital technology arising from their remote settings.

The Go ON UK research (2019) shows that the off-line population [those without access to the internet] are disproportionately rural, low income, older and illiterate:

- 64% of the off-line population live in rural areas.
- 50% of off-line individuals have an income below the poverty line.
- 18% are over 55 years.

Health literacy is the ability to access, assess and use health information. In our digital age, health literacy needs to be underpinned by digital navigation and digital literacy skills, so that individuals can find and evaluate information online as well as access digital health services. This is even more important as healthcare appointments move online. Also, one impact of the pandemic is that the voluntary sector cannot fund printed information materials and is producing materials online. Geodata commissioned by Health Education England shows coastal and rural communities are amongst those that struggle with health literacy an example of the eastern seaboard is set out below.



Source: Skills for Life data from 2011, combined with population projections were for 2016. Analysis commissioned by Health Education England from the University of Southampton.

Full geodata at http://healthliteracy.geodata.uk

Two examples of good practice established to address this issue which can be built on involve East Kent, which was an early adopter (2014) of improving digital literacy within local communitities (see case study). This intitial project and its outcomes has provided a platform for delivery of a similar project in Lincolnshire (see below), where 25% of the population are without basic digital skills:

East Kent: 'Touch a new world' 2014 pilot project

- At the time, 1,415 Home Library Service (HLS) customers were unable to physically visit a library and unable to access digital services and facilities.
- Offered training to customers who had never been online and did not have their own computer equipment, using a web-enabled tablet device lent to them for the period of the training.
- Provided training to HLS customers who already had their own computer equipment but lacked the skills and/or confidence to use it effectively.
- Matched each customer with a dedicated and trained volunteer to deliver 6 x 1 hour weekly sessions covering key aspects of going online.
- 21 volunteers were trained to deliver the programme initially, with expansion plans for the future.
- 91% of participants reported feeling extremely satisfied with the training with a new understanding of IT.

Lincolnshire: A pilot study area for Digital Ambassadors

- A quarter of the population in Lincolnshire do not posses the skills to confidently use technology or digital products in their lives.
- A large proportion that have no motivation to engage with the internet.
- The key area of focus is to increase the motivation to engage with barriers and opportunities within this area.
- This requires a workforce and the public being able to have great conversations about the use of digital products in the provision of care.

HEE National are supporting NHS Lincolnshire Community Health Services to develop a 12 month programme to create 'Digital Ambassadors' across the workforce and communities of the east coast, Lincs.

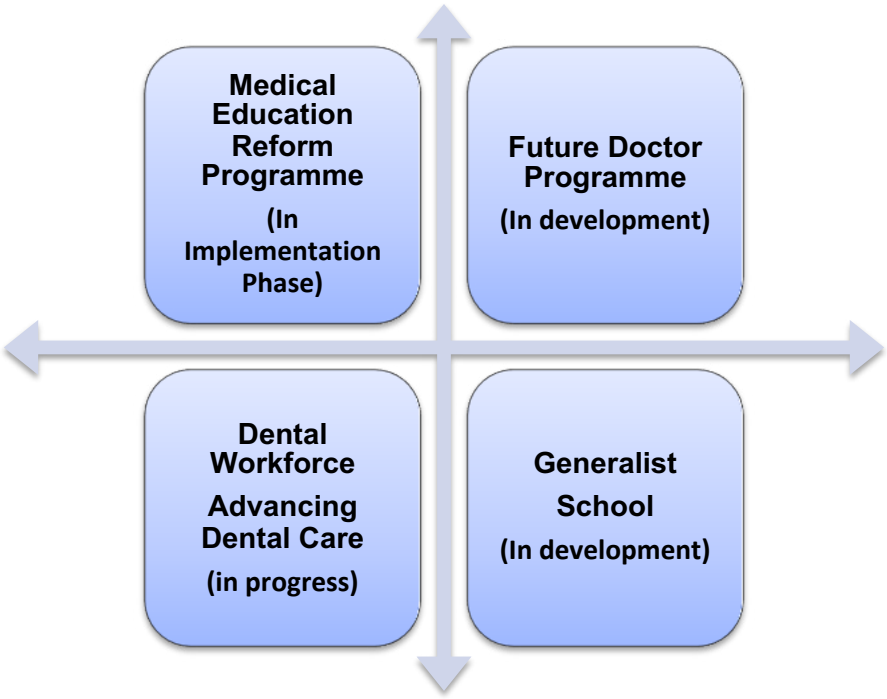
- Health education and training can be enhanced through innovation and the use of existing and emergent technologies.
- Digital literacy is person-centred and staff working in health and care need to be able to identify and develop their digital capabilities.
- To support local ownership of digital literacy and skills development, 'Digital Ambassadors' and an ICS development programme could be supported within the four pilot areas. This is already underway in Lincolnshire.
- Technology and e-enabled solutions have the potential to improve patient access to services, the quality of clinical services they receive and the outcomes they achieve.
- For health professionals, digital technologies provide access to continuing education and professional development, the provision of enhanced local services, networking, and collaboration.
- COVID-19 has increased the usage and adoption of digital technologies in rural and remote coastal settings.

HEE Programme Offer

There are several HEE education and training programmes and development innovations (see diagram below) that are supporting the rural and coastal agenda.

This proposal would require HEE's regional teams to work in collaboration with the proposed ICS pilot areas, supported by HEE's national teams as appropriate, to establish a targeted and sustained programme over multiple years.

The programme would be designed on a mix of existing proven interventions but be anchored around some key initiatives that internationally have bene proven to be effective in sustaining a local community's recruitment and retention of health professionals. These programmes are at varying stages of implementation but can be adapted to an integrated rural and coastal model as part of the overarching place-based transformation ambition.



It is clear that rural and coastal communities face significant and long-standing challenges in relation to health inequalities. Addressing this requires a new vision for professional practice in rural and coastal places which is locally distributed, community embedded and where education and learning leads to greater collaboration with other partners in health, care, local authorities, and communities. This is not about altering established approaches but building on existing programmes and activities, acknowledging the key drivers in the diagram below:

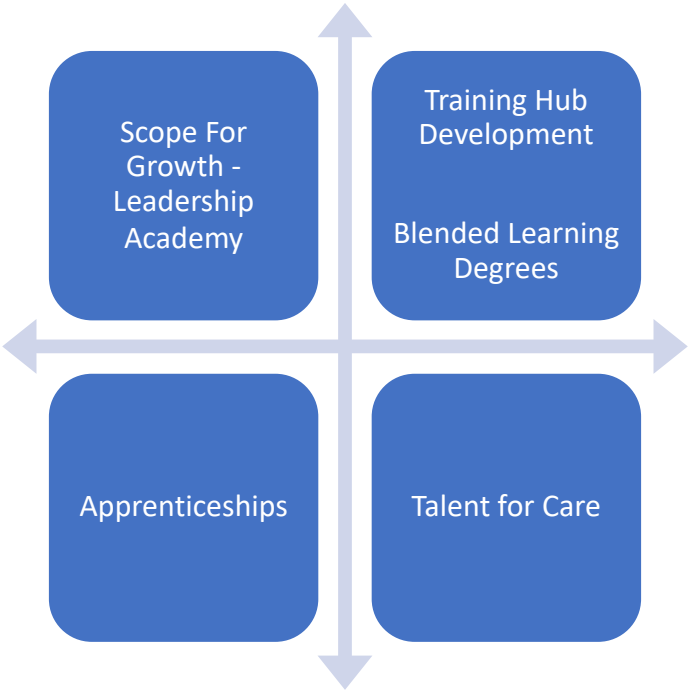
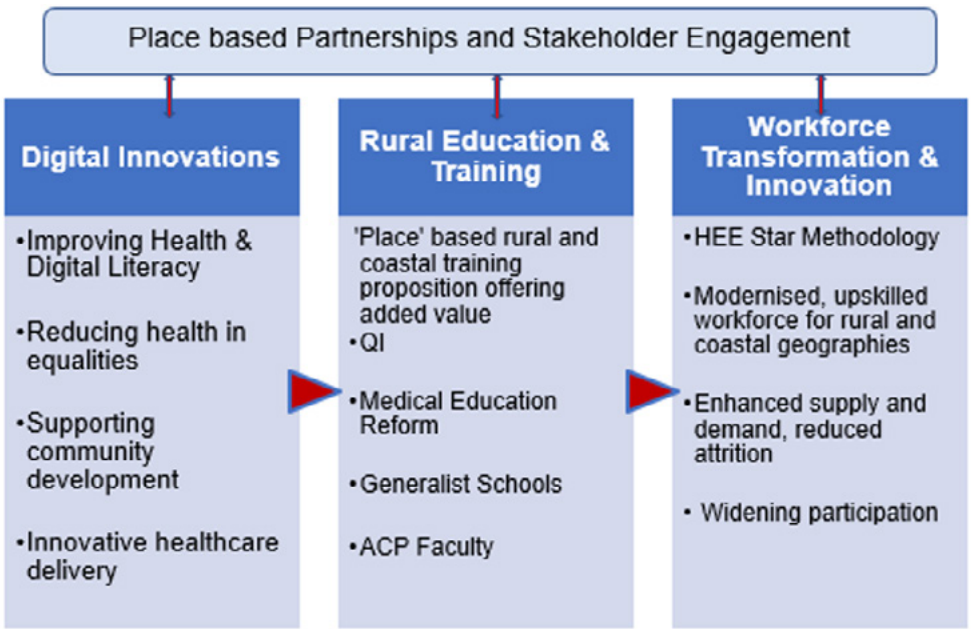


Figure: Proposed drivers for change

The diagram below summarises how these programme areas inform a rural and coastal partnership and stakeholder programme:



More details on the HEE offer are set out in Appendix 4.

Business Plan

The ambitions are aligned to the priorities set out in the 20/21 HEE Business Plan:

- Maximise impact of current education and training delivery.
- Robust QI to ensure continuous improvement using HEE's Quality Framework.
- Review the methods used ways to recruit, train and assess trainees whose skills the NHS will rely upon in future, while fully complying with the government measures needed to combat COVID-19.
- Collaborate with a partnership of organisations to ensure cohesive oversight of education, training and deployment and embedding workforce supply, education, and training principles into routine service delivery, and restoration and recovery work.

Additionally, the HEE annual mandate sets out priority areas and commitments around:

- Making sure the HEE Digital First places customers central in everything we do.
- Increasing the nursing workforce by expanding routes into the profession, attracting more undergraduates, improving support, and changing perceptions
- Building more multidisciplinary teams and a more flexible workforce to meet modern and emerging healthcare needs, launching a national consultation to establish what the NHS, patients, and the public want from 21st-century doctors.
- Supporting targeted action to prevent ill-health, improve patient safety, transform mental health and learning disability services, improve cancer outcomes and transform urgent and emergency care.
- Working more closely with national, regional and system partners to develop a more coherent approach to workforce policy and planning.
- Continue to welcome and support international workers.

- A rural coastal programme aligns to the HEE strategic goals, objectives and foundations of success contained in the Interim Business Plan.
- Rural and coastal areas have been impacted by Covid-19, reflecting the aging populations, pockets of deprivation and economic reliance on tourism and hospitality areas. Investing in these areas will support HEE's work around Recovery and Delivery.
- HEE investment in a rural and coastal programme will ensure education and training can act as a catalyst for change in developing a workforce skilled to meet the health and care needs of these communities.

Delivery plan

Based upon deprivation, workforce and digital data, and current activity across HEE geography, four ICSs with rural coastal areas have been selected as 'test beds' for education, training, and workforce transformation. The identified ICS are Lincolnshire, Norfolk & Waveney, Suffolk & North East Essex, Kent & Medway.

These ICS's face similar challenges in attracting, recruiting, and retaining a workforce needed to deliver the range of health care needs within their populations. At the same time, more work is needed to support, enable, and empower residents in these areas to make informed decisions about their care and wellbeing, self-manage their conditions, and remain active in their communities. Evidence suggests that a joined-up, place-based approach is necessary to tackle the complex causal pathway of inequalities.

Taking the population and workforce health needs into account, along with development of devolved budgets across the health and care system and working in partnership with Integrated Care Systems and CCG's, it is proposed (through a 'place' based approach in partnership with HEI's)[19] that the programme is piloted through several strands:

1. Work with local teams who have knowledge of the context and specific issues of those areas to fully understand the health and workforce issues.
2. Develop a programme of skills development to equip current & future workforce embedded in rural and coastal practice.
3. Support local communities to become centres of rural training excellence, contributing to a strong training programme.
4. Use MERP & Generalist Doctor programmes to influence the approach to medical and clinical training in England, drawing on global evidence.
5. Ensure trainees develop a broad range of skills needed for rural and coastal practice.
6. Ensure the service allows delivery of those skills.
7. Review previous initiatives and reasons for success and failure.

Digital technology will be a 'golden thread' throughout these programmes, driving transformation and innovation.

Ownership for delivery within each locality will be a partnership approach with HEE Transformation teams locally/nationally and ICS People Boards, which will provide governance and financial oversight. Investment is required to achieve successful outcomes and pump-priming HEE investment is recommended for a 2-year period. This is additional to current workforce development and transformation commitments to support and enhance existing ICS investments. However, it is anticipated that systems will also prioritise funding to support delivery against the identified suite of transformation projects.

