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:	**9 November 2022**
Subject:	**Chairman's Announcements**

1. Information Previously Requested - 12 October 2022 Meeting

East Midlands Ambulance Service (EMAS)

(a) New Entrants – During the remainder of the current financial year, EMAS Lincolnshire Division has twelve newly qualified ambulance technicians, and fourteen newly qualified paramedics due to begin their employment.

(b) Mutual Aid to and from Other Divisions of EMAS - Mutual aid (divisional 'drift') is calculated by comparing the number of hours the other divisions (Nottinghamshire, Leicestershire, Derbyshire and Northamptonshire) have supported Lincolnshire against the number of hours Lincolnshire has supported other divisions. If the number is negative, then Lincolnshire has given more in hours than it has received. If the number is positive, then Lincolnshire has received more that it has given out. The following table shows that since Quarter 2 of 2021, Lincolnshire Division has been in receipt of more support from other divisions than it has provided in return.

Hours	2021				2022	
	Q1	Q2	Q3	Q4	Q1	Q2
Lost (-) or Gained (+)	-734	+33	+230	+457	+301	+390

Lakeside Health Care, Stamford

Following consideration at the last meeting, a series of written questions were submitted to NHS Lincolnshire Integrated Care Board. These will be circulated separately to members of the Committee.

2. Nuclear Medicine at United Lincolnshire Hospitals NHS Trust

On 13 April 2022 the Committee approved its response to the consultation by United Lincolnshire Hospitals NHS Trust (ULHT) on its proposals for its nuclear medicine service. On 4 October 2022, the Board of ULHT considered the outcomes of the consultation and decided to move to a single-site model of care, based at Lincoln County Hospital.

Nuclear medicine uses small doses of radioactive substances (radiopharmaceuticals) in the diagnosis and treatment of diseases. Unlike conventional imaging, such as x-rays, nuclear medicine enables assessment of the function of organs, using up to twenty different tests. Nuclear medicine uses a gamma camera to detect the radiation in the patient.

Currently nuclear medicine is provided at all three of ULHT's main sites to approximately 3,200 patients each year. The main reasons for the consultation were:

- recruitment challenges for this highly specialised field;
- the age profile of the existing workforce, with 23% due to retire within five years;
- medical physics experts covering work which could be covered by staff in a lower grade;
- the robustness of the workforce located across three sites, in terms of sickness and leave;
- the five gamma cameras across the three sites not being fully used; and
- the age of the five gamma cameras, with two cameras at risk of a serious fault.

The consultation had set out two options: (1) the centralisation of the service at Lincoln County Hospital; and (2) the centralisation of the service at two sites: Lincoln County Hospital and Pilgrim Hospital, Boston

The Health Scrutiny Committee in its response did not support either option, as it was not convinced that the centralisation of the service would solve all the issues set out above, such as improving recruitment and retention and the age profile of the workforce. Furthermore, two new gamma cameras would be required in either option.

On 2 October 2022 the ULHT Board approved option (1), after considering a summary of all the consultation responses, as part of a decision report. The projected timeline, as reported to the Board, envisaged closing the service at Pilgrim Hospital from January 2023. This would mean about 80 patients per month would be required to use the service at Grantham or Lincoln as the alternative. From September 2023, the service would close at Grantham (depending on the installation of a third camera at Lincoln). This would mean 130 patients per month accessing the service at Lincoln, instead of Boston and Grantham.

It is proposed that an update on the implementation is brought to the Committee six months after the closure of the service at Pilgrim Hospital, Boston, as although the new arrangements would not be fully implemented, a significant number of patients would be using an alternative service.

3. Lincolnshire Long Covid-19 Information Hub

On 19 October 2022, a Lincolnshire long Covid information hub was announced. This digital resource is available for people suffering with the effects of long Covid, together with their friends and families. The hub provides guidance and information on long Covid to help people with symptom management and signpost them to further help. The Office for National Statistics states that the overall prevalence of long Covid remains high: 1.6 million people in England are estimated to have self-reported long covid symptoms lasting longer than four weeks, with 1.2 million reporting symptoms lasting longer than twelve weeks. The most common symptoms of long Covid are fatigue, shortness of breath, loss of smell and muscle aches.

