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

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 21 December 2016 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

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

District Councillors: G Gregory (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), J Kirk (City of Lincoln Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and 1 Vacancy (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
6	**Lincolnshire Sustainability and Transformation Plan** *(To receive a report from Simon Evans (Health Scrutiny Officer) which provides the Public Summary Document of the Lincolnshire Sustainability and Transformation Plan (STP) and invites the Committee to give initial consideration to the content of the STP and to consider a response to the engagement phase of the STP. Andrew Morgan (Chief Executive, Lincolnshire Community Health Services NHS Trust), Gary James (Accountable Officer, Lincolnshire East Clinical Commissioning Group) and Sarah Furley (Programme Director, Lincolnshire Sustainability and Transformation Plan) will be in attendance for this item)*	73 - 102
7	**Work Programme** *(To receive a report by Simon Evans (Health Scrutiny Officer) which invites the Committee to consider its' work programme for the coming months)*	103 - 108

Tony McArdle
Chief Executive
13 December 2016

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
23 NOVEMBER 2016

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

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

Lincolnshire District Councils

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

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Liz Ball (Executive Nurse, South Lincolnshire CCG), Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Alison Christie (Programme Manager, Health and Wellbeing Board), Simon Evans (Health Scrutiny Officer), Jane Green (Assistant Contract Manager for Dental and Optometry, NHS England), Dr Peter Holmes (Chairman, Lincolnshire East CCG), Gary James (Accountable Officer, Lincolnshire East CCG), Dr Suneil Kapadia (Medical Director, United Lincolnshire Hospitals NHS Trust), Tracy Pilcher (Chief Nurse, Lincolnshire East CCG), Jan Sobieraj (Chief Executive, United Lincolnshire Hospitals NHS Trust), David Stacey (Programme Manager, Public Health), Kevin Turner (Deputy Chief Executive, United Lincolnshire Hospitals NHS Trust) and Jason Wong (Chair, Local Dental Network, NHS England)

County Councillors R G Davies, M J Hill OBE, B W Keimach, D C Morgan, M A Whittington, Mrs S Woolley, L Wootten and R Wootten attended the meeting as observers.

40 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor Mrs E L Ransome.

There were no replacement members in attendance.

41 DECLARATIONS OF MEMBERS' INTERESTS

Councillor Mrs C A Talbot advised the Committee that she remained a patient of University Hospitals Nottingham but was also under the care of a team of nurses, on a regular basis, at United Lincolnshire Hospitals NHS Trust, which would be discussed under Item 7 – *United Lincolnshire Hospitals NHS Trust 2021 Strategy and Change Programme.*

42 CHAIRMAN'S ANNOUNCEMENTS

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

i) Wainfleet GP Surgery – Temporary Suspension of Registration

On 10 November 2016, the Care Quality Commission (CQC) temporarily suspended its registration of Wainfleet Surgery for a period of three months due to concerns for patient safety. The 2,200 patients on the Wainfleet list had been advised to register temporarily with other local GP practices, such as Hawthorn Medical Practice in Skegness.

Lincolnshire East Clinical Commissioning Group had provided support to the Wainfleet Surgery and further information on the role of the CCG in supporting the surgery and its patients would be provided to the Committee as part of Item 8 – *Lincolnshire East Clinical Commissioning Group Update.*

ii) Meeting with Lincolnshire West Clinical Commissioning Group

On 8 November 2016, the Chairman met with Richard Childs (Chairman), Dr Sunil Hindocha (Chief Clinical Officer) and Sarah Newton (Chief Operating Officer) of Lincolnshire West Clinical Commissioning Group. The discussion included the inspection of GP practices by the Care Quality Commission and the CCGs financial position.

iii) Working Group Meetings

The Chairman thanked eight Members of the Committee who had participated in the two working group meetings in the last month. On 2 November 2016, Councillors D Brailsford, R L Foulkes and T M Trollope-Bellew attended a working group at Stamford and Rutland Hospital which responded to the full business case for the merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust.

On 10 November 2016, Councillors C J T H Brewis, Mrs R Kaberry-Brown, J Kirk, R C Kirk and Mrs J M Renshaw attended the working group which responded to the Medicines Management Consultation.

The full responses were set out, for information, under Item 11 – *Work Programme and Responses to Consultations.*

iv) Final Business Case for the Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust

Further to the submission from the working group on the Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust, Board papers for both Trusts had been issued for meetings taking place in the following week and these papers included the Committee's submission. Each Board was expected to ratify the proposed merger on the basis of the business case.

v) Sustainability and Transformation Plans

As at 22 November 2016, it was understood that 30 of the 44 Sustainability and Transformation Plans (STPs) had been published. On 21 November 2016, the Chairman had received a copy of the Cambridgeshire and Peterborough STP which, like the other published STPs, was a five year strategy document rather than a consultation in its own right. The Cambridgeshire and Peterborough STP contained a commitment for public consultation, where necessary, on substantial variations to services.

The Chairman reported that there was an intention to publish the Lincolnshire STP no earlier than 8 December 2016 (the date of the Sleaford and North Hykeham by-election) and it was expected that an item would be included on the Committee's agenda at an appropriate time.

vi) Repeat Prescription Arrangements in Lincolnshire West Clinical Commissioning Group Area

On 21 November 2016, Lincolnshire West Clinical Commissioning Group announced a change to its arrangements for repeat prescriptions. Patients who chose to use a pharmacy to order repeat medicines on their behalf would instead be asked to order these prescriptions directly from their GP Practice. Designated carers, relatives or friends could also order on the patient's behalf.

NHS Lincolnshire West Clinical Commissioning Group stated that this would make prescribing safer and more cost efficient as some patients had acquired excessive stocks of unused medicines which needed to be stored safely and used within their expiry date. In extreme situations, patients had medicines which would last for months or even years, however the new system would enable GPs to keep a much closer eye on actual medicine usage by patients.

vii) Proving Nationality to Attend NHS Appointments

The House of Commons Public Accounts Committee had been considering how the NHS could recover costs from overseas patients who used its services. On 21 November 2016, Chris Wormald (the Permanent Secretary to the Department of Health) as part of his evidence to the Public Accounts Committee, cited Peterborough and Stamford Hospitals NHS Foundation Trust as an example of a Trust where patients who attended certain clinics were required to present a passport and one other form of identify in order to be treated. More information had been requested from the Trust but media reports suggested that the Trust had significantly increased this category of income since introduction of these arrangements in 2012.

viii) Lincolnshire Health and Care (LHAC)

A meeting had been arranged to take place on 8 December 2016 to discuss the LHAC. The Chairman advised that this meeting had been deferred to 25 January 2017.

43 MINUTES OF THE PREVIOUS MEETING OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE HELD ON 26 OCTOBER 2016

Councillor Mrs J M Renshaw advised that her name had been omitted from the minutes under minute number 37. Councillor Mrs Renshaw had indicated at the meeting that she would also participate in the working group to formulate a formal response to the Medicines Management Consultation. It was agreed that the minutes be amended to reflect this addition.

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 26 October 2016, with the amendment noted above, be approved and signed by the Chairman as a correct record.

44 LINCOLNSHIRE HEALTH AND WELLBEING BOARD ANNUAL ASSURANCE REPORT

Consideration was given to a report by Tony McGinty (Interim Director of Public Health) which provided information on current activity to ensure that the Health and Wellbeing Board was meeting its statutory duties in respect of developing the new Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Board Strategy (JHWS).

Councillor Mrs S Woolley (Executive Councillor for NHS Liaison and Community Engagement; and Chairman of the Lincolnshire Health and Wellbeing Board), Alison Christie (Programme Manager – Health and Wellbeing) and David Stacey (Programme Manager – Strategy and Performance) were in attendance for this item.

Under the Health and Social Care Act 2012 Health and Wellbeing Boards (HWB) were required to publish a Joint Strategic Needs Assessment (JSNA) for the local area. The protocol agreement, signed between the Lincolnshire Health and Wellbeing Board, Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire in December 2014, set out the working relationship and respective roles in delivering the shared ambition of improving health and wellbeing in Lincolnshire.

