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:	**15 September 2021**
Subject:	**Chairman's Announcements**

1. Information Requested at the Last Meeting – 21 July 2021

Lincolnshire Partnership NHS Foundation Trust Board Papers – 27 July 2021 *(Minute 19)* – The relevant papers were circulated to the Committee on 27 July 2021.

Chief Medical Officer's Annual Report for 2021 - Health in Coastal Communities *(Minute 23)* This was circulated to members of the Committee on 21 July 2021.

Covid-19 Briefing *(Minute 23)* This was circulated to members of the Committee on 21 July 2021.

Covid-19 – Information on Covid-19 App Alerts *(Minute 16)* As advised to members of the Committee on 27 July 2021, the County Council's Public Health Intelligence Team does not receive the data on the number of positive Covid-19 tests following an alert no the number of hospitalisations, as the App cannot be tracked to an individual level.

2. Pharmaceutical Needs Assessment

At the last meeting on 21 July 2021, the Committee made arrangements for being consulted on the development of the new Lincolnshire Pharmaceutical Needs Assessment, which was due to be approved by 1 April 2022. Since that meeting new guidance has been issued, and the consultation on the draft PNA is expected to take place between April and June 2022.

3. United Lincolnshire Hospitals NHS Trust – Application for University Teaching Status

On 23 July 2021, following a request from the Chief Executive of United Lincolnshire Hospitals NHS Trust, I sent a letter in support of the Trust's application for university teaching hospital status. My letter referred to the presentation from the Associate Dean of Medicine at the Lincoln Medical School in February 2020, where the Committee had recorded its strong support for the development of the medical school, which had opened to its first students in September 2019.

I also stated that I believed this would be a further step in developing and sustaining the NHS in Lincolnshire and teaching hospital status would in the medium to long term lead to benefits to all patients in Lincolnshire, and begin to reduce some of the health inequalities in the county.

4. United Lincolnshire Hospitals NHS Trust – Urology

On 23 June 2021, the Committee considered proposals from United Lincolnshire Hospitals NHS Trust (ULHT) for changes to its urology services. The Committee had been advised that planned urology services were delivered from Lincoln County Hospital, Pilgrim Hospital, Boston, Grantham and District Hospital and Louth County Hospital; and emergency urology admissions alternated at the weekends between Lincoln County and Pilgrim Hospitals, with emergency admissions at both Lincoln and Pilgrim Hospitals during the week.

In summary, ULHT had proposed that Lincoln County Hospital in future received all emergency urology admissions seven days per week. There would be increases in planned urology services at Grantham and District Hospital and Pilgrim Hospital, with a reduction of planned activity at Lincoln County. There would be no changes at Louth County Hospital. ULHT believed that this change would increase ULHT's capacity to perform planned surgery without disruption to patients; better meet the needs of ULHT's emergency cases; and see and treat more people.

On 21 July 2021, the Committee approved its draft response to the engagement exercise by United Lincolnshire Hospitals NHS Trust on changes to its urology services. In summary, the Committee did not believe that it was in a position to support the proposal for the reconfiguration of the Trust's non-elective hospital urology services. Whilst a rationale for change had been put forward, which included a significant increase in elective activity, the perceptions of the local community on the Trust's plans for Pilgrim Hospital are important and need to be fully addressed.

On 2 August 2021, the ULHT board approved the new arrangements, with its proposed implementation during August 2021. The ULHT Board was advised that a detailed data dashboard had been developed to monitor the impact of the service change and this would be reported to Trust Board on a regular basis.

5. Paediatric Services at Pilgrim Hospital, Boston - Short Stay Paediatric Assessment Unit

As reported to this Committee on 21 July 2021, I had received a copy of a letter, dated 19 July 2021, from Alison Marriott, on behalf of *SOS Pilgrim – Call to Action*, to Dr S Joachim (Divisional Clinical Director, Family Health) and Mr Simon Hallion (Managing Director, Family Health Division). This letter clarified the position of SOS Pilgrim regarding the short stay paediatric assessment unit at Pilgrim Hospital.

I have received a copy of the reply from Simon Hallion, dated 23 July 2021, which referred to ULHT's legal duty, under Section 242 of the NHS Act 2002, is to involve patients and the public in development of proposals for change and decisions about how services operate. ULHT's proposed twelve week engagement exercise would always have taken a comprehensive approach to doing this and was now intending to carry out this engagement exercise as a formal public consultation and would be plan the exercise on that basis.

6. United Lincolnshire Hospitals NHS Trust – Visiting Arrangements from 11 August 2021

With effect from 11 August 2021, United Lincolnshire Hospitals NHS Trust (ULHT) suspended its patient visiting arrangements. Exceptions to this suspension include end of life care, dementia or significant cognitive impairment, learning disability or autism and situations where the visit will be classed as a therapeutic intervention to manage distress. These exceptions will be at the discretion of the ward and require an individual risk assessment.

Separate arrangements apply to maternity department, which will allow one birthing partner to attend the birth and a partner to visit women and their baby either antenatal or postnatal, with visiting hours on maternity wards between 1pm and 7pm. Partners can attend all hospital maternity appointments. Women and partners are encouraged to perform lateral flow tests prior to appointments.

Separate arrangements also apply to paediatrics and neonatal services, where parents who do not show the symptoms of infection can visit their children on children's wards and neonatal units. In addition, parents with a baby in neonatal care have access 24 hours a day. This includes overnight stays where accommodation allows.

As an alternative to visiting, wards have tablets available that can support video calling to patients stay connected.

Similar arrangements have been in place at North West Anglia NHS foundation Trust since 14 August 2021. Northern Lincolnshire and Goole NHS foundation Trust introduced visitor restrictions at Diana, Princess of Wales Hospital, on 20 August 2021, but these restrictions were relaxed on 27 August 2021, except for two wards.