Next steps

- This paper has sought to explore the definition, data, and insights into these communities; identifying four ICS areas to pilot a rural and coastal programme that will transform education, learning and training within them.
- The proposed pilot ICS systems are Lincolnshire, Norfolk & Waveney, Suffolk & North East Essex, and Kent & Medway.
- The pilot fits within the HEE Interim Business Plan in maximising the impact of education and training and in COVID-19 Delivery and Recovery. It will ensure the NHS is an anchor for co-production of these pilots.
- The suite of HEE support would deliver transformation programmes aligned with core and place-based options:
  - **Core:**
    - » Widening participation and access to medical schools, with ambition to increase applications from rural communities by an additional 20% over 3 years.
    - » Innovative rural and coastal healthcare apprenticeship programmes.
    - » Health literacy programmes eg; digital Ambassadors, to increase digital and health literacy within rural populations.
  - **Place-based:**
    - » To pilot and implement Generalist specialist training programmes, targeted placements, and immersive out-reach experiences.
    - » Dental and Medical Education Reform in line with the HEE emerging national programmes.
    - » Promotion of advanced practice to support the medical workforce eg; ACP/AHP and Pharmacy.
    - » Explore TERS initiatives for primary care attraction and retention within medical and dental training.
    - » Expansion and adoption of technological opportunities in line with the HEE Digital Strategy.
- Existing HEE internal and external relationships and engagement are integral to the delivery of the programme. The findings of the pilot will be shared to deliver transformation in other rural and coastal areas and form part of the evidence base and knowledge exchange with global partners.

Appendices

Appendix 1: Global Context

This section of the report sets out key reference points from a global perspective.

Remote Workforce Stability

Utilising a multi-partnership collaboration of global partners living in northern rural and remote communities across Sweden, Norway, Canada, Iceland, and Scotland, Strasser et al (2018) developed *'The Making it Work: Framework for Rural Remote Workforce Stability'*[20]. This identified factors impacting on workforce recruitment and retention in rural settings, based on nine strategic elements (Figure 1). Although not exclusively related to education and training, the framework identifies how these factors are essential to delivery of rural healthcare and workforce retention.

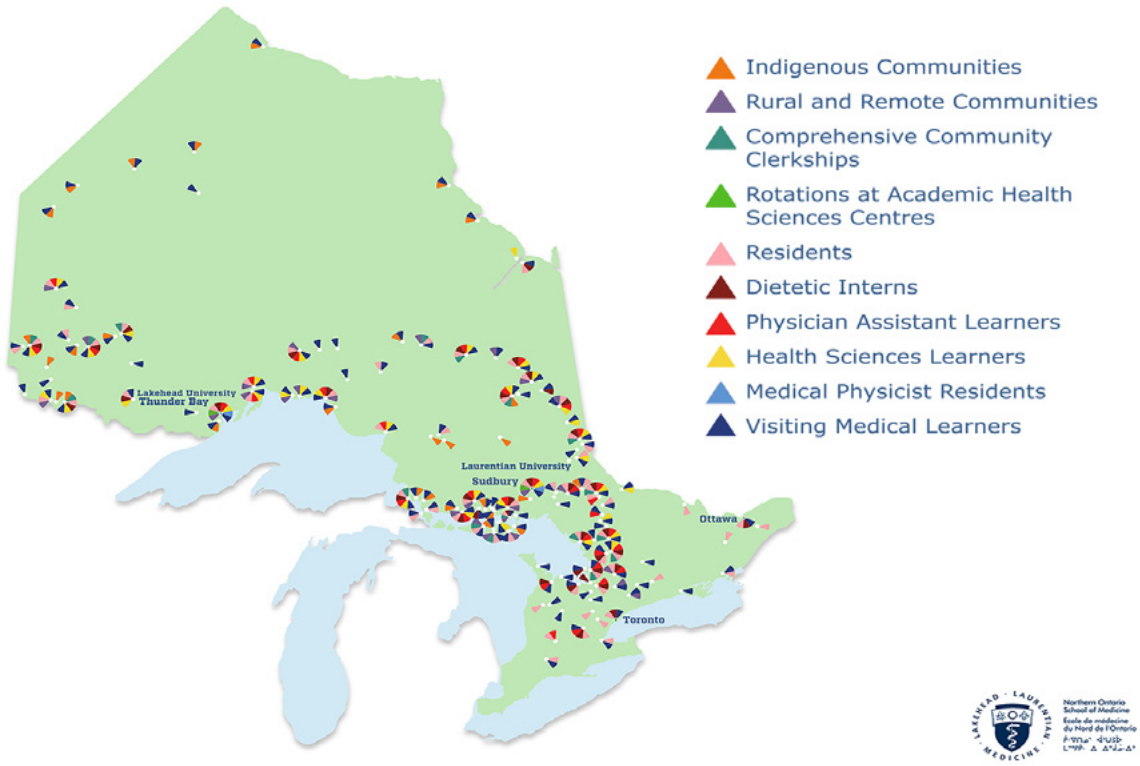
Figure 1: Integrated model for workforce stability

Rural Postgraduates

Applying rurality to postgraduate medical education and training has been exemplified in locally based postgraduate training pathways in rural areas of Australia and Canada, where the importance of this approach to training has led to:

- Increased medical graduate training numbers in rural under-served regions.
- 'Flipped training' - locating full specialty training programs in regional and rural centres, whereby specialty trainees are based in rural or regional clinical settings with some rotations to the cities.
- Increased desire for doctors viewing their regional or rural centre as 'home base' with the city rotations only as necessary to complete their training.
- Increased understanding in medical students of rural/remote community context and its impact on the health of rural/ remote populations.
- Teaching through 'community' rather than 'clinical' placements.

In Canada, the Northern Ontario School of Medicine[21] (NOSM) provides distributed community engaged learning to learners and interns, operating from 90 sites:



The placements have resulted in more generalist doctors, enhanced healthcare access for rural and remote communities, interprofessional cooperation, new health research and broader academic developments.

Rural Roadmap

Responding to rural urban disparities more widely, the Rural Road Map (RRM[22]) was developed by the Advancing Rural Family Medicine Canadian Collaborative Taskforce in 2017 – its work includes a multi-stakeholder rural health-care strategy that seeks to improve the retention of health care professionals in indigenous communities and provide cultural training for all heath care professionals. The Rural Road Map Implementation Committee (RRMIC) was formed in 2018 to support the delivery of the RRM. The RRMIC is seeking to strengthen links between health care providers and rural communities through the creation of networks of care that improve access to care and influence physician retention.

Rural Practitioner Initiatives

In response to the chronic shortage of rural practitioners in Australia, medical schools introduced compulsory rural clinical placements with the expectation that experience in rural settings would encourage a future interest in rural practice. Other countries offering Rural Generalist Medicine (RGM) include the United States. Japan, South Africa, and New Zealand.

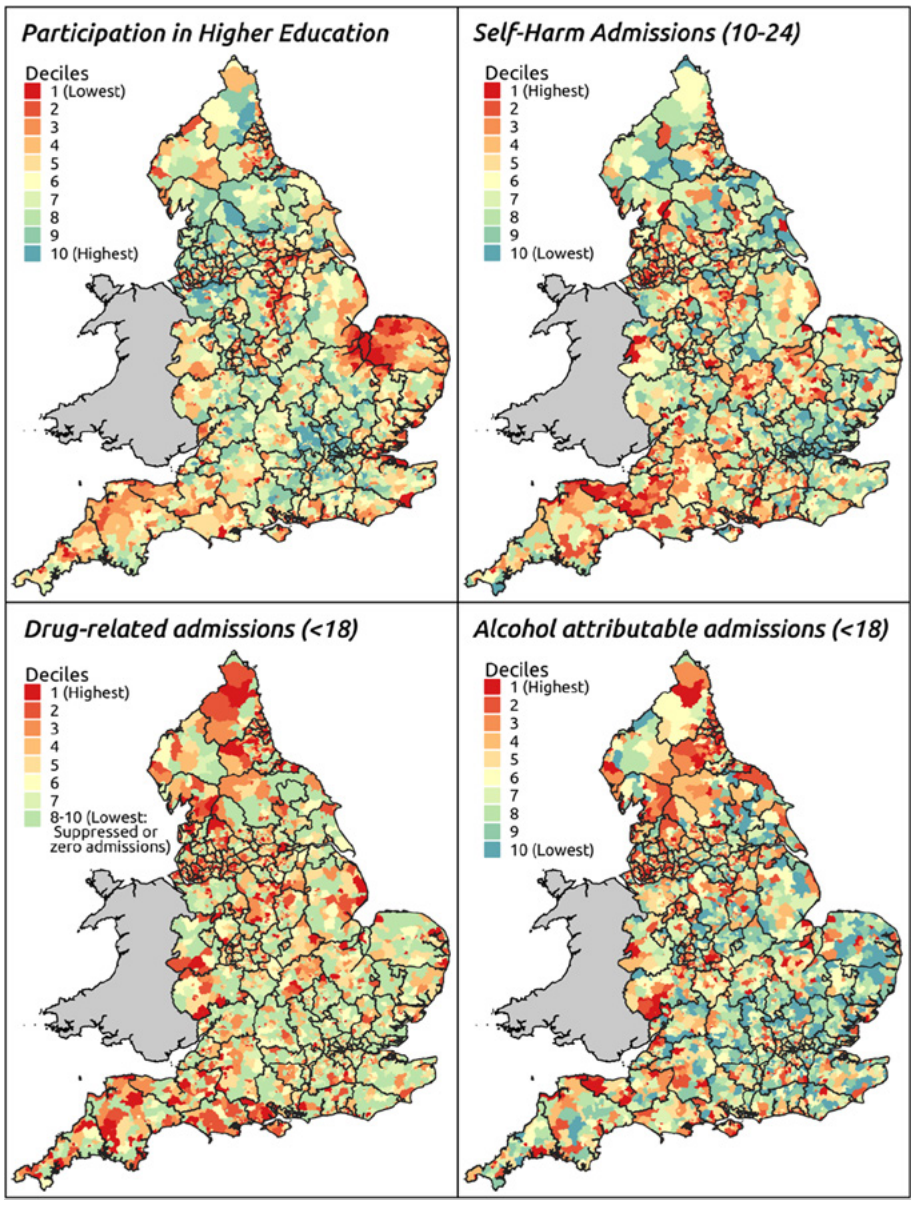
- Research indicates that a stable and well-trained workforce supports access to high-quality services which are responsive to community health needs and result in improved health outcomes for residents.
- Offering rural and remote placements for medical education and training leads to greater retention rates.
- These examples highlight the importance of reducing health inequalities by taking a place-based approach. Focussing on the needs of smaller areas requires designing appropriate responses that are wider than a medical or clinical approach, and that involve communities and stakeholders.
- This focus on localities leads to smart design, which best matches resources to local circumstances.

Telemedicine

Since 2010, several telemedicine programmes have been developed in rural areas in Spain including tele-dermatology, tele-ulcers, and tele-audiometry. Images are taken and attached to the patient's electronic medical record and then reviewed by hospital specialists who propose a treatment or action plan. In Central Catalonia the programme[23] has reduced waiting lists – with dermatology waits reducing from a mean of 30 days to a mean of 16 days when using telemedicine; referrals rates from rural patients increased as they had to make fewer journeys to access care, and for the 52,198 visits recorded between 2011 and 2019 telemedicine saved €780,397. eConsulta[24] is an asynchronous teleconsulting service between GPs and citizens. Introduced in 2015, the platform was already growing at a rate of 24,000 conversations, 44,000 messages, 5500 new users, and 140 new professionals per month before COVID-19 and has been growing exponentially throughout the pandemic.

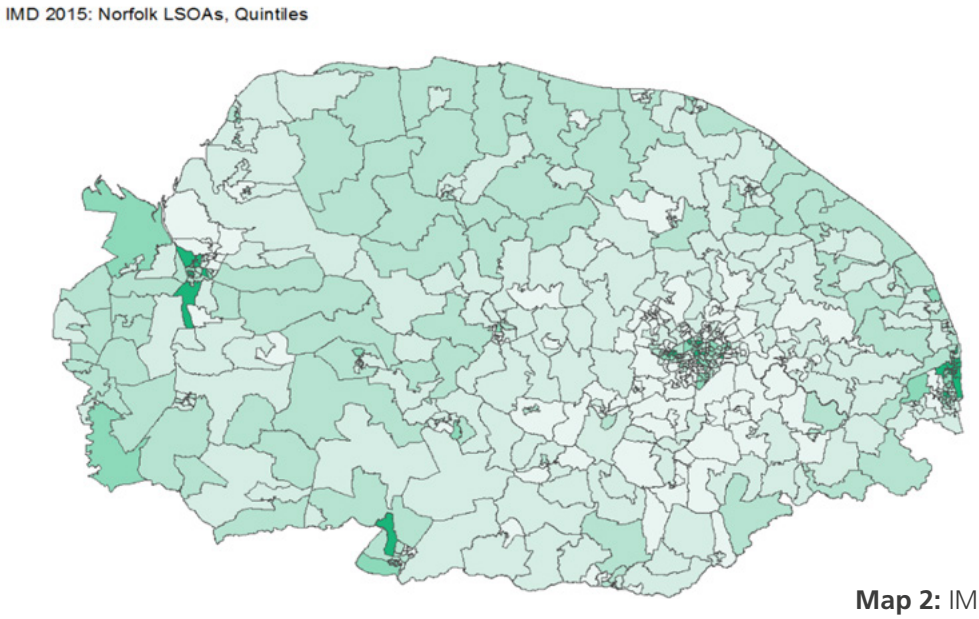
Appendix 2: Deprivation Context

In a coastal context, analysis by Professor Sheena Asthana at the Plymouth Institute of Health and Care Research has sought to use QGIS and ONS boundary data to build up 'coastal LSOAs' which lie within 500 metres of the mean high-water mark (excluding tidal rivers). Around 18.5% of the English population live in coastal LSOAs compared with the 25.4% of people who live within local authorities which include coastal foreshore. Professor Asthana's work cuts across the administrative geography of local authorities and ICSs in making it possible the model data on the prevalence of health risk factors, disease, and public health outcomes at a more granular level (map 1).

