HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
18 NOVEMBER 2015

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

Councillors R C Kirk, S L W Palmer, Miss E L Ransome, Mrs S Ransome, Mrs J M Renshaw, T M Trollope-Bellew and Mrs S M Wray

Lincolnshire District Councils

Councillors Dr G Gregory (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)) Mrs R Kaberry-Brown (South Kesteven District Council) and Mrs A White (West Lindsey District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Dr Vindi Bhandal (Chairman, South West Lincolnshire CCG), Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant Public Health Adults and Public Health Care), Simon Evans (Health Scrutiny Officer), Sarah Furley (Urgent Care Programme Director, Lincolnshire East CCG), Dr Sunil Hindocha (Chief Clinical Officer, Lincolnshire West CCG), Gary James (Accountable Officer, Lincolnshire East CCG), Allan Kitt (Chief Officer, South West Lincolnshire CCG), Lynne Moody (Director of Quality and Executive Nurse, South Lincolnshire CCG), Sarah Newton (Chief Operating Officer, Lincolnshire West CCG) and Clair Raybould (Head of Commissioning, South West Lincolnshire CCG)

County Councillors B W Keimach and Mrs S Woolley attended the meeting as observers.

54 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor D P Bond (West Lindsey District Council) and Councillor J Kirk (Lincoln City Council).

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor Mrs A White to the Committee in place of Councillor D P Bond (West Lindsey District Council) for this meeting only.

Apologies for absence were also received from Chris Weston (Consultant in Public Health).

Notice had also been received that Councillors T Boston and G Gregory would arrive late and asked that their apologies be conferred to the Committee.

55 DECLARATIONS OF MEMBERS' INTERESTS

There were no declarations of Members' interests at this point in the proceedings.

56 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed everyone to the Committee and made the following announcements:-

i) St Barnabas Hospice – Chief Executive

On 30 October 2015, St Barnabas Hospice announced the appointment of Chris Wheway as its new Chief Executive, having replaced Sarah-Jane Mills who was now leading on the Cancer Strategy within Lincolnshire. Chris Wheway had joined St Barnabas after twelve years' experience in the NHS in both Lincolnshire and Derbyshire. The Chairman was scheduled to meet the new Chief Executive in the next few weeks.

ii) Hospice Within a Hospital Award

With delight, the Chairman announced that on 8 November 2015 the Hospice in a Hospital, at Grantham and District Hospital, won the *Building Better Healthcare Award*. The unit at Grantham and District hospital was the first of its kind in the UK and was recognised for its innovative approach to patient experience. The unit was successful as best *End of Life Care Project,* and was recognised for its unique approach of providing care to patients under the responsibility of GPs, but with access to hospital nurses, doctors and therapists. The six-bed community hospice opened in September 2014 as part of a joint venture between St Barnabas Lincolnshire Hospice, United Lincolnshire Hospitals NHS Trust and South West Lincolnshire Clinical Commissioning Group.

iii) United Lincolnshire Hospitals NHS Trust

The Chairman had met with senior managers at United Lincolnshire Hospitals NHS Trust (ULHT) on two separate occasions. On 27 October 2015, a meeting was held with Kevin Turner, Acting Chief Executive, where a briefing was received on some of the system issues which had led to the continued deterioration of the Trust's financial position. On 4 November 2015, a meeting was held with Jan Sobieraj, Chief Executive Designate, where the challenges facing the Trust over coming months were discussed. Jan was due to take on the substantive role as Chief Executive on 7 December 2015.

iv) Lincolnshire Partnership NHS Foundation Trust

On 3 November 2015 the Chairman met with Alan Lockwood, Vice-Chairman, and John Brewin, Chief Executive of Lincolnshire Partnership NHS Foundation Trust (LPFT) to discuss the process for the Care Quality Commission Inspection scheduled between 30 November and 4 December 2015. Approximately 70 inspectors will form the inspection team and would visit the services provided by the Trust. The CQC report was expected to be published no earlier than March 2016.

