HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
16 OCTOBER 2019

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

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

Lincolnshire District Councils

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

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Mark Brassington (Chief Operating Officer, United Lincolnshire Hospitals NHS Trust), Katrina Cope (Senior Democratic Services Officer), Sue Cousland (General Manager, Lincolnshire Division, EMAS), Simon Evans (Director of Operations, United Lincolnshire Hospitals NHS Trust), Sarah Furley (Programme Director, Lincolnshire Sustainability and Transformation Partnership), Louise Jeanes (Cancer Care Programme Manager, Lincolnshire West Clinical Commissioning Group), Chris Weston (Consultant in Public Health (Wider Determinants)), Dr Carl Deaney (Marsh Medical Practice, North Somercotes), Dr John Parkin (Executive GP, Lincolnshire West Clinical Commissioning Group) and Dr Aurora Sanz-Torres (Consultant Clinical Oncologist and Clinical Director (Oncology and Haematology), United Lincolnshire Hospitals NHS Trust).

County Councillors Dr M E Thompson and Mrs S Woolley (Executive Councillor for NHS Liaison and Community Engagement) attended the meeting as observers.

32 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

An apology for absence was received from Councillor H Matthews (East Lindsey District Council).

33 DECLARATIONS OF MEMBERS' INTEREST

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

34 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 18 SEPTEMBER 2019

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 18 September 2019 be agreed and signed by the Chairman as a correct record, subject to the word '*Health'* at the bottom of page 6 and bottom of page 7 being amended to read *'Healthy'*.

35 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, the Chairman brought to the Committee's attention the Supplementary Chairman's announcements circulated at the meeting.

The Supplementary Chairman's announcements made reference to:-

- Trauma and Orthopaedics; and General Surgery – Information requested by the Committee at the 18 September 2019 meeting;
- Cancer Performance – Information requested by the Committee at the 18 September 2019 meeting; and
- Urgent Treatment Centres – Louth and Skegness.

The Executive Support Councillor for NHS Liaison and Community Engagement updated the Committee with regard to transport arrangements for patients in Skellingthorpe to the Glebe Medical Practice in Saxilby. The Committee was advised that unless provision was subsidised by the County Council, a bus service between Skellingthorpe and Saxilby was not a viable option. The Chairman advised the Committee that discussions would need to take place with the County Council's Transport Manager.

RESOLVED

That the Chairman's announcements presented as part of the agenda on pages 19 to 26; and the supplementary announcements circulated at the meeting be noted.

36 EAST MIDLANDS AMBULANCE SERVICE NHS TRUST - LINCOLNSHIRE DIVISION UPDATE

Consideration was given to a report from the East Midlands Ambulance Service (EMAS) NHS Trust Lincolnshire Division, which provided the Committee with an update on the progress made within the Lincolnshire Division of the East Midlands Ambulance Service.

The Chairman welcomed to the meeting Sue Cousland, Lincolnshire Division Manager, EMAS NHS Trust.

The presentation to the Committee made reference to key improvement elements that were being focussed on, which included culture change, leadership, workforce and recruitment, performance, collaborative working and the Divisional Work Plan. It was highlighted that the Care Quality Commission Inspection - Final Report had indicated a rating for the whole service of 'Good' and a rating of 'Outstanding' for caring. It was highlighted further that a new Executive Lead Officer had been appointed for Lincolnshire. The Committee was advised that the Clinical Senior Leadership Team were all working within the area; and that all Senior Leaders had been encouraged to attend a Leadership Programme. It was highlighted that the area operation management role was being undertaken in the locality, with conversations with staff, for example, taking place in hospital café's. The Committee noted further that the appraisal process had been reviewed; and that staff were being promoted based on a full assessment of their abilities.

The Committee was advised that the Strategy and Clinical Model had been approved and it was highlighted that a system approach to pre-hospital care was being developed to ensure that alternative pathways were available.

The presentation indicated that for 2018/19, 116 staff had been recruited. It was noted that staff turnover rate was between 8% and 10%. The Committee was advised that for 2019/20 the forecast was for 124 staff being recruited; and that more emphasis was being made on the east of the county. It was highlighted that there was funding for 2 additional Resource Managers. The Committee noted that there was also 6 Military Paramedics operating on an honorary contract basis providing more flexibility along the east of the county.