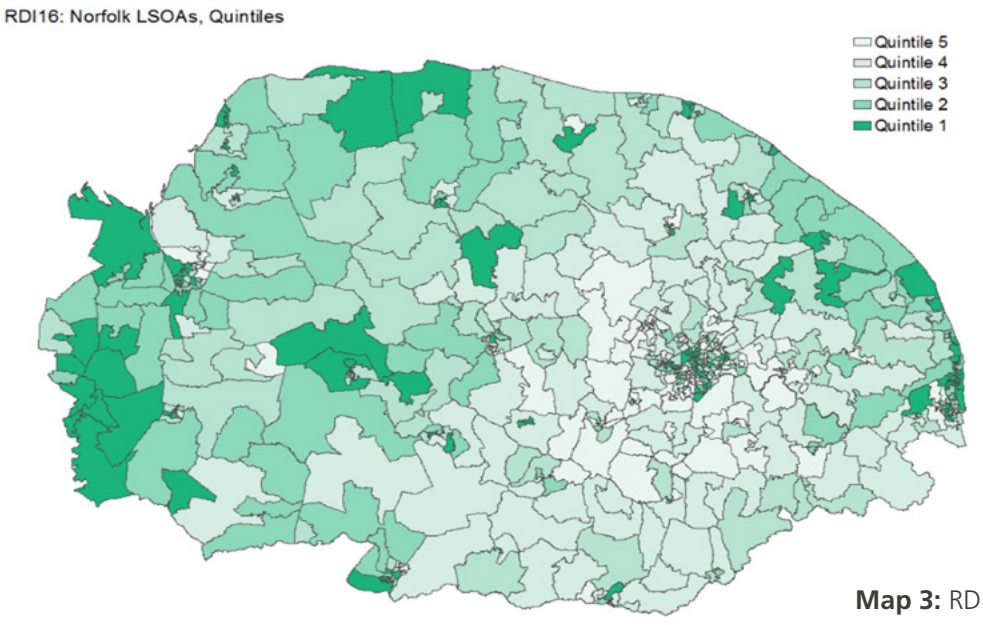


Map 1: Children on the periphery – health risking behaviour and progression into higher education

In a rural context, Professor Andy Jones at Norwich Medical School, University of East Anglia (UEA) is working with PHE to explore the development of a more precise means of measurement for rural deprivation to complement the English Indices of Deprivation (IMD). His approach used Norfolk as a test bed. The analysis includes IMD data sets relevant to rural areas and adds in average travel time to essential services and a population factor – looking at the ONS mid-year estimates of those aged 75 years and over. This has led to the production of a new Rural Deprivation Index[25] (RDI). The resulting RDI has the greatest increase deprived LSOAs in 'Rural town and fringe' [shown in maps 2 and 3]:

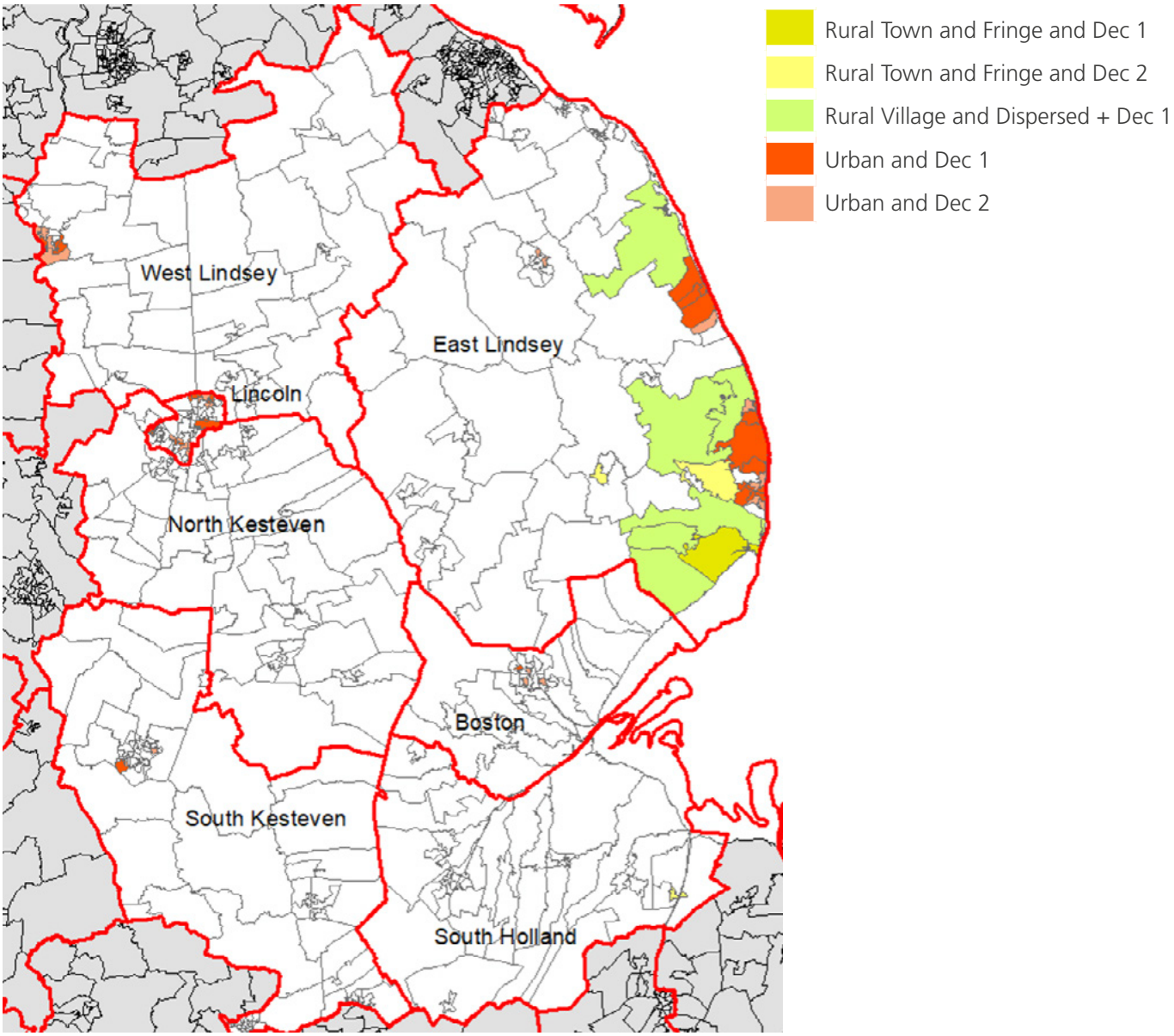


Map 2: IMD data

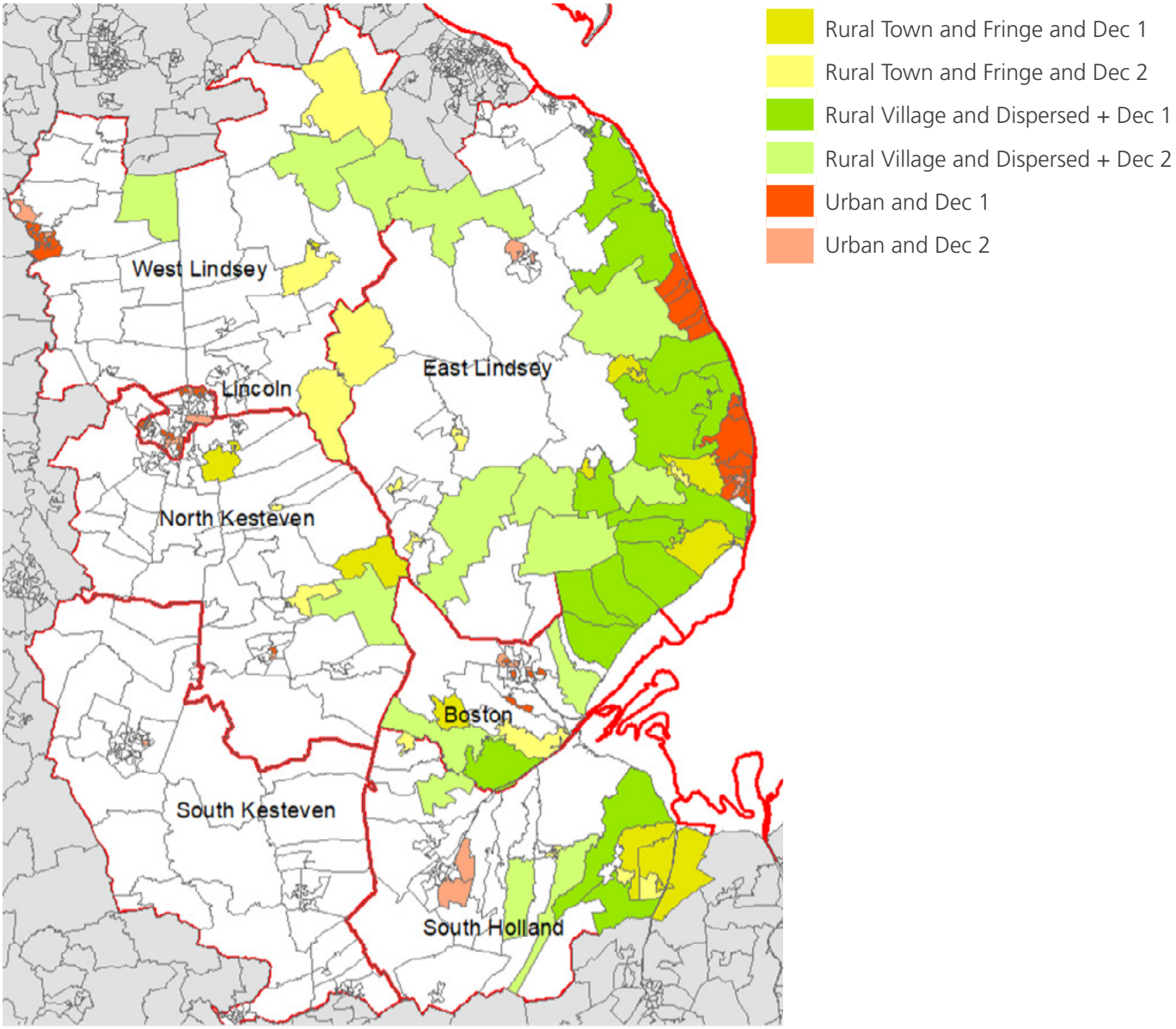


Map 3: RDI data

Professor John Shepherd (Birkbeck, University of London) has applied the IMD 2019 and RDI in Lincolnshire. This also shows a shift in rankings, with an increase in 'deprived' LSOAs when the RDI rather than IMD is applied, particularly for rural town and fringe [shown in maps 4 and 5]:

