HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
20 JANUARY 2016

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

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

Lincolnshire District Councils

Councillors G Gregory (Boston Borough Council), B Bilton (City of LIncoln Council), Mrs P F Watson (East Lindsey District Council), K Cook (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)) and Mrs R Kaberry-Brown (South Kesteven District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Mark Brassington (Chief Operating Officer – United Lincolnshire Hospitals NHS Trust), Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Simon Evans (Health Scrutiny Officer), Ian Hall (Senior Delivery and Development Manager - Trust Development Authority), Jim Heys (Locality Director Midlands and East (Central Midlands) - NHS England), Andy Hill (Lincolnshire Divisional Manager - EMAS), Stephen Hyde (Marketing and Fundraising Manager - LIVES), Gary James (Accountable Officer – Lincolnshire East CCG), Steve Kennedy (EMAS), Sarah Jane Mills (Director of Development and Services Delivery – Lincolnshire West CCG) Lynne Moody (Director of Quality and Executive Nurse – South Lincolnshire CCG), Dr Simon Topham (Clinical Director – LIVES)

County Councillor B W Keimach attended the meeting as an observer.

71 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors J Kirk (City of Lincoln Council), T Boston (North Kesteven District Council), D P Bond (West Lindsey District Council) and Miss E L Ransome (Lincolnshire County Council).

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor B Bilton to the

Committee in place of Councillor J Kirk (City of Lincoln Council) and Councillor K Cook in place of Councillor T Boston (North Kesteven District Council) for this meeting only.

Councillor Mrs S Ransome indicated that she would have to leave the meeting at approximately 2.30pm.

The Chairman reminded the Committee that should a Replacement Member be appointed at a meeting they would then be the Member for that meeting. Should the substantive Member join the meeting at a later time, they would be welcome but as an observer only.

72 DECLARATIONS OF MEMBERS' INTERESTS

In relation to Item 7 – *Cancer Services in Lincolnshire*, Councillor G Gregory advised that he was currently serving part of the cancer service (colon cancer) as part of his paid employment with United Lincolnshire Hospitals NHS Trust but felt that this discussion did not relate to his pecuniary interest.

Councillor Mrs P F Watson advised that she was a patient receiving cancer services but would remain for the discussion at Item 7 – *Cancer Services in Lincolnshire*.

Councillor S L W Palmer declared an interest in Item 7 – *Cancer Services in Lincolnshire* as a former patient receiving cancer services within the county.

In relation to Item 5 – *East Midlands Ambulance Service (EMAS) – Improvements and Performance* and Item 6 – *Lincolnshire Integrated Volunteer Emergency Service (LIVES),* Councillor S L W Palmer advised that he was a first responder and coordinator of the LIVES Sutton on Sea Group. When called out, he was active under EMAS.

In relation to Item 7 – *Cancer Services in Lincolnshire,* the Chairman, Councillor C A Talbot, advised that her daughter had received cancer treatment from United Lincolnshire Hospitals NHS Trust (ULHT) twice within the last ten years and had written with her concerns about the treatment received in 2015.

73 CHAIRMAN'S ANNOUNCEMENTS

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

i) Norovirus at Lincoln County Hospital

At various times over recent weeks, several wards at Lincoln County Hospital had been closed to new admissions owing to an outbreak of the norovirus. It was reported that of 15 January 2016, the norovirus outbreak at Lincoln County was declared over as there had not been any associated cases reported for 72 hours. Although three wards were still affected, these were being cleaned and would be fully open within the next few days.

ii) Lincolnshire Community Health Services NHS Trust – Meeting

On 11 January 2016, the Chairman met with Elaine Baylis (Chairman) and Andrew Morgan (Chief Executive) of Lincolnshire Community Health Services NHS Trust (LCHS). Several issues were discussed including progress with the Trust's application for Foundation Trust status. It was understood that the predicted date for the Trust's authorisation and establishment as a Foundation Trust would be late 2016.

Two changes to senior management had been made at LCHS: Danni Cecchini had been appointed as the permanent Director of Finance and Lisa Green had been appointed as Director of Nursing and Operations in place of Sue Cousland, who retired in December 2015.

iii) Healthwatch Lincolnshire – 17 February 2016

The Chief Executive of Healthwatch Lincolnshire, Sarah Fletcher, had contacted the Chairman regarding the content of the item from Healthwatch scheduled for consideration at the Committee on 17 February 2016. It was suggested that the report be an overall Mental Health Report from Healthwatch rather than having a CAMHS focus and to give consideration to CAMHS later in the year.

iv) East Midlands Congenital Heart Centre – Stakeholder Meeting

The first local authority stakeholder meeting of the year for the East Midlands Congenital Heart Centre took place on 14 January 2016 at Glenfield Hospital in Leicester. The Chairman was unable to attend the meeting but advised that NHS England had found overlap in the geographical areas where congenital surgical centres intended to provide a service. In order to address this, NHS England were to divide the country up into 'parts' and then ask the centres to bid for areas to which they wanted to provide the service.

The East Midlands Congenital Heart Centre continued to work towards the national standards. For example, they were on track to complete approximately 330 cases in the coming year; to co-locate their congenital heart services with all other children's services by 2019; and to have four surgeons, each undertaking 125 procedures per annum by 2021. The next stakeholder meeting was scheduled for 17 March 2016.