Some reference was made to the Ambulance Response Programme; and the Lincolnshire Trajectories for 2019/20. It was highlighted that there had been a 12% increase in activity so far during the year. The presentation also made reference to conveyance information to Emergency Departments by CCG. The Committee noted that the Lincolnshire West CCG had a number of robust pathways in place, and that work was on-going with the other CCG areas to increase the number of pathways available. Details of the hospital handover impact on performance were shared with the Committee; and it was highlighted that there had been a loss of 700 hours per week during the July peak, details of which were shown on the slide presented.

The Committee was advised that collaborative working with the Acute Hospitals was on-going; and it was highlighted that a Rapid Handover Protocol had been agreed, which was due to start from 4 November 2019. Reference was also made to a further co-responder team operating from Wainfleet; and that joint working arrangements with Lincolnshire Integrated Voluntary Emergency Service (LIVES) were going from strength to strength. The Committee was advised that various practices had been put in place to help maintain productivity; reference was made to PIN reporting, that better management and leadership focus was being put into the Call Centre; and more emphasis was being placed on ensuring the right response happened first time, which would help improve hospital turnaround.

In conclusion, the Committee was advised that transformation of the service was continuing, and that the Divisional Work Programme for 2019/20 would help the service move forward.

During discussion, the Committee raised the following issues:-

- The need for a written report, rather than a presentation, showing the progress made by EMAS for future meetings;
- The optimistic picture of the service;
- Information relating to the effect LIVES had on the EMAS targets. It was agreed this information would be forwarded to members of the Committee;
- One member enquired whether there was a central list of where Automated External Defibrillators (AED's) were located for the public to use. The Committee was advised that a list was held centrally at the Emergency Centre. It was noted that the service was automated; on request a member of the public would be provided with directions to find the AED, along with a code and instructions to unlock the AED;
- The education of other road users to assist response vehicle drivers. Reassurance was given that ambulance drivers were trained to deal with unpredicted situations. It was agreed that media awareness would be considered;
- The effects of trauma on staff. The Committee was advised that it was difficult to spot someone who was in need of help. Reassurance was given that any member of staff who had faced a traumatic experience would be stood down; and would receive either a telephone or face to face de-brief. The individual would then be referred for appropriate professional support;
- The effect problems with handovers at hospitals were having, and the potential risk as winter approached. Reassurance was given that a Seasonal and Divisional Escalation Plans were in place;
- Some concern was expressed regarding the number of patients under the 'See and Treat' heading for Quarter 1 and 2, on page 32 of the report. The Committee was advised that a lot of these patients were elderly, with no transport; some of whom did not require further treatment; and others needing further clinical assessment;
- The number of ambulance crews units available – The Committee was advised that during the summer there were extra crews. Confirmation was given that there was out of county drift, but where drift occurred, Lincolnshire usually received backfill. Clarification was given that patients had to be transported to where the need was required;
- Video recording – The Committee was advised that a third of the ambulances had 24/7 CCTV coverage inside and outside of the vehicle. Confirmation was also given that each ambulance was fitted with a Global Positioning System (GPS); and that staff were also tracked by their radios;
- Ambulance standing time. Confirmation was given that ambulances did not take 10 minutes to warm up. It was however highlighted that ambulances could be on 'run lock', but this was something that was avoided if possible. It

was highlighted that when an ambulance was connected to an electrical socket, the connection point's design allowed for a quick release; and

- Sharing of good practice – The Committee was advised that good practices were shared. It was noted that the service had excellent Area Managers who looked to see what worked elsewhere and whether the same service could be replicated in Lincolnshire.

The Chairman on behalf of the Committee extended thanks to the Lincolnshire Division Manager for an excellent update and for her open and frank presentation.

RESOLVED

1. That a further update report be received from the East Midlands Ambulance Service NHS Trust – Lincolnshire Division in six months' time.

2. That information be provided regarding concerning the role of LIVES.

37 HEALTHY CONVERSATION 2019 - HAEMATOLOGY AND ONCOLOGY, AND THE CANCER STRATEGY FOR LINCOLNSHIRE

The Chairman welcomed to the meeting Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group, Louise Jeanes, Cancer Care Programme Manager, Lincolnshire West Clinical Commissioning Group, Dr Carl Deaney, Marsh Medical Practice, North Somercotes, and Dr Aurura Sanz-Torres, Consultant Clinical Oncologist and Clinical Director (Oncology and Haematology), United Lincolnshire Hospitals NHS Trust.