The hub is available at the following link: Long Covid Information Hub | Lincolnshire (connecttosupport.org)

The long Covid information hub was developed by organisations in Lincolnshire, including Lincolnshire Community Health Services NHS Trust; Connect to Support Lincolnshire *(an online community advice directory)*; Every-One *(a Lincolnshire registered charity)*; and NHS Charities Together *(a national independent charity caring for the NHS).* People with long Covid were also involved in the hub's development.

4. Humber Acute Services Programme – Confirmation of Delay to Consultation

Further to my supplementary announcements at the last meeting, on 12 October 2022, the Chief Executive of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) has confirmed the planned change to the timing of the consultation on the Humber Acute Review, which will now take place after the local government elections in May 2023.

The Chief Executive of NLaG stated that the NHS Humber and North Yorkshire Integrated Care Board has made this decision, taking into the following factors:

- the changes to the political environments and NHS structures, including a new Secretary of State and the recently established integrated care boards;
- the continued uncertainty on the availability of capital funding for changes and improvements to buildings and infrastructure;
- the ability of the local community and staff to take part in a meaningful consultation process in what is expected to be a challenging winter for everyone; and
- making sure third parties, such as NHS England, have time to complete their technical and legal requirements.

NLaG states that in the next few months, it will continue to talk to staff, the public and community groups and ensure it is exploring the impacts of any potential changes.

5. Care Quality Commission – The State of Health Care and Social Care in England 2021/22

On 21 October 2022, the Care Quality Commission published its annual report on the State of Health Care and Social Care in England. The report has been emailed to members of the Committee and is available at the following link: State of Care - Care Quality Commission (cqc.org.uk)

In its own summary the CQC states the report focuses on cross-cutting themes rather than sector-specific findings, but highlights that as at 31 July 2022:

- 96% of GP practices were rated as good or outstanding.
- 75% of NHS acute core services were rated as good or outstanding.
- 77% of all mental health core services were rated as good or outstanding.

The CQC states that most people are still receiving good care when they can access it, but too often people cannot access the care they need. Only two in five people are able to leave hospital when they are ready to do so, contributing to record-breaking waits in emergency departments following a decision to admit, and dangerous ambulance handover delays.

The CQC also states that health staff want to provide good, safe care but struggle in a gridlocked system. This is reflected in growing public dissatisfaction with health services, which is mirrored in staff dissatisfaction. More staff than ever before are leaving health care and providers are finding it increasingly challenging to recruit, resulting in alarmingly high vacancy rates. Without action now, staff retention will continue to decline across health and care.

The CQC argues that people will be at greater risk of harm as staff deal with the consequences of a lack of access to community services, especially in areas of higher deprivation where access to care outside hospitals is under most pressure. In addition, the CQC states that people will be forced out of the labour market either through ill health or because they are supporting family members who need care.

The CQC refers to solutions only coming from long-term planning and investment, with local areas taking a whole system view that recognises the causes of the problems. Local leaders need to bring together data and information from providers and agree success measures that are focused on people's overall experience of care.

The CQC also highlights its concerns about specific service areas, in particular maternity services and services for people with a learning disability and autistic people, where the CQC continues to find issues of culture, leadership, and a lack of genuine engagement with service users. In response to the national challenges faced by maternity services, CQC has begun a new maternity inspection programme, which aims to help services improve, both at local and national level. Next year, the CQC's continuing its programme of focusing on services for people with a learning disability and autistic people, by looking at residential mental health settings.

6. Care Quality Commission – New Regulatory Model

The Care Quality Commission (CQC) has been developing a new regulatory model and on 27 October 2022 issued an update on its new approaches. The CQC has highlighted the following:

Gathering Evidence - The CQC will make much more use of people's experiences of care services and will gather evidence to support its judgements in a variety of ways and at different times – not just through on-site inspections. This means on-site inspections will support this activity, rather than being its primary way to collect evidence.

Frequency of Assessments - The CQC will no longer use a service's rating as the main driver when deciding when we next need to assess. Evidence collected or information received at any time may trigger an assessment.