7. Humber Acute Services Review

The Humber Acute Services Review (ASR) is looking at hospital services in two acute hospital trusts: Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust. NLaG operates three hospitals including Diana Princess of Wales Hospital, Grimbsy, and Scunthorpe General Hospital. Many patients in the north and north east of Lincolnshire use these two hospitals, so any changes to services are relevant to this Committee. It is expected that the Humber ASR will begin an engagement exercise in the coming months, which will involve this Committee. More detail is set out in Appendix A, which is based on the programme update, issued in June 2021.

8. Changes to Breast Oncology Services Across the Humber

On 24 August 2021, Northern Lincolnshire and Goole NHS Foundation Trust advised me of temporary changes to its breast oncology treatment. These are detailed in the letter from the Chief Executive in Appendix B.

9. Review of Non-Emergency Patient Transport and Consultation on the Eligibility Criteria

National Review of Non Emergency Patient Transport

On 2 August 2021, NHS England published its review of non-emergency patient transport. The full review document is at the link below, with the executive summary attached as Appendix C1 to this report.

https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/nepts-review/

Lincolnshire Clinical Commissioning Group (CCG), which is in the process of procuring a new contract for non-emergency patient transport with effect from 1 July 2022, has advised that the specifications issued to the prospective providers had referred to the imminent publication of the national review. NHS England had also provided the CCG with prior knowledge of the main findings of the review prior to publication, and these were covered in the market engagement event.

Consultation on Eligibility Criteria for Non-Emergency Patient Transport

As stated in paragraph 20(i) of the executive summary of the national report, proposals for consultation on the eligibility criteria for non-emergency patient transport have been published. Subject to the consultation, NHS England expects that they will be incorporated into new contracts from April 2022 and existing contracts from April 2023.

The consultation document on the eligibility criteria for non-emergency patient transport is found at:

https://www.engage.england.nhs.uk/consultation/eligibility-for-non-emergency-patient-transport/

As the proposed criteria (See Appendix C2) include significant additions to the existing criteria, it is proposed that the Committee should respond to the consultation by the closing date of 25 October 2021, with a draft response will be submitted to the next meeting of the Committee on 13 October 2021.

10. Temporary Relocation of Services at John Coupland Hospital Gainsborough

NHS Property Services, which manages the John Coupland Hospital site in Gainsborough, are planning repair works to the Scotter building during 2022. These works can only go ahead once clinical areas are vacated, and services relocated in Gainsborough. Lincolnshire Community Health Services NHS Trust (LCHS) has announced that the changes will include:

- some services, including community nursing, specialist services, community therapy and Lincolnshire Sexual Health, will be relocated from September 2021 to the Pottergate Surgery, which is about half a mile from the John Coupland Hospital site with good public transport links; and
- Scotter Ward will be relocated on the current John Coupland Hospital site later in 2021.

LCHS states that it does not expect clinic times and dates to change and there should be minimal impact on patients; and will provide further updates once more details have been received from NHS Property Services. LCHS has stated that it is committed t continuing to deliver services in Gainsborough and it will use this opportunity to engage with members of the public in Gainsborough to hear their views on community services as we look to bring the estate in line with what patients and staff would expect from a modern care environment.

11. The Sidings Medical Practice in Boston - Procurement Engagement Events and Survey

Lincolnshire Community Health Services (LCHS) currently provide primary medical services at the Sidings Medical Practice in Boston under a caretaking contract, which is due to end on the 30 June 2022. Lincolnshire Clinical Commissioning Group (CCG) will undertake a full procurement to find a provider for a new contract starting on 1 July 2022, to ensure the continuation of primary medical services within the area. There will be no changes to the surgery opening hours and this process is to ensure services continue to be provided from the Sidings Medical Practice.

As part of the procurement, the CCG is engaging with patients, their families and carers to find out their views, before a full procurement process to find a provider commences. There are two patient engagement events on:

- Saturday, 11 September 2021, 8:30am – 12:00pm at the Boston Marketplace, PE21 6EJ – Stall (near the NatWest bank)
- Thursday, 16 September 2021, 6:30pm - 8.00pm at The Sidings Medical Practice , 14 Sleaford Rd, Boston PE21 8EG

In addition to the events, a patient survey was launched on 9 August, which is available at: https://nhslincolnshire.qualtrics.com/jfe/form/SV_cwti08wnNabKel8 . Paper copies are also available in the practice, or by telephoning 07890 047409. The closing date for completion of the survey is 24 September 2021.

12. Annual Public Meetings 2021

NHS organisations are required to hold an annual public meeting, at which the annual report is usually presented, and achievements from the previous year and plans for the coming year may be highlighted. There is an opportunity for members of the public to put questions to the Board. These meetings usually take place during September or October. As with 2020 annual public meetings for 2021 will be taking place remotely.

As of 6 September 2021, the following dates have been confirmed:

- 14 September, 12.30pm - 1.30pm – Lincolnshire Community Health Services NHS Trust. Details are available at https://www.lincolnshirecommunityhealthservices.nhs.uk/about-us/our-trust-board

- 22 September, 5pm – 7pm, Lincolnshire Clinical Commissioning Group. Details are available at https://lincolnshireccg.nhs.uk/event/annual-public-meeting-2021/

- 29 September, 10am to 11.30am – Lincolnshire Partnership NHS Foundation Trust. Details are available at https://lincolnshireccg.nhs.uk/invitation-to-join-us-at-this-years-lpft-annual-public-and-members-meeting-wednesday-29-september/

Other dates will be reported when available.

13. Overview of Local NHS Performance

Regular performance monitoring of the NHS activity is a responsibility for the board of directors of each local NHS organisation. Each board receives an integrated performance report at each regular meeting. This Committee's remit is not to duplicate the role of each board of directors. However, where members of the Committee may be interested in the performance of a particular NHS organisation, the dates of each local board of directors meeting, together with a link to the relevant agenda page are set out below. In most instances, each NHS organisation aims to publish its reports at least three working days prior to the meeting date.