The Health and Wellbeing Board was established in April 2013 as a strategic forum bringing together key leaders from the health, public health and care systems to work together to improve the health and wellbeing of the people of Lincolnshire.

The current format of the JSNA had been in place since 2011 and a programme of review was agreed by the Board in March 2015. The Committee contributed to the engagement exercise by submitting a formal response in December 2015.

Stakeholder feedback received during the review had highlighted a number of weaknesses in JSNA processes in addition to a wide variation in the levels of awareness and use of the JSNA itself. A number of respondents reported that they were either unaware of the JSNA or had not used the document and buy-in across partners had also been inconsistent as many perceived this as the responsibility of Public Health with little awareness of the statutory nature of the JSNA.

Based on this feedback, the HWB agreed the review approach based around topic expert panels using the current JSNA as the starting point for the fundamental review which began in April 2016. Expert Panels, made up of appropriate representatives from the County Council, Clinical Commissioning Groups, health providers, District Councils and voluntary and community sectors had been set up to support Topic Leads to undergo a refresh of each of the topics. A dedicated Data Analyst had supported the process along with the JSNA Support Officer.

In addition, a multi-agency JSNA Strategic Delivery Group (JSNA SDG) had been established by the HWB to steer the review process and approve changes to the JSNA prior to its publish in Spring 2017. This included a Peer Review process which would ensure that each topic commentary met the agreed set quality standard before approval was given by the JSNA SDG.

The current Joint Health and Wellbeing Strategy (JHWS) was scheduled to end in 2018 and the review of the JSNA was expected to form the basis on which a new JHWS would be developed. Proposed principles for the development of the next JHWS were presented to the HWB in June 2016 in addition to a draft prioritisation framework.

The following core principles for developing the next JHWS had been agreed by the HWB in June 2016 to assist in achieving the adoption of the prioritisation framework:-

1. Stakeholder engagement;
2. A clear and transparent process;
3. Careful information management;
4. Decisions based on clear value choices; and
5. Selection of agreed prioritisation methodology which takes into account the ranking/scoring of a range of factors or 'criteria'.

Final amendments to the prioritisation framework had been made following the meeting of the HWB on 27 September 2016 and had been included at Appendix B to the report for the Committee's consideration.

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

- It was explained that the JSNA was an interactive website and not a specific document and therefore continually updated with new information and data as it became available. It was also an evidence base to underpin the strategy and commissioning plan;

- Where reference was made to specific local policies within the topics, the framework had been written in such a way that those policies would be included for consideration as part of that topic;
- Each topic required completion of a template, which included access to services and rurality of the county. This would then be evidenced within each topic line;
- A suggestion was made that one District Councillor on the Health and Wellbeing Board was not sufficient to represent all District Councils in Lincolnshire. In response it was stated that the Health and Wellbeing Board operated on the basis that the district council representative cascaded relevant information to other district council colleagues;
- Concern was noted that the JSNA contained a lot of "jargon" and was not user friendly for the general public or Councillors representing residents. Work was ongoing to develop a more user friendly document and to include more infographics;
- The Committee was reminded that the Health & Wellbeing Board was a Committee of Lincolnshire County Council and was held in public and relevant paperwork made available;
- The Chairman requested that the sentence on page 18 of the agenda pack be explained – *"The framework itself performed in a fairly consistent way following sensitivity analysis and so is judged to be fit for purpose from this perspective."* It was clarified that this sentence referred to a piece of analysis done on the framework where the topics were scored independently of each other;

At 10.45am, Councillor T Boston (North Kesteven District Council) joined the meeting.

- The workshops had received a broad section of representatives from across the districts, both individuals and elected members. The Committee stressed that the workshops needed more notice to ensure good attendance and felt that this had not been given previously;
- The Committee accepted the offer to consider the JSNA as a working group and it was suggested that from June 2017 onwards would be the most appropriate time to undertake this. In the meantime, it was agreed that an update would be presented at the February meeting of the Committee.

RESOLVED

1. That the fundamental review of the Joint Strategic Needs Assessment be noted;
2. That the Joint Health and Wellbeing Strategy Prioritisation Framework be noted; and
3. That a further update be presented to the Committee at its meeting in February 2017.

45 EMERGENCY CARE SERVICES AT GRANTHAM DISTRICT HOSPITAL

The Chairman reported the findings of research undertaken prior to the meeting in order to assist the Committee with their consideration of this item:-

- In 2007, Lincolnshire Primary Care Trust (PCT) held a consultation entitled *Shaping Health for Lincolnshire*, which included a proposal for a network of two major A&E Departments (Lincoln County and Pilgrim Hospitals) which were to be supported by other A&E Departments and minor injury units. This proposal was opposed by the Health Scrutiny Committee for Lincolnshire but supported by 88% of respondents to the consultation. Lincolnshire PCT adopted the proposal in November 2007. It was understood that the main effect was the restriction of stroke admissions at Grantham;
- A subsequent consultation in 2013 entitled *Shaping Health for Mid Kesteven* included a commitment to Grantham A&E, but did not put any further restrictions on the types of patients, which may be received at Grantham A&E, other than putting a GP into Grantham A&E, and linking the A&E with the out-of-hours service; and
- It was understood that patients who required emergency surgery and certain paediatric emergencies had not been treated at Grantham A&E since at least 2002. One of the key issues to be addressed was the definition of a Level 1 A&E and the difference between a Level 1 and a minor injuries unit.

The Chairman made a statement reminding all present that the purpose of the Committee was to scrutinise NHS Healthcare; and the Health and Wellbeing Board and their services and outcomes and not for the Committee to criticise individuals to stray in to matters which were the proper remit of other organisations, such as employment issues.

In accordance with the County Council's Constitution, the following local Councillors expressed their wish to speak:-

- Councillor D C Morgan (Grantham South);
- Councillor R Wootten (Grantham North);
- Councillor R G Davies (Grantham North West); and
- Councillor L Wootten (Grantham East).

A request was made to the Chairman, by Councillor R G Davies, to allow a spokesperson from the "Fighting 4 Grantham Hospital" campaign group to address the Committee also. The Chairman granted the request and invited Melissa Darcey to join the meeting.

Following the accepted convention, local members and the member of the public would be allowed to speak for up to three minutes.

The Chairman then invited Councillor D C Morgan to address the Committee, during which the following points were noted:-

- In addition to her role as a local member for Grantham, Councillor Morgan confirmed that she was also the Chair of SOS Grantham Hospital and, in total, represented approximately 6000 residents in Grantham town centre area;
- Immediate reinstatement of 24/7 services at Grantham A&E Department was sought;
- A request was made that the Committee scrutinise the reasons given by United Lincolnshire Hospitals NHS Trust to close Grantham A&E Department overnight;
- A review in to the information submitted to NHS Improvement for approval of this temporary closure was requested; and
- In relation to the impact of the closure, research undertaken by SOS Grantham Hospital found that the closure posed a higher risk to more people in the local area than suggested by the assessment information provided by ULHT.

Councillor R Wootten was invited to address the Committee, during which the following points were noted:-

- Councillor Wootten advised the Committee that he addressed the Committee on behalf of himself, Councillor M A Whittington (Grantham Barrowby), Councillor B Adams (Colsterworth Rural) and Councillor M J Hill (Folkingham Rural);
- Two public rallies had taken place in protest at the closure and 41,000 people had signed a petition to support its re-opening;
- 30,000 Grantham residents were seen at Grantham A&E last year, 5,000 of which were admitted for further treatment;
- The Trust were urged to retain services as ambulances were already waiting longer than expected;
- The people of Grantham were being expected to travel up to 30 miles to access the nearest A&E;
- GP appointments could take up to four weeks so it was unsurprising that A&E attendance had increased;
- A document had indicated that there were no plans to downgrade the services at Grantham A&E and Councillor Wootten asked why this had changed;
- Having attended the ULHT Board meeting in Boston on 1 November 2016, it had been disappointing to find that the closure would be extended to February 2017 without any public consultation; and
- The Committee was requested to do all that was necessary to rectify the situation.

Councillor R G Davies was invited to address the Committee, during which the following points were noted:-

- The personal impact on residents and families of Grantham, in particular those with children, was highlighted; and
- It was suggested that a number of untruths had been shared with residents on numerous occasions which had resulted in the perception that these were, in fact, truths.