Assessing Quality - The CQC will make judgements about quality more regularly, instead of only after an inspection as currently. The CQC will use evidence from a variety of sources and look at any number of quality statements to do this. Its assessments will be more structured and transparent, using evidence categories as part of the assessment framework and giving a score for its findings. The CQC stated that the way it makes its decisions about ratings will be clearer and easier to understand.

Ratings for Services – The four existing ratings (*outstanding, good, requires improvement* and *inadequate*) will continue. Initially the CQC will continue to publish only the rating, but intends to publish a score, which will be open and clearer about how it reached its rating, as well as showing if a service is close to another rating. For example, for a rating of good, the score can show if the service is near to *outstanding* or *requires improvement*.

Full details are available at: Assessing services - Care Quality Commission (cqc.org.uk)

7. The Future of General Practice – House of Commons Select Committee Report

On 20 October 2022, the House of Commons Health and Social Care Select Committee published a report entitled: *The Future of General Practice.* The full report is available at: The future of general practice (parliament.uk). The report's summary has been reproduced in full as at Appendix A to these announcements.

8. Secretary of State for Health and Social Care

On 25 October 2022, the Rt Hon Steve Barclay, MP, was appointed as the Secretary of State for Health and Social Care. He had previously served as Secretary of State from 5 July to 6 September 2022. The ministerial team is as follows:

- Will Quince, MP, Minister of State
- Helen Whately, MP, Minister of State
- Dr Caroline Johnson, MP, Parliamentary Under Secretary of State
- Neil O'Brien, MP, Parliamentary Under Secretary of State
- Maria Caulfield, MP, Parliamentary Under Secretary of State
- Nick Markham, CBE, Parliamentary Under Secretary of State

APPENDIX A

THE FUTURE OF GENERAL PRACTICE

Report from the House of Commons Select Committee on Health and Social Care
20 October2022

The summary from the House of Commons Select Committee on Health and Social Care's report is reproduced below. The full report is available at: [The future of general practice (parliament.uk)]

1. Every working day more than one million people attend an appointment at their local GP surgery: general practice is the beating heart of the NHS and when it fails the NHS fails. We know up to 90% of healthcare is delivered by primary care. Yet currently the profession is demoralised, GPs are leaving almost as fast as they can be recruited, and patients are increasingly dissatisfied with the level of access they receive.

2. The root cause of this is straightforward: there are not enough GPs to meet the ever-increasing demands on the service, coupled with increasing complexity of cases from an ageing population. In May this year there were an estimated 27.5 million appointments in general practice, more than two million more than in 2019. Yet over the same period, the number of qualified, full-time equivalent GPs working in the NHS has declined by nearly 500 from 28,094 to 27,627.[1] This gap between demand and capacity leaves GPs working harder and facing more burnout as patients find it harder than ever to see them.

3. One result of this has been high reliance on the use of locum doctors, and the number of newly qualified GPs choosing to work in such roles rather than as salaried GPs or as partners. This is a symptom rather than the cause of the problem. Urgent work needs to be done to stop a bidding war for the services of locums and establish requirements for a minimum fair share of administrative duties.

4. Alongside worsening access to care, the decline of continuity of care in general practice is one of the most concerning impacts of the pressure on general practice. Since 2004 the majority of GPs have not had individual lists of patients even though there is clear international and UK research showing that seeing the same GP over a long period of time leads to fewer hospital visits, lower mortality and less cost for the NHS. Recent pressures have made it even less likely people will see the same doctor regularly and even more likely for patients to depend on overstretched emergency services. The fundamental division of labour between emergency and non-emergency care has broken down.

5. There can sometimes be a trade-off between access and continuity, and we believe that the balance has shifted too far towards access at the expense of continuity. Seeing your GP should not be like phoning a call centre or booking an Uber driver who you will never see again: relationship-based care is essential for patient safety and patient experience. It is also much more motivating for doctors.

[1] NHS Digital, General Practice Workforce, June 2022 - NHS Digital, 28 July 2022

6. Improving the accountability of care for individual patients through GP lists should not replace the team-based approach that is becoming increasingly important. It will not always be appropriate for GPs to provide care personally when, for example, it could be done so more efficiently by a practice nurse or a physician associate. But from the patient's point of view it should always be clear where responsibility for their care lies, which outside hospital will normally be their GP.