NHS Organisation	Remaining Board Meetings in 2021
Lincolnshire Clinical Commissioning Group https://lincolnshireccg.nhs.uk/library/board-meeting-papers/board-meeting-papers-202122/	29 September 27 October 24 November 22 December
United Lincolnshire Hospital NHS Trust https://www.ulh.nhs.uk/about/board-meetings/	7 September 5 October 2 November 7 December
Lincolnshire Community Health Services NHS Trust https://www.lincolnshirecommunityhealthservices.nhs.uk/about-us/our-trust-board/trust-board-papers	14 September 9 November
Lincolnshire Partnership NHS Foundation Trust https://www.lpft.nhs.uk/get-involved/meeting-dates-and-minutes/board-directors-meetings/navigate/23762/6774#ccm-block-document-library-table-23762	30 September 4 November 2 December
North West Anglia NHS Foundation Trust https://www.nwangliaft.nhs.uk/about-us/trust-board/board-papers-meetings/	12 October 14 December
Northern Lincolnshire and Goole NHS Foundation Trust https://www.nlg.nhs.uk/about/board-meetings/	5 October 7 December
East Midlands Ambulance Service NHS Trust https://www.emas.nhs.uk/about-us/trust-board/next-board-meeting/archive-board-papers/	7 September 2 November

14. Complaints Information

Role of Health Overview and Scrutiny Committees

> "Although health scrutiny functions are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends." *(Local Authority Health Scrutiny – Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny – Department of Health 2014)*

As indicated above, the Secretary of State's guidance health overview and scrutiny committees may use information on complaints to get an impression of services.

Attached as Appendix D to this report is paper, which provides information on the numbers of complaints during 2021/22, together with the key topics of complaint and how the NHS is is responding to the themes.

15. Appointment of Amanda Pritchard as NHS Chief Executive

On 28 July 2021, the NHS announced that Amanda Pritchard would become its Chief Executive with effect from 1 August 2021. The previous Chief Executive, Sir Simon Stevens, had announced in April 2021 that he would be standing down at the end of July after seven years in the post.

Amanda Pritchard was previously the NHS's Chief Operating Officer. In this role she had overseen NHS operational performance and delivery, as well as implementation of service transformation and patient care improvements set out in the NHS Long Term Plan. Before joining NHS England and NHS Improvement in 2019, she had served as the Chief Executive of Guy's and St Thomas' NHS Foundation Trust in London, and had also been Deputy Chief Executive at Chelsea and Westminster NHS Foundation Trust.

APPENDIX A

The Humber Acute Services Review Programme

The information set out below is based on the Humber Acute Services Review programme update, issued in June 2021; and newsletter of 23 August 2021.

Overview

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

The Case for Change, published in November 2019, explains in more detail why services need to change and sets out some of the challenges; and work is actively underway to design potential solutions across the following three programmes of work:

- **Interim Clinical Plan** (Programme One) – stabilising services within priority areas over the next couple of years to ensure they remain safe and effective, seeking to improve access and outcomes for patients.
- **Core Hospital Services** (Programme Two) – long-term strategy and design of future core hospital services, as part of broader plans to join up services across all aspects of health and social care.
- **Building Better Places** (Programme Three) – working with a wide range of partners in support of a major capital investment bid to government to develop our hospital estate and deliver significant benefits to the local economy and population.

Programme One (Interim Clinical Plan)

The main aim of the Interim Clinical Plan is to stabilise the identified fragile or vulnerable services to ensure they remain safe and effective. The identified services are:

- Cardiology
- Neurology
- Dermatology
- Oncology
- Ear Nose and Throat (ENT)
- Ophthalmology
- Gastroenterology
- Respiratory
- Haematology
- Urology

Creating and embedding clinical leadership across the Humber for each speciality remains a significant priority in order to deliver fully networked services for the benefit of all patients. Indirect benefits to patient and their families, include:

- Improved consistency in care, treatment and administration.
- Consistent approach to clinical prioritisation and management of waiting lists across the Humber geography – ensuring equity of service for patients in all localities.
- More efficient use of clinical and non-clinical workforce capacity.

Programme Two (Core Hospital Service)

The overall objective of this programme is to design sustainable and effective service models for the future delivery of hospital services. This work is being led by our clinical teams who are currently working to design potential models of care for the following core hospital service areas:

Urgent and Emergency Care

There are some things that make it harder for the hospitals in the Humber area to provide the best urgent and emergency care. These are the challenges to be tackled through this programme:

- Compared to other parts of the country, more people use the Humber's emergency departments and more people are admitted to hospital in an emergency situation.
- The hospitals also have a higher proportion of patients arriving by ambulance or helicopter.
- The hospitals currently have difficulties meeting some important clinical standards, including the four-hour A&E standard (which states that 95% of patients attending A&E should be admitted, transferred or discharged within four hours),
- When people use the hospitals they often have to wait longer or stay in hospital longer than people with similar conditions in other parts of the country. Some of this is linked to the way services are organised and difficulties putting in place 'seven day working'.
- There are also a high number of vacancies within the medical, clinical and nursing workforce.

Maternity, Neonatal Care and Paediatrics

Across the Humber, there are around 9000 babies born every year – every hour a new baby is born somewhere in the Humber. These births are not spread out evenly across the different sites in our region and the hospital maternity units in Scunthorpe and Grimsby are small when compared to other areas in the country.

Maternity services also rely heavily on neonatal (care provided for new-born babies who need extra support) and paediatric services (care for children and young people). Changes

in one service area could have a knock-on effect on the other. The Humber's paediatric services face a number of challenges, in particular, relating to recruitment:

- There are differences in how maternity care is provided across the region and women are telling us that they have less choice than women in other parts of England.
- Compared to other parts of the country, a larger proportion of babies are born prematurely and need extra care. There are also more women with higher risk pregnancies.
- Due to the relatively low number of births on the Grimsby and Scunthorpe sites, it is difficult to ensure all our staff keep up their skills because they are not seeing the recommended numbers of low birth-weight babies.
- New standards around numbers of staff needed in neonatal and paediatric services are stretching the existing workforce further, meaning it is even more challenging to continue to staff the services safely.
- Hospitals are not always able to meet important clinical standards set out by the Royal College of Paediatrics and Child Health, particularly around immediate access to senior paediatric staff.
- Recruiting paediatric trainee doctors and paediatric nurses remains a problem – not only across the Humber, but nationally.