The Chairman invited Councillor L Wootten to address the Committee, during which the following points were noted:-

- As the largest town in Lincolnshire with continuous growth, many industrial estates and the A1 corridor and the East Coast Mainline running through it, it was felt that services in Grantham A&E should be extended rather than reduced or withdrawn;
- Grantham had areas of deprivation, as did many parts of the county, and the Committee was asked to consider why residents should travel to other A&E departments at their own, great, expense;
- It was noted that Neighbourhood Teams were still unavailable which further impacted on healthcare provision for these residents; and
- The Committee was urged to give their understanding, compassion and support in reinstating these services to Grantham.

Melissa Darcey was invited to address the Committee, during which the following points were noted:-

- A Facebook page had been set up by the campaigners which had become a source of support to the community over the last two months. It was reported that residents had been contacting them worried, scared and unable to access emergency care at all hours of the night;
- Having attended the ULHT Board meeting in Boston, in November, the group had been disappointed with the perceived lack of consideration given to the issues faced by Grantham residents resulting in the overnight closure being extended; and
- A plea was issued to ULHT to realise the actual impact on real people of their actions. ULHT were also requested not to label the campaigners as 'scaremongers' and to consider the 'real' concern for the people of Grantham.

A report by Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust (ULHT)) was then considered which provided details of the decision made on 2 November 2016, by the Trust Board of ULHT, for the partial closure of the A&E Department at Grantham and District Hospital to continue for a further three months, at least.

Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust (ULHT)) and Dr Suneil Kapadia (Medical Director – United Lincolnshire Hospitals NHS Trust (ULHT)) were in attendance for this item.

It was stressed that the decision to close Grantham A&E Department between 6.30pm and 9.00am had been taken by the ULHT Board. The role of NHS Improvement was to ensure that the correct procedures had been followed in making the decision but not to confirm the decision itself.

The Committee was advised that the reduction in opening hours at Grantham and District Hospital had enabled the A&E Department at Lincoln County Hospital to be supported up to an additional 85 hours per week by middle grade and consultant staff from the A&E Department at Grantham and District Hospital.

It was reiterated to the Committee that all options had been considered with an aim to deliver a safe service for all three Emergency Departments at ULHT. The provision of these emergency services, particularly at Lincoln County Hospital, remained fragile and, on the grounds of patient safety, required the continued support of A&E medical staff from Grantham and District Hospital.

A threshold of 21wte (whole time equivalent) middle grade doctors had been set as the minimum level required to safely staff all three A&E Departments (Lincoln, Pilgrim and Grantham) when the decision was made to reduce the opening hours of Grantham A&E Department. The report demonstrated that the recruitment drive had identified the potential to reach this threshold but not until February 2017 and further anticipated that a further period of induction to enable new recruits to become fully operational would be required.

The ULHT Trust Board had considered the following four options for the A&E Department at Grantham and District Hospital:-

1. To reinstate a 24 hour Accident & Emergency Department at Grantham and District Hospital;
2. To keep the current opening hours of 0900-1830;
3. To extend the opening hours beyond its current position;
4. To reduce the opening hours from its current position.

Since the report was published, the Committee was provided with the following points to note:-

- Although the temporary closure was regrettable, ULHT urged the Committee not to confuse the expected content of the Sustainability and Transformation Plan (STP) and Lincolnshire Health and Care (LHAC) document with the action taken in this case;
- Lincoln County had received applications from ten middle grade/consultant candidates, of whom four had been offered positions. The successful candidates would be required to undergo an English exam, receive validation from the General Medical Council (GMC) and produce the necessary visas. This process meant that the earliest these posts would be filled would be January/February 2017;
- Concerns raised about children being in the department after 9pm when the last shift ended had been addressed. This had now been extended to 10pm and procedure implemented where a consultant would remain with the child until transfer to another facility was undertaken; and
- Page 48 of the agenda pack suggested that Lincolnshire Police had used 78 hours of police hours on eight occasions where they would have normally used Grantham. This statement had been made by Lincolnshire Police and ULHT was seeking further information on the breakdown of those hours.

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

- A list of services not provided by Grantham A&E Department during normal opening hours included multiple trauma, cardiac conditions, strokes, GI

bleeds, acute surgical emergencies, maternity and paediatrics (although children would be seen, GPs were advised not to refer to an A&E Department routinely). The exclusion protocol had been included within the agenda pack and could be found on page 53;

- It was reiterated that ULHT had not taken this decision lightly and agreed that it was not an ideal solution. However, it was deemed to be the least worst option when the presenting factors were considered in July and August 2016 and accepted that some patients would have had a poor experience as a result;
- Some members understood the frustrations of residents in the Grantham area but also recognised the issue of patient safety and the risk involved in keeping a department open without the minimum level of doctors;
- The appointment of doctors was a complex issue due to the many factors involved throughout the application and appointment process. Assurance could not be given that doctors would be in post in January and February 2017 but that the Trust continued with their endeavours to do so;
- The report of the Royal College of Physicians (RCP) in September 2016 indicated that recruitment difficulty was a national issue and one which meant that the market was extremely competitive, giving doctors choice in positions available. Despite the financial pressures faced by ULHT, money was being spent in all areas of recruitment to increase the number of doctors available in order to reopen Grantham A&E;
- It was stated that the intention was to reopen Grantham A&E and that all efforts would be made to reach that goal. It was clarified that the status quo prior to 16 August 16 would be implemented once the department was reopened;
- All relevant organisations had been made aware of the situation posed across all three A&E Departments which resulted in the action taken. It was stressed that the only reason the hours of the department had been temporarily reduced was due to the lack of qualified staff to sufficiently cover all three departments;
- There had been a shift in services over the last 20 years and therefore it was inappropriate to react to the public demand to reinstate services which had not been in place since 2010 or, in some cases, 2002;
- A shortage of nurses, therapists and medical staff was prevalent across the NHS as a whole and the challenge continued to encourage people to choose a career in the NHS as they would contribute to the community whilst developing as an individual;
- It was suggested that the number of junior medical staff (trainees) moving in to secondary care (hospitals) was likely to decrease further and the intent was to alter training to give greater emphasis to the community;
- Although recruitment remained a key issue, it was reported that the retention rates for the Trust were good although could be improved. A Lincolnshire-wide strategy was being developed to attract and encourage more people to live and work in Lincolnshire.

RESOLVED

1. That the closure of Accident and Emergency Services between 6.30pm and 9.00am at Grantham and District Hospital be deemed a substantial variation in the provision of health services in the Grantham and surrounding area, for the purposes of Regulation 23(1) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013;
2. That it be recorded that the Health Scrutiny Committee for Lincolnshire was not reassured that Accident and Emergency Services would be reinstated at Grantham and District Hospital between 6.30pm and 9.00am by February 2017; and that as a result the Committee concluded that the closure of the Accident and Emergency Services between these times was, in effect, permanent; and
3. That a referral be made to the Secretary of State for Health in accordance with Regulation 23(9)(c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, on the basis that the closure of Accident and Emergency Services at Grantham and District Hospital between 6.30pm and 9.00am was not in the interests of health service provision in the Grantham and surrounding area.

46 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST: 2021 STRATEGY AND CHANGE PROGRAMME

A report by Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust (ULHT)) was considered which provided an update on the development of United Lincolnshire Hospitals NHS Trust's *2021 Strategy and Change Programme* to deliver the strategy.

Kevin Turner (Deputy Chief Executive – United Lincolnshire Hospitals NHS Trust (ULHT)), Jan Sobieraj (Chief Executive – United Lincolnshire Hosptials NHS Trust (ULHT)) and Dr Suneil Kapadia (Medical Director – United Lincolnshire Hospitals NHS Trust (ULHT)) were in attendance for this item.

Due to the significant service and financial challenges faced by many NHS Trusts, United Lincolnshire Hospitals NHS Trust was in the process of developing a five year strategy which would align to Lincolnshire's Sustainability and Transformation Plan (STP). It was agreed that this strategy would be managed by the 2021 Programme Board, led by the Chief Executive.