7. The Government and NHS England have made several changes over recent years to help general practice become more sustainable and change the way patients receive care, such as the creation of Primary Care Networks and the introduction of a range of new professionals into general practice. However, our inquiry has found that these developments, while welcome, are not yet making a meaningful impact on the future sustainability of general practice. Instead, we heard that patients can become confused over who they are signposted to and why, leaving GPs dealing with multiple complex cases one after another and as a result, contributing to clinician burnout and concerns by the clinicians they might make mistakes or not be able to practise safely. This combination of intensely complex cases, done at speed, with fear over reprisals on the individual clinician is driving a systemically toxic environment in primary care.

8. Instead, the Government and the NHS should be bolder. We recommend abolishing the Quality and Outcomes Framework (QOF) and Impact and Investment Framework (IIF) which have become tools of micromanagement and risk turning patients into numbers. GPs should be treated like professionals and incentivised to provide relationship-based care for all patients by restoring individual patient lists. The Government's decision to introduce an additional two-week wait target for GP appointments, while well-intentioned, does not address the fundamental capacity problem causing poor GP access.

9. To help achieve this the Government should examine the possibility of limiting the list size of patients to, for example, 2,500 on a list, which would slowly reduce to a figure of around 1,850 over five years as more GPs are recruited as planned. These numbers should reflect varying levels of need in local populations. This would draw us closer in line with our European counterparts, and help improve access and continuity. It should only be implemented in a way that does not undermine the fundamental rights of patients to access a GP.

10. Continuity of care is beneficial for all patient interactions even if it cannot always be offered. It should not therefore be available only for patients with complex needs, because part of the purpose of a long-term relationship between a doctor and patient is to prevent chronic or long-term illness before it happens.

11. Historically one of the key drivers of innovation and improvement in general practice has been the GP partnership model, which gives GPs the flexibility to innovate with a focus on the needs of their local population. We know there are significant pressures on GP partners at the moment but the evidence we received was clear that the partnership remains an efficient and effective model for general practice if properly funded and supported. It is important that the model of general practice can vary according to local needs, so other models of delivery should also continue to be explored where this works for local communities. Whether or not in a partnership model, the professional status of GPs should not be undermined by the inappropriate refusal of GP referral decisions.

12. Rather than hinting it may scrap the partnership model, the Government should strengthen it. For GP partners at the end of their careers, one of the biggest barriers to staying on longer is the huge pensions tax bills that many face. We continue to call for the Government to take specific action to allow senior doctors, including GPs, to carry on working without facing these tax bills. We welcome the focus on this issue in the Government's *Plan for Patients*, but the Government must provide further detail on what changes it will introduce. Partnerships as entities also need support with complex issues around premises they own which may not be fit for purpose. The Government should consider adopting the approach taken on this issue in Scotland which allows a route for GP partners to remove the property risk from their businesses.

13. As part of a broader overhaul of primary care, the NHS should dramatically simplify the patient interface. Currently patients with urgent care needs are left wondering whether to call their surgery, the out of hours service, 111 or to go to A&E. Many people are not clear about the difference between such services and the most appropriate option, further adding to the pressures on general practice.

14. We also heard very clearly that the issues facing general practice are not equal everywhere in the country. In some parts of the country challenges such as workforce shortages are significantly more acute, and these are often areas where there are already higher levels of ill-health and deprivation. The Government and NHS England must develop a better mechanism to award funding to more deprived areas to replace the Carr-Hill formula which is insufficiently weighted for deprivation at present. This funding change should be used to support further work to ensure equal access to general practice across the country.

15. Finally, it is time to recognise the need to make the job not just manageable but once again fulfilling and enjoyable. General practice really should be the jewel in the crown of the NHS, one of the services most valued by its patients. For doctors it should allow a cradle to grave relationship with patients not possible for other specialties but for many infinitely more rewarding. To do that general practice needs to have its professional status restored with a decisive move away from micromanagement and short staffing to a win-win environment in which investment in general practice reduces pressure on hospitals and saves resources for the NHS.

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