The review team have been asking women, their partners and families what matters most to them when making choices about where to give birth. This will help to design maternity and neonatal services that will work better in the future. The review team is also listening to children and young people, their parents, carers and friends to help us shape the future of paediatric services.

Planned Care and Diagnostics

Across our hospitals thousands of patients are seen every week for planned operations or other treatment, scans and other tests. The way planned care and diagnostic services are set up, however, means hospitals are not always making the best use of the equipment, buildings and workforce. As a result are not getting the best possible outcomes.

- In many of services, too many patients are waiting too long to be seen. This has become worse as a result of the Coronavirus pandemic.
- Too often appointments run late or are cancelled at the last minute because the staff, equipment or buildings need to be used to treat patients who have come in as emergencies.
- It is not possible to meet important clinical standards across all our hospital sites.
- As with other services, it is difficult to recruit and retain a large enough workforce with the right skills and experience to meet the needs and demands of the population.
- Old buildings and equipment cause backlogs in getting reports on scans or other images. The unreliability of some of the imaging equipment and machines can lead to incorrect clinical conclusions.

We know from our engagement already that being seen and treated as quickly as possible is very important to local people. In planning for the future, we will pay particular attention to tackling long waiting lists and designing services that can see patients quickly and efficiently.

Preparation of Pre-Consultation Business Case

Work on programme two is moving at pace towards the publication of a Pre-Consultation Business Case by early 2022, followed by a statutory public consultation. In many cases, emerging pathways of care within services are not standalone or independent; and will require us to consider how we deliver more services out of hospital in a community setting.

Initial work has highlighted the potential benefits that can be delivered from community-based pathways or services; and we are working closely with teams in out of hospital and primary care transformation programmes and are seeking to develop a joint understanding of future demand.

The most common areas of positive feedback so far were in relation to:

- **workforce** – praising kind, compassionate and caring staff;
- **waiting times** – praising efficient and well-run services; and,
- **clinical standards** – commenting on how safe and well looked after respondents felt.

The most common areas where respondents felt improvements could be made were in relation to:

- clinical outcomes – in particular improving **communication** with patients and between different parts of the health and care system; and,
- **travel and access** – in particular improving access to car parking facilities.

Programme Three (Building Better Places)

The NHS in the Humber continues to work with a wide range of partners including local authorities, universities, local enterprise partnerships and development partners on proposals to develop the hospital estate and deliver significant, wide ranging community benefits across the Humber.

Work continues on seeking approval to develop a large-scale capital investment plan for the hospital estate that will support better clinical care but also make a significant contribution to the wider economic regeneration of the region. This investment could be linked to not only hospital infrastructure but also across community diagnostics, out of hospital transformation and social care.

APPENDIX B

Changes to Breast Oncology Services Across the Humber

Set out below is the text of a letter from Dr Peter Reading, Chief Executive of Northern Lincolnshire and Goole NHS Foundation to Councillor Carl Macey, Chairman of the Health Scrutiny Committee for Lincolnshire, dated 24 August 2021.

Dear Councillor Macey,

I am writing to you to let you know we recently had to make a temporary change to the breast Oncology service across the Humber region on the grounds of patient safety. This temporary change means all newly diagnosed breast Oncology patients will have their first appointment with a specialist at Castle Hill Hospital in Hull; and will impact on a small number of patients within the Lincolnshire County Council boundary who would previously have been seen in Grimsby or Scunthorpe. However, please be assured that this temporary change does not impact on chemotherapy treatments; and these will continue to be provided at both Grimsby and Scunthorpe for new and existing patients.

Please note the following details to help explain the reasons and background to this temporary change:

- Hull University Teaching Hospitals (HUTH) currently provides the breast Oncology clinicians to deliver the Oncology service run in Northern Lincolnshire and Goole (NLaG) NHS Trust. Oncologists are the specialists which lead the care of patients with all types of cancer. They work closely with other colleagues in large multidisciplinary teams that focus together on treating the patients.

- The arrangement between HUTH and NLaG is formalised through a Service Level Agreement which covers all outpatient clinics (new and follow-up appointments), as well as chemotherapy review and support to nursing teams in clinic, ward rounds and inpatient reviews.

- The Oncology service has, in recent years, seen the introduction of new and more effective treatments and at the same time has become increasingly challenged because of a growing national and international shortage of medical and clinical oncologists. In addition, patients are living longer with their cancer, receiving more lines of treatment and are often on treatment for prolonged periods of time rather than having what used to be seen as traditional chemotherapy for a defined short period. The Oncology senior team is at present carrying five Whole Time Equivalent (WTE) consultant vacancies plus three locums, out of an establishment of 23 WTE consultants. This has happened along with sickness leave, an increased – and growing – service demand, and an increased complexity of new chemotherapy regimens. As a result the Oncology team cannot continue to deliver all aspects of the current service with such a limited staffing resource.

- The breast team has seen a decrease in WTE consultants providing a service to this tumour site in recent years: Six WTE Oncologists previously delivered this service and now HUTH have 2.80 WTE Oncologists. NLaG previously had three WTE breast Oncologists from HUTH delivering this service across Northern Lincolnshire and this has now reduced to one locum Oncologist.

- There has also been an increase in referrals to Oncology and breast Oncology now accounts for approximately 25% of NLaG's cancer workload. A reduction in specialists and an increase in demand have had, together, a significant adverse impact on the work of this tumour site.

As a result of these continuing pressures a temporary plan has been agreed by HUTH, NLaG and the relevant Clinical Commissioning Groups (CCGs) on the grounds of patient safety. This change means all breast Oncology patients accessing the Humber Oncology service will receive the same level of service and timely clinical input to progress their care and treatment; and all newly diagnosed breast patients will have their first appointment with a specialist at Castle Hill Hospital in Hull. In line with ongoing commitments made towards supporting patients there will be access to transport available for patients meeting the criteria.