Work had been undertaken to ensure that the development of the five year strategy was in line with the STP. Following initial consultation and engagement with key stakeholders the ambitions noted below were agreed:-

- Our Services will:-
    - Be Centres of Excellence;
    - Be secure in Lincolnshire where possible; and
    - Get things right first time, valuing patient's time.
- Our Patients will:-
    - Want to choose us for their care and be our advocates; and
    - Shape how our services run.
- Our Staff will:-

- Be proud to work at ULHT;
- Always strive for excellence and continuous learning and improvement; and
- Challenge convention and improve care.

It was reported that these ambitions would be realised through the delivery of key priorities which were being developed into improvement programmes. These programmes would be managed by the 2021 Change Programme and would provide the transformational change platform to enable the organisations to achieve future sustainability. The programmes include:-

- Redesign of clinical services to extend future sustainability;
- Productive Hospital to improve Market Share seeing and treating more patients currently accessing elective care outside ULHT;
- Review of the workforce to address future gaps, design new roles and develop more flexible models of delivery;
- Improve productivity, efficiency and Estates;
- Improve staff engagement – delivering safer and better outcomes for patients; and
- Targeting quality improvement.

Development and delivery of the Five Year Strategy would be underpinned by communication, engagement and consultation, plans for which were being finalised.

It was agreed that a working group be established to provide the initial views on the strategy with a view to holding one meeting in early/mid-December and it was also agreed that the Health Scrutiny Officer would seek nominations from the Committee. It was agreed also that Healthwatch Lincolnshire would nominate a representative for the working group.

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

- It was suggested that more positive press coverage was required to counteract the negative media currently surrounding ULHT. Staff within the Trust worked extremely hard to provide excellent patient care but it was acknowledged that, despite good news stories being shared with the press, the focus was inevitably on the failures;
- As patients had the right to choose where they underwent elective care, the responsibility of the Trust was to attract more patients in choosing services in Lincolnshire for elective care;
- Over 60% of planned care patients had indicated that they would travel a considerable distance to access better service and it was accepted that it was not the principle in question but the practicalities involved in such a rural county.

RESOLVED

1. That the report be noted; and

2. That a working group be established to consider initial views on the Five Year Strategy.

The Committee agreed to consider Item 8 – Lincolnshire East Clinical Commissioning Group Update after the lunch break.

NOTE: At 1.20pm, the Committee adjourned for lunch and reconvened at 2.00pm. On return, the following Members and Officers were in attendance:-

County Councillors

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

District Councillors

Councillors J Kirk (City of Lincoln Council), Mrs P F Watson (East Lindsey District Council), T Boston (North Kesteven District Council) and C J T H Brewis (South Holland District Council) and Mrs R Kaberry-Brown (South Kesteven District Council)

Officers in attendance

Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant in Public Health), Simon Evans (Health Scrutiny Officer), Jane Green (NHS England), Dr Peter Holmes (Chairman – Lincolnshire East CCG), Gary James (Accountable Officer – Lincolnshire East CCG), Tracy Pilcher (Chief Nurse – Lincolnshire East CCG) and Jason Wong (Chair – Local Dental Network, NHS England)

Healthwatch

Dr B Wookey

47 LINCOLNSHIRE EAST CLINICAL COMMISSIONING GROUP UPDATE

The Chairman invited Tracy Pilcher (Chief Nurse – Lincolnshire East CCG) to provide an update on the announcement of the temporary closure of the Wainfleet Surgery.

During an inspection of 30 GP practices, the Care Quality Commission (CQC) had identified significant concern within this practice. An action plan was developed and implemented however a follow-up inspection by the CQC identified that sufficient progress had not been made which resulted in the practice being placed in a high risk category. As a result, the following action was taken:-

- A suspension was placed on the practice from 8.00am on 10 November 2016;
- Discussions with the nearby Hawthorn practice resulted in an agreement to temporarily transfer all 2200 patients from the Wainfleet practice;
- Patients were given the option to register with other practices on a permanent basis;

- All high risk patients registered with the Wainfleet practice were considered to ensure access to appropriate services was maintained;
- Communication was being undertaken to advise all concerned of a helpline;
- Additional non-emergency transport for Wainfleet patients to attend Hawthorn Practice had been deployed on a short term basis; and
- Practice boundaries were being redrawn in line with patient lists to ensure access to primary care services for all residents.

The Committee was invited to ask questions, during which the following points were noted:-

- CQC registration had been suspended although payment for the GMS contract had continued to ensure the running of the surgery whilst the necessary changes were made;
- A risk assessment had been undertaken by the CQC to enable a decision to be made. Some of the data presented suggested to the CQC that patients were not being assessed safely with one minute appointments being held;
- Temporary home services had been put in place for patients unable to travel to the temporary practice;
- It was reported that the Hawthorn practice had 10k patients registered currently. A telephone line in to the Wainfleet practice was currently transferred to a staff member at the Hawthorn practice dedicated to taking calls from Wainfleet patients only.

The Committee congratulated Lincolnshire East CCG on the actions taken to deal with this issue.

A report by Gary James (Accountable Officer – Lincolnshire East CCG) was considered which provided an update on the activities of Lincolnshire East CCG (LECCG) and included information on the lead commissioning arrangements undertaken by LECCG.

Gary James (Accountable Officer – Lincolnshire East Clinical Commissioning Group) and Dr Peter Holmes (Chairman – Lincolnshire East Clinical Commissioning Group) were in attendance for this item.

Lincolnshire East CCG was in its fourth year of commissioning services for a population of 245,000 patients with the last twelve months facing unprecedented demands for services across the NHS as a whole. It was clear that there was a requirement for the NHS to change and adapt in order to meet the needs of patients and to become more effective and efficient.

The report presented key facts and figures for LECCG:-

- Coverage of three localities;
- 244,907 people looked after;
- Approximately 296,800 outpatient attendances;
- 802,000 GP appointments in 2015/16 in 30 GP Practices;
- Approximately 2,200 babies delivered;

- Approximately 55,500 A&E attendances;
- Approximately 23,300 emergency admissions;
- £1,484.00 resources per person per year;
- £996k healthcare services spend per day; and
- £363.4m total spend on healthcare services in 2015/16.

Lincolnshire East CCG had become the lead commissioner for United Lincolnshire Hospitals NHS Trust (ULHT) in the last year, having previously been the commissioners of services from Lincolnshire Community Health Services, East Midlands Ambulance Service NHS Trust, non-emergency patient transport and NHS 111 services. Development of the relationship with ULHT was thought to have gone well over the last twelve months and, despite being challenging, discussions had remained positive.

Agreement on the 2016/17 ULHT contract had been reached on time and without recourse to arbitration for the first time in over a decade which was good for patients and the NHS as it was an indication of the service working together and avoiding engagement in lengthy bureaucratic issues.

The CCG had also fully delegated authority for Primary Medical (General Practice) services, the commissioning of which was managed through the Primary Care Co-commissioning Committee (PCCC). The PCCC was constituted to avoid any conflicts of interest with GPs as members of the CCG. The focus this year had been on the sustainability of general practice, development of a primary care strategy and management of the development and investment of GP services.

Achievements over the last year had included:-

- Isolation in rural areas had been address through "Talk, Eat, Drink (TED" in partnership with East Lindsey District Council;
- Development of a Diabetes service specification;
- Delivery of care home schemes in Boston and Skegness;
- Ongoing work on dementia support services;
- Antimicrobial resistance addressed; and
- Investment in GP Practices to deliver case management for the over 75s.

98% of the CCG's total resources, which equated to £363.4m, had been spent on the purchase of healthcare during 2015/16. Buy-in of services from NHS trusts was 60% of that total and was the largest expenditure.

Increased funding had been received for 2016/17 however increasing demand for services had led to some significant financial pressures on budgets. The CCG was reacting to this pressure by taking measures to improve productivity and giving focus to services with the highest priority.

NHS England assessed all CCGs through a performance framework of quarterly reviews and provided an annual summative. For 2015/16 LECCG, in line with all other CCGs in Lincolnshire, was rated overall as "Required Improvement". It was

reported that it was not possible to achieve a better rating than this unless the finance element of the assessment received a "good" rating, which LECCG did not.