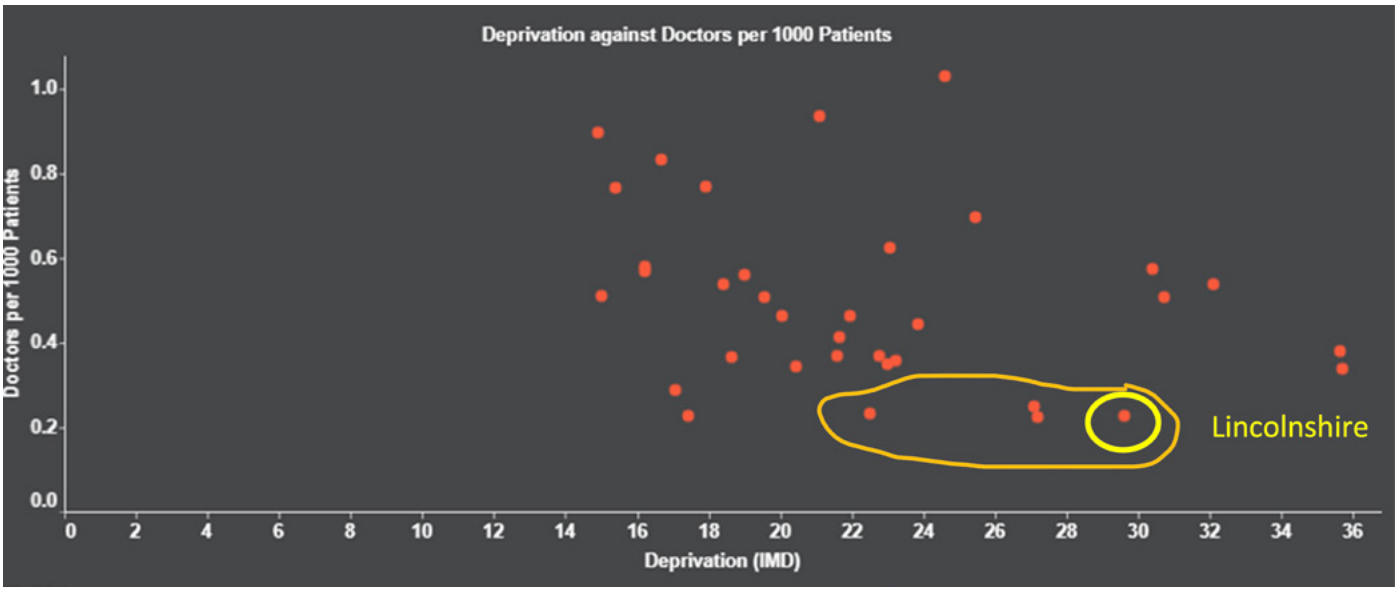


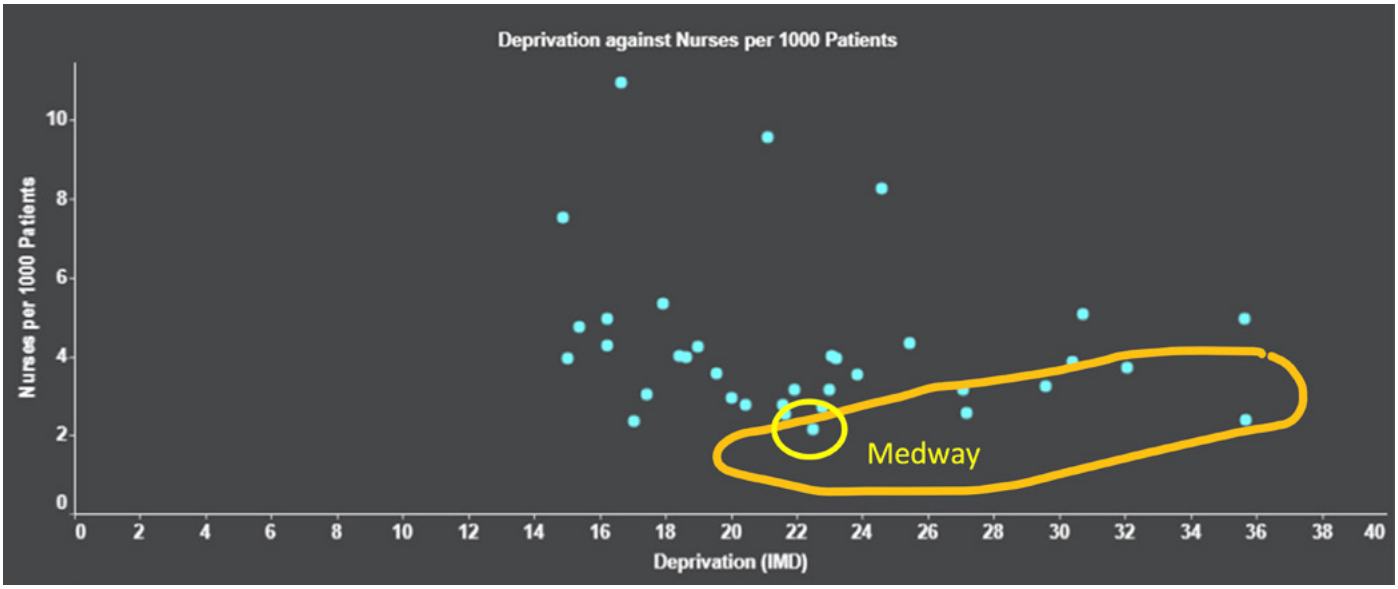
Map 4: Lincolnshire IMD – deciles 1 and 2



Map 5: Lincolnshire RDI – deciles 1 and 2

Appendix 3: Examples of Workforce Distribution





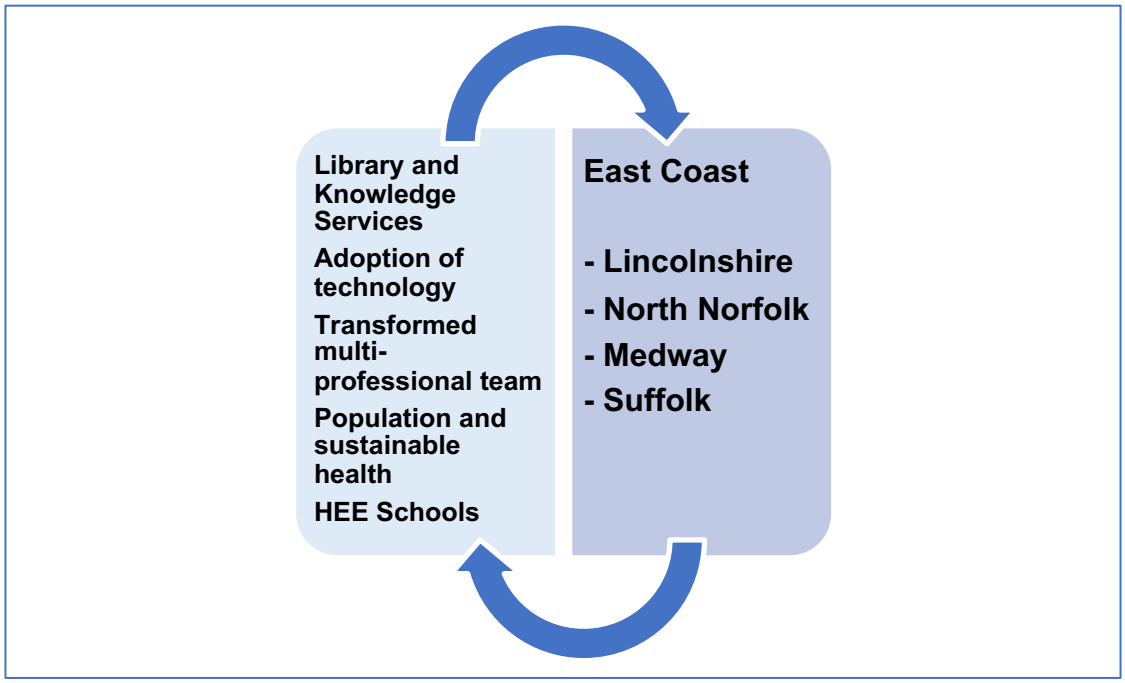
Appendix 4: HEE Offer

1. Medical Education Reform Programme (MERP)

- The MERP Programme will develop an attractive package of education and training for trainees by working with organisations and stakeholders, in rural and coastal settings, prioritising place-based contexts. The programme will highlight the benefits of an extended scope of practice for clinicians in rural places and the impact that these skills can have within a community and their impacts on the social determinants of health.
- The development of a clearly defined programme supports the determination and commitment of HEE to support training in smaller places[26].
- It is anticipated that the rural and coastal programme will support and allow expansion of the ambitions set out earlier in this paper, to ensure that trainees gain access to skill development in a place-based setting, in a 'rural context'.
- Evidence emphasises the need for developing a 'multi skilled professional' and support workforce with generalist skills on the widest practicable basis amongst health and social care workers in rural areas.
- Research commissioned by the National Centre for Rural Health and Care (NCRHC) – "Rural Workforce Issues in Health and Care" led by the University of Birmingham[27] highlighted the need to view workforce development in terms of an employment pathway.
- This innovative approach to education, training and development will help to overcome complexities in the 'attractiveness' of rural training, as evidenced by Vaughan et al., (2020) where smaller and rural hospitals are low on trainees post preferencing.
- The benefits of developing a 'Specialist Generalist' within rural health and care settings is well documented in 'The Making it Work: Framework for Rural Remote Workforce Stability'.
- The Framework is a strategy designed for rural and remote healthcare organisations to ensure the recruitment and retention of vital healthcare personnel. Developmental work is underway through the Future Doctor programme.
- Work is underway to explore the distribution of undergraduate and medical training placements across England. GMC data shows approximately 80% of doctors completing their specialty training settle within 50 miles of the area they trained. Aligning the education and training investment equitably and redistributing training posts to under-doctored areas should provide long-term, sustainable, and cost-effective healthcare for the local population, but must be carefully planned to not destabilise services which lose posts. Where new training opportunities are created, these will be places in areas of need, which will negate the requirement to redistribute posts.
- Employers are working with the support of HEE to establish a Doctor (Medical) Apprenticeship route. There is an opportunity to create apprenticeship opportunities in remote and rural areas most in need.

2. Future Doctor Programme/Generalist Schools

- There is already synergy and symbiosis between the emerging Generalist and rural/coastal programmes and the pilot geographies (Appendix 1):

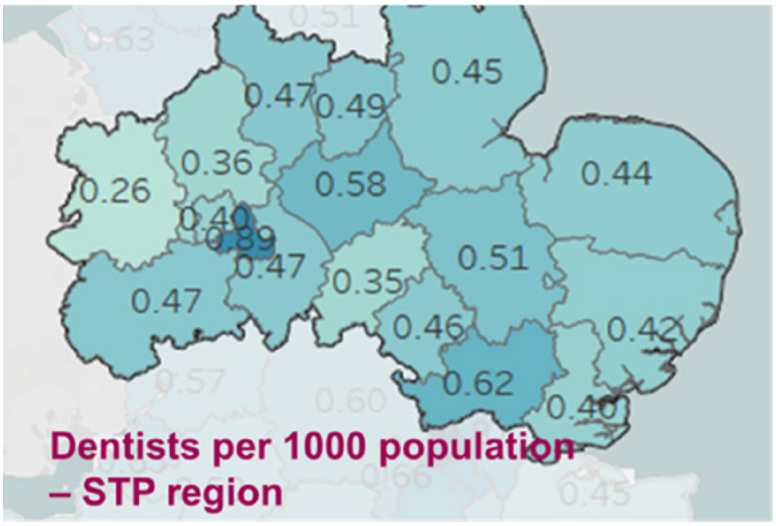


- The Rural and Coastal Programme offers the potential as a catalyst for the adoption of each of the 8 identified 'Generalist' themes within a rural 'place' and context, particularly within the education and training of medical trainees.
- This adoption and spread methodology will be supported through developments such as:
  - Campus for Future Living (Lincolnshire)
  - Breaking Barriers Innovations projects (Medway)
  - Digital Skills Academy (North Cumbria)

3. Dental Education Reform Programme

Dental workforce development is high on the NHSE and HEE agenda, aligned to an on-going national review of dental delivery within the Advancing Dental Care (ADC) review.

The number of dentists and their teams is significantly lower in rural and coastal areas (see illustration). In 2019 England had 24,545 dentists performing NHS primary care activity in 2018-19, equivalent to 0.44 dentists per 1000 population. Comparing the number of dentists to the closest analogous OECD figures for Germany and Italy (those 'licensed to practise'), their figures are 1.18 and 1.02 dentists per 1000, respectively.



Triangulating across sources, therefore, presents a similar message of fewer dentists per head of population than comparable European countries. However, it is also observed that England has fewer NHS primary care dentists per person than the other devolved UK nations. ADC aims to develop an education and training infrastructure that can respond to the changing needs of patients and services, which is encouraging a multi-professional approach and increasing the preventive aspect of healthcare. The ADC Review commenced in April 2018, and the final ADC report will be launched in Autumn 2021.

The dental aim of the programme is to improve population health, which aligns to the HEE health and digital literacy strategy, underpinning a life-course perspective to health. This is impacted by health inequalities, which could be addressed through increased placement capacity for trainees (medical, dental, nursing) on HEE training programmes for example.

Case study: Lincolnshire

'An aspiration of the Rural and Coastal Programme is to enhance the provision of dental services across the region, whilst offering the opportunity to build dental workforce for the future, through existing collaboration with the NHS Lincolnshire Talent Academy 'Future Dentist' programme, but also through the development of the 'Campus for Future Living'.

Within the Midlands Dental Deanery, utilising Lincolnshire as an exemplar through the Campus for Future Living model, affords HEE a unique opportunity to influence and health and care delivery from disease management to disease prevention, through an education and training perspective.

The imbalance can be reduced if postgraduate dental training places are distributed more equitably across England. This will help reduce the geographic disparities in workforce distribution and improve patient access to dental care in the future. In conjunction with NHSE/I, the HEE Dental Reform Programme will explore the training and service provision needs across England to develop a patient-centred approach to future training provision and, where necessary, make the case for new posts.

Dental advanced practice will support the central developments to liberate the treatment skills of dental care professionals and increase the prevention and population health activities within the team, reaching out into community, care homes and schools

To achieve this, workforce ambitions and initiatives include:

- Attract dentists and trainees though provision of (a) training (b) CPD and (c) community network skills.
- Train dentists with a specific programme in rural dentistry, focussing on place-based care.
- Drive technological advances, using telehealth and remote consultations.
- Partnership working with centres of excellence, developing specialist services from major teaching hospitals and institutes that will open access to both face-face and remote consultant clinics.
- Support health and digital literacy with local communities through outreach clinics & community initiatives
- Interdisciplinary working with Neighbourhood Teams
- Ambition to new research projects focussing on the rural challenges of delivering high quality oral and dental care.
- In the UK there has been no established research specifically addressing dental diseases within remote populations
- Migration of the younger population into cities has altered the skills required to practice dentistry in the rural areas.

4. Digital Interventions & Technology Enhanced Learning (TEL)

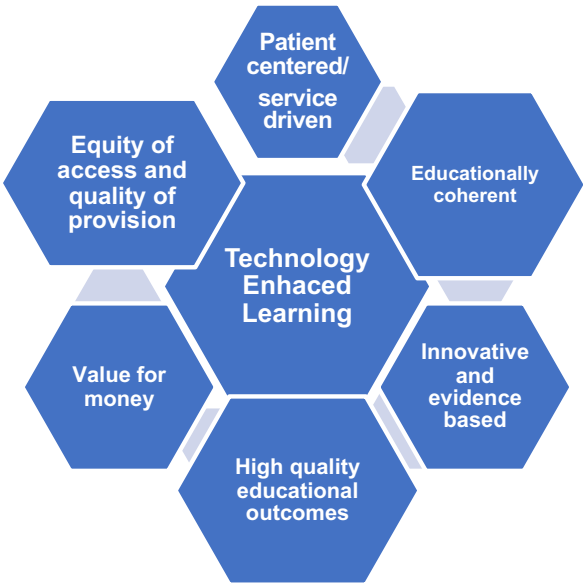
- A rural and coastal programme can support the ambitions of HEE TEL to deliver its ambitions of driving a paradigm shift in the adoption of immersive technologies, particularly within rural contexts, to support the delivery of direct education, simulated clinical practice, patient safety and human factors training.
- Utilising the range of digital interventions and programme already in existence within HEE and in partnership with NHSx and NHSEI, there is an opportunity to deliver a digitally ready, transformed workforce for the 21st Century. This will support digital leadership skills and digital workforce capacity building.
- The four pilot areas are already early adopters of digital technology but require further support to progress digital education and training of workforce and in particular digital literacy skills training.