All the breast patients will be managed by HUTH from a single waiting list and each patient will be given priority by clinical need regardless of referral source. Any Lincolnshire patients who require chemotherapy will be transferred to the NLaG nurse-led chemotherapy service and will continue to receive their treatment at the Diana Princess of Wales (DPoW) Hospital in Grimsby or Scunthorpe General Hospital as is the case now. Making this change now means all patients can be seen by a medical expert in the management of their cancer therapy by concentrating this work in one location. This approach maximises the use of consultant time in reviewing patients. Work on all other tumour sites (Upper GI, Colorectal, Lung and Urology) will continue to be delivered from DPoW.

Given cancer referrals are expected to continue to grow in the coming months and years, a long-term solution for Oncology across the Humber is in the process of being developed. This plan needs to be clearly spilt into two distinct components:

- To stabilise the breast Oncology service which will require the appointment of either substantive or locum consultants.
- To enhance and develop the wider Oncology workforce. This can only be achieved with very significant ongoing investment from all parties to recruit additional staff, to support the consultant-led team delivered model. The service needs to be able to recruit flexibly so that suitable staff of different grades can be appointed as and when possible.

The details set out above represent a service change on the basis of patient safety. Like many other systems we experience significant issues in recruiting specialist Oncology staff. Our proposed work plan for the delivery of Humber Acute Services includes a review of Oncology services and how it may be best delivered in the longer term; and would expect to fully engage with you as these develop over the coming months.

I trust these details are helpful and please share this information with other members of the Health Scrutiny Committee for Lincolnshire. Please let me know should the Committee have any questions and/or wish to discuss any of the above in more detail; and I will provide any further details requested and attend a future meeting of the Committee if that would be helpful.

I look forward to hearing from you.

Yours sincerely

Dr Peter Reading
Chief Executive

APPENDIX C1

Improving Non-Emergency Patient Transport Services

Report of the Non-Emergency Patient Transport Review

Executive Summary

1. Our experience of healthcare does not start and stop at the hospital door. Transport to and from treatment can make a significant difference to patients' wellbeing, and sometimes to their safety and health.

The Importance of Patient Transport

2. When Healthwatch undertook an extensive nationwide conversation about improving the NHS, nine out of ten people highlighted the importance of convenient ways of getting to and from health services. Age UK, Kidney Care UK and other patient groups have emphasised similar conclusions; and how transport can be a major challenge to many patients today.

3. This report sets out measures for improving an important element of travel to healthcare: NEPTS. These NHS funded transport services support those people whose medical condition or mobility constraint would otherwise be a major barrier to getting to treatment. It draws on the findings of a national Review, which has worked closely with the sector. Our aim is to ensure that NEPTS is more responsive, fair and sustainable.

Non-Emergency Patient Transport Today

4. While most people can travel to treatment independently or with support from family and friends, NEPTS play an important role for those whose medical condition or severe mobility constraint means that other forms of transport are not suitable.

5. NEPTS deliver 11-12 million patient journeys each year, covering around half a million miles each weekday.

6. Out of every 20 journeys, approximately nine are for patients attending outpatient appointments, seven renal dialysis, and four are discharges or transfers to other hospital settings. Three quarters of users are aged over 65.

7. Patient transport services typically have four components:

- **Co-ordination and triage capacity** – to assess eligibility, broker and manage journeys, and signpost people to independent transport.
- **Specialist transport services** – for those who need adapted vehicles or support from staff with particular training. There are up to 300 Care Quality Commission (CQC) registered ambulance providers delivering these services.

- **Non-specialist services** such as private hire/taxis and community transport – some areas now draw on over a hundred providers to flexibly deliver to those with less severe needs.
- **Reimbursement** of travel costs to allow patients or their families to cover the costs of private transport. In addition, those on a low income or meeting other criteria are entitled to reimbursement through the **Healthcare Travel Costs Scheme**.

8. We estimate that around £460 million is spent on NEPTS a year – at an average cost of around £38 per journey. That represents about £1 in every £275 spent by the NHS, approximately the same as the total cost of radiotherapy.

9. Data from a small number of healthcare trusts suggests that the use of the Healthcare Travel Costs Scheme is comparatively low. Extrapolating from this small sample indicates that national expenditure may be around £5-10 million a year.

10. Patient transport emits 57-65 kilotonnes of carbon dioxide equivalent emissions per year, which constitutes approximately 20% of the NHS' direct travel emissions, as well as contributing to increased air pollution levels.

Challenges and Opportunities

11. Patients often enormously value the transport they receive. The review has heard many examples of how the approximately 10-15,000 full time equivalent (FTE) staff and hundreds of volunteers provide patients with good care and support.

12. Since the advent of the COVID-19 pandemic, providers of transport have shown enormous flexibility. They have adapted to social distancing requirements, often involving a rapid shift from group to individual transport. They have stepped up to develop better ways to safely discharge patients from hospital. Collaboration between providers has deepened.

13. However, alongside these positive examples, the review has found that patient transport services are too often variable in quality and responsiveness. For example, one survey found that on at least one occasion in the previous two years, nearly a third of patients had waited over three hours for transport back from treatment. People are also often left uncertain as to when their transport will arrive, creating needless waiting and anxiety.

14. Eligibility for NEPTS is inconsistently applied across England, with each Clinical Commissioning Group (CCG) typically developing their own interpretation of government guidelines.

15. Service commissioning, planning and management has been poor in some areas. We estimate around a quarter of journeys are cancelled or aborted each year – around 3 million trips – an indication that communication and integration between providers of healthcare, transport and patients could be much better. Commissioners and providers also expressed concerns about procurement and contracting. We are aware of four contracts being handed back or terminated in 2017 and 2018 alone.

16. Nor is the sector yet environmentally sustainable. Patient transport needs to be at the forefront of the NHS' commitment to become the first net zero carbon healthcare system by 2040.