LECCG did, however, gain a "top performing" rating for diabetes work which had presented a huge challenge.

Increased public engagement had been a focus of LECCG and a patient council and patient viewpoint panel had been established in addition to the active patient participation groups within GP practices.

The use of National patient feedback systems continued and it was thought that major improvements in patient engagement via these methods would be important as the CCG moved toward public consultation of the Sustainability and Transformation Plan (STP) and LHAC (Lincolnshire Health and Care) plans.

In relation to System Leadership, LECCG provided the lead commissioning role for urgent care across the County and had led on Urgent Care, Women and Children's Care and development of the Local Digital Roadmap as part of the STP and LHAC work. It was acknowledged that the STP was an important strategic plan which aimed to establish the NHS in Lincolnshire on a path to improved and more sustainable services.

The future would be an extremely challenging period for the NHS due to unprecedented levels of demand but LECCG stressed that focus remained on the needs of patients within the County. It was hoped that the improvements made in public engagement and continued strong clinical leadership would strengthen the ability to address the challenges ahead.

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

- Concern was raised in relation to the amount of medical equipment wasted after minimal use, e.g. zimmer frames, shower chairs, etc. It was explained that packaged sterile, goods could not be used even if the packing appeared sealed as there was no guarantee that tampering had not taken place. Additionally, it had been found that replacement of equipment was more cost effective than the process of recycling;
- The Pharmacy Review continued to be of focus for the CCG but it remained unclear how the new guidance could be implemented in Lincolnshire as over half of GP practices provided dispensary services which meant the community was less reliant on pharmacies than in some areas;
- The Committee urged Lincolnshire East CCG to promote themselves more within the report in future. The report did not clearly show all of the challenges faced by the CCG and encouraged them to proudly promote achievements;
- Continuing care for patients remained a challenge as a full assessment was required for each individual to assess both health and social need;
- The report stated that £1484 per person per year was allocated for health care. It was explained that the CCG received slightly more than other areas due to the sparsity and rurality of the county although this amount was

minimal. The formula used to reach this amount depended on age; profile; deprivation; morbidity and rurality;

- In relation to the temporary suspension of the Wainfleet practice, NHS England did provide some resources to assist with the additional costs involved as a result;

The financial position was expected to be clear by March 2017 therefore Lincolnshire East CCG was requested to provide a further update to the Committee in March 2017.

RESOLVED

1. That the report and update be noted;
2. That a further update be added to the Work Programme for the Health Scrutiny Committee for Lincolnshire scheduled for 15 March 2016.

At 3.00pm, Dr B Wookey and Councillors Mrs S Ransome and Mrs R Kaberry-Brown left the meeting and did not return.

48 NHS DENTAL SERVICES OVERVIEW FOR LINCOLNSHIRE

A report by NHS England (Central Midlands) was considered which provided an overview of the NHS dental services commissioned in Lincolnshire and an update on the new Special Care Dentistry Service arrangements from 1 December 2016.

Jane Green (Assistant Contract Manager for Dental and Optometry – NHS England (Midlands and East (Central Midlands))) and Jason Wong (Local Dental Network Chair – NHS England) were in attendance for this item.

NHS England had been responsible for commissioning primary and secondary care dental services since April 2013 and a commitment made to oral health and dentistry.

NHS England's clinical aim for each dental practice was to deliver high quality NHS clinical services were defined as:-

"patient-centred and value for money primary care dental services, delivered in a safe and effective manner, through a learning environment, which includes the continuing professional development of dentists and other dental professionals"

The Central Midlands Local Officer was responsible for commissioning NHS primary, community and secondary care dental services and had two locality teams who managed dental and optometry commissioning. Within the Central Midlands region, Lincolnshire formed part of the North Locality which also covered Leicestershire and Rutland.

Within Lincolnshire 69 practices delivered 76 contracts including:-

- 49 practices providing general dental services (10 restricts contracts);
- 1 pilot contract to provide general dental services;

- 15 practices providing general dental and orthodontic services;
- 5 contractors providing orthodontic services;
- 5 contractors providing minor oral surgery services; and
- 1 Special Care Dentistry Service contractor.

NHS dental contractors were transferred to the new NHS Dental contract in April 2006 which monitored units of dental activity (UDA) target for general dental practice and units of orthodontic activity (UOA) for orthodontic contracts.

Patient charges were changed with the introduction of the new contract which was simplified in to three treatment bands ranging from £19.70 to £233.70.

An Oral Health Needs Assessment (OHNA) for the North Locality was developed by Public Health England in conjunction with NHS England Central Midlands Local Office. The document had been submitted for gateway approval and would be published once received.

The OHNA reviewed the demographics of the resident population, provision of services, access to NHS dental services and also made recommendations for consideration by commissioners. The review identified that the access rate in the following Local Authority areas was similar to, or above, the NHS England and Leicestershire and Lincolnshire averages:-

- West Lindsey (for children and adults);
- North Kesteven (for children);
- South Kesteven (for children and adults); and
- East Lindsey (for children and adults).

The access rate in the following areas was below the NHS England and Leicestershire and Lincolnshire average:-

- Boston (for children and adults);
- Lincoln (for children and adults);
- South Holland (for children and adults); and
- North Kesteven (for adults).

The Local Office also reviewed the outcomes of the draft OHNA along with other intelligence in order to develop the dental commissioning intentions and it had been agreed to commission new dental contract to improve access in priority areas within the resource envelope available:-

- Boston;
- Lincoln;
- Sleaford (North Kesteven); and
- Spalding (South Holland).

All newly qualified dentists were required to complete one year dental foundation training following completion of their dental degree, a process managed by Health Education England (HEE). Foundations dentists were assigned to accredited dental practices with an identified mentor who would provide support throughout this training

process. Funding was provided to cover the cost of the Foundation Dentist and to support the accredited mentor. 26 training places were available across Leicestershire and Lincolnshire, three of which were secured within Lincolnshire practices.

Dental Commissioning Guides provided a standardised framework for local commissioning of dental specialities and were available to Local Offices.

Local Offices were expected to work closely with the Managed Clinical Networks (MCN), Regional Dental Public Health Consultants and Dental Local Professional Networks (LPN). Guides available were Special Care Dentistry (Adults); Orthodontics; and Oral Surgery and Oral Medicine.

The Local Dental Professional Network (LPN) for Leicestershire and Lincolnshire was established in 2013 and the Steering Group developed work priorities each financial year with progress monitored by NHS England Central Midlands. Although engagement from the dental health community, HEE, Public Health and Local Authorities had been good, engagement with CCGs had been a challenge which continued to have little success.

Recognition had been given nationally to the Dental LPN for the work on older patients oral health in Lincolnshire and was linked to the Oral Health Promotion Strategy.

Non-recurrent funding had been secured to fund a pilot for improved access to interpretation services across Leicestershire and Lincolnshire from NS England.

Challenges identified by the LPN related to:-

- Access to Restorative Services;
- Formation of Gerodontology MCN to focus on Older peoples, people with Dementia and Mental health issues oral health;
- Delivering prevention to families who have experienced extraction with General Anaesthetic for tooth decay;
- Encourage the increase in foundation training practices in Lincolnshire;
- Increasing the level of Oral health promotion activities in Lincolnshire in partnership with Lincolnshire County Council;
- Implementation of Health Gums Do Matter toolkit and increase the knowledge of the General Dental practitioner of the relevance of oral health on general health and vice versa.

Dedicated support across Central Midlands had been secured by NHS England for performance management of dental secondary care contracts, to review secondary care dental pathways to improve access and commission new pathways.

Managed Clinical Networks for Special Care Dentistry, Orthodontics and Minor Oral Surgery had been established by the LPN also.

Lincolnshire County Council became responsible for improving health and reducing inequalities for its local population from 1 April 2013 which included commissioning of oral health promotion programmes and epidemiology surveys. LCC had agreed that this would be commissioned by NHS England's Special Care Dentistry Service contract on their behalf.

NHS England had completed a procurement process to secure service provision of Specialist Care Dentistry Service from 1 December 2016 and the contract awarded to Community Dental Services (CDS-CIC) in June 2016 on a seven year contract term with the option to extend for a further three years.