A full report would be circulated to the Committee.

v) Lincolnshire Integrated Volunteer Emergency Service (LIVES) – Appointment of Chief Executive

Lincolnshire Integrated Volunteer Emergency Service (LIVES) had announced the appointment of their first full-time Chief Executive Officer. Nikki Silver would take up the position with effect from 2 April 2016. Nikki was previously the Deputy Director of Operations, Family and Healthy Lifestyle and Urgent Care at Lincolnshire Community

Health Services NHS Trust (LCHS) and had previously presented to the Committee on 20 May 2015 on School Nursing and Health Visiting services.

vi) United Lincolnshire Hospitals NHS Trust (ULHT) – Appointment of Chairman

At the last meeting of the Committee it was report that Ron Buchanan would retire as Chairman of United Lincolnshire Hospitals NHS Trust in March 2016. The Chairman had been invited to attend a stakeholder event on 21 January 2016 to meet applicants for the Trust's new Chairman. The Chairman would then be asked to provide feedback to the panel prior to the formal interviews.

vii) Hospice within a Hospital, Grantham

The Chairman had been invited to attend the formal opening of the Hospice within a Hospital in Grantham on 21 January 2016. The Hospice was to be opened by the actor, Warwick Davis. Unfortunately, this event coincided with a stakeholder event at Pilgrim Hospital which the Chairman would attend and therefore this invitation had been, regretfully, declined.

viii) Special Care Dentistry Engagement Briefing Report

On 21 December 2015, NHS England Central – East Midlands issued a briefing paper to the Health Scrutiny Committee on Special Care Dentistry. Special Care Dentistry was concerned with the oral health of individuals with a physical, sensory, medical, emotional or social impairment or disability. The briefing paper reported the findings of an engagement exercise with patients during 2015 and would inform NHS England's procurement of the service in the coming year. The Chairman highlighted the fact that engagement activity found that the majority of respondents confirmed that the existing services exceeded their expectations.

The briefing paper would be circulated to the Committee.

ix) Acute Trust Financial Position

Recent coverage in the national press had highlighted the financial challenges faced by acute hospital trusts. The Chairman had requested research be undertaken and had found that, based on figures available in December 2015, the six acute trusts most used by Lincolnshire residents were, between them, predicting a deficit in the current financial year of £220 million. United Lincolnshire Hospital NHS Trust predicted a deficit of £59.9 million which comprised the largest single element of the total. This remained a concern but the Committee looked forward to hearing how these financial challenges could be addressed in the coming year.

The paper would be circulated to the Committee.

x) Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21

A key document had been published on 22 December 2015 entitled: *Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21*. The Chairman had

requested a specific report to be prepared on this document and this would be considered by the Committee at Item 9 of the agenda. It was expected that several aspects of the document would affect the future work programme of the Committee.

74 MINUTES OF THE MEETING OF THE COMMITTEE HELD ON 16 DECEMBER 2015

RESOLVED

That the minutes of the meeting held on 16 December 2015 be approved and signed by the Chairman as a correct record.

75 EAST MIDLANDS AMBULANCE SERVICE (EMAS) - IMPROVEMENTS AND PERFORMANCE

A report by Sue Noyes (Chief Executive of East Midlands Ambulance Service NHS Trust) was considered which outlined the key areas of performance within the East Midlands Ambulance Service (EMAS) and, in particular, the Lincolnshire Division. The report included an update on the work and ongoing projects being carried out to enhance and support performance.

Andy Hill (Lincolnshire Divisional Manager – EMAS) and Steve Kennedy (Divisional Support Manager – EMAS) were in attendance for this item of business.

Members were given an overview of the report which provided Quarter Two Performance Data (July, August and September 2015). It was also reported that the Care Quality Commission (CQC) had inspected EMAS in November 2015, the outcomes of which were expected in early 2016.

It was reported that the Lincolnshire Division had achieved the Red 1 target for the quarter (76.56%). This had been challenging with the Division falling short of the required target by 1.44%. Handover delays at hospitals were detailed in Table 2 of the report but it was stressed that these figures were subject to validation. Overall activity in comparison to Quarter Two in 2014/15 had increased by 6%

EMAS had noted that inter facility transfers (IFTs) from Grantham and District Hospital had increased by 23% compared to 2014/15. In order to establish the reason for the increase a review was being undertaken. The review would also identify what actions would be required to mitigate impact on performance in the South Lincolnshire and South West Lincolnshire CCG areas. Once the review was complete, the findings would be made available to the Committee.

Close working with United Lincolnshire Hospitals NHS Trust (ULHT) had resulted in proactive management of handover delays although this remained an ongoing issue which was being reviewed as part of the Recovery Plan for ULHT. December 2015 saw the deployment of a clinical navigator by the Division to Pilgrim Hospital which was to liaise with ULHT staff to efficiently signpost patients thereby freeing up EMAS resources to respond to other calls. The impact of this initiative would be reported to the Committee once available. It was confirmed that Hospital Ambulance Liaison

Officers (HALOs) would also continue to be deployed to all sites where pressures were identified.

An EMAS Healthwatch Task Group had been formed between the Trust and Healthwatch Lincolnshire to consider and act upon initiatives in response to local need. Engagement with both System Resilience Groups (SRGs) and Urgent Care Working Groups was well established with representation and participation being regular and inclusive. Unique initiatives with partner organisations, including CCGs, Integration Executive, Local Resilience Forum (LRF) and others were congoing in support of the improvements necessary for the wider Lincolnshire health economy.

The following initiatives had been developed to improve service and performance:-

- Mental Health Car Initiative;
- Mobile Incident Unit, Butlins – Skegness;
- Clinical Assessment Car Initiative;
- South Lincolnshire Investments/Initiatives;
- Joint Ambulance Conveyance Project (JACP) – Stamford, Woodhall Spa and Long Sutton;
- Clinical Navigator role at Pilgrim Hospital, Boston; and
- Addressing patient handover delays within the acute trusts.