The report provided the Committee with an update on Cancer Lincolnshire's Long Term Plan 2019/24, and the vision and strategy for delivering effective and accessible haematology and oncology services for patients in Lincolnshire; it also provided details of the emerging option for oncology and haematology as part of the Lincolnshire Acute Services Review.

It was highlighted in Lincolnshire there were currently 27,500 people living with cancer and that this figure was expected to rise to 45,400 by 2030. It was highlighted further that cancer prevalence was across the four locality areas and ranged from 2.7% to 3.2% (national average being 2.6%). The Committee was advised that the most common cancers were Breast, Lung, Colorectal & Prostate and of these, colorectal was the most common cancer in Lincolnshire. It was highlighted that although survival rate had improved for most cancers, the difference between survival rates for the most survivable cancers and the less survival cancers was significant at 55%. It was highlighted that the strategy aimed to improve survival rates, and improve early diagnosis and prevention.

The Committee noted that over the next five years the Lincolnshire Sustainability and Transformation Partnership would be working with the East Midland Cancer Alliance provider trusts and McMillan towards building on progress and improvements already made on the Cancer Programme. Details of the ambitions for survival, screening,

early diagnosis, treatment, personalised care and workforce were detailed within the report.

Reference was also made to interventions to be implemented from 2021 onwards, which included the Lung Health Check Programme, and Rapid Diagnostic Pathways.

The key areas of focus for transformation were detailed on pages 45 and 46 of the report and included improvements to screening, diagnosing cancers earlier and faster, and ensuring that there was universal access to optimal treatment and adopting faster, safer and more precise treatments; and offering personalised care for all patients.

During discussion, the Committee raised the following issues:-

- One member enquired why there was a predicted rise in the number of patients with cancer to 45,000 by 2030. The Committee was advised that this figure was influenced by three factors: the ageing population; earlier diagnosis; and lifestyle choices which included obesity, smoking and alcohol consumption. Confirmation was given that work was on-going with the public to tackle a number of these long term issues. It was noted that all the measures to help improve the service would also increase the number of patients. Details of the benefits of the Case for Change were shown in Section 3 of the report. An example given to the Committee of smarter working was prostate triage, which involved looking at everyone connected to the process, to ensure that all efficiencies were being explored;
- Presentation of patients at accident and emergency departments. The Committee was advised that patients were often diagnosed at stages three and four, after presenting at an accident and emergency department; and that Lincolnshire was higher than the national average in this regard. It was highlighted that changes to pathways and providing GPs with new tools would help to reduce these instances;
- The role of the East Midlands Cancer Alliance. The Committee was advised that the Alliance had a facilitating role to improve outcomes for cancer patients across the East Midlands area;
- Children's cancer – It was noted that the responsibility for children's cancers was with the specialised commissioning team. It was noted further that GPs would always refer children to specialist centres;
- Workforce – A question was asked as to whether there was sufficient staff with the right skill set to deliver the improved outcomes. The Committee noted that GP international recruitment was going well, with 80 GPs having been recruited into England, with a further round expected. It was highlighted that staff would be developed to ensure there was an integrated approach from acute care to community services;
- Patient data. The need to promote to patients the benefits of sharing data across health services;
- Cancer diagnosis at stages one and two (page 48) a question was asked whether Lincolnshire would meet its target of diagnosing 75% of cancers at stage one and two by 2023. It was agreed that patients needed to be

encouraged to take part in screening programmes; this was a challenge, but with more collective working to encourage patients to take responsibility for their health, the target could be achieved;

- The location of the eleven radiotherapy networks. The Committee was advised that this was part of a national programme; and the boundaries of the radiotherapy networks had not been finalised; and
- Locations the mobile chemotherapy unit would be attending; and how patients would be made aware of this option. The Committee was advised that there was one mobile unit and eligible patients were made aware of the service, which was not suitable for all patients. The Committee noted that the service would be available at Grantham, Skegness, Louth, Spalding and that it was hoped to expand the service further.

In the second part of the presentation, the Committee was advised of the clinical speciality for haematology and oncology; and that at the Clinical Summit held in February 2018, the key concern highlighted had been the impact of workforce challenges limiting the ability to provide adequate cover across the county, which had resulted in the failure to meet performance against national waiting times standards for cancer and non-cancer. The report presented provided details of current performance and provision; and also provided details of the Case for Change for Lincolnshire, with an emerging option for sustaining haematology and oncology services in Lincolnshire, details of which were shown on page 52 of the report.