Work between NHS England, Lincolnshire Community HealthCare NHS Trust and Community Dental Services had been ongoing since June 2016 to ensure a smooth transition between services and providers.

All referrers across the health community would be advised of the revised referral process and all stakeholders would receive an updated brief and media release during November 2016 prior to the commencement of the contract on 1 December 2016.

The Committee was invited to ask questions, during which the following points were noted:-

- Further explanation of the banding structure for pricing was explained. If, for example, band two work was carried out and needed to be repeated within a couple of months, this would be covered under the first payment. Should the work be band one or three then a further payment would need to be made;
- Lincolnshire found it harder than other areas of the country to recruit, especially in the east of the county. There was thought to be enough dentists providing NHS dental treatment in the country but that these were not necessarily based in the areas of need;
- Practices were being encouraged to recruit and also offer positions to foundation dentists. It would also help if those trained in Lincolnshire (or any other area) were contracted to stay within the county for a set period on completion of that training. Unfortunately, the contract did not allow for that;
- Anecdotal evidence had been received that some dentists had not been accepting children from a young age. A 'refusal form' had now been implemented to ensure that if any dentist did refuse a child patient for being too young, they could be challenged;
- The Health and Social Care Act 2012 had resulted in the promotion of oral health falling under the remit of Local Authority Public Health function and there had been campaigns to support oral health. Lincolnshire Smiles Programme had 12 practices affiliated to it to promote oral hygiene in schools across the county but additional funding would help further promotion;

RESOLVED

That the report and update be noted.

49 DELAYED TRANSFERS OF CARE - THE NEXT STEPS

Consideration was given to a report from the Director Responsible for Democratic Services which asked the Committee to consider the next steps for its review and scrutiny of delayed transfers of care (DTOC).

Simon Evans (Health Scrutiny Officer) introduced the report which confirmed that the issue had been considered by the Health Scrutiny Committee for Lincolnshire who made a request for the Adults Scrutiny Committee to also consider this. The Adults Scrutiny Committee accepted this request and the item was considered at the following meetings of the committee:-

- 6 April 2016;
- 7 September 2016; and
- 19 October 2016.

In the meantime, reference had been made to delayed transfers of care within three reports to the Health Scrutiny Committee for Lincolnshire.

The request for consideration by the Adults Scrutiny Committee was made on the basis that this committee was the lead for the scrutiny of the Better Care Fund (BCF) which, for 2016/17, included the reduction of delayed transfers of care as a key measurement.

The Adults Scrutiny Committee had considered two reports where delayed transfers of care formed a substantial element. Firstly, as part of an item on *Seasonal Resilience of Adult Care* in April 2016; secondly, in October 2016, when it considered *Adult Care Acute Delayed Transfers of Care*; and also within the detailed performance information as part of the Quarter 1 Performance Monitoring Report on the Better Care Fund in September 2016.

On the 19 October 2016, the Adults Scrutiny Committee resolved to note the information presented and, as part of the discussion, suggested that the Health Scrutiny Committee for Lincolnshire take the lead on scrutinising this issue in the future. It was further suggested that a joint meeting or working group be established to give further consideration to the topic.

The Health Scrutiny Committee had continued to receive information on DTOC as part of its regular consideration of Urgent Care Updates and the inclusion of this information had reflected the importance of 'patient flow' to ensure the effective operation of the urgent care system.

The Health Scrutiny Committee could continue in its role of scrutinising DTOC as part of its role with focus on NHS organisations and their efforts to reduce delays. Similarly, the Adults Scrutiny Committee would continue to receive quarterly performance information on the Better Care Fund which included extensive detail on DTOC performance.

In order to consolidate and enhance the individual scrutiny activity of each committee, it was suggested that a joint informal meeting or working group be established. Outcomes would then be reported to each committee.

The Committee was invited to ask questions, during which the following points were noted:-

- Members who also served on the Adults Scrutiny Committee indicated that consideration of this item at that committee had not led to satisfactory outcomes and they would support a joint approach to the topic;
- The Committee concluded that joint working between the two committees was essential for this issue as it overlapped both Health and Social Care;
- As a member of the Health Scrutiny Committee for Lincolnshire, the Vice-Chairman of the Adults Scrutiny Committee was keen to establish a working group. It was agreed that an invitation be made the Adults Scrutiny Committee seeking it's agreement for a joint working group and to nominate members to participate;

RESOLVED

1. That the report be noted; and
2. That a working group be established compromising of the following Councillors S L W Palmer, Mrs S M Wray, Mrs J M Renshaw, J Kirk and Mrs C A Talbot; and
3. That an invitation for representatives of the Adults Scrutiny Committee to join the working group be submitted to the Adults Scrutiny Committee.

50 WORK PROGRAMME AND RESPONSES TO CONSULTATIONS

Consideration was given to a report by the Health Scrutiny Committee for Lincolnshire which gave the Committee the opportunity to consider its work programme for the coming months and also provided the Committee's final response to two consultations.

The consultations referred to were in relation to the merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust; and the Medicines Management Consultation.

In relation to the merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust, the Committee established a working group, on 21 September 2016, to draft and finalise the response of the Committee to the Full Business Case. The deadline for the response was 7 November 2016 and the response of the Committee would be reported to both Trust Boards at their meetings in November 2016.

On the basis of the information received, the Committee supported the full business case for the merger and was reassured that the outcome of the merger would not impact directly on Lincolnshire patients. In addition, in the event of a significant change of service in the future, the Committee would seek to be involved in any consultation on service change, led by the appropriate commissioners.

The full response of the Committee could be found at Appendix B to Agenda Item 11 on pages 113/114 of the agenda pack.

A working group was also established, on 26 October 2016 to draft and finalise the response of the Committee to the Medicines Management Consultation which was being undertaken by the four clinical commissioning groups in Lincolnshire. The response of the Committee on the proposals put forward are noted below:-

- *Proposal 1 – To restrict providing over the counter/minor ailment medicines for short term, self-limiting conditions* – the Committee supported the principle of self-care for very minor ailments but noted that some medicines, such as paracetamol or ibuprofen were cheap and widely available in supermarkets, etc. Some over the counter medicines, including cough syrups, thrush creams or child paracetamol, however, were not as cheap nor readily available. The Committee recorded its concerns that this may have an impact on low income families;
- *Proposal 2 – To restrict the prescription of gluten-free foods* – the Committee supported the proposal to limit prescribing of gluten-free foods to loaves of bread, bread-flour and bread mixes (in accordance with Coeliac UK's recommended quantities). However, GP's should be advised to take account of the impact of these arrangements on particular individuals and allow discretion in exception circumstances to prescribe additional products;
- *Proposal 3 – To restrict prescribing of baby milks and specialist infant formula* – the Committee noted that specialist baby milks and infant formulas may cost up to four times as much as standard milk and formulas. The Committee expressed concern about the potential impact on low income families and believed that GPs should be allowed to use discretion in these circumstances;
- *Proposal 4 – To restrict prescribing oral nutritional supplements* - the Committee strongly supported the "food first" approach for those with low appetites or a degree of malnourishment. Concern was noted that some care homes relied too much of nutritional supplements when they should encourage residents to eat food. The Committee was mindful that there may be exceptional circumstances and the need for GPs to take account of the impact on low income families; and
- *General Comments*
    - the Committee noted that each proposal included the word "restrict" rather than "discontinue" as this provided an element of reassurance that discretion would be applied by GPs;
    - Concern was raised that a six week period of consultation had been too short although the Committee acknowledged the pressures on the four clinical commissioning groups to reduce expenditure during the remainder of the 2016/17 financial year;
    - The Committee was concerned that the consultation document had not been widely circulated due to some GP practices choosing not to make the document available in their waiting rooms;

The full response of the Committee could be found at Appendix C to Agenda Item 11 on pages 115/116 of the agenda pack.

The Committee made no comments on the content of the work programme but agreed that an item on Lincolnshire Health and Care (LHAC) and the Sustainability and Transformation Plan (STP) be added to the work programme for the December meeting, on the assumption that the STP would be published on 12 December 2016.