In relation to the Joint Ambulance Conveyance Project (JACP) Project Data, Lincolnshire Fire & Rescue (LFR) and EMAS had developed a pilot project aimed at improving the quality of service and outcomes for patients in Lincolnshire. The project had built on LFR's existing co-responder scheme, run in partnership with EMAS and Lincolnshire Integrated Voluntary Emergency Service (LIVES), in which on-call retained firefighters from 21 stations responded to medical emergencies, delivered first aid, provided oxygen therapy and administered defibrillation and cardiopulmonary resuscitation.

The Fleet Services Strategy was agreed by the EMAS Board in March 2015 and highlighted the case for investment in the EMAS fleet to respond to a range of challenges. A commitment had been made to invest between £19m - £24m over the next five years on new vehicles and would ensure that the age profile of the fleet was reduced to seven years by the end of the financial year 2018/19.

The allocation of ambulances to the Lincolnshire Division had been identified from the age profile of all ambulances within the fleet. Lincolnshire received 46% (37 of 80 acquired) of the new vehicles in 2012 therefore did not have the same aging vehicles as other Divisions.

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

- It was noted that the figures reported in South Lincolnshire were of concern to the Committee. This was acknowledged and explained that there had been 600 hours of resource drift in December 2015 alone for DCA's and solo responders. Work was ongoing to rectify this situation and to more

appropriately utilise the resources available. Specific information on the resource drift in December would be provided to the Committee;

- Turnaround times and delays in hospitals all impacted on response time and in the south of the county in particular. There had been a recruitment drive but the benefit of this would not be felt until mid-March 2016 due to the requirement for newly appointed staff to undergo 750 hours of supernumerary training;
- There had been an increase in handover delays at each of the sites although had seen success at Pilgrim Hospital following the appointment of the Clinical Navigator. This role was designed to detect certain clinical conditions of patients conveyed to hospital and make preparations to avoid the A&E department and transfer immediately to an appropriate ward. It was stressed that this role was navigational but had appeared to have a tremendous amount of success;
- The Clinical Navigator role was not a duplication of the HALO role which had been an ad hoc position which was put in place to support the hospitals. The Clinical Navigator was a new role designed to proactively manage delays;
- Red calls coming through to EMAS from other sources were unable to be downgraded and this had been reflected in a change to the Ambulance Quality Indicators (AQI);
- Figures were requested regarding the number of 111 calls resulting in unnecessary conveyance to A&E. EMAS representatives felt that this information should be available and would take this as an action point to provide to the Committee following the meeting;
- Hear and Treat was a telephony based treatment system that enabled management of lower priority calls, which often resulted in the despatch of a vehicle not being required;
- It was confirmed that the maximum number of ambulances available during peak times was 48 within Greater Lincolnshire with approximately 10 in the East of the County. Shifts were 12 hours from 0630 to 1830hrs and 1830 to 0630hrs. In addition to these ambulances, a further 12 were available to be tied in. Ringfencing vehicles would be difficult but EMAS also had a Clinical Assessment Car and a Mental Health Car in the County which assisted in the appropriate utilisation of resources;
- LIVES were acknowledged and applauded for their voluntary support of the scheme which was reported as a model envied across other ambulance services across the country. It was a model to be nurtured and embellished and rolled out further;
- In relation to the Toughbooks, it was explained that it was a robust working environment so they do suffer some knocks. Despite this, it was acknowledged that the tag system wasn't adequate for the needs of the ambulance service. The new equipment incorporated a different system to the tags, further to hardware development, which was a positive step forward. The model in the south was to be rolled out to the north west and east of the County;
- The table shown at 2.2 on page 27 of the report showed the Quarter 2 performance figures for JACP. The figures were combined data and a full breakdown would be sent to the Committee following the meeting;

- Clarification of the figures in table 1 was provided. RED1 and RED2 data was outcome data which was able to be shared. 95% was the conveyance target with 75% as the response time target. In terms of the survival figures for those calls against national benchmarks, 8 minutes was a target set nationally and there was a lot of ongoing work to ensure allocation of the right response and despatch to that call. Details of this work would also be shared with the Committee following the meeting;
- A job advertisement was currently out, from Lincolnshire Community Health Services (LCHS) for two full-time Clinical Navigators in Lincoln and Boston. The ambulance service was current covering these roles and a meeting was scheduled to discuss the roles in greater detail. Although there was no tangible data of the impact of these roles at present, anecdotal feedback had been positive;
- A&E handover times at Grimsby were a concern for residents in the East Lindsey district. This was acknowledged that a Clinical Navigator would benefit Grimsby but this would be dealt with by the processes North East Lincolnshire;
- Within planning, winter pressures were considered. Rotas needed to be flexed to utilise staff over those particular months. At peak times road accidents become a huge cost to EMAS which was not necessarily as a result of the weather but the increased activity on the roads. EMAS was working with local road safety partnerships to ascertain why the activity had increased;
- Concern was raised about the performance figures and asked how Lincolnshire was performing in relation to other areas within the East Midlands. Other areas in the East Midlands were experiencing the same issues and problems but Lincolnshire appeared to be the highest performing division within EMAS currently, having held its year-to-date RED1 target;
- Although the figures within the South Lincolnshire CCG area were down to 50%, that was a measurement on two jobs alone, one target was reached, the other was not. With such low numbers to measure, the percentage will always be fairly low but it was also stressed that although performance and percentage were important, quality of the service provided was key;
- A suggestion was made to utilise NSL Ambulances (Human Touches) to assist with Inter Facility Transfers (IFT). This was felt to be a valid suggestion as NSL was currently contracted to do non-emergency work. Dedicated Transfer Crews were currently being considered but EMAS would like to run that from their own workforce rather than utilise third parties due mainly to the cost involved but this did highlight the need for dedicated IFT crews;
- The figures throughout the report show the response time of the first person to respond to the call rather than when an ambulance arrived. A breakdown of the data from the arrival of the first responder to the time of arrival of an ambulance capable of conveying the patient was requested;
- "Other Conveyances" on page 27 of the report included figures of self-conveyance but also where third parties had conveyed patients to hospital;
- For future reports, it was requested that Kings Lynn hospital be included within the figures as patients from the South Holland area were often taken to this hospital for treatment;