Technology Enhanced Learning (TEL)

Engaging with the Technology Enhanced Learning (TEL) programme across the four pilot geographies will ensure that technology is used as part of a learning solution for the benefit of patients to:

- Reduce inefficiencies,
- Improve access,
- Reduce costs,
- Increase quality, and.
- Make medicine more personalized for patients.

The diagram below sets out the key facets of the programme:



E-Learning for Health Care

- HEE has an opportunity, via the approaches to medical and clinical education and training within this paper, to enhance education, not only through educational reform and learning in 'place', but to utilise the e-LfH package to further support and enhance the quality of training within rural settings.
- The eLfH hub is has a far and wide reach in its current form, but could utilise the models from Australia and Canada, to develop a suite of rural education programmes, tailored to the needs of rural communities, supported by rural doctors and specialists.

Existing digital resources available from e-LFT which can contribute to reducing health inequalities in rural and coastal areas

The Health Equity Assessment tool has been developed by PHE to enable professionals to systematically identify and address health inequalities and equity in their work programmes or services. This e-learning supports the use of the tool, providing the context and purpose, outlining the benefits of using the tool, and takes the learner step-by-step through each stage of the tool. It also provides a general introduction to health inequalities and equity, as well as examples of good practice.

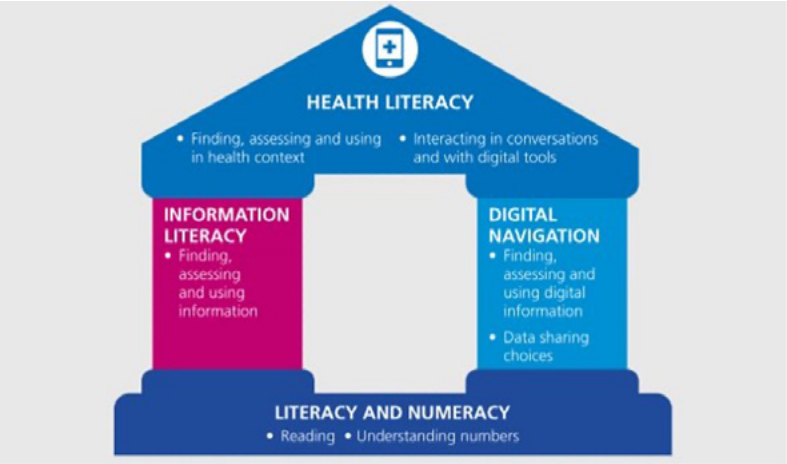
HEE's Population Wellbeing Portal, which is hosted by e-Learning for Healthcare, provides a central location for a curated collection of digital resources to support health and care workforces to improve the health and wellbeing of the public. The contains links to e-learning, toolkits, videos, webinars, and various publications. The portal has a section on health inequalities which signposts to various external resources. The curated content available via the portal will migrate to HEE's Learning Hub in due course.

The All our Health e-learning sessions support PHE's All our Health Framework, a call to action to all health and care professionals to embed prevention into their everyday practice. A new e-learning session on Health Inequalities is currently under development and is expected to be available by the end of the summer.

The embedding public health into clinical practice digital learning resource, developed by PHE aims to support clinicians to embed population health approaches into their clinical practice.

Digital Literacy

In line with Health Education England's Knowledge for Healthcare[28] strategy, the national NHS knowledge and library services team is leading health and digital literacy and patient information activity with local communities. This cross-sectoral initiative is co-ordinated through a national Health and Digital Literacy Partnership comprising the Chartered Institute for Library and Information Professionals, Libraries Connected and Arts Council England. The Partnership is working with multiple organisations.



NHS knowledge specialists share techniques with information providers in other sectors, including public libraries, education, and prisons. Further work is planned with pharmacists, sharing techniques and resources. Librarians and information providers in the community are ideally placed to support citizens to develop health literacy. Health literacy skills build on information literacy and digital navigation skills taught by information workers. The aim is to integrate health and digital literacy skills development into existing infrastructure and create a platform for shared assets to sustain support for citizens' health literacy skills.

5. Population health and prevention initiatives

Population Health

HEE's multi-disciplinary Population Health Fellowship programme is already growing a workforce of clinical professionals who can incorporate population health approaches into their everyday jobs across all of HEE's 7 regions. There is potential for future cohorts of population health fellows to work in tandem with the Rural and Coastal Transformation programme including its pilot geographies.

Alongside the fellowship, HEE has developed a population health curriculum to support the learning programme. This has mapped each curriculum area to free to access digital resources designed to build capability and competence in population health, a digitised version of this curriculum toolkit will be available by the autumn 2021.

Health Inequalities

HEE's national Long -Term Condition and Prevention programme has a range of initiatives and products aimed at strengthening capability in population health and reducing health inequalities. These offers include the Population Health Fellowship, Advanced Clinical Practice framework in public health and various digital resources. A Task and Finish group has been established by the programme and is seeking to develop a strategic position on health inequalities education and training. The Task and Finish group will achieve this by considering what HEE currently offer, what is planned and what can further contribute to action on health inequalities.

NHS Health Checks / CVD Prevention

The NHS health check programme, currently offered to people aged between 40 and 74, is designed to spot the early signs of cardiovascular disease, one of the conditions most associated with health inequalities. There are plans to develop and re-design approaches to the Health Check to improve the effectiveness by targeting deprivation and certain protected characteristic groups, thereby engaging with people with the greatest health needs, actively reducing health inequalities. This will include rural and coastal communities.

HEE has a digital offer to support learning around the NHS Health Check service through e-Learning for Healthcare and is working with system stakeholders to explore how this offer can be strengthened.

Maternity programme

The evidence from national confidential enquiries into maternal deaths and morbidity (MBRRACE-UK) and other reports show consistent health inequalities for mothers and babies from black, Asian, and mixed ethnic groups and for those from the most deprived areas. NHSEI has developed an equity strategy for maternity and neonatal services, setting out a programme of work aimed at achieving equity for all those who receive and provide NHS maternity and neonatal care.

HEE is committed to supporting the implementation of the maternity equity strategy in several areas:

- Through a training offer to support the implementation of the Midwifery Continuity of Carer (MCOC) service model that targets mothers at highest risk of poor outcomes
- Through a dashboard available at regional level to support Local Maternity Systems with workforce planning
- Through joint work with appropriate stakeholders to better understand variation in the delivery of maternity and neonatal services in rural areas.

Long Term Conditions

In addition to work on CVD prevention HEE is working with system partners to deliver improvements along the entire patient pathway for three long term conditions, cardiovascular disease, stroke, and respiratory disease. Recent work in this area includes:

- The development of a stroke toolkit
- Six stroke rehabilitation films
- Working at local level through the Integrated Stroke Delivery Networks to enable workforce transformation using the HEE star tool.

Toolkits are in development to support clinicians working across the cardiovascular disease and respiratory pathways.

The Advanced Practice work to streamline rehabilitation, working across systems with local assets e.g., local authority gyms, social prescribing aims to reduce inequalities by maximizing functional recovery and keep people in work.

Allied Health professional (AHP) support in rural areas

Access to AHP services in rural and coastal communities are essential to optimising rehabilitation, functional independence, mental health recovery aiming to keep people in work, in their own homes, socially engaged and fit to care where needed. To minimise health inequalities, we need children with special educational needs to access speech and language therapy and occupational therapy in schools to learn to engage with the national curriculum, speak, write, and move, this offers the option to end school with transferable skills and qualifications, keeping young people out of the criminal justice system due to poor early years therapy support is a primary aim.

Access to professions e.g., prosthetists and orthotists to optimise independent mobility, orthoptists for early years and late years vision support to optimise independence and function are key to reducing health inequalities and maximising life chances but are unseen. To get a job when you cannot walk or see is increasingly challenging system wide immersion in local communities with schools and communities offering work experience, summer internships etc is vital to build community aspiration for roles they didn't even know existed, supported by system based AHP apprenticeships from support workforce to ACP across the AHP professions is vital to build a workforce from and reflective of the community, vested in the people and places.

The highly autonomous skills set of the allied health professions enables flexible and adaptable workforce solutions, as seen in the primary care AHP roles in the new contract enabling redistribution of work around clinical teams by liberating the full trained expert skills et of the professions to support medical colleagues within the team, enable people to receive earlier diagnosis, management, and self-care support to minimise people on waiting lists who do not need to see a medic.

Advanced Clinical Practice (ACP) support in rural areas

ACP offers several workforce solutions, working across multi-professional teams. Advanced roles exist across professions and specialities, supporting developed professional skills and shared skillsets to meet patient needs. This enables the professions to broaden their support to populations and enables intelligent clinicians to be retained in roles where they can meet the needs of their populations expand their skills, champion their professional unique skills, and open career opportunity to consultant roles.

Appendix 5: Case studies' overview: aims and targeted strategic Framework elements

Cases studies		Sweden	Norway	Canada	Iceland	Scotland
Case studies aim		Recruit healthcare personnel to Storuman municipality	Improve recruitment and retention of GPs in three case municipalities	Stabilize the physician workforce in Nunavut	Recruit and retain specialized physicians in Akureyri Hospital	Improve recruitment and retention of rural multidisciplinary teams
Plan	Assess population service needs		All municipalities evaluated their service model and ended up extending their number of GPs with one extra GP to reduce the workload.			Develop marketing strategies; friendly and informative RR communication processes and information packages; and identify appropriate and accessible education and support.
	Align the service model with population needs			Development of the contract model for new physicians.		
	Develop a profile of target recruits			Inuit/northern physicians serving Inuit.		
Recruit	Emphasize information sharing	Establishing an alumnus register to send newsletters with job relevant information to people (approx. 2800) who might be interested in moving back to Storuman.		Development of a cultural orientation app for healthcare providers in Nunavut.	Information meetings with Icelandic medical students in Iceland, Hungary, and Slovakia, and with Icelandic specialists and specialists in training working in Sweden to introduce and promote the hospital.	Accessible user-friendly marketing outlets promoting rural vacancies. Development of an effective template including information on recruit profile, work area, work colleagues, and what rural and remote working in the area is like.
	Community engagement	Establishing a relocation coordination officer in Storuman municipality.			Including a member from the community council in the project group.	Co-designing community information for candidates.
Retain	Supporting spouses/families	Development of a couple recruitment strategy.			Meeting with potential recruits and their families with a member from the municipality to inform of opportunities.	Develop and implement a buddy support system and educational support package.
	Supporting team cohesion					Team approach to developing vacancy adverts.
	Ensure relevant professional development		Establishment of a programme with salaried educational positions for GPs to specialize in family medicine (ALIS-Vest/ALIS-Nord).	Continuing Education and Professional Development (CEPD) events for physicians.	Development of a tailored education programme for new recruits. Some physicians got 3 months extended educational leave to auscultate and do research work.	Piloting of eBook to aid access to evidence-based practice. Development of new Multi-Professional Rural Practitioners Programme and Qualification Pathway
	Training future professionals	Developing a rural education stream as part of the medical school curriculum at Umeå University.		Health careers promotion camp for high school students from around Nunavut.	Work to get accreditation from the Royal College of Physicians to allow Akureyri Hospital to educate specialist in internal medicine and anaesthesia.	Multi-professional partnership package promoting joint training across professions.

Appendix 6: External partners instrumental in working with HEE to deliver projects within the programme

Organisation name	
Breaking Barriers Innovations (BBI)	An independent research programme informing the radical improvement of public services using locality-driven, joined up approaches as opposed to top-down driven blueprints. HEE is working in partnership with BBI across the South-west, Essex, and Kent
National Centre for Rural Health & Care (NCRHC)	NCRHS acts as a governance vehicle for formal collaboration amongst partners interested in the four key drivers of impact in rural health and care, as well as influencing policy and strategy. HEE is working with the NCRHC to support the investment bid – Campus for Future Living, Mablethorpe, Lincs.
Academic Health Science Network (AHSN)	Catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients. HEE is working with the AHSN to embed the STAR methodology across the regions and in Cumbria to develop the Digital Skills Academy.
Lincoln International Institute for Rural Health	University of Lincoln established, the institute conducts world-class research focusing on the greatest health issues facing rural communities both locally and globally. HEE is working regionally to support health inequalities research.
HEI's	Positive discussions have been undertaken with universities who have or are developing, rural agendas within their research portfolio or who have a rural element to education programmes. Discussions with University of Waitako, New Zealand, Aberystwyth, Lincoln, Chester & Keele. HEE is seeking to establish closer connections with these HEI's to support the education and training agenda for rural activity.
NHSx & NHSEI	Leading the largest digital health and social care transformation programme in the world & will speed up the digital transformation of the NHS and social care. Both organisations are supporting the development of health and digital literacy and health inequality programmes of work in Lincolnshire and across regions.
NHS Lincolnshire Talent Academy	Exemplar of applying best practice to 'Future Workforce', working with health and care organisations, in partnership with local schools, colleges and universities. Successful adoption of a 'Grow our Own' methodology (see Nurse Cadet example in Appendix 2). Successfully implemented local Dr You, Aspiring Medic Dentist & a wide range of trailblazing apprenticeships across Lincolnshire Health & Care system. Widening participation agenda supporting workforce supply along the east coast, Lincs.
Royal Colleges	Support from the 23 Royal Colleges and Faculties will be instrumental in delivery of the programme as it develops, through consultation with DEQ.

Appendix 7: Programmes of work already underway or in development, across rural ICS localities within this paper

A) South-west England

Programme	Partnership / Stakeholders	Activity
Place Based Development of Health & Care Workforce	• Breaking Barriers Innovations • HEE Regional • Local Authority	**Cornwall:** • Ambitions to show the benefits of greater local integration and joint action across health, social care and housing sectors for better health and wellbeing outcomes and to reduce health inequalities. **Somerset:** • Creating a sustainable trainee pipeline at all levels of competency for Health & Social Care services, enabling a consistent approach and career pathway underpinning Apprenticeship opportunities. • Ambition to explore possibilities of Further Education contribution to develop Somerset as a `brand` to attract recruits to entry level H&SC roles.