It was noted that consolidating haematology and oncology inpatient care at Lincoln County Hospital would provide the opportunity for a more consistent achievement of clinical standards, as well as supporting the ability to manage immunosuppressed patients in an appropriate setting; and addressing the concerns raised by the Care Quality Commission in April 2017. The Committee noted further that it would also provide the opportunity to improve facilities as part of the wider change on the Lincoln Hospital site, thus meeting the NICE guidelines for the management of neutropenic sepsis patients; as well as providing an opportunity to accommodate the increase in outpatient activity.

It was also highlighted that in consolidating the services at Lincoln County Hospital would also help to attract and retain talented and substantive staff through the building of a successful service, which offered the opportunity to work in a centre of excellence model.

During discussion, the Committee raised the following points:-

- A question was raised on the key challenges for the service and to the centralisation of the service. Reassurance was given that the preferred emerging option would mean that outpatient facilities would be increased and Lincoln County Hospital would restore its specialist provision. The Committee noted that the issue of transportation was currently being reviewed with the County Council, as to how family members and carers were to move around the county. It was noted that if the service provided was efficient and effective, it would result in shorter lengths of stay in hospital;

- Financial Resource - The Committee noted that capital investment would be required to increase the number of beds at Lincoln Hospital site; and
- Patient Choice agenda – Reassurance was given that if patient choice was exercised for initial diagnosis by, patients opting to go out of county, they invariably remained with that provider throughout their treatment. It was highlighted that where patients opted to go out of county, the funding would follow the patient. It was highlighted further that the main thrust of the change was to make services in Lincolnshire the best they could be.

The Chairman extended thanks to the representatives for their informative presentation.

RESOLVED

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

38 COMMUNITY PAIN MANAGEMENT SERVICE

The Chairman advised that Mrs Sandra Harrison, an East Lindsey District Councillor had made a written request to address the Committee concerning the community pain management service. The Chairman advised further that in accordance with usual practice he had invited Mrs Harrison to speak for a period of 3 minutes to address the issues set out in the report.

In her short statement to the meeting, Mrs Harrison expressed concerns relating to the fact that patients and stakeholders had been misled about the service contracted by the Lincolnshire West CCG to Connect Health. The Committee was advised there had been poor communication with patients; and some spinal injections were no longer available from the Community Pain Management Service.

The Chairman welcomed to the meeting Sarah-Jane Mills. Chief Operating Officer, Lincolnshire West Clinical Commissioning Group and Dr John Parkin, Executive GP, Lincolnshire West Clinical Commissioning Group to respond to the issues raised.

The Committee was advised that best practice as defined by the National Institute for Health and Care Excellence (NICE) and the British Pain Society had reduced the number of recommended interventions; this included the withdrawal of facet joint injections and acupuncture. It was highlighted that some epidural type injections were still available for painful conditions such as sciatica. It was highlighted that the most appropriate care would be informed by clinical need, national guidelines, and shared decision making. It was highlighted further that the new service brought many additional options for people living with pain, in addition to those treatment currently available.

The report presented provided details of the procurement process, the transition of patients; new referrals; locations; activity; and the challenges of introducing the new service.

The Committee noted that there had been some problems during the transition period, details of which were shown at paragraph 4 of the report.

The Committee was advised that Connect Health had established a Community Pain Management hub in Lincoln and were running 13 clinics across Lincolnshire. It was highlighted that Connect Health had made repeated attempts to establish premises for a pain service in Stamford, but to no avail. This had caused some problems with appointments, as staff in the Referral Management Centre were unaware of the geography and infrastructure of Lincolnshire and the challenges the local population faced with regard to transport.

The Committee noted that feedback on the service provided by Connect Health had been variable, details of complaints and compliments were shown on pages 62 and 63 of the report presented.

Reassurance was given that the new service was being proactively managed, with fortnightly operational and monthly contract meetings taking place with Connect Health; support was being provided to patients who were having difficulties with transition to the new provider; and regular contact was being made with Connect Health, to ensure that individual patient concerns are being managed or resolved.