- In relation to the Recovery Programme at ULHT, the Chief Executive of EMAS had a seat on the Lincolnshire Recovery Board and was proactively supporting the trust with Pathfinder and Clinical Navigators to reduce the amount of patients being taken in. The Chairman requested that this information be included within the report from EMAS for the next scheduled update;
- The work between Healthwatch Lincolnshire and EMAS regarding the potential initiatives of local needs was in the early stages but there was an intention to develop a formal protocol for this. The Chairman requested the findings from this task group be presented to the Committee;
- A number of unique initiatives were mentioned in the report and these were further explained as continued work with CCGs and community teams in terms of projects; paramedics on bikes; Clinical Navigators, etc. Also an Alliance Agreement with CAS was a key piece of work;
- The Committee acknowledged that there was a lot of positive activity but requested the outcomes of the activity.

RESOLVED

1. That the report and comments be noted; and
2. That a further update be scheduled for the meeting of the Health Scrutiny Committee for Lincolnshire on 20 April 2016.

76 LINCOLNSHIRE INTEGRATED VOLUNTEER EMERGENCY SERVICE (LIVES)

A report by Lincolnshire Integrated Volunteer Emergency Service (LIVES) was considered which gave information on the emergency response service, provided by trained volunteers, to medical emergencies throughout Lincolnshire. The service supported the services provided by the East Midlands Ambulance Service as the statutory ambulance service provider.

Dr Simon Topham (Clinical Director – LIVES) and Stephen Hyde (Marketing and Fundraising Manager – LIVES) were both in attendance for this item.

Dr Topham gave a presentation to the Committee which included the following slides:-

- Who are we?;
- Charitable Aims;
- What does this look like?;
- Activity and Performance;
- LIVES Calls (Making a Difference);
- So you short up EMAS then?;
- Finance;
- Clinical Governance;
- LIVES New in the Last Year;
- LIVES The Future;
- Challenges;
- Summary.

The charitable objectives of LIVES were:-

> *To provide Immediate Medical Care to any person injured in an accident or involved in any medical emergency in the area of Lincolnshire, North East Lincolnshire or any area reasonably close to. To advance the principle of Pre-Hospital Emergency Care on a national basis; providing advice and guidance in all aspects of such care, including the delivery of training and provision of approved emergency equipment.*

There were over 160 responder groups across Lincolnshire, with approximately 700 active LIVES Community First Responders (CFRs) and LIVES Medics.

LIVES Medics may attend the following incidents:-

- Life-threatening medical emergencies;
- Cardiac arrest;
- Paediatric emergencies;
- Road traffic collisions;
- Major trauma;
- Major incidents;
- Responding to requests for on-scene advanced clinical support.

LIVES medics offered skills appropriate to their level of professional. The highest level medic members were able to offer some, or all, of the following skill sets:-

- Advanced airway management and management of the difficult airway including pre-hospital emergency anaesthesia ("medically induced coma");
- Advanced ventilatory strategies;
- Advanced vascular access techniques;
- Sedation and advanced analgesia;
- Senior clinical support and decision making;
- Major incident management; and
- Further critical care interventions.

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

- Congratulations were given to LIVES for the successful defibrillation rates;
- LIVES had not needed to recruit actively over the last three years as numbers had been maintained. There was a cost to recruitment and funds were limited so could only expand the service when funds allowed. In relation to medics, volunteers were only accepted who were in certain areas of needs to ensure better coverage;
- The resilience of individuals within their own home was not necessarily what happened within an acute situation. Having shadowed a paramedic, it was found that repeat visits were made to the same house for the same reason therefore an acknowledgement that services need to increase communications to ensure better utilisation of resources;

- A suggestion that District Councils may be able to support recruitment of volunteers in their own areas was welcomed. It was reported that the south of the county was a particularly challenging area where new responders were needed;
- During the presentation, LIVES reported that they had responded to 9.3% of all EMAS Red1 calls in Lincolnshire which contradicted the figures quoted by EMAS during their presentation. The Committee requested that the Health Scrutiny Officer seek clarification from both organisations;
- The First Responders were deployed by the Emergency Centre at Bracebridge Heath on contact by the ambulance service so they were aware of the level of responder required and attending the scene. It was explained that if a level 3 responder was deployed but the administration of drugs was required (which only level 4 and up would carry) then they would look to have an EMAS responder go earlier;
- Although first on the scene, responsibility for that patient would be handed over to a medic and finally to an EMAS employed member of staff. If the responder was a doctor they would have a duty of care under the General Medical Council (GMC) to ensure that the patient received the best possible care available;
- Community responders carried adrenaline from level 3 and up;
- There were 28 level 4 responders throughout the county, 17 of which were medics. Level 1 was an introduction to the service so volunteers moved to level 2 within a matter of weeks and these responders provided defibrillation, oxygen therapy and life support. Level 3 responders had additional skills, for example they were trained in attending Road Traffic Collisions;
- The membership had been surveyed to ask for indications of particular interest of care provision so that responders were allocated appropriately for their level of confidence. 180 volunteers had indicated that they wanted to be CAS responders but there was a degree of frustration due to telephony and technology issues for CAS. Should responder be on a CAS call but a RED calls comes in to their area, they would give apologies to the CAS call and attend the RED call, returning to the CAS call afterwards;
- Congratulations were given on the new scheme of engaging with and teaching Year 10 students in Lincolnshire emergency procedures. The training was for bystander CPR within LIVES following successful trials in Sweden, where it was proven that 15/16 year olds could be trained to help collapsed and non-breathing people. 100 students at Boston College had been trained, all of whom confirmed that they would now feel confident in helping someone who had collapsed;
- When asked when this would be rolled out across all schools in Lincolnshire, it was explained that funding was needed to be able to do that, unfortunately. A grant had been acquired for schools in North Lincolnshire and the Committee suggested that the seven Lincolnshire MP's be approached to support this initiative;
- It was thought that Lincolnshire could lead this initiative as LIVES was recognised nationally and, for a minimal amount of funding, could roll this out to all secondary schools across Lincolnshire;