17. These challenges have arisen due to systemic factors: the inherent uncertainty around eligibility; a lack of data and transparency undermining both good commissioning and accountability; and contracts that do not incentivise investment or innovation.

18. The positive news is that there are also significant opportunities to address these issues. Technology in transport co-ordination is allowing demand and capacity to be much better connected. Measures to reduce the need for outpatient appointments by 30% should free up travel resource for reinvestment in other parts of NEPTS and reduce emissions. ICSs provide the institutional architecture for healthcare providers to collaborate in planning and delivering transport better. The expansion of electric vehicle charging infrastructure and increased availability of electric vehicles enables reductions in carbon emissions and improvements in air quality.

A New National Framework for Patient Transport

19. The needs and opportunities identified in this review define three major objectives for non-emergency patient transport: to be more consistently **responsive**, **fair** and **sustainable**:

- NEPTS needs to be high-quality and consistently patient-centred: minimising waiting times, keeping people informed, better integrating transport into the treatment pathways and giving people more control.
- More detailed national eligibility criteria and consistent standards are required to underpin good local planning and delivery.
- NEPTS needs a clear path to net zero carbon, to work with local communities and continuously improve productivity through investment and innovation.

20. This review therefore sets out a **new national framework for non-emergency patient transport**, comprising of five components.

(i) **Updated national guidance on eligibility for transport support** to:

(a) Clarify eligibility for those with a medical need, cognitive or sensory impairment, significant mobility need, or safeguarding need.
(b) Introduce a new universal commitment to transport support for all journeys to and from renal dialysis, offering access to appropriate specialist transport, non-specialist transport or simple and rapid reimbursement of patient costs, planned through shared decision making.

(c) Reinforce the expectation that people will otherwise be responsible for their own transport, while allowing discretion where treatment or discharge may otherwise be significantly delayed or missed.

Specific proposals for consultation are published alongside this report. Subject to this consultation, we expect that they will be incorporated into new contracts from April 2022 and existing contracts from April 2023.

(ii) **Support for wider transport planning and journeys for all patients**. We propose to:

(a) Significantly simplify the process for accessing the Healthcare Travel Cost Scheme (HTCS) and integrate the scheme far more closely with NEPTS and wider transport co-ordination. The ambition is to process reimbursement in a matter of days, with an absolute maximum of 30 days for valid claims compared to up to 90 days at present.

(b) Ensure, at a minimum, that all patients can access advice on alternative travel options, including community transport.

(c) Support the growth of community transport, particularly volunteer recruitment and integration with transport co-ordination hubs; with innovative approaches developed in three pathfinder areas.

We will seek to implement these changes as rapidly as possible, including working with DHSC to make any legislative changes required to the HTCS by the end of 2023 at the latest.

(iii) **Increased transparency**, to incentivise patient-focused provision and enable greater learning and accountability. This will include:

(a) Model activity measures and **key performance indicators** (KPIs) to allow more consistent monitoring of patient experience, communications and satisfaction, journey delivery and value for money.

(b) A **national minimum dataset** covering key elements of patient journeys including volumes, waiting and journey times for different types of journey. These will be published every six months.

More detailed proposals are available on the FutureNHS Collaboration platform. Following engagement with stakeholders, we will publish the final measures by March 2022 so that the first tranche of national data can be published by the end of 2022.

(iv) A clear path to a **net zero NHS patient transport sector**. The NHS is committed to net zero and therefore is committed to using a fully zero emission fleet across all operations. The NEPTS providers engaged in this review have shared this commitment.

We expect the NHS as a whole to have a fully zero emission fleet ahead of its commitment to become net zero by 2040. Within this, we expect all NEPTS vehicles, except ambulances and volunteers using their own vehicles, to be zero emission by 2035, irrespective of contract duration. To achieve this target a progressive gradual decarbonisation of NEPT vehicles has been agreed, which apply to contracts issued or renewed after the set date below.

Date	Vehicle Emission Targets

From 2021	No immediate changes
From 2023	50% of vehicles used to deliver the contract are of the latest emission standards, ultra-low emission vehicles (ULEV) or zero emission vehicles (ZEV)
From 2026	75% of vehicles used to deliver the contract are ULEV or ZEV, including minimum 20% ZEV
From 2030	100% of vehicles used to deliver the contract are ULEV or ZEV, including minimum 20% ZEV
2035	**100% of vehicles used to deliver the contract are ZEV**

At a later date, NHS England and NHS Improvement will set out plans for when it expects all ambulances to be zero emission; NEPTS providers will need to comply with future plans for ambulances and this will be reflected in further guidance and standards.

(v) **Better procurement and contract management**, to improve service responsiveness and enable investment and innovation we:

(a) are providing initial advice in this report and further best practice principles/proposals on the FutureNHS collaboration platform which we will continue to develop with the sector. We advise that contracts for core specialist provision are agreed for a minimum of five years, comprise of a combination of fixed and variable payments, and that tender processes run for a minimum of 60 days; and that non-specialist provision draws on wider transport markets.

(b) will clarify core standards for specialist and non-specialist provision

(c) introduce model service specifications with specific elements, covering co-ordination, specialist provision, non-specialist provision and reimbursement.

Core standards and model specifications will be available by December 2022 following joint development work with the sector.

Implementation

21. This is a strategic framework to enable local improvement. From April 2022, subject to legislation, NHS ICS bodies would assume responsibility for overseeing NEPTS and transport support more widely.

22. It would be for NHS ICS bodies to determine how best to deliver this responsibility, but we expect that in addition to implementing the five components of the national framework:

- Each ICS body should have a lead officer with responsibility for oversight of non-emergency patient transport.
- In line with the aims of ICSs, healthcare providers should be closely involved in the planning, commissioning and management of services to ensure that transport forms an

integrated part of wider pathway improvements including discharge, outpatient transformation and renal services.

- Oversight and budget management should look at NEPTS delivery, reimbursement, the Healthcare Travel Costs Scheme and wider transport facilitation in the round.
- Each ICS body should consider coordinating with other system-level and regional partners including urgent and emergency transport providers, local authorities and neighbouring ICSs where appropriate.