Appendix 7: Continued

B) Lincolnshire

Programme	Partnership / Stakeholders	Activity
Campus for Future Living	• NCRHC • East Lindsey D.C. • HEI's • NHS Lincolnshire, Social Care • 3rd Sector • HEE Regional & National	• A medical and innovation hub of national significance focusing on attracting and developing healthcare professionals, research, and providing intergenerational future living. • Place based context within a socio-economically deprived locality (Mablethorpe), Lincolnshire east coast. • Expand Clinical & Medical placements, transformation & upskilling of workforce.
Personalisation	• HEE Regional & National • NHSEI • NHSX	• Mablethorpe & Skegness as pilot sites for the 'Empower the Person' programme.
Health & Digital Literacy	• Lincolnshire Community Health Services NHS Trust • HEE Regional & National • Voluntary & 3rd Sector	• 'Digital Ambassadors', to support communities and health/care workforce to improve health & digital literacy across the East Coast, Lincolnshire.
Population Health Management	• University of Lincoln • Lincolnshire NHS Health & Care System • HEE Local	• Engagement with rural and marginalised communities and its focus on research where the health need is rather than in 'traditional' health care settings. • Co-creating with community, a stronger evidence bases around contextual factors that limit the effectiveness (real world implementation) of interventions with known efficacy.
Workforce Development, Education and Training	• NHS Lincolnshire Talent Academy • NHS Lincolnshire Health & Care System • HEI's • HEE Regional	• 'Grow our own' approach to workforce. • Apprenticeship Trailblazing e.g.: Physiotherapy, Occupational Therapy, Pharmacy • Career progression programmes e.g.: nurse cadet to RN/RN(MH) • Widening Participation Programmes (East Coast) e.g.: 'Dr You' Project • Redevelopment of Education & Training Centre, Pilgrim Hospital, Boston • Transformation & Upskilling of workforce

Appendix 7: Continued

B) Cumbria

Programme	Partnership / Stakeholders	Activity
Digital Skills Hub	• Academic Health Science Network • HEE North • NIHR • Royal College of Surgeons • HEI's	• Vision for using alternative technology as a different way to learn, teach and orientate. • Use local NHS to 'test bed' Virtual Reality, Augmented Reality, and Immersive Technology.

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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:	**13 July 2022**
Subject:	**Humber Acute Services Programme – Update**

Summary:

This report provides the Committee with an update on the progress of the Humber Acute Services Programme. The previous update was considered on 15 December 2021, as part of an initial phase of pre-consultation engagement.

At the next meeting on 19 January 2022, the Committee approved a response to the pre-consultation engagement, which highlighted the importance of services provided by Northern Lincolnshire and Goole NHS Foundation Trust.

Actions Requested:

The Committee is requested to consider the information presented and identify any further action.

1. Background

Hospital Trusts Involved in Humber Acute Services Programme

The Humber Acute Services Programme covers the services provided by two acute hospital trusts: Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH). Two of the three main hospitals operated by NLaG are Diana, Princess of Wales (DPoW) Hospital in Grimsby, and Scunthorpe General Hospital, which between them are used by a significant number of residents in the administrative county of Lincolnshire. By way of an overview, for 2021-22 Lincolnshire CCG commissioned £51.2 million of acute hospital activity from NLaG, as part the CCG's baseline contract.

Update on the Programme

An update on the Humber Acute Services Programme will be presented by the following Representatives from the Programme Team:

- Ivan McConnell, Programme Director
- Linsay Cunningham, Associate Director Communications and Engagement

The Humber Acute Services Programme Update and Briefing (July 2022) are attached at Appendices B and C respectively.

Previous Committee Consideration

The Committee considered a presentation on 15 December 2021. The key points are summarised below:

- The case of change had been compiled in November 2019.
- The three parts of the programme are: the *Interim Clinical Plan,* the *Core Hospital Services* and *Building Better Places*.
- The *Core Hospital Services* element involves the development and appraisal of viable options for the following services:
  - urgent and emergency care;
  - maternity, neonatal care and paediatrics;
  - planned care and diagnostics.
- 4,000 patients, members of the public and staff had participated in an engagement exercise between February and May 2021.

On 19 January 2022, the Committee agreed its response to the pre-consultation engagement, which is attached at Appendix A. In summary, the Committee

- recorded its views on the likely impacts of any changes services on Lincolnshire patients;
- requested details of any patient flows for any services where reconfiguration proposals are developed;
- requested that other councils, such as East Lindsey District Council, are alerted to the consultation; and
- sought updates on the outcomes for capital funding bids of £700 million, which would include funding for a new Scunthorpe General Hospital.

Joint Overview and Scrutiny Committee Arrangements

A joint health overview and scrutiny committee is being established in the North Yorkshire and Humber Integrated Care Board area. Councillor Carl Macey has been appointed to represent this Committee on the joint committee.

3. Consultation and Conclusion

The Committee has recorded its intention to submit a response to the planned consultation on any service changes arising from the Humber Acute Programme, which affect Lincolnshire residents.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Letter from Councillor Carl Macey, Chairman of the Health Scrutiny Committee for Lincolnshire to the Ivan McConnell, 19 January 2022
Appendix B	Humber Acute Services Programme Update (July 2022)
Appendix C	Humber Acute Services Programme Briefing (July 2022)

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

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

Ivan McConnell
Programme Director
Humber Acute Services Review Programme

(via email to: Ivan.McConnell.nhs.net)

19 January 2022

Dear Mr McConnell

HEALTH SCRUTINY COMMITTEE LINCOLNSHIRE
HUMBER ACUTE SERVICES PROGRAMME

The Health Scrutiny Committee for Lincolnshire would like to thank members of the Humber Acute Services Programme team for attending and presenting on the programme to the Committee on 15 December 2021. The Committee welcomed the clarity of the documentation and the candour of the responses made to the questions.

The Committee would like to confirm the importance of the acute hospital services provided by Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) for the residents of Lincolnshire, in particular for those residents in East Lindsey and West Lindsey. For example, the Diana, Princess of Wales, Hospital (DPOW) in Grimsby is considered by many people in the Louth and the surrounding area, as their nearest and preferred acute hospital.

Any substantial changes to the services provided at DPOW are likely to have a significant impact on local residents, for example increased travel times or patients choosing to have treatment from United Lincolnshire Hospitals NHS Trust, which in turn would add pressure to this trust. Furthermore, NLaG also provides several services at Louth County Hospital, such as community midwifery, so any changes to these services would be likely to lead to a direct local impact.

The Committee understands from the presentation that where services changes are due to be proposed an analysis of patient flows from Lincolnshire into NLaG (as well as into Hull) is being prepared and will be made available, either as part of the pre-consultation business case or the consultation document. The Committee urges that this analysis is sufficiently detailed so that the impacts from any changes in services can be assessed for Lincolnshire residents.

Whilst it is acknowledged that four other health overview and scrutiny committees have a stronger interest in the Humber Acute Services Programme by virtue of patient numbers, the Health Scrutiny Committee for Lincolnshire would like to formally record its interest in responding to the planned consultation on services. The Committee would also like to request that local authorities such as East Lindsey District Council are engaged, so that they can prepare a response to the consultation.

In the coming months, the Committee would welcome any updates from the programme team on developments, for example the outcome of the capital bid for approximately £700 million, to support, among other developments, the rebuilding of Scunthorpe General Hospital and the refurbishment of critical care at DPOW.

Yours sincerely,

Councillor Carl Macey (CllrC.Macey@lincolnshire.gov.uk)
Chairman of the Health Scrutiny Committee for Lincolnshire

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Humber Acute Services Programme Update

(July 2021)

Purpose

1. A comprehensive overview of the programme was provided to the Committee in November 2021. The purpose of this report is to provide members with a further update on progress, timelines and next steps.

Background

2. The Humber Acute Services (HAS) Programme is designing hospital services for the future across the Humber region to deliver better and more accessible health and care for the population. The programme involves the two acute trusts in the Humber – Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) – and the four Clinical Commissioning Groups (CCGs).

3. The Programme sets out a vision that: everyone across the Humber will have access to the best possible healthcare and opportunities to help them live healthy, happy lives. All partners across the health and care system in the Humber have an important role to play in the short, medium and longer-term to deliver this vision, which is much wider than the acute hospital sector alone.

Core Hospital Services (Programme Two) Update

4. The Core Hospital Services element of the programme concerned with developing the long-term strategy and design of future core hospital services, as part of broader plans to work more collaboratively with partners in primary, community and social care.

5. The work across Programme Two is clinically led and involves detailed options development and appraisal to help identify clinically viable models for core hospital services:

    - Urgent and Emergency Care
    - Maternity, Neonatal Care and Paediatrics
    - Planned Care and Diagnostics

6. To support the development of potential models of care for the future of core hospital services, an extensive period of engagement has been undertaken with clinical teams (from hospital, primary care, mental health and community services), staff, patients, service-users, the public and their representatives. Annex A sets out some of the high-level themes and insight gathered through the public engagement that have helped to shape the potential models of care.

7. Beginning in November 2021 and due to complete by the end of July 2022, ***a multi-step, multi-faceted approach***, to evaluation has been adopted. The purpose of this process is to narrow down the possible solutions to those that are most able to address the issues identified within our Case for Change and provide the best possible solutions for our population.

8. Step One of the evaluation process took place from November to December 2021 and involved a series of workshops to assess the advantages and disadvantages of different potential models of care. In total 117 people participated in the workshops.

9. Step Two began in February and involved another series of workshops (throughout March 2022), supported by ongoing evaluation and analysis across a range of areas.

10. Specifically, step two of the evaluation process will incorporate further analysis across key areas based on feedback throughout the programme and important changes to our strategic context:

    - Safety of maternity models (Ockenden review).
    - Travel and accessibility
    - Displacement impact on neighbouring health economies
    - Economic and Social impact
    - Workforce modelling
    - Financial analysis / costing

11. The outputs from these analyses will be combined with the feedback from both sets of workshops to support the finalisation of the options for inclusion in the Pre-Consultation Business Case (PCBC).

12. In April 2022, the work was subject to an independent review by the Yorkshire and Humber Clinical Senate. The Senate Panel was supportive of the work undertaken to date and will publish its findings in July or August 2022.

Capital Investment (Programme Three) Update

13. Our current healthcare estate is one of our biggest challenges – with many of our buildings being old, unfit for purpose, not very ecologically friendly and in need of immediate investment.

14. We are seeking approval to develop a large-scale capital investment plan for our hospital estate across the Humber that will support better clinical care but also make a significant contribution to the wider economic regeneration of the region.

15. In response to the government's invitation for expressions of interest from NHS trusts wanting to be considered for inclusion in the next wave of the New Hospitals Programme, we submitted an expression of interest in September 2021 – in the region of £720m – for the development of healthcare infrastructure across the Humber.

Update on Governance Arrangements for the Interim Clinical Plan (Programme One)

16. Creating unified Humber-wide services is a fundamental aim of the Interim Clinical Plan (previously referred to as Programme One). Great strides have been made towards this goal – by establishing joint clinical leadership teams across specialities; developing visions for the future and formulating service strategies to achieve those visions. This work has helped establish the foundations necessary to stabilise and improve services.

17. On 1st April 2022, the focus of the Interim Clinical Plan moved into a new phase – with operational teams working jointly across both trusts, concentrating on mobilisation and implementation of the service strategies.

18. Reflecting this change, the day-to-day governance arrangements for the Interim Clinical Plan changed moving out of the programme management arrangements of the Humber Acute

Services Programme – with a Joint Development Board maintaining oversight of mobilisation and implementation, reporting through to the Committees in Common.

Conclusion

19. **Our local health system across the Humber needs to change**. It is not always meeting the needs of everyone in the region and, without changes to the way services are organised, this will likely worsen in the future.

20. Over the coming weeks, **we aim to complete our multi-step evaluation process** to enable completion of our Pre-Consultation Business Case (PCBC).

21. The decision about how to progress will be made by the NHS body with legal responsibility for strategic planning of healthcare services across the Humber. Following the implementation of the Health and Care Act (2022) on 1st July, this responsibility now rests with NHS Humber and North Yorkshire Integrated Care Board (ICB).

22. We are working collaboratively to put forward potential options on what hospital care might look like in the future (in five to ten years) and **aiming to consult with the public (and other key stakeholders) later this year.**

Ivan McConnell
Director of Strategic Development/Director Humber Acute Services
Northern Lincolnshire and Goole NHS Foundation Trust

Contact Officer: Linsay Cunningham
Associate Director of Communications and Engagement – Humber Acute Services
Humber and North Yorkshire Health and Care Partnership
Telephone: 07803 411544
Email: linsay.cunningham@nhs.net

Background Papers

Your Birthing Choices – Maternity and Neonatal Care (June 2022) full feedback report and summary report.
What Matters to You – Parents, Carers and Guardians (March 2022) available here.
What Matters to You – Children and Young People (March 2022) available here.
What Matters To You – Our Staff and Teams (October 2021) available here.
What Matters To You (May 2021) full feedback report and the summary report.
The Yorkshire and Humber Clinical Senate report (November 2020), available here.
Accident & Emergency Public / Patient feedback report (October 2020) available here.
Hospital Services for the Future – Targeted engagement (February 2020), available here.
Hospital Services for the Future – Workshop Feedback Report (October 2019), available here.
Humber Acute Services Review: Case for Change (November 2019), available here.