It was also agreed that two items would be brought forward on to the Work Programme for the meeting scheduled for 17 February 2015. These were Adult Psychology Services and Universal Health.

v) Lincolnshire and Nottinghamshire Air Ambulance

The Lincolnshire and Nottinghamshire Air Ambulance had given a presentation to the Committee in October 2014. Peter Aldrick, who had been the Chief Executive of the Lincolnshire and Nottinghamshire Air Ambulance for sixteen years, would be retiring in January 2016 and Karen Jobling had been appointed as his replacement. Karen had 25 years' experience at senior management level in the charity sector and previously held the post of Executive Director at the World Cancer Research Fund International/UK.

vi) East Midlands Ambulance Service NHS Trust – Inspection by the Care Quality Commission

On 16 November 2015, the Care Quality Commission began its inspection of the East Midlands Ambulance Service, which would continue until the end of the week. The inspection would consist of approximately 100 inspectors to the East Midlands and would be undertaken as part of the CQC's new regime. The CQC would be applying its new inspection regime, based on the five questions, *Are they safe? Are they effective? Are they caring? Are they responsive to people's needs?* and *Are they well-led?*

vii) Accessing Urgent Care in Lincolnshire

United Lincolnshire Hospitals NHS Trust (ULHT) issued a media release on 16 November 2015 which emphasised the available alternatives to attending Accident and Emergency Departments. The media release stated that the patients should not attend A&E if the matter was not serious or life-threatening as many illnesses could be better treated by visiting the local pharmacy, calling 111, visiting the local GP or GP out-of-hours services, attending a walk-in centre or minor injuries unit.

viii) Medical School for Lincolnshire

Page 11 of the minutes of the meeting, of the Health Scrutiny Committee for Lincolnshire, held on 21 October 2015 referred to a letter being prepared to be despatched to the Secretary of State, urging him to establish a medical school in Lincolnshire. The Chairman confirmed that she had put her signature to the letter

and understood that other signatures would be also be added and the letter sent to the Secretary of State by the end of November 2015.

ix) Lincolnshire Community Health Services NHS Trust Headquarters

Lincolnshire Community Health Services NHS Trust (LCHS) was relocating its headquarters from Sleaford to Welton House (Greetwell Place, Lincoln) and to Beech House (Lincoln). All staff from Bridge House, Sleaford, were expected to have moved over to Lincoln by the end of November 2015.

x) Stay Well This Winter

The Committee were reminded that the NHS had launched a national campaign, *Stay Well This Winter*, which provided advice to people over 65 or with long term conditions on how to prepare for winter. The advice covered items such as keeping the home at no less than 18 degrees.

57 MINUTES OF THE MEETING OF THE COMMITTEE HELD ON 21 OCTOBER 2015

RESOLVED

That the minutes of the meeting held on 21 October 2015 be approved and signed by the Chairman as a correct record.

58 UPDATE ON DELEGATED COMMISSIONING ARRANGEMENTS FOR GP SERVICES - LINCOLNSHIRE WEST CLINICAL COMMISSIONING GROUP

A report by Dr Sunil Hindocha (Chief Clinical Officer – Lincolnshire West Clinical Commissioning Group) and Sarah Newton (Chief Operating Officer – Lincolnshire West Clinical Commissioning Group) was considered which described the new responsibility Lincolnshire West Clinical Commissioning Group had for commissioning GP services and the governance arrangements in place to mitigate potential conflicts of interest.

Dr Sunil Hindocha (Chief Clinical Officer – Lincolnshire West Clinical Commissioning Group) and Sarah Newton (Chief Operating Officer – Lincolnshire West Clinical Commissioning Group) were in attendance for this item of business.

Members were advised that commissioning of primary care services had previously been carried out by NHS England, but NHS England had invited all CCG's to take over responsibility for commissioning those services. All four CCGs in Lincolnshire had applied to take on delegated responsibility for GP commissioning. Since 1 April 2015, the CCG had been responsible for carrying out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, other than those relating to individual GP performance management which had been reserved to NHS England.

The following activities were included:-

- General Medical Services (GMS), Primary Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts, including the design of PMS, APMS contracts, contract monitoring, contractual action and removing a contract but not the alteration of the Terms and Conditions of any national contract;
- Design, development, introduction and monitoring of newly enhanced services ("Local Enhanced Services" and "Directed Enhanced Services"), and modification or cessation of existing schemes;
- Design and management of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- To determine whether to establish new GP practices within the area;
- Approval of practice mergers;
- Decision making on 'discretionary' payment (e.g. returner/retainer schemes).