- The Committee were invited to undertake this training. The Health Scrutiny Officer would contact all members and seek to arrange a suitable date;

The Chairman thanked LIVES, on behalf of the Committee, for the work that they and their volunteers do in order to work in partnership with EMAS to deliver a fantastic service for the people of Lincolnshire.

RESOLVED

That the report and comments be noted.

At 12.40pm, Councillor B W Keimach left the meeting and did not return.

77 CANCER SERVICES IN LINCOLNSHIRE

A report by Sarah-Jane Mills (Director of Development and Service Delivery – Lincolnshire West Clinical Commissioning Group) was considered which invited the Committee to comment on the progress with regards to the development of Cancer Services throughout Lincolnshire.

Sarah-Jane Mills (Director of Development and Service Delivery – Lincolnshire West Clinical Commissioning Group) and Mark Brassington (Chief Operating Officer – United Lincolnshire Hospitals NHS Trust (ULHT) were in attendance for this item of business.

The Chairman reminded the Committee that Theme 3 of the Joint Health and Wellbeing Strategy focussed on *Delivering High Quality Systematic Care for Major Cause of Ill Health and Disability*. A key priority in this theme was to reduce mortality rates from cancer and improve the take-up of screening programmes.

The provision of a comprehensive range of services to promote improved outcomes for people affected by Cancer remained a priority for Lincolnshire. The prevalence and outcomes for local residents were in line with the national average and development of local services was coordinated by Lincolnshire West Clinical Commissioning Group. The strategic framework for the development of local services reflected the recommendations of the National Cancer Strategy and had been developed to reflect local priorities, challenges and the outcomes of the Cancer Summit in February 2015.

The Lincolnshire Health and Care System remained committed to driving the continued improvement of cancer services and had established a network with key stakeholders, coordinated by Lincolnshire West CCG, to further promote the development of services for local people.

Overall patient experience had a national average of 88% and it was reported that Lincolnshire East CCG scored 83%, Lincolnshire West CCG 88%, South Lincolnshire CCG 89% and South West Lincolnshire 82%.

United Lincolnshire Hospitals NHS Trust (ULHT) were the primary provider of Cancer Services for Lincolnshire and, on the basis of the number of patients treated, was in the top ten list of cancer treatment providers in England.

To further support the Improvement Plan, ULHT invited the National Intensive Support Team and secured additional service improvement capacity from the East Midlands Strategic Clinical Network. The key themes of the improvement plan were:-

- Improve access within 14 days;
- Improve access to diagnostic tests;
- Review and refresh systems and processes to facilitate efficient management of patients on a cancer pathway; and
- Recruit to the Lead Cancer Nurse post

The national End of Life Care Strategy built on the recommendations outlined in NICE guidance for Supportive and Palliative Care. As a result, a dedicated palliative and end of life care strategic development group had been established to support the continued improvement of services for people in Lincolnshire. The work programme had included:-

- Redesign of community service provision to provide 24 hour access to specialist support;
- Introduction of EPaCCS (Electronical Palliative Care Coordination Systems) – an IT solution to support access to patients' advanced care plan in all settings;
- Continued provision of education to staff in all settings;
- Contributed to the development of a countywide/cross organisational Do Not Attempt Resuscitation Policy;
- Developing arrangements to facilitate improved access to palliative care medicines in the community; and
- Continued development of supportive palliative care services in the community.

During the last year, two new investments had been commissioned:-

- Chemotherapy Bus – the development of Chemotherapy Closer to Home Services in Lincolnshire was being delivered and developed via a Chemotherapy Bus, with the potential to improve patient experience and choice by reducing travel and waiting times for chemo delivery. The bus was equipped with four chairs, refrigerated storage for drugs, a toilet and a quiet seating area for patients and carers. Medical, nursing and pharmacy services were provided by ULHT and two chemotherapy trained nurses were required to staff the unit per day, working on a rotational basis from the chemo suite teams.

  29 treatment regimes had been identified which were suitable for delivery in a community setting with risk stratified as 11 low and 18 medium and initial assessment and first cycle of treatment being made at the main centres. The mobile unit was currently utilised at Grantham Hospital (and on the Lincoln Hospital site for additional capacity) and a roll out plan was in place once Louth and Skegness sites had established the electrical coupling required.

The plan had been somewhat delayed due to chemotherapy trained staffing shortages.

- A new LINAC machine, used to provide radiotherapy treatment, had become operational with a second machine scheduled in 2016

The main objectives of the improvement plan were:-

- To work with local communities to increase the number of people who attend the screening programme;
- To develop community services to support people affected by cancer so that they may be partners in their care and treatment, both during and beyond treatment;
- To improve access to diagnostic services in order to support referral to diagnosis in four weeks;
- To work with the East Midlands Clinical Network and other partners to support the development and implementation of best practice clinical pathways;
- Continually improve the systems, processes and policies so as to facilitate the proactive management of patients on their cancer pathway; and
- To support the continued development of palliative and end of life care services.