RESOLVED

1. That the Work Programme, with the addition noted above, be agreed;
2. That the response of the Committee to the Full Business Case for the Merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust be noted; and
3. That the response of the Committee to the Medicines Management Consultation, undertaken by the four clinical commissioning groups in Lincolnshire, be noted.

The Chairman advised that an attendance analysis for the Committee had been done and expressed disappointment at the attendance from two District Councils. The Committee was asked to ensure that apologies were submitted and to provide a substitute member wherever possible.

The meeting closed at 3.35 pm

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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

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 December 2016**
Subject:	**Congenital Heart Disease Services**

Summary:

On 8 July 2016, NHS England announced that "subject to consultation with relevant trusts and, if appropriate the wider public" it was decommissioning congenital heart disease surgery ("Level 1 services") from the East Midlands Congenital Heart Centre (formerly known as Glenfield Hospital). On 20 July, the Health Scrutiny Committee for Lincolnshire considered this announcement and authorised the Chairman to write to NHS England to seek a commitment to full public consultation.

In September 2016, NHS England committed to a public consultation, with an expectation the consultation document would be issued during December 2016. On 23 November 2016, NHS England announced that the consultation would now begin in 2017. The purpose of this item is to enable to the Committee to engage with NHS England prior to the beginning of the consultation.

Will Huxter Regional Director of Specialised Commissioning, NHS England, will be attending the meeting to present information and respond to questions.

Actions Required:

To provide comments to NHS England in advance of the public consultation on Congenital Heart Disease, which is due to be launched in early 2017.

1. Background

Announcement by NHS England - 8 July 2016

As reported to the Health Scrutiny Committee on 20 July and 21 September 2016, NHS England stated on 8 July 2016:

"Subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England will also work with University Hospitals of Leicester NHS Trust and Royal Brompton & Harefield NHS Foundation Trust to safely transfer CHD surgical and interventional cardiology services to appropriate alternative hospitals. Neither University Hospitals Leicester or the Royal Brompton Trusts meet the standards and are extremely unlikely to be able to do so. Specialist medical services may be retained in Leicester."

On 21 July 2016, the Committee unanimously agreed that to decommission Level 1 Paediatric Cardiac and Adult Congenital Heart Disease Services from the East Midlands Congenital Heart Centre would constitute a substantial variation, as defined by Regulation 23 of the *Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.* The Committee also unanimously agreed that the Chairman would write to NHS England outlining the Committee's views and seeking NHS England's commitment to full public consultation.

NHS England's report: Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: Report of the National Panel, was published on 15 July 2016 and is attached at Appendix A.

Correspondence Between the Chairman and NHS England

Correspondence between the Chairman and NHS England has established or confirmed the following:

- No final decisions have been taken about the future of University Hospitals of Leicester NHS Trust or any of the other congenital heart diseases services in England declined to undertake public consultation.
- Information regarding consultation about the proposals will be communicated as widely as possible, well in advance of consultation starting. NHS England will make sure that the consultation takes account of those services which could be impacted by changes to CHD services, including paediatric intensive care and ECMO.
- NHS England is now in the pre-consultation engagement stage.
- The national and regional panel assessments of Congenital Heart Disease (CHD) centres against key standards in the new service specification, which came into effect on 1 April 2016, were completed in June 2016. Following these assessments, the Committee of NHS England agreed with the recommendation that centres assessed as ‘not satisfactory and highly unlikely to meet service standards’ should be served notice that NHS England was minded to cease to contract their

services. Providers were informed of these assessments at the end of June 2016. Any necessary public involvement would be undertaken before service changes were implemented.

Individual Assessment Reports

On 13 September 2016, NHS England published individual assessment reports for 21 hospital trusts. All these reports are available at the following link:

www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/#reports

The NHS England Standards Compliance Assessment report relating to the University Hospitals of Leicester NHS Trust is attached at Appendix B to this report.

NHS England has visited University Hospitals of Leicester NHS Trust to meet to staff, patients and other stakeholders about NHS England's assessment of the Trust against the standards. NHS England advises that there has been extensive correspondence and discussion since that visit.

NHS England Blogs

Blogs by Will Huxter have been published on the NHS England website. Three of these are included in Appendix C of this report. The most recent blog, 23 November, indicates that consultation will not begin until early in 2017.

Briefing for Local Government

In September 2016, a briefing entitled *Briefing for Local Government on Proposed Changes to NHS Specialist Services for People with Congenital Heart Disease* was circulated to the Centre for Public Scrutiny for onward distribution to local authority health overview and scrutiny committees. A copy of this briefing in the format published on the NHS website, dated 14 October 2016, is attached at Appendix D.

2. Conclusion

This item aims to provide comments to NHS England in advance of the public consultation on Congenital Heart Disease, which is due to be launched in early 2017.

3. Consultation

This item provides the Committee with information in advance of an expected public consultation on congenital heart disease services.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: Report of the National Panel *(NHS England 15 July 2016)*
Appendix B	Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment: Hospital Trust: University Hospitals of Leicester NHS Trust *(NHS England – 13 September 2016)*
Appendix C	Will Huxter Blogs on Congenital Heart Disease (13 September, 19 October and 23 November 2016)
Appendix D	Briefing for Local Government on Proposed Changes to NHS Specialist Services for People with Congenital Heart Disease.

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

NHS England

Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: Report of the National Panel

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Commissioning Operations**	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**05565**
Document Purpose	Other (see Description)
Document Name	Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: Report of the National Panel
Author	NHS England
Publication Date	15 July 2016
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs , Medical Directors, Directors of Nursing, NHS England Regional Directors, NHS England Directors of Commissioning Operations, NHS Trust CEs
Additional Circulation List	
Description	This document provides a report of the self-assessment process carried out with current level 1 and level 2 congenital heart disease centres in England.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Will Huxter Senior Responsible Officer for the CHD Programme NHS England 105 Victoria Street, London SW1E 6QT www.england.nhs.uk

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

"This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net"

Contents

1 Introduction

NHS England is the direct commissioner of congenital heart disease (CHD) services, as prescribed specialised services. On 23 July 2015, the NHS England Board agreed new standards and service specifications for CHD services, with the expectation that in future all providers would meet the standards, leading to improvements in service quality, patient experience and outcomes. The Board agreed a go-live date of April 2016 to begin implementation of the new standards, embedded in contracts with providers, with a standard-specific timetable giving up to five years to achieve full compliance.

The standards are based on a three tier model of care with clear roles and responsibilities (and standards) for each tier. Networks will help local services to work closely with specialist centres, to ensure that patients receive the care they need in a setting with the right skills and facilities, as close to home as possible. The three tiers are:

> ***Specialist Surgical Centres (level 1)***: These centres will provide the most highly specialised diagnostics and care including all surgery and most interventional cardiology.
>
> ***Specialist Cardiology Centres (level 2)***: These centres provide specialist medical care, but not surgery or interventional cardiology (except for one specific minor procedure at selected centres). Networks will only include level 2 centres where they offer improved local access and additional needed capacity.
>
> ***Local Cardiology Centres (level 3)***: Accredited services in local hospitals run by general paediatricians / cardiologists with a special interest in congenital heart disease. They provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from the Specialist Surgical Centre, allowing more care to be given locally.

The Board agreed proposals for commissioning the service and endorsed initial work with providers to develop proposals for ways of working to ensure the standards would be met. This work with providers commenced in April 2015, culminating in the submission of proposals in October 2015. Seven submissions were received, some from networks based on a single surgical centre, others from new multi-centre networks. The proposals were comprehensively assessed by a commissioner led panel, with clinician and patient/public representation. The panel advised that certain standards were considered particularly important for service quality, safety and sustainability:

- Surgeons should be part of a team of at least four, with an on-call commitment no worse than 1:3 from April 2016 and that each surgeon must undertake at least 125 operations per year. From April 2021 a minimum 1:4 rota will be expected.
- Surgery should be delivered from sites with the required service interdependencies. The standards specify which services should be on the same site, and the level of responsiveness required from these and other services. Some of the requirements for co-location are new, so hospitals have until April 2019 to meet them.

NHS England accepted the panel's assessment that, taken together, the initial provider proposals did not provide a national solution and giving more time was unlikely to yield a different outcome.