All CCGs responsible for GP commissioning were required to establish an independent Primary Care Commissioning Committee to exercise and oversee the delegated Primary Care commissioning functions. Lincolnshire West CCG had a committee of 11 members and was chaired by a lay member, as per guidelines, and made up of the following (those with voting rights are indicated with a *):-

- Lay Chair of the CCG*
- Chief Operating Officer or nominated deputy*
- Chief Nurse or nominated deputy*
- Chief Finance Officer or nominated deputy*
- Lay member for Public and Patient Involvement*
- Lay member for Primary Care*
- Secondary Care Clinician Governing Body member*
- NHS England representation
- Clinical Accountable Officer
- GP Clinical Advisor
- The four CCG locality chairs

Since the report had been published, a further lay member had been appointed.

It was further noted that the Conflicts of Interest Policy had been revised in accordance with new guidance and approved as part of the CCGs application to take on delegated primary care commissioning.

The revenue budget for commissioning GP primary care services had been delegated to the CCG along with the budget for GP IT. At present, infrastructure funding had been retained centrally. Some NHS England staff had been assigned to the four Lincolnshire CCGs to support administration but the management allowance for CCG's had been set nationally and had not increased as a result of taking on the additional responsibility. It was reduced by 10% in 2015/16.

CCGs who had taken on responsibility for delegated primary care commissioning were required, as part of the new assurance process, to submit a quarterly

declaration. The declaration for the first quarter of 2015/16 had been included as part of the report.

The Primary Care Commissioning Committee met monthly and had discussed a number of key issues, including:-

- Concordat for the Sharing of Information and the Management of Concerns relating to the Professional and Contractual Performance of Primary Medical Practitioners;
- Estate issues;
- Quality assurance for primary care;
- Quality and Outcomes Framework (QOF) 2013/14 – Heart Failure Indicator Performance by Practice;
- Practice/locality profiles;
- Prescribing and physiotherapy;
- Policy for practices in crisis (including failing practices)
- Individual practice issues;
- Care Quality Commission reports.

Members were given the opportunity to ask questions during which the following points were noted:-

- Annex A to the report provided an accurate picture of delegated functions for Quarter 1. Section 6 of the Self-Certification document required confirmation that an internal audit had been done to ensure the systems and processes were correct. It also required a signature from the Accountable Officer in addition to the Chairman of the Audit Committee;
- Although all CCGs were required to have a framework in place, it was acknowledged that these would be slightly different in each area. For example, Lincolnshire East CCG, South Lincolnshire CCG and South West Lincolnshire CCG operated a joint advisory group, as this was felt to be more time effective for these organisations;
- The ambition was to work better with partners to ensure integrated services at primary care level;
- Within the membership of the Primary Care Commissioning Committee on page 24 of the report, it was noted that there was a Lay Chair of the CCG. The sentence in brackets following this (*or lay vice chair if the chair is a General Practitioner)* was an error and should not have been included as GPs are unable to chair this Committee;

At 10.30am, Councillor T Boston joined the meeting.

- The Primary Care Commissioning Committee was open to the public and the CCG used the media, advertising and stakeholder meetings to promote attendance which had varied from meeting to meeting. It was suggested that posters be put up in each of the GP Practices within the locality to widen awareness of the Committee;
- The CCG continued to work with the Central Lincolnshire Joint Planning Unit as there was a concern about the decreasing workforce, in primary care, and

increasing populations. The infrastructure was being considered with a view to building on the support already available;

NOTE: The Chairman declared a personal interest as a member of the Central Lincolnshire Joint Strategic Planning Committee.

- When asked what influence the CCGs would have over the amount of procedures being performed outside of Lincolnshire, it was reported that at least 73% of patients were treated in acute care within Lincolnshire;
- Patients were able to decide if they would prefer care in a different county although it was acknowledged that this could have a financial implication as Lincolnshire had a lower market forces factor applied as part of the national tariff. It was stressed that the CCGs had no influence over the market forces factor applied as that was a national decision;
- When the responsibility for delegated GP commissioning arrangements was given to the CCGs administration costs were not included. They did, however, receive support from NHS England in 'people' resource;

RESOLVED

1. That the report and comments made be noted; and
2. That an update and report on progress of delegated commissioning be scheduled for a future meeting of the Health Scrutiny Committee for Lincolnshire.