The key actions during the next six month were reported as:-

- Support continued improved performance against the national waiting time standards;
- Where appropriate, support direct access to diagnostic investigations;
- Work with colleagues in public health to gather information which would further support our understanding of issues for the local population;
- Secure funding to support the appointment of a Project Manager to lead the development of community based cancers support services;
- Develop links with tertiary centres to facilitate the review of clinical pathways and where appropriate explore the development of formal alliances;
- Review and consider the Danish model with respect to utilising different diagnostic strategies to facilitate access for patients at high risk of cancer; and
- To work with key stakeholders to develop sustained improved access to breast services.

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

- Two elements of work were ongoing to encourage people to take up the opportunity of screening, following work undertaken with the screening team which highlighted some exceptions to the uptake of screening, especially in some areas which were below the national average. The CCG were working to understand how to target that particular group and specific work was being done in relation to people with learning difficulties;
- An observation had been made that if a GP practice endorsed the need to undergo screening then a patient was 10% more likely to have that done. Some work was planned over coming months to find those gaps and work with

local GPs, neighbourhood teams and community teams to promote screening and raise awareness;

- There were two opportunities for older ladies to be self-motivated. Education was the first, with a screening programme to continually reinforce the importance to be included as self-care and for them to take wider responsibility for their own healthcare. Secondly, local GP surgeries could encourage patients to attend for screening on an individual basis;

Councillor Mrs S M Wray declared an interest at this point as she has a close connection with a current cancer patient.

- Although the focus was on early access to services and diagnosis, there was an ongoing piece of work with the Cancer Improvement Group to improved continued access to diagnostics and the framework for reporting to ensure this was prioritised;
- It was reported that CT and MRI were challenged areas which could work better internally and, due to this, there was a specific piece of work ongoing for CT, looking at improving the timeline for repeat scans and availability of reports;
- MRI were working closely with the CCGs to identify providers and have 98% of the market but ULHT were aware of other capacity within the health service who could assist with that pressure. A new MRI machine would also become available once all the necessary check and training had been completed;
- The importance of talking to patients and clinicians to find the pressure points on the system was starting to work and improvements being made. Diagnostics remained a national challenge and work was ongoing with the East Midlands Network on how this could be better delivered;
- A programme of work in relation to radiology across the region and sharing resources in order to reduce delays was due to go live;
- Historically, screening performance for a six month period was below expected standards but from an outcome standard nationally, the Trust were within target and the outcomes in line with the rest of the country. Performance had improved and, in November, the Trust achieved 82.6% against 85% which was above the national average for performance;
- Cancer outcomes were measured on two levels, one year survival and five year survival and all CCGs were within the national average for those outcomes. It was acknowledged that those outcomes could be improved with early diagnosis;
- A suggestion was made to include a date in the reminder letter for self-referrals as this may make people realise that it is for them in particular and not just a blanket reminder. This would hopefully encourage them to diarise the date and be more likely to arrange screening. This suggestion was welcomed and would be taken back to the screening team for further consideration;
- It was unclear when there would be a programme for ovarian cancer screening but further investigation would be done and a response would be provided to the Health Scrutiny Officer to report back to the Committee;

At this point of the meeting, Councillor S L W Palmer advised that he had a serious investigation complaint lodged with ULHT from July 2015.

- A request was made to include actual figures in the report rather than the national average. It was explained that the information presented was how it was received from national colleagues following collation but that they would look at this further to ascertain if comparable figures could be provided;
- Wherever patients felt there was extended waits, they were encouraged to escalate those to the PALS team for investigation;

RESOLVED

1. That the report and comments be noted; and
2. That a further update to the Committee be scheduled for April or May 2016.

NOTE: At this stage in the proceedings, the Committee adjourned for luncheon and, on return, the following Members and Officers were in attendance:-

County Councillors

Councillors Mrs C A Talbot (Chairman), R C Kirk, S L W Palmer, Mrs S Ransome, Mrs J Renshaw, T M Trollope-Bellew and Mrs S M Wray.

District Councillors

Councillors C J T H Brewis (Vice-Chairman) (South Holland District Council), B Bilton (City of Lincoln Council), K Cook (North Kesteven District Council), Mrs P F Watson (East Lindsey District Council), G Gregory (Boston Borough Council) and Mrs R Kaberry-Brown (South Kesteven District Council)

Healthwatch Lincolnshire

Dr B Wookey.

Officers in attendance

Andrea Brown (Democratic Services Officer), Kakoli Choudhury (Consultant in Public Health), Simon Evans (Health Scrutiny Officer), Ian Hall (Senior Delivery and Development Manager – Trust Development Authority), Jim Heys (NHS England, Locality Director – Midlands and East (Central Midlands)), Lynne Moody (Director of Quality and Executive Nurse, South Lincolnshire CCG)

78 LINCOLNSHIRE RECOVERY PROGRAMME

A report by Jim Heys (Locality Director (Midlands and East (Central Midlands) – NHS England) and Jeff Worrall (Portfolio Director – Trust Development Authority) was considered which asked the Committee to consider and comment on the content and,

in particular, focus on the extent of the positive outcomes of the Lincolnshire Recovery Board to-date.

Jim Heys (Locality Director (Midlands and East (Central Midlands) – NHS England) and Ian Hall (Senior Delivery and Development Manager – Trust Development Authority) were in attendance for this item.

The Lincolnshire Recovery Programme (LRP) was developed to provide a senior level coordinating programme structure, which supported performance improvement and the further development of a clinically safe and financially sustainable health and care model, across Lincolnshire. The aims of the LRP were to:-

- Improve the performance of United Lincolnshire Hospitals NHS Trust (ULHT) against the NHS Constitutional standards so that all required targets were achieved;
- Continue to improve quality within ULHT and across the health community;
- Develop a financial strategy and plan to deliver improvements to the financial position across Lincolnshire; and
- Design an underpinning workforce/Organisational Development strategy and plan.

The Lincolnshire Recovery Programme Board was jointly chaired by NHS England and the Trust Development Authority.

With effect from April 2016, the TDA would merge with Monitor whose role included regulation and performance management of NHS Foundation Trusts. This new organisation would be known as NHS Improvement.

The purpose of the Lincolnshire Recovery Board was:-

1. To oversee achievement of the programme aims for an initial period of twelve months from July 2015, following which those responsible for health and care system delivery would be in a position to no longer require this level of intervention;
2. To agree a programme structure which held senior leadership from all represented organisations to account and oversee high level intervention and support;
3. To ensure that the boards of each organisation represented were signed up to the LRP aims and programme structure;
4. To accept recommendations from the Operational Programme Group with regards to the scope and expected outcomes from the programme work streams;
5. To act upon exception reports and items for escalation from the Operational Programme Group in order to ensure the programme aims were achieved;
6. To ensure that dependency issues between the LRP and the Lincolnshire Health and Care (LHAC) Programme were managed in a manner which avoided duplication between the programmes or adverse impact on either programme; and
7. To identify the need for additional support to facilitate achievement of the Programme aims and agree approaches to secure the support;

Outcomes of the programme to date included:-

- The delivery of the Referral to Treatment (RTT) incomplete standard from 92%. The Department of Health had introduced this operational standard in April 2012. Incomplete pathways were the waiting times for patients waiting to start treatment at the end of a month and were also often referred to as waiting list waiting times and the volume of incomplete RETT pathways as the size of the RTT waiting list;
- ULHT was on track to deliver the 62 day cancer standard with a 12% improvement from 70% achievement (September) to 82% (November) against a national standard of 85%;
- The A&E standard of 95% within 4 hours varied by site and was the subject of intense support from all parties. A revised trajectory for delivery was being developed. The current year to date delivery was 88%;
- ULHT was currently forecasting a deficit position of £59 million against the planned deficit of £40 million, which was a £19 million adverse variance. The system was developing plans to be presented to the LRP Board on 8 January 2016 to address the current deficit position; and
- The LHAC programme reported on progress to the LRP although this was subject to a separate governance and decision making structure.

Members were invited to ask questions, during which the following points were noted:-

- Clarification of the difference between the Lincolnshire Recovery Programme Board and the Operational Board Programme Group. The operational group had a slightly broader membership and the board was an opportunity for the accountable officers of each organisation to agree the action plan for the forthcoming 30 days. This groups proved helpful as the members were in a position to ensure what was agreed was delivered and, if not, could be held to account by NHS England and the TDA;
- NHS England and the TDA felt that this structure was the best way for progress to be monitored, through the programme board, on a temporary basis until back on track;
- As a recovery board, it was asked if they were confident that this would be the position in July 2016, following the 12 month Recovery Programme, and would no longer require this level of intervention. The Board were confident that it had been set up for 12 months as it needed to be time limited and not become a substantive part of the management process. It had been clearly stated that this was an interventional recovery programme but the challenge remained around constitutional standards, etc. There was a confidence that those standards would be delivered and expected that all actions would be met although acknowledged that financial sustainability would be ongoing;
- When asked how the deficit would be rectified and when the two authorities would be confident that intervention was no longer required, it was advised that this would need two elements, Trust specific and broader. For the Trust, a number of escalation beds had been opened which increases agency costs (it was stressed that this was not the reason for the increased deficit alone but

was a significant contributing factor). Part of the work of NHS England and the TDA was to close those beds both quickly and efficiently which was both challenging and complex but would assist with reducing the increased deficit;

- Links to other organisations were being developed to reduce the necessity for patients to resort to a hospital setting and this was being monitored as part of the Recovery Board;
- It had become clear through the Recovery Programme Board meetings that recent planning guidance and understanding about what was driving the increasing deficit was being reinforced. Although the deficit was apportioned to ULHT, it was acknowledged that there was a number of contributing factors for consideration and the Recovery Programme Board were undertaking a full analysis to ascertain the key issues to be addressed;
- It was reported that the LHAC could make a lot of progress due to its foundation elements but it was not designed to include guidance on how to reach financial viability. It was suggested that the LHAC could be the first step on the five year plan to reach financial viability;
- Unless secondary care providers were able to reduce delivery costs, the gap would continue to broaden as the NHS Tariff changed each year, generally reduced although there had been some address of that within recent guidance. An additional £1.8bn to the NHS would allow providers to become balanced but there was no more funding after that. Years 2, 3 and 4 would require transformational change to reach financial and clinical sustainability;
- Quarter 3 had started to see the overspend run rate diminish which had been assisted by work done on the immediate management control of the organisation. Fortnightly meetings were ongoing with ULHT in relation to agency staff and the reduction of costs in that area;
- NHS England and the TDA were not aware of the maximum amount of deficit which ULHT could reach without severe implications. The two organisations were in frequent contact with the Department of Health and were unaware that a level had been set at this stage;
- The complexity of the health services was acknowledged and stressed that to get through the recovery programme would require more joined up working between organisations to ensure delivery was more meaningful to patients and users and to provide a simple navigation process for patients;
- The Committee were unclear as to the solutions set out to rectify or improve the situation ULHT were in. It was explained that the LHAC provided guidance for the 50k population within Lincolnshire linking neighbourhood teams, GP practices, etc, which would cover the countywide services but what it did not include was how they linked with other, regional, organisations;
- Having been included within the ECIP issues, South West Lincolnshire had witnessed the flow in wards at Pilgrim Hospital, with commissioners, ECIP, social care, etc, and agreed where improvements could be made to allow safe discharge and streamline the process. Despite being from different organisations, all the right people came together at the same time to improve service delivery and this was the ethos required to sustain improvement within the health service;
- Concern was raised regarding the Comprehensive Spending Review (CSR) and the cuts to the preventative work currently undertaken by local Councils

impacting back on to the NHS. It was explained that the NHS made representations about how funding was allocated, for example the Better Care Fund. Although consideration could be given to certain issues, it was reported that this could not be influenced at this level but that they were issues which would require collective resolution;

- Individuals treated for preventable diseases could save the NHS a considerable amount if they took responsibility for their own personal health and wellbeing. Further suggestions was to widen this responsibility to supermarkets and what they make available (i.e. high sugar content) or pharmaceutical companies;
- Opportunities to improve efficiency whilst improving quality within large complex organisations were always available and the improvements made so far were a good example. The increased spend on agency staff was linked to urgent care flow, reduction of escalation beds and consideration of the budget and any genuine savings which could be made;
- Some patients were brought in to hospital to be told face to face that they had a negative test result but it had been suggested this could be done over the telephone or by post, in the most appropriate way deemed for that particular department. This would then save money and free up appointments for patients who require treatment thereby reducing waiting times. Although a relatively small change, it could see a large difference;
- Winter pressure planning within the NHS usually ran until the end of March therefore plans were in place should services become overwhelmed by escalation procedures;
- Government policy in relation to agency workers was to reduce the number employed and to reduce the cost significantly so that it was comparable with NHS workers;
- A suggestion to open two empty wards within hospitals by Lincolnshire Community Health Services to assist with DTOC rates was made and this was acknowledged as something which the Recovery Programme Board would give consideration too. Patients should be directed to the right place of care the first time and it was the role of the Board to consider all options as part of the wider recovery programme;
- Care and convalescent homes were discussed and encouraged to be reinstated to relieve pressure on hospitals. A range of packages were being made available for individual needs but the range of requirements for individuals was complex. Although there were a number of options within the voluntary sector, it was acknowledged that a number of volunteers were elderly themselves and were not being replaced by younger volunteers thereby causing concern that the voluntary sector may be unable to sustain service delivery in future years;

At 3.35pm, Dr B Wookey left the meeting and did not return.

RESOLVED

1. That the report and comments be noted; and
2. That the outcomes and final submissions be presented to the Committee at its meeting in May 2016.

79 DELIVERING THE FORWARD VIEW: NHS PLANNING GUIDANCE 2016/17 - 2020/21

A report by Simon Evans (Health Scrutiny Officer) was considered which provided information on the NHS publication *"Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21"* published on 22 December 2015 and intended for Commissioners, NHS trusts and NHS foundation trusts.

Members were given an overview of the guidance which had been prepared by NHS England, NHS Improvement (Monitor and the Trust Development Authority), the Care Quality Commission, Health Education England, the National Institute of Health and Care Excellence and Public Health England. Building on the NHS Five Year Forward View required two connected plans from the local NHS:-

- A five year Sustainability and Transformation Plan (STP)
- A one year Operational Plan for 2016/17

The guidance also stated that the planning process had been put forward to execute three independent tasks:-

- Implementing the Five Year Forward View;
- Restoring and maintaining financial balance; and
- Delivering core access and quality standards for patients.

The link for the full document was:-

https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

The nine 'must do's' for 2016/17 for every local system were:-

1. Develop a high quality and agreed STP, and subsequently achieve what was determined as the most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View;
2. Return the system to aggregate financial balance. This included secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs would additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality;
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues;
4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95% of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75% of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots;

5. Improvement against the maintenance of the NHS Constitution standards that more than 92% of patients on non-emergency pathways should wait no more than 18 weeks from referral to treatment, including offering patient choice;
6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission;
7. Achieve and maintain the two new mental health access standards: more than 50% of people experiencing a first episode of psychosis would commence treatment with a NICE approved care package within two weeks of referral; 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme would be treated within six weeks of referral, with 95% treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia;
8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rollout out care and treatment reviews in line with published policy; and
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

To support long-term planning, NHS England had set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations would rise by an average of 3.4% and the report outlined the promise that no CCG would be more than 5% below its target funding level.

During 2016/17 the NHS trust and foundation trust sector would be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund would replace direct Department of Health (DH) funding. Quarterly release of these Sustainability Funds to trusts and foundation trusts would depend on achieving recovery milestones for:-

- Deficit reduction;
- Access standards; and
- Progress on transformation

Members were invited to ask questions, during which the following points were noted:-

- It was requested that the Health Scrutiny Officer email the full guidance document to the members of the Committee;
- The Chairman requested volunteers for a working group of the Committee to further consider this document and the implications for Lincolnshire. Initial came from the Chairman, Vice-Chairman and Councillors J M Renshaw, S M Wray, R C Kirk and S L W Palmer.

RESOLVED

That the report and comments be noted.

80 WORK PROGRAMME

The Committee considered its work programme for forthcoming meetings.

It was anticipated that the CQC would issue their inspection reports in time to be considered at the March meeting of the Committee and it was agreed to add this to the Work Programme.

The Chairman advised that she had been contacted by Sarah Fletcher, Chief Executive of Healthwatch, to gain the views of the Committee in regard to the Mental Health report. Healthwatch have suggested deferring consideration of the CAMHS item until later in the year and to give focus to the Mental Health overview at the meeting of the Committee in February 2016. This suggestion was put to the Committee and agreed.

RESOLVED

That the contents of the work programme, with the amendments noted above, be approved.

The meeting closed at 3.55 pm

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