During discussion, the Committee raised the following issues:-

- One member enquired as to when appointments would be available in Louth. The Committee was advised that appointments would be made available shortly;
- On the poor communication with patients and the lack of clarity regarding the new service, which was illustrated by some personal experiences, the representatives agreed to look at these outside of the meeting. Some members felt that communication with patients could have been better, so that patients had a realistic expectation of the new service from Connect Health; and
- Lack of public engagement in the process, and lack of knowledge by some patients that the service actually existed. The Committee was advised that the service had been in operation for over 10 years with access to the service being via the GP. Clarification was given that this was not a new pain service, just a transformation of an existing service, in line with guidance received.

On behalf of the Committee the Chairman extended thanks to the representatives for their update; and expressed concern at the unawareness of the additional 1,200 patients that United Lincolnshire Hospitals Trust moved over in July; and to the mobilisation phase of the new contract. The Chairman also requested that an update on the key performance indicators should be received by the Committee in three months' time.

RESOLVED

That a further update on the Community Pain Management Service be received in three months' time, which should include information of key performance indicators.

39 INTEGRATED COMMUNITY CARE

The Chairman welcomed to the meeting Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group and Dr John Parkin, Executive GP, Lincolnshire West Clinical Commissioning Group.

The Committee gave consideration to a report from the Lincolnshire Sustainability and Transformation Partnership, which provided an update on the implementation of the Integrated Community Care portfolio; and the progress made in four of the key programme areas, details of which were shown on pages 66 to 69 of the report presented.

Attached at Appendix A to the report was a copy of a Briefing Document: Understanding Primary Care Networks for the Committee to consider:-

- Neighbourhood Working;
- Introduction of Primary Care Networks;
- Use of Technology; and
- Development of Specialist Community Services.

The Committee noted that feedback received from Healthy Conversation 2019 had confirmed that local people were asking for care closer to home; for access to services to be a simpler process; and to be able to receive a high standard of care from compassionate professionals.

The Committee was advised that an Integrated Community Care programme was the key enabler to delivering sustainable modern health care. That alongside the development of Primary Care Networks, neighbourhood working and the upgrading of service models, work was on-going to explore how technology could help enhance local service provision that would enable clinicians to better identify patients who would benefit from proactive interventions.

In conclusion, the Committee was invited to submit comments to the Lincolnshire Sustainability and Transformation Partnership as part of the Healthy Conversation 2019 engagement exercise.

During discussion, the Committee raised the following comments:-

- Reference was made to the boundaries for Primary Care Networks (a national initiative) and locally-developed Neighbourhood Teams. The Committee was advised that there was much similarity, but also some variation, but it was hoped that Primary Care Networks would create greater integration and joint working both across General Practice and other agencies. Clarification was given that Primary Care Networks were a grouping of local general practices

that were able to collaboratively work, sharing staff and expertise, whilst maintaining the independence of individual practices. Further information relating to Primary Care Networks was contained in Appendix A to the report;

- Explanation as to the role of a new Clinical Pharmacist with a Primary Care Network, details of which were shown on page 68 of the report;
- Dates applicable for the phasing in of neighbourhood working. The Committee was advised that the establishment of neighbourhood teams had started in 2017 (Phase 1) and that Phase 2 had started at the end of 2018 start of 2019. It was highlighted that Primary Care Networks had been established in July 2019, and that their development was still a work in progress;
- Clarification was given that communities and clinicians were working together to design services; and
- The timescale for all neighbourhood teams to be fully functional. The Committee noted that neighbourhood teams were not all operational and that the phasing in of services was on-going. It was noted that over the last two years the teams had focussed on building the links with partners in their local communities; and that that the next phase of development was to be led by the Assistant Director, Adult Fraility and Long Term Conditions, Lincolnshire County Council, which would focus on addressing the barriers that prevent fully integrated patient care. The priorities for this phase were shown on page 67 of the report.

The Chairman on behalf of the Committee extended thanks to the representatives for their update.

RESOLVED

1. That the Chairman be authorised to provide feedback on behalf of the Committee as part of the Healthy Conversation 2019 engagement exercise on Integrated Community Care.

2. That a copy of the completed Primary Care Network map be circulated to members of the Committee, when this was finanlised.

The Committee adjourned at 1.45pm and re-convened at 2.15pm.