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Humber and North Yorkshire
Health and Care Partnership

Humber Acute Services Programme

Briefing

July 2022

The Humber Acute Services Programme aims to deliver new models of care and infrastructure investment across a challenged health and care system

Humber and North Yorkshire Health and Care Partnership

Challenges

- Delivery of Constitutional Standards
- Complex population health needs
- Unwarranted variation in pathways of care
- Tactical plans
- Ageing and failing infrastructure: buildings/digital
- Do not deliver College/National Guidance/standards
- Recruitment and retention issues

Programme 2: Core Service Change

- Urgent and Emergency Care
- Maternity/Paediatrics and Neonatal Care
- Planned Care concepts

Programme 3: Strategic Capital

- SGH £350m
- HRI £250m
- DPoW £120m

£720m

Opportunities

- Improved access/outcomes and reduced waiting times
- Standardised service models
- Increased use of technology
- Increased collaboration – cross organisation/sector
- Build local skills and contribute to local economy
- Optimise training opportunities and new skills
- Fulfil our role as Anchor Organisations and in Levelling Up

A significant proportion of the work that is required has been completed – the programme is at a critical point

Humber and North Yorkshire Health and Care Partnership

We are here

Case for Change — Nov 2019

Clinical Senate Review (#1) — Nov 2020

Clinical Senate Review (#2) — March 2022

Pre-Consultation Business Case — March 2022

Decision-Making Business Case — March 2023

Engagement/Surveys

Continued Engagement

Case for Change

Prog design and early engagement

Models of Care Design

Evaluation

Travel and Access

Workforce

Enablers – OOH and Digital

Assurance Reviews

Capital Pre SOC

Options for Consultation

Clinical Senate

Briefings – Internal/External

NHSE/I Gateway — August 2022

ICB Approval — Sept/Oct 2022

End Nov 22 – Mid Mar 23 — **Consultation**

Capital SOC

*all dates are tentative and subject to change

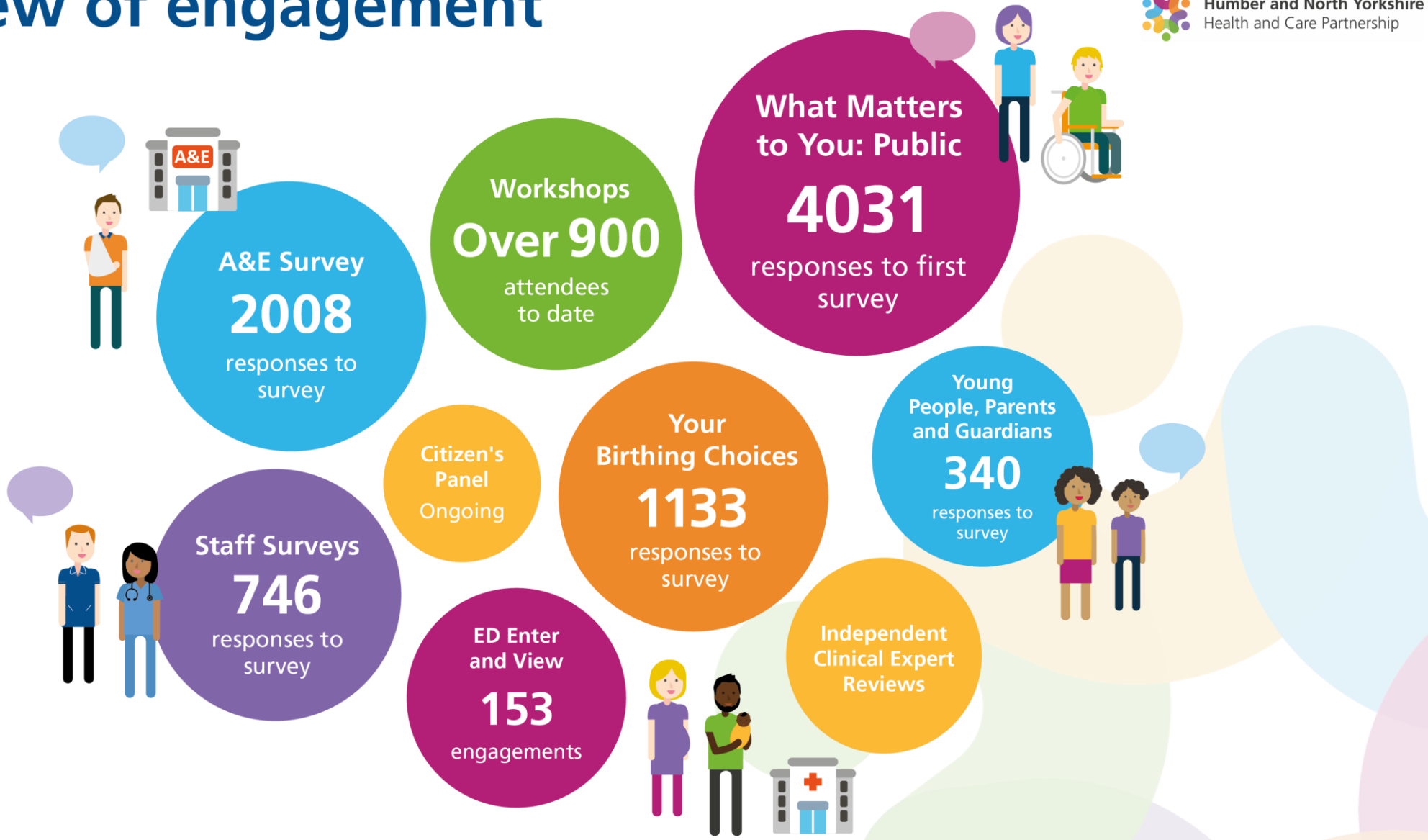
We have identified a wide range of issues and challenges across our Humber hospitals, which mean we need to look at doing things differently.

Humber and North Yorkshire Health and Care Partnership

- ***We're not providing the standards we should be in all our services***
  - Pressures in urgent and emergency care impact upon planned care
  - Clinical standards and Royal College guidelines around staffing and activity levels (e.g. how many patients go through a service each year) are increasingly challenging to meet
  - Temporary staff are often required to fill gaps in rotas
- ***We don't have enough staff to continue to do everything everywhere***
  - shortages of staff with specific skills in some services
  - 25% vacancy rate within Paediatric training grade doctors (across Northern Lincs)
  - vacancy rates in our Emergency Department teams range from 6% up to 28%
  - We are looking at new roles and different workforce models (e.g. rotational posts, joint services across the Humber to provide career development and support recruitment and retention)
- ***Some of our buildings and equipment are not fit for the future***
  - Current buildings not designed for modern methods of care
  - Critical Infrastructure Risks = £59m, Backlog Maintenance issues = £105m
  - Seeking £720m through New Hospitals Programme
  - This would radically improve the infrastructure and bring a wide range of additional benefits e.g. the creation of new, high-quality jobs, support R&D and innovation and help to grow the local economy.

Overview of engagement

Humber and North Yorkshire Health and Care Partnership



We have listened to patients, service-users, staff and other stakeholders to influence the design and evaluation of potential models of care

Humber and North Yorkshire Health and Care Partnership

Surveys

8370 responses

Workshops and focus groups

c.**1000** engagements

What Matters to You?

- I am seen and treated quickly
- I am kept safe and well looked after
- There are enough staff
- Things go well for me
- Everyone can access care
- I know services will be there
- I am able to get there
- Buildings/equip
- Value for Money

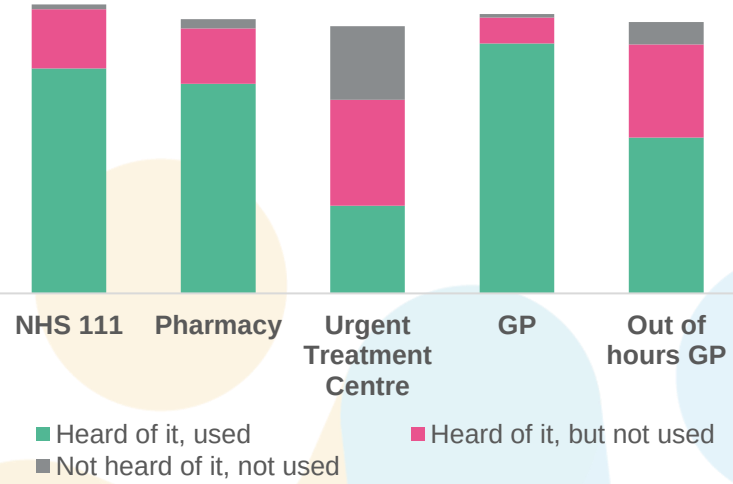
Your Birthing Choices

- I am kept safe and well looked after
- I am seen and treated as quickly as possible
- There are enough staff
- Things go well for me
- Everyone can access care
- I know services will be there
- I am able to get there
- Buildings/equip
- VfM

Alongside Midwifery-led Unit

- Hospital Maternity Unit
- Standalone Midwifery-led Unit
- Home birth

Urgent and Emergency Care



Children and Young People

- I feel cared for and safe
- I don't have to wait too long
- There are enough Drs & nurses
- The building is nice
- Things are fair
- It's easy to get to

"Can't see the trees…"

"Would like toys to play with while waiting."

Summary of key issues and challenges raised through engagement with stakeholders throughout our programme

Humber and North Yorkshire Health and Care Partnership

Woman and birthing people have told us that **safety** is their number one priority

They also identified that the facilities available (e.g. for partners to stay) and support services are also important

Clinical engagement has also highlighted the need to consider safety within potential models for maternity services

"If things go wrong you have to make a journey to get help. I could not risk being away from emergency equipment when two lives are at stake."

"Hospitals make me anxious, and I feel there is more chance of intervention"

"But if you've got midwifery-led unit and you get a lady deliver a very sick neonate, what do you do with that neonate if you've got no neonatal staff there?"

Travel and accessibility are key concerns for all our stakeholders

Ensuring people can access care and considering the travel impact of any options for patients, staff and carers are really important factors.

"Grimsby and Scunthorpe are quite far in distance ... [for] families that can't afford travel it would be a big impact."

"A lot of people use public transport. They (will) have to pay more to go and visit their relatives."

The impact of displacement on neighbouring health economies needs to be understood

"For me it's the geographical location and the impact it has on the other EDs in the region..."

Surveys

8370 responses

Workshops and focus groups

c.1000 engagements

Having the right workforce is important to staff and patients alike

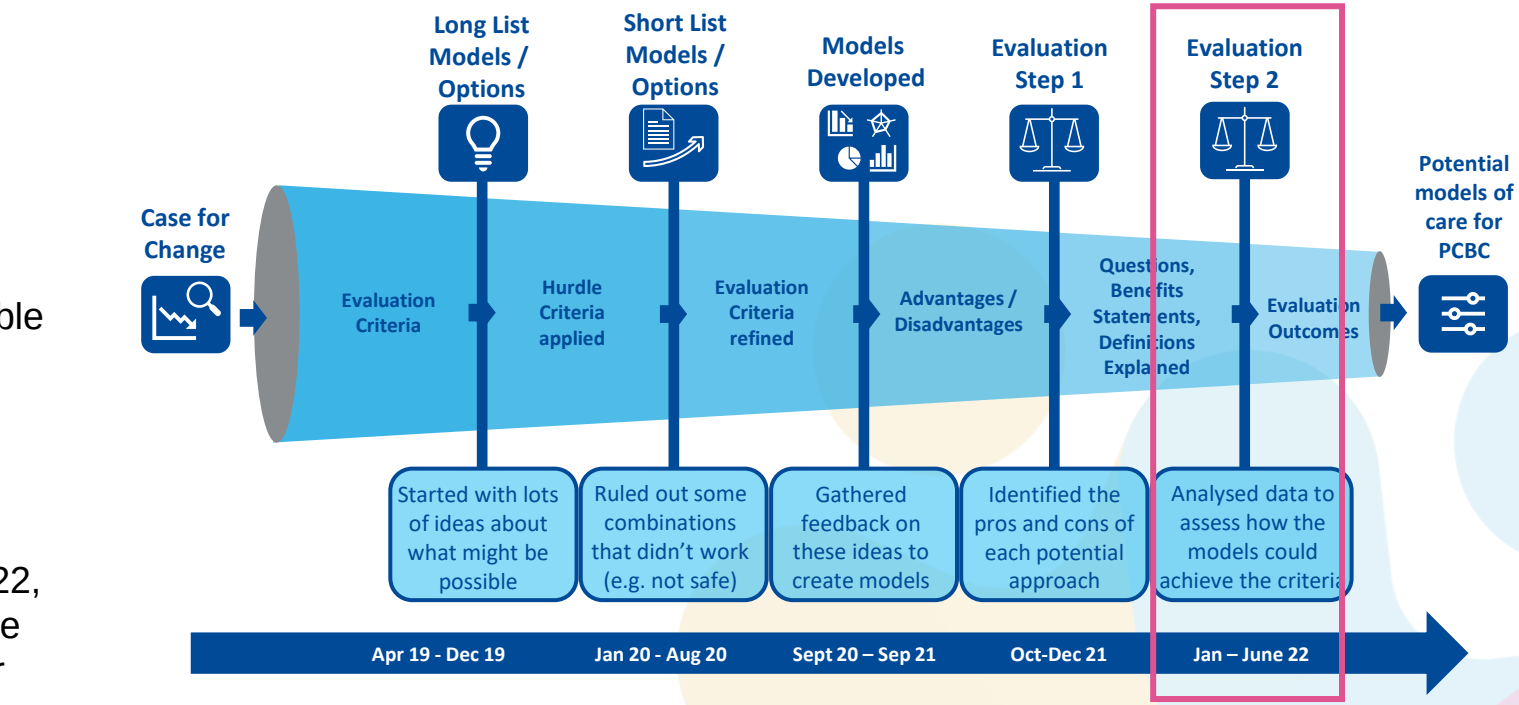
"Good staffing levels to ensure a good work/life balance, (not having to constantly cover staff shortages)."