23. We anticipate that the impact of the above changes will enable significant improvements in patient transport within the same financial resources:

- We consider that the outpatient transformation programme should release at least 4% of NEPTS resources by 2023/24 which can be redirected to address additional resource pressures arising from the updated eligibility criteria, particularly the universal renal transport support offer, and greater use of the HTCS. This is based on a conservative estimate of resources released and engagement with areas on the implications of the new eligibility criteria.
- We also anticipate that productivity should be improved through introduction of longer-term contracts to enable investment, a more differentiated approach between specialist transport, non-specialist transport and reimbursement, and better use of co-ordination to improve utilisation.
- The cost of purchasing and leasing zero-emission vehicles will fall over the next decade, with battery powered electric vehicles expected to reach cost parity with internal combustion engine vehicles by 2030 or earlier.

The delivery of these measures assumes that patient transport services are no longer significantly impacted by the COVID-19 pandemic. If infection prevention and control measures are still in place from April 2022, it is possible that the timetable for the delivery of some actions may need to be reassessed.

24. To support the delivery of the measures set out above, NHS England and NHS Improvement is establishing a dedicated NEPTS Review implementation programme, led by a small team. The team will work closely with transport providers, patient groups, ICSs, and regional teams to deliver these actions. This will include a senior level Implementation Advisory Group, ensuring that the work is supported and challenged by experts and representatives of all these groups with a stake in better patient transport.

APPENDIX C2

Proposed Changes to the Eligibility Criteria for Non-Emergency Patient Transport

The consultation document proposes the follow eligibility criteria for non-emergency patients transport:

(a) Patients have a **medical need** for transport, typically because they:

- require oxygen which they are unable to self-administer during transit;
- need specialised equipment during the journey;
- need to be closely monitored during their journey;
- need to be transferred to another hospital ;
- have a medical condition, have undergone major surgery such as a transplant, and /or the potential side effects of treatment are likely to require assistance or monitoring during their journey;
- reside in a nursing home or hospice without access to suitable transport to healthcare treatment;
- have a medical condition or disability that would compromise their dignity or cause public concern on public transport or in a taxi, and do not have access to appropriate private transport; or
- have a communicable disease, for which travel on public transport or in a taxi is not advised, and do not have access to appropriate private transport.

(a) Patients have a **cognitive or sensory impairment** requiring the oversight of a member of patient transport staff or suitably trained driver, meaning that they:

- have dementia or another mental health condition which requires the assistance of patient transport staff to ensure a safe journey;
- have a confused state of mind, learning / communication difficulties, hearing loss, impaired sight, to such an extent that they are unable to use public transport or a taxi, and do not have a carer who is able to transport them; or
- pose a risk to themselves or others through independent travel. (please note that secure mental health transport for high-risk patients is managed separately from non-emergency patient transport).

(b) Patients have **a significant mobility need** which cannot be met through public or private transport, including the support of available family or friends or a taxi (including available mobility or assisted taxis or community transport provision). Examples are likely to include patients who:

- need to travel lying down for all or part of the journey and/or need a stretcher or sling/hoist for their journey;
- need specialist bariatric provision;
- are unable to self-mobilise (ie unable to stand or walk more than a few steps);

- have been clinically determined as at risk from using public transport due to being immune-compromised, and do not have access to appropriate alternative private transport (personal vehicle or taxi unless taxi travel advised against on clinical grounds); or
- are wheelchair users who do not have access to an appropriate alternative source of transport, do not have a specially-adapted vehicle (or are unable to use the vehicle for that journey), and they require the assistance of patient transport staff to undertake the journey.

(c) Patients are travelling to or returning from **in-centre haemodialysis**, in which case specialist transport, non-specialist transport or rapid reimbursement for private travel will be made available after a shared decision making process to consider the appropriate requirements of the patient.

(d) There is a **safeguarding** concern raised by a relevant professional in relation to the patient travelling independently, which means that the patient requires the oversight of a suitably trained driver or other patient transport member of staff.

(e) In the opinion of an authorised eligibility assessor, no other transport is suitable or available given the patients wider mobility or medical needs, not covered in criteria (a) – (e), and treatment or discharge would be missed or severely delayed as a consequence. Transport options which should be exhausted prior to provision of PTS include:

- the patient's own transport – eg the person does not have a car or would not be able to drive due to medical side-effects of treatment;
- a relative, friend or carer who could help out;
- patient booking their own taxi, including a mobility or assisted taxi – reasonable efforts should be made to book a taxi;
- public transport, including community transport, where the public transport journey is not unreasonably complex or long; or
- transport which people are entitled to as part of funded social care provision or a social security benefit.

APPENDIX D

SUMMARY OF COMPLAINTS

In each case these summaries have been based on the Trust's annual complaints report and the annual quality account.

A. UNITED LINCOLNSHIRE HOSPITAL NHS TRUST

During 2020-2021 ULHT received 520 complaints. However, there were 627 complaints responded to within that period. Of the 627 complaints that were closed, 127 cases were carried over from the previous financial year. The following themes were identified:

Outpatients:

- Delay in appointments
- Poor communication with Patients
- Communication with relatives and carers
- Delay in giving information and result

A&E:

- Lost property
- Poor communication with patient
- Communication with relatives and carers
- Security issues during Covid-19

X-Ray/CT:

- Poor communication with patients
- Cancellations/refusal to undertake X-ray /CT
- Wait for appointment/length of wait

<u>Poor Communication</u>

Poor communication features in all of the above areas. During the Covid-19 pandemic staff on the wards faced competing demands on their time as they tried to balance delivering high standards of care alongside answering calls to family members to provide them with updates. Due to these concerns being raised the Trust has implemented the communication work stream to improve communication with families.

<u>Lost Property</u>

During the Covid-19 pandemic many patients had multiple wards moves and the property lists were not always completed or updated during the moves. This resulted in property being misplaced or lost. The Trust has produced a Patient Property Policy which is to be adopted Trustwide. This will ensure that all patients' property is recorded correctly within

the medical notes and updated if a patient is moved to a different area. This will potentially reduce the number of PALS concerns and Complaints received by the Trust.