59 SOUTH WEST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP - GENERAL UPDATE

A report by Allan Kitt (Chief Officer – South West Lincolnshire Clinical Commissioning Group) was considered which provided an update on the activities within South West Lincolnshire Clinical Commissioning Group covering urgent care, planned care, primary care and commissioning support in addition to information on mental health and learning disabilities for which South West Lincolnshire CCG was the lead commissioner.

Allan Kitt (Chief Officer – South West Lincolnshire CCG), Dr Vindi Bhandal (GP Chair) and Clair Raybould (Chief Commissioning Manager) were all in attendance for this item of business.

Members were given a brief overview of the report, the aim of which was to update the Committee on developments with South West Lincolnshire CCG. The CCG covered a population of approximately 130,000 and was centred around the market towns of Grantham and Sleaford. Although there was only one practice area within the CCG's area where deprivation was above the national average, the prevalence of disease was significantly higher than the national average. This included cardiovascular disease, diabetes and respiratory disease. Cancer mortality was improving overall with mortality for breast, lung and gastrointestinal better than the national average. Overall, cancer survival rates were worse than the national average despite steady improvement.

The CCG's Strategic Plan had been underpinned by the work consulted on and shared with the Scrutiny Committee and of the Shaping Health for Mid Kesteven Programme. The work had focussed on the following key areas:-

- Urgent Care
  - The Hospice in Hospital was a joint venture between local GPs, St Barnabas Hospice, ULHT and the CCG. It was fully operational at Grantham and District Hospital and was, for the first time, providing local inpatient palliative care;
  - Fifteen new intermediate care beds had been commissioned in partnership with Lincolnshire County Council, Lincolnshire Community Health Services and local GPs. This provided an alternative to hospital admission as well as a means to avoiding unnecessary hospital stays. In order to manage the inevitable winter pressures, it was planned to expand these bed numbers;
  - Close working with ULHT and Lincolnshire Community Health Services had enabled a single integrated reception area to open where Out of Hours, the GP in A&E and the Emergency Assessment Unit (EAU) team worked in partnership;
  - Ambulatory emergency care at Grantham Hospital was now complete and was being made operational for the winter enabling a robust alternative to admission to ensure more patients received a diagnosis and urgent treatment without unnecessary hospital stays;
  - Non-elective admissions across all providers within South West Lincolnshire CCG, including ULHT, Nottingham University Hospitals NHS Trust, Sherwood Forest NHS Foundation Trust, fell by 7% in 2014/15. The CCG's non-elective admissions had fallen between 6% and 7% each year for the past three years and it was not expected that, in light of the aging population and high disease burden, that this would continue;
  - Emergency admission rates for the CCG were significantly lower than the national average although it was reported that admission rates for all Lincolnshire CCG's were lower than average.
- Planned Care
  - Focus was on the delivery of referrals to treatment standards for our patients as significant problems as a result of difficult access at ULHT had been experienced by patients. The CCG now reported that 92% of patients were scheduled to be treated on time and not subjected to any delays;
  - Focus was on improving cancer access following the loss of breast services at Grantham as a result of staff shortages. Despite the current standard of service and access not being satisfactory to the CCG, this had shown a steady improvement, largely as a result of the use of services outside Lincolnshire in both Nottingham and Peterborough;
  - New provider relationships were being developed and access to the independent sector and NHS Trusts outside of Lincolnshire were increasing in an attempt to secure steady access. The CCG was

well placed to access alternative providers due to a lack of capacity in Grantham, Lincoln and Boston;

  - A pilot scheme had been launched for a new hearing loss service within Specsavers in Grantham to provide an alternative to current hospital services which were unable to meet demand. The service was expected to enable hospital services to focus on serious cases and give faster local access. An evaluation of the pilot would take place after twelve months and, if successful, would be fully procured.