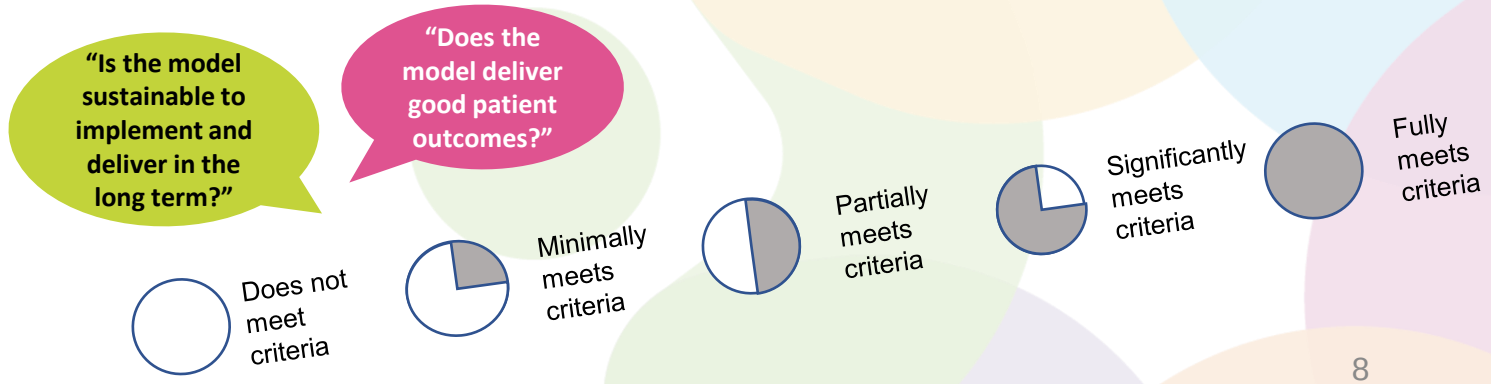
"Get more staff as it is evident that wards are undermanned which comes at a price to the patient who are just a number."

We are following a multi-faceted evaluation approach to provide an assessment of the potential models of care

Humber and North Yorkshire Health and Care Partnership

- The evaluation process we are following is iterative, adopting ***a multi-step, multi-faceted approach***, to narrow down the possible solutions to those that are most able to address the issues identified within our Case for Change and provide the best possible solutions for our population.
- To ensure a robust and consistent process, all possible combinations of the potential future models of care were evaluated (unless there was a clear rationale already identified to rule them out). This included reviewing some previously discounted ideas.
- Multiple workshops took place throughout March 2022, following a balanced room approach, involving a wide range of stakeholders, including clinical teams, other professionals, partners, patient representatives and other lay members.
- In total **130 people** took part in the workshops.





Evaluation workshops

130 participants

Evaluation of potential models of care and finalisation of Pre-Consultation Business Case

(estimated completion July 2022)

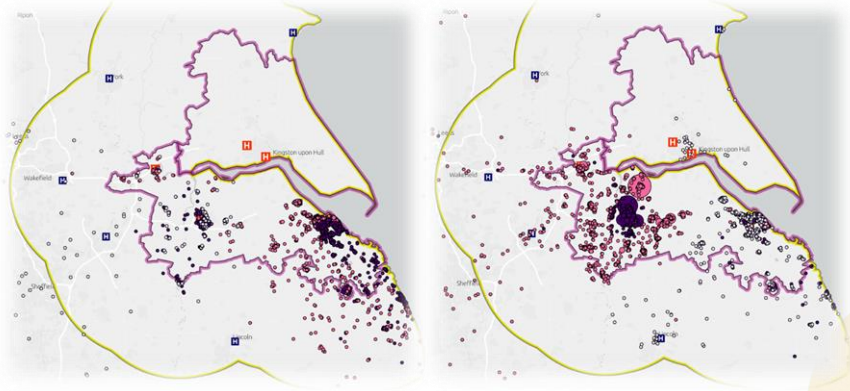
Humber and North Yorkshire Health and Care Partnership

Ockenden Review

- Key issue = safety
- Review the models (and variations) against recommendations from Ockenden Report (part 2) to determine viability and workforce implications.
- Re-run workforce modelling/assumptions to confirm maternity models.

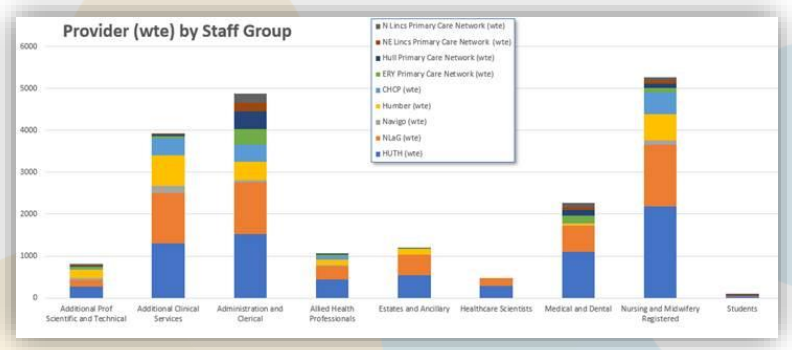
Travel Mapping

- Utilise travel impact (GIS) data and mapping to confirm travel impact for staff, patients and carers / family against each of the models / variations.



Workforce Modelling

- Review workforce modelling and staffing requirements for each model
- Alignment with out of hospital workforce planning and recruitment (link to ICS/Place work)



Displacement impact mapping

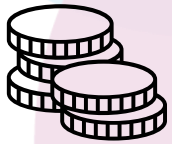
- Model impact of UEC displacement on neighbouring trusts based on admission ratio / Length of Stay / bed occupancy scenarios for 5 patients per day and 10 patients per day to determine impact on neighbouring health economies.

Economic impact assessment

- Conduct high level (macro) economic analysis of impact of each model / variation to support evaluation.

Financial analysis

- Undertake a full financial assessment of the shortlisted models of care to inform pre-consultation business case



Clinical Senate Review (April – May 2022)

Humber and North Yorkshire Health and Care Partnership

"I congratulate the programme on the excellent and comprehensive work that has been progressed since our last visit in developing the significant range of options to address the challenges being faced. It is evident that those involved in this process have worked very hard to get to this point and we hope this report helps to make the decisions that are needed a little easier."

Prof Chris Welsh
Chair Clinical Senate

Points to Note

- Panel considered recommending we discount options that have a **significant displacement impact** but concluded it was not their role – our work was comprehensive in this area and should support our ongoing discussions
- Recommended information on **impact of models** is placed up front in Consultation document
- The panel supported the approach to evaluation and reducing options – panel recognised detailed travel analysis already completed and stressed need to finalise pre consultation
- The panel advised that the PCBC to DMBC will need to consider **detailed rota planning** for UEC
- Panel discussed the **issues of a standalone MLU** and highlighted numbers that opened and closed – panel have identified that should a standalone MLU be in the options that the clinical model must ensure appropriate risk assessment
- Panel raised the issue of running obstetric-led maternity services and the **issues of staffing** – and cited feedback in recent CQC/Regulatory reports along with proposed guidance changes and **Ockenden 2**

We have worked with “Out of Hospital Programme” Leaders to map dependencies and support their work programmes through our work

Humber and North Yorkshire Health and Care Partnership

Out of Hospital

- Engagement in Clinical Models Design – workshops/focus groups
- Specific engagement with working groups – e.g. UECN
- System wide workforce mapping and links to ICS Workplans
- Shared data analysis
- Digital programme mapping and links to ICS Digital Strategy and Programmes
- Dependency mapping – CDC
- Consideration of estates through Strategic Estates Group

Hospital

Emergency Department

Acute Assessment Unit

Paediatric Assessment Unit

Maternity and Obstetrics

Neonatal

Medical Specialities

Surgical Specialties

Joint Working

Frailty
End of Life
UTC/UCS
Urgent Community Response (2hrs)
Hear and treat/see and treat
Long Covid
Virtual Wards
Long term conditions
Community Diagnostic Hubs
Connected Health Network (CHN) (including PIFU)*

*Rheumatology, Cardiology, Diabetes, ENT, Urology
Orthopaedics, Respiratory, Skin, Gastroenterology, Dementia, MSK, Pain, Gynae

Children’s
Integrated Health and Care
Community Hub
Community Care (The Ill Child)
Palliative and End of Life Care
Neurodiversity Service

Clinical enablers
Intelligent booking scheduler
Clinical messaging tool
Any-to-any booking

‘Out of Hospital’

Enhanced health in care homes
Anticipatory Care
Social Prescribing
Smoking cessation
Weight Management
Falls Prevention
Clinical Assessment Service
7 day crisis response
Mental Health

Key
Already in place or can be undertaken now
In development but not yet active
Opportunities for working together in the future

PIFU = Patient Initiated Follow Up

Timeline and Next Steps

Humber and North Yorkshire Health and Care Partnership

We are here

Case for Change — Nov 2019

Clinical Senate Review (#1) — Nov 2020

Clinical Senate Review (#2) — March 2022

Pre-Consultation Business Case — March 2022

Decision-Making Business Case — March 2023

Engagement/Surveys (Nov 2019 – March 2022)

Continued Engagement (March 2022 – March 2023)

- Case for Change
- Prog design and early engagement
- Models of Care Design
- Travel and Access
- Workforce
- Enablers – OOH and Digital
- Assurance Reviews
- Capital Pre SOC
- Evaluation
- Clinical Senate
- Options for Consultation
- Briefings – Internal/External
- NHSE/I Gateway — August 2022
- ICB Approval — Sept/Oct 2022
- End Nov 22 – Mid Mar 23 — **Consultation**
- Capital SOC

Only after the responses to the consultation have been considered will a decision will be made about how to progress.

**all dates are tentative and subject to change*

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:	**13 July 2022**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary

This report sets out the Committee's work programme, and includes items listed for forthcoming meetings, together with other items, which are due to be programmed. The Committee is requested to consider whether any further items should be considered for addition to or removal from the work programme.

Actions Requested

To consider and comment on the Committee's work programme.

1. Background

At each meeting, the Committee is given an opportunity to review its forthcoming work programme. Typically, at each meeting three to four substantive items are considered, although fewer items may be considered if they are substantial in content.

2. Work Programme for Today's Meeting

13 July 2022		
	Item	*Contributor*
1	Cancer Care Update	Lincolnshire Integrated Care Board: • Clair Raybould, Director for System Delivery • Sarah-Jane Gray, Deputy Cancer Programme Manager • Kathie McPeake, Macmillan Living with Cancer Programme Manager United Lincolnshire Hospitals NHS Trust: • Colin Farquharson, Medical Director (ICS Senior Responsible Officer for Cancer)
2	The Lincolnshire People Board Strategy for Recruiting and Retaining Talent	Maz Fosh, Chief Executive, Lincolnshire Community Health Services NHS Trust. Ceri Lennon, Senior Responsible Officer for the Lincolnshire People Board
3	Humber Acute Services Programme - Update	Representatives from the Humber Acute Programme: • Ivan McConnell, Programme Director • Linsay Cunningham, Associate Director Communications and Engagement

3. Future Work Programme

14 September 2022		
	Item	*Contributor*
1	North West Anglia NHS Foundation Trust – General Update	Caroline Walker, Chief Executive North West Anglia NHS Foundation Trust.
2	Lincoln Medical School - Update	Professor Danny McLaughlin, Associate Dean of Medicine, Lincoln Medical School
3	Lincolnshire Pharmaceutical Needs Assessment – Consideration of Final Draft	Lucy Gavens, Consultant in Public Health, Lincolnshire County Council

14 September 2022		
	Item	*Contributor*
4	Sustainability Transformation Partnership Clinical Care Portal Data Sharing - Update	Lincolnshire County Council (Adult Care and Community Wellbeing) Representatives: • Theo Jarratt, Head of Quality and Information • Samantha Francis, Information and Systems Manager Representatives from United Lincolnshire Hospitals NHS Trust
5	Lincolnshire Partnership NHS Foundation Trust – Consultation on Mental Health Rehabilitation Services	Representatives from Lincolnshire Partnership NHS Foundation Trust

12 October 2022		
	Item	*Contributor*
1	East Midlands Ambulance Service Update	Representatives from the East Midlands Ambulance Service: • Ben Holdaway, Director of Operations • Sue Cousland Divisional Director, Lincolnshire Division
2	Update on GP Services – Integrated Care Board	Sarah-Jane Mills, Director for Primary Care and Community and Social Value Lincolnshire Integrated Care Board
3	Update on GP Services – Lincolnshire Local Medical Committee	Dr Reid Baker, Medical Director, Lincolnshire Local Medical Committee
4	Future Commissioning Arrangements for Dental Services, Ophthalmology and Pharmaceutical Services	Sarah-Jane Mills, Director for Primary Care and Community and Social Value Lincolnshire Integrated Care Board
5	Lakeside Healthcare	Lincolnshire Integrated Care Board Representatives: • Sandra Williamson, Director for Health Inequalities and Regional Collaboration • Sarah-Jane Mills, Director for Primary Care and Community and Social Value

9 November 2022		
	Item	*Contributor*
1	Lincolnshire Integrated Care Strategy	Representatives of the Lincolnshire Integrated Care Partnership

14 December 2022		
	Item	*Contributor*
1	Four NHS Services in Lincolnshire: Stroke Services; Orthopaedics; Grantham Urgent Treatment Centre; and Community/ Medical Beds at Grantham Hospital	Pete Burnett, Director of Strategic Planning, Integration and Partnerships, Lincolnshire Integrated Care Board

18 January 2023		
	Item	*Contributor*
1	Dental Services in Lincolnshire	Representatives from NHS England

4. Working Group Activity

Suicide and Mental Health

This working group, comprising Councillors Carl Macey, Sarah Parkin, Tom Smith, Angela White and Mark Whittington, is due to hold its first meeting on 27 July.

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

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk