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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**12 September 2018**
Subject:	**Chairman's Announcements**

1. Pennygate Health Centre, Spalding

Following the retirement from general practice of Dr Nathu, Pennygate Health Centre in Spalding is due to close on 7 September 2018. Pennygate Health Centre currently has 3,460 registered patients.

From 10 September 2018 as an interim arrangement Lincolnshire Community Health Services NHS Trust (LCHS) will provide GP services to Pennygate patients at the Johnson Hospital, Spalding. There will be no job losses and the current staff at the practice will transfer to Lincolnshire Community Health Services to provide the GP services at the Johnson Hospital.

Patients currently registered at Pennygate will automatically transfer to Johnson Hospital under the care of LCHS. They will be able to access the same level of GP services with the exception of dispensing services - as there will be no dispensary for transferring patients at Johnson Hospital. To get their prescriptions dispensed patients will need to go to a pharmacist of their choice.

The Patient Advice and Liaison Service (PALS) can advise patients with any concerns, including how to register with another GP practice if this is their choice (provided their home address falls within the practice's catchment area).

South Lincolnshire Clinical Commissioning Group is keen to hear patients' views, and have arranged for a series of question and answer drop-in sessions to be held at Pennygate Health Centre, between 4 and 7 September.

2. United Lincolnshire Hospitals NHS Trust (ULHT) – Orthopaedic Surgery

On 15 August 2018, United Lincolnshire Hospitals NHS Trust (ULHT) announced a six month trial (beginning on 20 August), aiming to improve the experience and outcomes for orthopaedic patients across the county by reducing the number of cancelled operations. The plan includes making Grantham and District Hospital an orthopaedic centre of excellence and one of the top five performing sites in the country for the number of joint replacements.

ULHT has been learning from some of the top performing hospital trusts in the country who offer a better service by separating their elective and emergency orthopaedic surgery, resulting in better outcomes for patients. Under the plans patients are likely to see the same consultant throughout their care and still have their outpatient, pre and post-operative appointments locally.

ULHT has stated it has listened and responded to public opinion gathered during recent engagement sessions where the vast majority of people said they would be happy to travel to a centre of excellence for their planned operations, as long as they could still have their other pre and post-operative care locally.

Trauma and emergency care will continue at Lincoln, Boston and Grantham. However a small number of trauma patients with a broken hip (anticipated to be approximately 40 patients during the length of the trial), will be cared for at Lincoln or Pilgrim instead of Grantham. This will enable the teams to better care for hip fracture patients in line with national best practice.

Grantham Hospital will become a hub for planned inpatient care, more than trebling the volume of cases it takes now; and the number of surgical patients will rise by 60%. The additional inpatients will come from ULHT's other sites and their care will run alongside the hospital's existing day case workload. If the pilot is successful, the plan will be to secure a multi-million pound investment in theatres at Grantham Hospital, with bold visions to make it one of the top performing hospitals in the country for joint replacements.

By protecting and ring-fencing orthopaedic and inpatient beds at Grantham, there will no longer be the need to cancel planned surgery due to emergencies. ULHT says this will be good news for those patients who have waited and planned ahead for their routine surgery, as 900 operations were cancelled last year. The plan is to almost double the day case workload at Louth Hospital to around 1,080 cases each year. The plans will enable Lincoln and Pilgrim hospitals to focus on complex and emergency orthopaedic care and paediatrics. Critical care arrangements will remain unchanged.

3. East Midlands Ambulance Service – Annual General Meeting

On 7 August 2018, the East Midlands Ambulance Service NHS Trust AGM took place. The Vice Chairman, Councillor Chris Brewis, attended the meeting on behalf of the Health Scrutiny Committee, and his report is set out in Appendix A to these announcements.

4. NHS England Annual Assessment of Clinical Commissioning Groups

On 12 July 2018 NHS England published its annual assessment of Clinical Commissioning Groups (CCGs) for 2017/18. The annual assessment has been undertaken using an Improvement and Assessment Framework, with the overall assessment derived from each CCG's performance against the indicators in the Framework. Each CCG receives an overall assessment that places their performance in one of four categories: outstanding, good, requires improvement, or inadequate. Of the 207 CCGs in England rated in 2017/18, 20 were outstanding; 100 were good; 69 require improvement; and 18 were inadequate.

Each Lincolnshire CCG was rated as requires improvement for 2017/18. This compares to 2016/17, when two of the CCGs (South Lincolnshire and South West Lincolnshire) were rated as good, and the other two required improvement.

5. Clinical Commissioning Groups – Joint Working

Following the last meeting of the Committee on 11 July, the Chairman wrote to the Chairs of each of the Clinical Commissioning Groups (CCGs) in Lincolnshire, expressing the Committee's disappointment at the lack of progress with joint arrangements between the four CCGs, in particular the absence of any formal delegated authority from the CCGs to the Joint Commissioning Committee.

Two responses have been received, which are set out in Appendix B to these announcements.

6. Future Configuration of Head and Neck Cancer Services - East Midlands

On 11 July, 2018, I received a letter from Susan Bowler, Assistant Director, Specialised Commissioning, East Midlands, which has been also been sent to the eight other chairs of the health overview and scrutiny committees in the East Midlands. The letter advises that head and neck cancer services are fragile and proposes discussions on proposals for reconfiguration of services. I have been advised that this is a low volume / high complexity service, and last year 17 patients were referred from United Lincolnshire Hospitals NHS Trust to Nottingham for their first treatments. The text of the letter is in Appendix C of these announcements.

A meeting of east midlands health scrutiny committee chairs is due to take place on Tuesday 11 September in Nottingham, and I will report the outcome.

7. Integrated Care Provider Contract – Consultation by NHS England on Contract Content

On 6 August 2018, NHS England launched a consultation on the contracting arrangements for integrated care providers (ICPs). NHS England has stated it is seeking views from stakeholders and the public as well as explaining what the draft ICP contract is, why it is useful and what it would mean for patients and the NHS. The closing date for the consultation is 26 October 2018. Further details are in Appendix D of these announcements.

The Health Scrutiny Committee is asked to decide if it would like to respond to the consultation. If the Committee were to respond to the consultation, a working group is suggested to work through the consultation documentation and draft a response. The Health and Wellbeing Board is planning to consider the consultation on 25 September.

8. National GP Patient Survey

On 9 August, NHS England published the results of the GP Patient Survey. Some information on the survey is set out in Appendix E.

9. Out of Hours Service in Lincolnshire – Care Quality Commission Inspection

On 20 August 2018, the Care Quality Commission published its inspection report on the Lincolnshire out of hours service, which is operated by Lincolnshire Community Health Services NHS Trust. The overall finding from the inspection was *Good*. Although the service was previously rated as *Good* in 2017, improvements acknowledged within the report include:

- progress with the implementation of the medical workforce model, including employing GPs rather than using locums;
- an increase in the number of advanced clinical practitioners; and
- systems in place to ensure medicines are dispensed safely and in the appropriate packaging.

The CQC has advised the Trust to continue to improve by ensuring planned changes to signage are implemented in Lincoln County Hospital, and for the programme of recruitment to continue to ensure staffing levels are appropriate and sustainable.

The full report is available at: https://www.cqc.org.uk/location/RY5H1

Annual General Meeting of the East Midlands Ambulance Service
(7 August, 2018, EMAS Headquarters in Nottingham)

Report by Councillor Chris Brewis, Vice Chairman of the Health Scrutiny Committee for Lincolnshire

The AGM was principally presented by the Chairman, Pauline Tagg, and the Chief Executive, Richard Henderson. I found the AGM by some way the most positive one I had (sporadically I admit) attended, and felt at the end more 'upbeat' about future progress.

It had been a challenging year, and the Care Quality Commission, whilst noting improvements, specifically mentioned a need for improvement on 'safety'.

84 Front Line and Operation Control staff had been recruited during the year, and there had been a marked improvement (i.e. reduction) in staff turnover, or 'churn'. I pointed out that in future years the 'net' figure of recruitment might be more meaningful. There remained a need to recruit more staff. I suggested that presentations at schools, colleges, etc, pointing out the long term career prospects, might be productive.

Though making savings of £6.1 million in 2017-2018, more money for investment had been forthcoming.

As we have already had reported to us, it had long been acknowledged that the 'eight minute' target was unrealistic.

Flu vaccinations among EMAS staff had risen 12 per cent to 73.5 per cent, the second highest level in the country.

Handover delays at some Accident and Emergency departments remained a continuing, though thankfully reducing, problem.

Richard Henderson alerted the need for more people to be trained in CPR and the proper use of defibrillators. Volunteers were needed to become competent CPR administers, or 'good Samaritans'.

Early administration of antibiotics to victims or suspected victims of sepsis remained a serious issue.

What some members will recall as the 'Tuf Book' – or the electronic patient report form (ePRF), had been much improved.

Finance – More staff and equipment were still needed.

Reviews with CCG commissioners were taking place, with regard to activity, pricing and strategy.

More serious support for staff was always needed. There remained 'hard to access' groups, and EMAS had held their first ever 'equality day' in a move to address any shortcomings.
Average 'age' of the fleet of vehicles is 4 years. £1.6 million had been invested in up-to-date defibrillators.

Similar rurality problems to those in Lincolnshire were being experienced in parts of Northamptonshire.

More paramedics were now available thanks to the programme at Nottingham Trent University. I mentioned our hopes of the medical school in Lincoln having similar results.

I raised the issue of Lincolnshire response times. A serious investment in newer and more ambulances in Lincolnshire is to take place, I was assured. I think we need periodic reports on that in more detail.

Delays at the Queen Elizabeth Hospital, King's Lynn, and Peterborough City Hospital were much less of a problem than heretofore.

I spoke up for the JACP [Joint Ambulance Conveyance Project] and the co-operation in the joint blue light project headquarters in South Park was spoken of by all with considerable enthusiasm.

I felt it was a positive meeting, and thanked all for the opportunity to attend.

Councillor Chris Brewis, 28 August 2018

Clinical Commissioning Groups – Joint Working

The two responses to the Chairman's letter on the Lincolnshire CCG Joint Commissioning Committee are set out below

(1) Dr Stephen Baird, Chair of Lincolnshire East CCG Governing Body

Dear Councillor Macey,

Thank you for your communication regarding the Shadow Joint Committee of the Lincolnshire Clinical Commissioning Groups. I share your disappointment that to date formalisation of the interim shadow arrangements has not been possible.

Lincolnshire East is keen that such a body does indeed have proper delegated authority from individual CCGs so that it can act “once for Lincolnshire” in matters where a Lincolnshire-wide approach is appropriate, whilst retaining for local CCG control those issues where localism and local input is paramount.

Feelings amongst individual CCG members in some CCGs is strong - both professional, clinical and lay membership, who have voting rights in these matters.

I am sure that within in the various layers of local and national government similar debates occur.

I expect these matters to be determined in the near future, one way or another, as I agree the persistence of the current transitional arrangements is increasingly unsatisfactory and detrimental to the commissioning process within Lincolnshire.

(2) Richard Childs, Lay Chair, Lincolnshire West CCG

Dear Councillor Macey

Thank you for your letter of 18 July which I am now replying to.

You will be pleased to hear that progress is being made in improving the way CCGs work collaboratively and increasingly the joint committee is showing its worth. The critical issue delaying greater and more formal delegation is genuine concern by governing boards that full and unrestricted delegation to the committee could compromise the ability of local clinicians to determine what happens locally by moving ‘power’, as they would see it, upwards and away from localities. Whilst some are less worried about this than others, rushing this process and not being inclusive would be counterproductive and antagonise local players. In a sense we have to travel at the speed of the slowest ship. That, I would concede is frustrating for some but inevitable.

In reality a significant number of issues are already dealt with by one CCG on behalf of the others and this range from commissioning across a range of services to quality oversight and QIPP savings. As a result some real progress has already been made but by evolution rather than revolution. I expect the trend will speed up as it is increasing seen to represent opportunity rather than threat. I do not, however, anticipate a 'big bang'.

As I think I said at the meeting (but may not) the downside of the Lansley changes was that it fragmented health management and introduced a considerable number of local legal entities who have specific duties to safeguard local engagement and delivery and encouraged (albeit unintentionally if predictably) 'silo' working. Whilst the changes clearly also led to really beneficial local clinical and patient engagement, they created significant bureaucracy to underpin the new structures. Seeking to undo this (which is what we all recognise is necessary and are trying to do) without a change in the legal duties and practices of each CCG, can only happen with consent. Nothing can be imposed on anyone unless it is done by NHS England - and there appears to be no stomach for that.

Overall real progress is being made and I am very optimistic, but it will take time. It is a pity, perhaps, that those who argued against some of the Lansley bureaucracy when it was being created were not listened to. Had they been, we could have introduced local clinical engagement and input but avoided the considerable attendant bureaucracy Lansley brought which has wasted so much time and money and which we are now trying to sort out. This is, of course, my personal view and I doubt very much if it would be articulated by the NHS England hierarchy or even seen by them as a 'politically correct' comment – even if they thought it. Probably annoyingly for them, I do not feel so constrained in what I say!

I will share your wish to see progress and I will write again when I have further news.

Please share this letter in its entirety with those who you feel would wish to see it.

Future Configuration of Head and Neck Cancer Services - East Midlands

Letter from Susan Bowler, Assistant Director, NHS England
Specialised Commissioning East Midlands, 11 July 2018

Head and Neck Cancer Services across the East Midlands are currently fragile, largely due to shortages of medical staff and other clinical staff. The hospitals in the East Midlands are providing support to one another and a lot of effort has gone into recruiting to vacant posts and maintaining a service. However, some patients are being asked to attend a different hospital to their local service, in order to receive treatment in an appropriately, timely way.

The current position indicates that this is unsustainable and so we need to ensure there is a clear and reliable pathway for patients diagnosed with a head and neck cancer, which provides them with quick access to the high quality care they require.

Specialised Commissioning, NHS England, has been requested by the Midlands and East Regional Executive to lead on a project to develop a range of options which would deliver a more sustainable head and neck cancer service across the East Midlands.

The project is in its initial stages and we wanted to ensure all Scrutiny Committees are sighted on timescales; project outputs; and engagement strategy.

The purpose of this letter is to inform you of our concerns, outline the approach we are taking to develop the options, and ask you to form a Joint Health Overview and Scrutiny Committee for the East Midlands, to ensure collective system-wide scrutiny of this piece of work, which may recommend long-term changes to these services.

It is anticipated that the development of options will be completed at the end of October along with a pre consultation business case. Following this, a new project will start with the aim to get to a preferred option. It is expected that this will require further public consultation and the leadership and the governance for that project may be different to this current one.

I would like to ask that a Joint Health Scrutiny Committee be set up across the East Midlands in early September to ensure system wide discussion and scrutiny of the options. We are, of course happy to attend individual Overview and Scrutiny committees, but feel that a Joint Committee would provide the best opportunity for the system wide discussion that is required.

I appreciate that this is a significant request and, if helpful, we could arrange a private meeting with Chairs in order to discuss the issues and the most appropriate way to ensure the involvement of Health Scrutiny.

APPENDIX D

Draft Integrated Care Provider Contract – A Consultation

Further Information and Consultation Questions

On 6 August 2018, NHS England launched a consultation on the contracting arrangements for integrated care providers (ICPs).

Terminology

Previously, this draft ICP Contract was referred to as the draft accountable care organisation (ACO) contract. NHS England has stated it has changed this terminology in recognition that, as reported by the House of Commons Health and Social Care Committee, use of the term "accountable care" has generated unwarranted concerns that what is being proposed is akin to models and organisations established in the United States under that name.

NHS England believes the term "integrated care provider" better describes its proposals to promote integrated service provision through a contract to be held by a single lead provider organisation.

Content of Consultation

The consultation questions (in Appendix A) tend to be focused on the content of ICP contract and related arrangements, and not on the principle of ICPs.

The consultation documents and supporting documentation are available at the following link: -

https://www.engage.england.nhs.uk/consultation/proposed-contracting-arrangements-for-icps/

The documentation includes:

- Draft Integrated Care Provider (ICP) Contract – A Consultation – *41 pages*
- Draft Integrated Care Provider (ICP) Contract – Easy Read Consultation – *22 pages*
- Draft Integrated Care Provider (ICP) Contract - Consultation Package – Questions and Answers – *13 pages*
- NHS Standard Contract (Integrated Care Provider) Particulars – *88 pages*
- NHS Standard Contract (Integrated Care Provider) Service Conditions – *41 pages*
- NHS Standard Contract (Integrated Care Provider) General Conditions – *98 pages*

In addition, there are eight further supporting documents.

Consultation Questions

The twelve consultation questions, which largely focus on the detailed content of the draft contract documentation are set out below: -

Question 1 - Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health, and where appropriate, care services? *Yes/No/unsure; and please explain your response.*

Question 2 - The draft ICP contract contains new content aimed at promoting integration, including:

- Incorporation of proposed regulatory requirements applicable to primary medical services, included in a streamlined way within the draft ICP contract
- Descriptions of important features of a whole population care model, as summarised in paragraph 30

a) Should these specific elements be amended and if so how exactly? *Yes/no/unsure; and please explain your response.*
b) Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services? *Yes/no/unsure; and please explain your response.*