- Mental Health and Learning Disabilities
  - As the lead CCG for the area, the CCG were leading the work on the deployment of £2m of recurrent investment from the Lincolnshire CCG's on the Parity of Esteem Programme. This was focussed on the delivery of a robust 24 hour 7 day liaison service and response to A&E, working with urgent services and to ensure that the 24 hour and 7 day CAMHS services worked coherently with adult mental health services;
  - Work was ongoing with Lincolnshire Partnership NHS Foundation Trust (LPFT) to manage the impacts for the closure of Long Leys Court Assessment and Treatment Unit and to work closely with them to ensure that high quality safe placement alternatives were located for the remaining service users in that unit;
  - Development of a community based model was being jointly considered with LPFT as an alternative, giving full compliance with requirements of national policy, and was expected to put Lincolnshire at the leading edge of modern learning disability services;
  - Work also continued with LPFT's leadership and clinical teams to deliver improvements set out in a single quality plan which had been reviewed by the Health Scrutiny Committee for Lincolnshire;
- Primary Care
  - Three successful bids had been submitted to the Primary Care Infrastructure Fund, following work with practices in the CCG area, to provide additional consulting and team working space. A programme of building work was currently being rolled out as a result;
  - Development of a quality infrastructure, including quality dashboards and a process based on practice visits by the CCG, was ongoing in conjunction with practices to ensure that they were making best use of resources and delivery high quality services;
  - CQC inspections had taken place with certain practices in the South West Lincolnshire CCG area and work was ongoing with those practices highlighted by the CQC as "requiring improvement" to ensure that issues were improved as soon as possible;
  - There had been investment in practices in care coordination at a local level to ensure that practices were able to provide coordinated and joined up care. This had included provision of non GP resources enabling practices to free time to manage the care of those with the most complex needs;
  - It was reported that South West Lincolnshire CCG had again delivered all of its financial obligations and was awarded the "Best CCG to Work In" by the Health Service Journal and Nursing Times in

2015. This accolade resulted in the CCG being one of the five best NHS organisations to work in nationally which was acknowledged as a significant achievement for the team;
    - Close working with partners on the development of the Lincolnshire Health and Care Strategic Outline Case was to continue in the future;
- Commissioning Support
    - Partnership working with South Lincolnshire CCG had resulted in the CCG being the first in the country to successfully access the new national Lead Provider Framework for commissioning support. The framework offered CCG's a choice of accredited providers for 'back office functions' which ranged from payroll to IT support. It was reported that, following a rigorous selection process, Optum had been selected as the new provider of these services. A transition process would commence from the current provider, Greater East Midlands Commissioning Support Unit.

Members were given the opportunity to ask questions during which the following points were noted:-

- Lincolnshire West CCG were leading a piece of work to bring together all organisations who held responsibility for end of life care. This was expected to improve those services by developing an alliance format. Additionally, medical support within hospices were delivered by GPs rather than hospitals which further improved the communication;
- Challenges faced across Lincolnshire were varied and it was acknowledged that health problems as a result of good living could be as complex as those in an area of deprivation;
- The role of Neighbourhood Teams had not been included in the report as it had now become a fundamental part of the service. It was suggested and agreed that future reports should include the explicit role of Neighbourhood Teams to make it clear for both the Committee and the public;
- Emergency units were in place across all three hospitals within Lincolnshire although had differing names. Clarification was received that it was the Emergency Assessment Unit (EAU) in Grantham and the Medical Assessment Unit (MAU) in Lincoln;
- The Ambulatory Care Unit was also able to undertake some of the emergency assessments without admitting patients. The Ambulatory Care Unit was physically located near to A&E and also to the Emergency Assessment Unit (EAU) to ensure the flow of patients was clear and easy for all involved;
- Intelligence and service user voice would be included within the contract monitoring with Lincolnshire Partnership NHS Foundation Trust and all issues addressed within the Quality Improvement Plan. The CCG were confident that the temporary closure of services had not reduced the quality of service but improved them. The ambition was for Lincolnshire to be at the forefront of these types of services;
- Mental health patients picked up by the police were required to be taken to a place of safety under Section 136. The police were working with LPFT to fully develop a suitable and safe pathway;