Additional apologies for absence for the afternoon part of the meeting were received from Councillors M T Fido, M A Whittington, S Barker-Milan (North Kesteven District Council) and Dr B Wookey (Healthwatch Lincolnshire).

An apology was also received from Councillor Dr M E Thompson (Executive Support Councillor for NHS Liaison & Community Engagement).

40 IMPACT OF OVERNIGHT CLOSURE OF GRANTHAM AND DISTRICT A & E

Pursuant to minute number 30(1) from the meeting held on the 18 September 2019, the Committee gave consideration to a joint report from United Lincolnshire Hospitals NHS Trust and the Lincolnshire Sustainability and Transformation Partnership, which

provided the Committee with information on the impact of the overnight closure of Grantham A & E, in the first instance, on Peterborough City Hospital.

Additional information from North West Anglia NHS Foundation Trust had been circulated to members of the Committee for consideration, prior to meeting. The information circulated provided the Committee with answers to the four questions detailed on pages 94 and 95 of the report.

The Chairman welcomed to the meeting Mark Brassington, Chief Operating Officer, United Lincolnshire Hospitals NHS Trust.

The Committee noted that there was still some ambiguity regarding the figures presented, as a result of differing data collection regimes.

The Chief Operating Officer responded to questions raised, which included the following issues:-

- The effect of proposed housing development in Grantham on Grantham & District Hospital. Some members contended that the potential growth of Grantham warranted the need for Grantham A & E to be open 24 hours. The Committee was reminded that as Grantham Hospital formed part of the Acute Services Review, no changes would happen until after the outcome of the public consultation on Grantham A & E was implemented. Reassurance was given that housing growth area was considered when looking at sustaining Grantham Hospital; and the Committee noted that work was on-going with the district council concerning future options ;
- One member reminded the Committee that the reason the Grantham A & E had been closed overnight was on the grounds of patient safety. The Committee was advised that some doctors had been recruited from overseas; however, as most did not have the required skill set, they were required to undertake a period of training for the General Medical Council as part of the CESR (Certificate of Eligibility for Specialist Registration) programme;
- A question was asked where patients would be taken if a major trauma incident happened on the A1. The Committee was advised that patients would be taken to the Queen's Medical Centre, Nottingham, which had been the region's major trauma centre since 2012;
- Developer contributions under planning legislation – There was some discussion on how the NHS submitted its responses to consultations on local authority planning applications; and
- A question was asked as to whether consideration would be given to making Grantham an A & E rather than an Urgent Treatment Centre. The Committee was advised that at present, there were no plans for Grantham to become an A & E. The Lincolnshire NHS's preferred option was for an Urgent Treatment Centre in Grantham.

On behalf of the Committee the Chairman extended thanks to the Chief Operating Officer for his update; and advised that the information presented would be noted; including the assurance that the impact of the overnight closure would be managed

until such time as the outcome of the public consultation was implemented. A request was also made for as much information as possible being included on the impact of the proposed changes for Grantham A & E in its published consultation material. The Chairman also advised that additional information would be requested from Nottingham University Hospitals NHS Trust, University Hospitals of Leicester NHS Trust to be considered alongside the information available for Pilgrim Hospital, Boston and Lincoln County Hospital.

RESOLVED

1. That the information presented concerning the Impact of Overnight Closure of Grantham and District A & E be noted, including the assurance from the NHS in Lincolnshire that the impact of the overnight closure of Grantham A & E had been and would continue to be managed until such time as the outcome of the public consultation on Grantham A & E was implemented.

2. That the Lincolnshire Sustainability and Transformation Partnership be urged to include as much information as possible on the impact of the proposed changes for Grantham A & E in its published consultation materials.

3. That the additional information on the impact of the overnight closure of Grantham A & E be requested from Nottingham University Hospitals NHS Trust, and University Hospitals of Leicester NHS Trust, to be considered alongside the information available for Pilgrim Hospital Boston and Lincoln County Hospital.

41 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which enabled the Committee to consider and comment on the content of its work programme as detailed on pages 103 to 106 of the report presented.

The Committee put forward the following suggestions:-

- Out of Hours Services, including 111 (Integrated Urgent Care); and
- Louth Hospital Inpatient Services.

RESOLVED

That the work programme presented be agreed subject to the potential inclusion of the items referred to above and those requested at minute numbers 36 (1)(2), 38, 39(2), and 40(3).

The meeting closed at 2.55 pm

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