Delay in Appointments

During the Covid-19 pandemic numerous patients' appointment were cancelled or rescheduled. Numerous strategies were employed to inform patients and reassure them that their appointment would be rescheduled at a later date. Due to issues with patients having difficulties contacting the appointments department for an update, additional staff have been employed to ensure that calls are being answered and patients are updated accordingly. Appointments letters have also been updated giving contact numbers where they can call to obtain an update.

Changes in Practice from Complaints

Below are some examples of changes that have occurred as a result of complaints during 2020/21:

- Alignment with the Dementia Training Standards Framework set out by NHS Health Education, England. The framework sets out how NHS organisations should care for patients with dementia and aims to support the development and delivery of appropriate and consistent dementia education and training for our staff
- Training was developed for doctors to perform ward based chest drain insertion
- In-house pharmacist in A&E to improve medication compliance
- An Accountability handover document was developed to improve Health Care Support Staff documentation
- Due to consultant to consultant referrals being mislaid and not actioned causing a delay in chemotherapy for patients, a new process has been adopted. The secretary will process the referral letter, which will require the signature and instruction from the consultant. If there is no instruction or signature the secretary will bring this to the attention of the consultant to prevent any near misses and delay in treatment.
- As a result of the delays, Ultrasound are currently undergoing an expansion to incorporate two additional scan rooms. This will allow for an increase of scans to be undertaken.
- Development of an electronic referral system for patients identified with ulcers who require review by diabetic foot team.
- Patient property policy being updated to ensure robust processes for the safekeeping of personal items is adhered to.

B. Lincolnshire Community Health Services

During 2020/21 Lincolnshire Community Health Services NHS Trust (LCHS) received 123 formal complaints compared with 233 during 2019/20, a decrease of 48%. The primary theme of access to treatment or medication continues to be the top, followed by patient-care. The table below provides a breakdown of the complaints received by subject.

Complaint by Subject	**Number**
Access to Treatment or Drugs	42
Patient Care (including Nutrition / Hydration)	36
Values and Behaviours of Staff	14
Privacy, Dignity and Wellbeing	12
Admissions, Discharge and Transfers	6
Communications	6
Waiting Times	2
End of Life Care	1
Integrated Care	1
Other	1
Prescribing Errors	1
Trust Administration	1
TOTAL	123

<u>Improvement Opportunities for 2021-22</u>

LCHS has identified areas where they can continue to improve the service, which include:

- Complaints team will continue to roll-out the training piloted in April and May of this year across the Trust to improve patient and community experience of LCHS services as well as supporting teams to develop their responses to concerns and complaints.
- LCHS will, and the committee are asked to support and champion, the patient partners and volunteering services developments as well as encouraging LCHS staff and patients to share their experiences so we can learn and improve the care we provide.
- Review options for capturing protected characteristics data from persons wanting to raise concerns and complaints.

C. Lincolnshire Partnership NHS Foundation Trust

During 2020/21 Lincolnshire Partnership NHS foundation Trust recorded a total of 150 complaints

Complaint by Subject	**Number**
Communication	42
Access to Services	36
Values & Behaviours of Staff	30
Admissions & Discharge	10
Patient Care	10
Clinical Treatment	9
Appointments	4
Prescribing Errors	3
Restraint	2
Commissioning Services	1
Privacy & Dignity	1
Waiting Times	1
Other	1
TOTAL	**150**

D. Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) received 290 formal complaints during 2020/21, which represented a 26% decrease from the previous year.

Learning Lessons

The following learning identified through the complaints process is shown below through examples:-

- Patient underwent surgery in Hull and to the plan was to receive follow up care at Scunthorpe General Hospital, but the referral from Hull was not received and the patient was lost to follow up.
  Learning – to prevent this happening again the two Trusts are working together to develop an electronic referral process.

- Recurring Trust wide theme in complaints about communication
  Learning - Multiple methods of sharing learning are currently in use, including ward newsletters, team meetings and individual conversation. The Trust Learning Lessons Newsletter will contain detailed examples of poor communication and the impact on patients and their families.

- Surgical pathway incorrectly closed by Data Quality
  Learning- Investigation identified individual learning and need for cross checking of all pathway data open.

- Failure of breast reconstruction
  Learning – Introduction of oncoloplastic multi-disciplinary team, and psychology involvement introduced preoperatively .This will improve the patient pathway.

D. North West Anglia NHS Foundation Trust

The figures set out in the table below are based on the records of NHS Digital and show the number of complaints by subject for 2020/21.

Complaint by Subject	**Number**
Integrate Care	324
Communication	195
Values & Behaviours of Staff	87
Admissions & Discharge	35
Privacy & Dignity	29
Waiting Times	26
Access to Treatment or Drugs	21
Appointments	15
Facilities Services	7
Trust Administration	6
End of Life Care	5
Patient Care	3
TOTAL	**753**

As stated in the Trust's quality account, it continues to use feedback from surveys and complaints to address areas of performance which fall short of their standards.

E. East Midlands Ambulance Services NHS Trust

During 2020/21, the East Midlands Ambulance Service NHS Trust (EMAS) received 58 formal complaints requiring investigation compared to 132 in 2019/20, a reduction of 74. Of the 58 complaints, eight related to Lincolnshire. The subject matter of the 58 EMAS complaints was as follows:

- 46 related to accident and emergency services
- 1 related to non-emergency patient transport (EMAS provides this service in Derbyshire and Northamptonshire)
- 11 were trust wide

The three general themes related to:

- attitude of staff
- quality of care
- delayed response to the patient

General approaches to learning from serious incidents and formal complaints include:

- communication of key learning points through education, training, communication and awareness;
- clinical case reviews and reflection of the practice by individuals;
- amendment to policies, procedures and practices;
- themes being reviewed by the incident review group which consists of multi-disciplinary membership; and
- shared learning incorporated in learning from events sessions.