- It was acknowledged that the report could read that partnership working had ceased due to the language used. It was stressed that partnership working was a continuous process and one which was key to service delivery success;
- It was confirmed that cost efficiencies would arise from Optum undertaking the Commissioning Support Unit functions for the CCG, and there was expected to be a quality gain, the process for awarding the contract was done as part of the National Framework Agreement from NHS England which include ten approved providers, all of which were within the quality and monetary framework requirements;
- Although CQC inspections of GP practices often highlighted poor practice, the Committee was asked to acknowledge that these inspections found examples of good practice, but the aim was to be outstanding;
- The district councillor representing South Kesteven District Council on the Committee asked it to be recorded that the South Kesteven District Council was impressed by the improvements made by the CCG in the area;
- Discussions were ongoing with the Communications Lead to promote to the public how positive these improvements had been. It was though that a paid editorial may be required to ensure that the public were aware of the changes;
- In relation to Neurology, work was ongoing to develop a more community-based, nurse-led, neurology base and proposals around those developments would be presented at a future date. It was anticipated that the Lincolnshire model would change considerably;
- A Cancer Improvement Plan was in development which would be shared with the Committee;
- It had been agreed to open an additional four beds, over and above the 16 already open, as and when needed to support winter pressures. Those beds were in one location which would help to manage staff and ensure efficiency. The beds were also based in the Order of St John Care Home in Grantham and not the hospital as it was more cost effective and efficient to have them set up in this way;
- Grantham's proximity to Nottingham led to more patient availability in Lincolnshire when patients chose to take treatment out-of-county. Although there was a financial pressure it was due to the market forces factor and, on balance, the CCG would prefer that people received the appropriate treatment without delays;

The Chairman thanked officers for their presentation and gave formal congratulations, on behalf of the Committee, on their recent achievements.

RESOLVED

That the report and comments made be noted.

It was agreed to take Item 8 – Work Programme prior to Item 7 – Urgent Care – Constitutional Standards Recovery and Winter Resilience.

60 WORK PROGRAMME

The Committee considered its work programme for the forthcoming meetings.

The Health Scrutiny Officer advised that there were no changes to the published work programme for consideration but asked the Committee to note that the meetings in December 2015 and January 2016 would be all day.

Councillor E L Ransome asked that her apologies for the December meeting be noted.

Further to comments at the last meeting of the Committee, Councillor T M Trollope-Bellew advised that the consultation in relation to Stamford car parking charges closed on 19 November 2015. Following discussion, it was agreed that a representation should be submitted on behalf of the Committee. It was agreed, therefore, that the submission from Stamford Town Council to Peterborough and Stamford NHS Foundation Trust be sought on the Trust's proposals to introduce parking charges at Stamford and Rutland Hospital, with a view to a response being made to the Trust on behalf of the Committee, setting out the Committees opposition to the introduction of parking charges.

RESOLVED

1. That the contents of the work programme be approved; and
2. That the submission from Stamford Town Council to Peterborough and Stamford NHS Foundation Trust be sought on the Trust's proposals to introduce parking charges at Stamford and Rutland Hospital, with a view to a response being made to the Trust on behalf of the Committee, setting out the Committee's opposition to the introduction of parking charges.

61 URGENT CARE - CONSTITUTIONAL STANDARDS RECOVERY AND WINTER RESILIENCE

The Chairman explained that the paper had been presented to the agenda planning meeting on 5 November 2015 where it was requested that the fines and penalties, noted on page 42 of the report, be defined further. In addition to that, the Chairman asked that the Committee note the following points prior to consideration of this item:-

- Tabled 2 on page 40 of the report provided statistics in relation to United Lincolnshire Hospitals NHS Trust. It was confirmed that the table was accurate and the Chairman expected that the figures for 'patients' and 'days' would be further clarified during the presentation;
- A full range of data was readily available on the NHS England website regarding delayed transfers of care, which recorded delays for each NHS Trust, by local authority, as well as by the cause of delay.

Consideration was given to a report from Gary James (Accountable Officer – Lincolnshire East CCG) and Sarah Furley (Urgent Care Programme Director –

Lincolnshire East CCG) which provided information on the Constitutional Standards recovery plan for urgent care and the winter plans.

Gary James (Accountable Officer – Lincolnshire East CCG) and Sarah Furley (Urgent Care Programme Director – Lincolnshire East CCG) were both in attendance and provided members with a detailed overview of the report.

As set out in the NHS Constitution, a minimum of 95% of patients attending at an A&E department in England should be seen, treated and either admitted or discharged within four hours. Recent evidence had shown that there was an increased risk of harm to patients should the four hour A&E standard fall below 90%.

National Context

During Quarter 3 2014/15 (winter 2014) the four hour A&E standard declined to a lower level than at the end of the same period the previous year which had been a sharp decline nationally. Since winter 2014-15, work had been undertaken to identify the factors driving the sudden decline in A&E performance in order to take action and prevent it from recurring this year.