Question 3 - The draft ICP contract is designed to be used as a national framework, incorporating core requirements and processes. It is for local commissioners to determine matters such as:

- The services within scope for the ICP
- The funding they choose to make available through the contract, within their overall budgets
- Local health and care priorities which they wish to incentivise, either through the locally determined elements of the financial incentive scheme or through additional reporting requirements set out in the contract

Have we struck the right balance in the draft ICP contract between the national content setting out requirements for providers, and the content about providers' obligations to be determined by local commissioners? *Yes/no/unsure; and please explain your response.*

Question 4 - Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers? *Yes/No/unsure; and please explain your response.*

Question 5 - We have set out how the ICP contract contains provisions to:

- guarantee service quality and continuity
- safeguard existing patient rights to choice
- ensure transparency
- ensure good financial management by the ICP of its resources.

a) Do you agree or disagree with our proposal that these specific safeguards should be included? *Agree/ Disagree/unsure; and please explain your response.*
b) Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they? *Yes/No/unsure; and please explain your response.*

Question 6

a) Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts? *Yes/No/unsure; and please explain your response.*
b) If yes, how exactly do you think we should create this?
c) Are there any specific features of the proposed options for GP participation in ICPs that could be improved? *Yes/No/unsure; and please explain your response.*

Question 7

a) Do you think that the draft ICP contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services? *Yes/No/unsure; and please explain your response.*

b) If not, what specifically do you propose? *Please explain your response.*

Question 8 - The draft ICP contract includes safeguards designed to help contracting parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP:

- It provides a framework within which decisions can be taken by the ICP, based on a defined scope of services which the commissioners require the ICP to deliver
- It includes a number of specific protections, outlined in paragraph 83, which together prohibit the provider from carrying out any activity which may place commissioners in breach of their statutory duties

Are there any other specific safeguards we should include to help the parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP? *Yes/No/unsure; and please explain your response.*

Question 9 - The draft ICP contract includes specific provisions, replicating those contained in the generic NHS standard contract, aimed at ensuring public accountability, including:

- requirements for the involvement of the public as explained in paragraphs 89-93
- requirement to operate an appropriate complaints procedure
- complying with the 'duty of candour' obligation

a) Should we include much the same obligations in the ICP contract on these matters as under the generic NHS standard contract? *Yes/No/unsure; and please explain your response.*

b) Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through an ICP contract? *Yes/No/unsure; and please explain your response.*

Question 10 - It is our intention to hold ICPs to a higher standard of transparency on value, quality and effectiveness, and to reduce inappropriate clinical variation. In order to achieve this the draft ICP contract builds on existing NHS standards by incorporating additional provisions describing the core features of a whole population model of care and new requirements relating to financial control and transparency:

a) Do you think that the draft ICP contract allows ICPs to be held to a higher standard of value, quality and effectiveness and to reduce inappropriate clinical variation? *Yes/No/unsure; and please explain your response.*

b) Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation? *Yes/No/unsure; and please explain your response.*

Question 11 - In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP contract, or for avoiding, reducing or compensating for any impacts that introducing this contract may have? *Yes/No/unsure; and please explain your response.*

Question 12 - Are there any specific equality and health inequalities impacts not covered by our assessment that arise from the provisions of the draft ICP contract? *Yes/No/unsure; and please explain your response.*

National GP Patient Survey

On 9 August 2018, NHS England published the results of the GP Patient Survey. The GP Patient Survey 2018 compiled responses from almost 760,000 people across England on their overall experience of healthcare services provided by GP surgeries. The survey found that in England 84% of patients described their overall experience of their GP practice as very or fairly good.

The survey results are published by individual practice and also by CCG area. The findings for GP practices each Lincolnshire CCG area are as follows, for the question: "Overall, how would describe your experience of your GP Practice?" -

	Number of Responses	Overall, how would you describe your experience of your GP Practice? (Percentage)				
		Good	Fairly Good	Neither Good nor Poor	Fairly Poor	Poor
All England	747,970	46	38	10	4	2
Lincolnshire East	3,312	39	40	12	5	4
Lincolnshire West	3,073	45	38	11	4	2
South Lincolnshire	1,957	47	40	8	4	1
South West Lincolnshire	1,744	47	36	12	4	1

The survey also included questions on access to GPs, making appointments, the quality of care received from GPs and other health professionals, waiting times, and satisfaction with opening hours and out-of-hours NHS services. The full detailed results are available at the following website:

https://gp-patient.co.uk/surveysandreports

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