Analysis from a report from Monitor in September 2015 (*A&E Delays: Why did patients wait longer last winter?*) indicated that half of the decline in A&E performance against the four hour target in winter 2014 could be explained by factors such as each hospitals inability to accommodate the increase in A&E attendance. Monitor findings had advocated that measures taken by hospitals and urgent care system to improve patient flow through hospital departments other than A&E may be highly effective in avoiding another sharp decline in performance.

Local Context

Although there had been an improvement nationally in the four hour A&E standard since winter 2014, Lincolnshire had not recovered to the same extent. Figures indicated that England were 94.32%, the East Midlands 94.70% and Lincolnshire at 89.9%.

It was reported that Pilgrim Hospital was running with a higher bed occupancy than other sites and it was acknowledged that medical beds had a higher bed occupancy than surgical beds.

In excess of 100 acute care beds had been closed in ULHT during 2013/14 and this had continued into the first six months of 2014/15 which had previously been reported to the Committee. The beds had been predominantly closed to ensure that safe staffing levels were achieved to enable a sustainable service.

Delayed Transfers of Care (DTOCs) were a significant issue for Lincolnshire as resulted in three main delays – completion of assessment, further non acute NHS care and care packages in own home. In July 2015, there were 1291 lost bed days in ULHT due to delayed transfers of care which equated to approximately 42 beds at 95% bed occupancy, a rate of 4.1%. NHS England wanted the rate to be reduced to

2.5% by the end of September 2015, releasing 17 beds, but it was suggested that this target would not be achieved.

Lincolnshire's Constitutional Standards Recovery Plan

In June 2015, the Trust Development Agency (TDA) and NHS England put the Lincolnshire health system in to a recovery programme and a Constitutional Standards Recovery Plan was developed. This was monitored through a new governance structure, the Lincolnshire Recovery Programme Board, chaired by NHS England and the TDA, which met monthly. The plan covered urgent care, cancer and also Referral to Treatment (RTT) standards.

The urgent care element of the Constitutional Standards Recovery Plan was split into the following critical projects:-

- Pre hospital
- Emergency departments
- Length of Stay (The Patient Flow Bundle – SAFER)
- Out of Hospital Care (Complex discharges and community capacity)

The plan was for the four hour A&E standard to be received by October 2015 and it was reported that this had not been achieved, with the performance at ULHT standing at 85.47%. Additional actions were being finalised in time to be presented at the next meeting of the Lincolnshire Recovery Programme Board on 20 November 2015.

The Emergency Care Improvement Programme (ECIP) was to be in Lincolnshire for the next three months. ECIP were a national clinically led programme that offered intensive practical help and support to urgent and emergency care systems that were failing to recover. They were assisting 28 urgent and emergency care systems across England under the most pressure.

Lincolnshire's Winter Plan

Lincolnshire health and care agencies had developed a winter plan which was to be presented to the System Resilience Group (SRG) on 10 November 2015 for ratification. The following key areas were included within the plan:-

- Anticipate that included Adverse Weather conditions, seasonally related illness;
- Assess that identified risk this winter;
- Prevent that included public communication campaigns, flu prevention, business continuity and maximising the role of Neighbourhood Teams with the Voluntary and Community Sector;
- Prepare which maximised capacity in services and how to maximise availability of staff through reducing sickness. The section also identified responses in case of industrial action and different ways of working, e.g. integrating therapies;

- Respond – Lincolnshire's Escalation and Surge Plan had been refreshed this autumn and detailed the arrangements and procedures which SRG partners in Lincolnshire would utilise in the event of surge and capacity issues, irrespective of cause, affecting one or more partners in order to sustain the provision of high quality responsive care. Within the plan, escalation trigger levels, actions and responsibilities had been clearly defined and shared amongst key stakeholders;
- Recover – the Escalation and Surge Plan also set out de-escalation levels which would support system recovery and a formal post-winter debrief session was planned for April 2016.

Fines and Penalties

Through a contractual mechanism, health commissioners had two types of fines which could be applied to non-achieving organisations. A financial penalty for not achieving an operational standard and a national quality requirement was calculated on a monthly basis and members of the SRG had previously agreed that all urgent care related contractual fines and penalties would be aggregated and made available for application by the SRG as appropriate in-year. A Contract Performance Notice (CPN) which withheld 2% of income until the standard had been achieved was the other penalty which could be applied.

In the event a CPN was issued, commissioners would meet with the receiving provider and a Recovery Action Plan (RAP) agreed. Once that was achieved, the 2% funds which had been withheld would be returned. It was acknowledged that the 2% would have already been committed by the provider as part of the totality of their annual budget which would be spent on that pre-commitment. Should the RAP not be delivered the commissioners had choices available to them on how to reinvest the 2%.

It was accepted that urgent care was a complex adaptive system which was dynamic in terms of its interactions and relationships between professionals, services and organisations. Increased demand was not driving the Lincolnshire urgent care system so it had to be those interactions. The interactions were non-linear meaning small changes in inputs, physical interactions or stimuli could cause large effects or very significant changes in outputs/performance.

Within Lincolnshire there was now a shared understanding that these interactions were detrimental to flow through the acute hospitals, exacerbated by a reduced number of beds and high occupancy, and high numbers of delayed transfers of care, exacerbated by reduced capacity in domiciliary care and reablement services. The Recovery Plan was focussed on improving those interactions and the Winter Plan was focussed on the wider system actions which would impact on system resilience.

Members were given the opportunity to ask questions during which the following points were noted:-

- As of the morning of 18 November 2015, 72 escalation beds had been opened;

- Figures in Table 2 were further explained. The 'Patients' figures were the snapshot figure, based on the number of patients in hospital at midnight on the last Thursday of each month and 'Bed Days' reflected the cumulative total of lost bed days;
- Concern was noted about 'self-funders' within care homes and the potential for the homes to cease taking local authority patients due to the profits involved. It was noted that supply and demand resulted in some care homes increasing their prices in winter 2014. There was not an even spread of these placements, for example, a lot of places were available in the Skegness area but none in Grantham and Sleaford;
- Community hospital beds were running at 13.8% Delayed Transfers of Care (DTOC) rate which was significantly higher than before but consideration was being given to the reason for this figure but it was not expected that there would be any difference between community hospitals and acute hospitals;
- The Committee expressed concern about the number of meetings, boards and groups, which were being held to rectify these issues and asked if they were hindering the process at all. In response, the Committee was advised that most meetings were held monthly and had been effective to-date;
- In relation to 30-day beds the average length of stay had been 33-38 days. The funding was through the NHS and patients were placed in a home of their choice. Care would be delivered by the care home but there were no wraparound care services but patients do have a care manager. The main issue with this service was that patients could be there for the maximum time without receiving the necessary therapies which were necessary to assist recovery. Some patients were also kept in those beds when they should have been sent home so work was on going on transitional care. This project would have to be carefully managed as there were 130 patients in 30-day beds at any one time;
- Lincolnshire County Council had re-procured the reablement service during 2015 with the new provider starting on 3 November 2015 and the statement in the report (page 41) that the procurement of domiciliary care and reablement had, and continued to have, significant negative impact on delayed transfers of care was further explained. Whilst Lincolnshire compared well with other local authorities, during the period of the reprocurement exercise there had been an increase in delays arising from Adult Social Care over the past three months, which might lead to increases in future reporting periods;
- It was agreed that a copy of the Emergency Care Improvement Programme (ECIP) would be forwarded to the Health Scrutiny Officer;
- It was agreed to send the Winter Plan Framework, electronically, to the Health Scrutiny Officer for wider circulation to members;
- Fines would be removed and funds withheld. £267k had been levied in fines in Quarter 1, across the whole system but the fines could then be returned to develop an improvement plan. Once there was evidence that the plan was being implemented the funds would be returned. To keep the partners working together and supporting each other it was stressed to the Committee that blame should not be apportioned, particularly as this could lead to further breakdowns in relationships, thereby providing a worse service for patients;

- New national guidance had been released for delayed discharges in both the acute and community hospitals;
- A suggestion was made to include a definition of particular charts, e.g. Statistical Control Chart, in future reports to assist members and the public;
- Although it may have appeared that the work on the winter plan had commenced in November, too late to address the winter pressures, the Committee were reassured that the process and planning had commenced in February 2015 and had been ongoing until this point;

RESOLVED

1. That the report and comments made on the Constitutional Standards recovery plan for urgent care be noted;
2. That the winter plans be noted;
3. That a future update be added to the Work Programme for March 2016.

The meeting closed at 1.37 pm

This page is intentionally left blank