It was decided therefore that action should be taken to ensure that the April 2016 standards were met as soon as possible, with immediate action to ensure that appropriate short term mitigations are put in place in the meantime to provide assurance of safety. The process reported in this paper was endorsed by NHS England's Specialised Services Commissioning Committee (SSCC).

2 The assessment process

A further process to assess compliance with the standards was launched in January 2016. It set out 14 requirements organised into five themes:

1. Ensuring that paediatric cardiac / ACHD care is given by appropriate practitioners in appropriate settings
2. Ensuring that those undertaking specialist paediatric cardiac / ACHD procedures undertake sufficient practice to maintain their skills
3. Ensuring that there is 24/7 care and advice
4. Ensuring that there is effective and timely care for co-morbidities
5. Assuring quality and safety through audit

Within the 14 requirements, this assessment covered 24 paediatric standards (and the corresponding adult standards) considered to be most closely and directly linked to measurable outcomes (including the surgical and interdependency standards previously highlighted) and to effective systems for monitoring and improving quality and safety.

Providers of CHD level 1 & 2 services were asked to provide evidence of their compliance with the April 2016 standards. As the standards are being introduced in a phased way to allow hospitals longer to prepare for the more demanding standards, consideration was also given to the ability of providers to reach the later requirements.

Where providers could not demonstrate that standards are met, they were asked to describe their plans to achieve the standards and the mitigating actions they proposed to take to provide assurance of the safety and quality of services until all the standards were met. An acceptable development plan was considered to be one that gave a high degree of assurance (in the view of NHS England) that the standard would be met within 12 months of the standard becoming effective.

This process was closely based on NHS England's usual approach when introducing a new service specification.

Additional information was needed in order to complete the process and this was requested in March 2016. These additional returns were assessed in April 2016.

Each set of returns was initially evaluated at a regional level by the NHS England specialised commissioning team, followed by a national panel review to ensure a consistency of approach. The national panel brought together NHS England staff from its national and regional teams with representatives from the Women and

Children's Programme of Care Board and the Congenital Heart Services Clinical Reference Group to provide wide ranging and senior clinical advice and patient and public perspectives. NHS England then gave each provider organisation the opportunity to comment on the factual accuracy of its assessment, so that the provider's comments could be taken into account before the assessment was finalised.

This report of the national panel's findings represents NHS England's assessment of compliance with the standards and the action it is proposing to take, subject to appropriate public involvement and/or consultation.

3 Specialist Surgical Centres (level 1)

3.1 Overall assessment

The detailed assessment of each centre, based on the evidence submitted is summarised here.

	Green	Green / Amber	Amber	Amber / Red	Red
	Meets all the requirements as of April 2016.	Meets most of the requirements as of April 2016 and has good plans to meet the rest within max. 12 months.	Should be able to meet the April 2016 requirements with further development of their plans.	Does not meet all the April 2016 requirements and is unlikely to be able to do so.	Current arrangements are a risk.
North			Alder Hey Leeds	Newcastle	Central Manchester
Midlands and East		Birmingham Children's	UH Birmingham	Leicester	
London		Great Ormond Street	Barts Guy's and St Thomas'	Royal Brompton	
South			Bristol Southampton		

We found that none of the centres met all the standards tested. This was not unexpected, as the standards were designed to ensure that all services were brought up to the level of the best of existing practice - to be stretching and drive improvement without being unrealistic.

The differences we found between centres, particularly between those rated green/amber and those rated amber/red were starker than the ratings alone may

imply. Those rated green/amber scored 12 out of 14 with only quite small and easily achievable improvements needed to move to a 100% rating. This contrasts strongly with the centre rated red which met only 6 of the 13 areas tested and where the required improvements would be extensive, and considered by the national panel not to be realistically achievable. Indeed it is this - our assessment of whether it is realistic to expect the providers rated amber/red to be able to meet those requirements where they fall short - that separates them from those providers rated amber (rather than a simple assessment of how many of the requirements are met).

The national panel's assessment confirmed that two elements of the April 2016 standards present a particular challenge and this was reflected in the assessments of those centres rated red and amber/red:

3.1.1 Minimum volumes of surgical / interventional activity for individual consultants and the minimum size of a surgical or interventional team.

During the process to develop the standards, surgeons told us that the number of operations they each carried out was the most important factor in achieving good surgical outcomes. Bigger teams are more resilient and better able to support the development of subspecialty practice. The standards require that each surgeon undertakes a minimum of 125 operations per year. This is a minimum threshold rather than a target. They also require that from April 2016 surgeons are part of a team of at least three, and from April 2021 part of a team of at least four. Although some centres significantly exceed the minimum required activity to support the required surgical teams, the national panel found that others (Manchester, Newcastle and Leicester) had not demonstrated that they met the minimum requirement:

- Manchester has fewer than 100 operations annually undertaken by a single surgeon, with interventional cardiology provided on a sessional basis. Appropriate 24/7 surgical or interventional cover is not provided. The national panel considered this to be a risk, and rated the centre red.
- Newcastle reported insufficient activity for three surgeons in 2014-2015. At the time of the national panel's assessment, Newcastle predicted that it would not perform 375 operations annually until 2016 - 2017. The national panel noted that the full standard (effective from 2021) requires a team of four surgeons rather than three, and considered that there was no realistic prospect of this being achieved during this period. Newcastle's response to the fact check indicated that activity in 2015 - 2016 had been higher than expected and had taken its activity to a level sufficient to support a three surgeon team. This is provisional data (as it is not yet validated by NICOR) but if confirmed, and sustained beyond one year, and if the activity was distributed appropriately between three surgeons, would meet the April 2016 requirement.
- Leicester reported insufficient activity for three surgeons in 2014-2015 and 2015-16. Leicester's response to the fact check indicated an expectation that the April 2016 requirement would be met over the three year period 2016-2019 and that it considered it was on target to achieve it in 2016-2017, though no additional data was supplied. Although Leicester described plans to increase activity, the national panel considered that this did not provide sufficient assurance to be confident that the requirements would be met during the next 12 months. The national panel noted that the full standard (effective

from 2021) requires a team of four surgeons rather than three, and considered that there was no realistic prospect of sufficient activity to support this requirement being achieved during this period.

While activity is expected to rise overall across the country, and repatriation of interventional activity from non-specialist centres will provide modest help, this will not resolve the problem that there is not enough activity nationally to support the number of centres now delivering the service.

3.1.2 Availability of advice, care and support from interdependent clinical services

The standards require that a range of other specialists needed by children with CHD must be able to deliver care at the patient's bedside at any time of day, seven days a week and 365 days a year. This is because many children with CHD have multiple medical needs. Co-location of specialised paediatric services is also considered important because it allows much closer working relationships to develop between paediatric cardiology specialists and the wider specialised paediatrics team. For hospitals where all of these services are not provided on the same site, this is more challenging:

- Leicester delivers care for children from a mainly adult hospital and the national panel found that assurance of 24/7 bedside care from a full range of paediatric specialists was lacking. Leicester's response to the fact check indicated an expectation that for a number of these the April 2016 requirement would be met by April 2017. The national panel noted that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time. Leicester does not currently meet these requirements and the national panel considered that it would not realistically be able to do so by 2019.
- Royal Brompton delivers care for children from a mainly adult hospital. While the national panel found that assurance of 24/7 bedside care from a full range of paediatric specialists was lacking, Royal Brompton submitted additional evidence in response to the fact check which provided this assurance. However, the national panel noted that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time. Royal Brompton does not currently meet these requirements and the national panel considered that it would not realistically be able to do so by 2019.
- Newcastle provided evidence to show that it is able to meet the April 2016 requirements. The national panel noted, however, that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time, and that the current arrangements at Newcastle would not meet these requirements.

3.2 Other issues

Care by CHD specialists

The standards require that surgery and interventional practice for CHD patients must only be undertaken by CHD specialists. Some level 1 centres told us in their submissions that this is not always the case, and doctors who are not recognised specialists in the care of CHD are sometimes involved. Some of the centres argue that this represents a legitimate approach because of their specialist skills. This needs to be urgently addressed with those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

Surgical and interventional practice

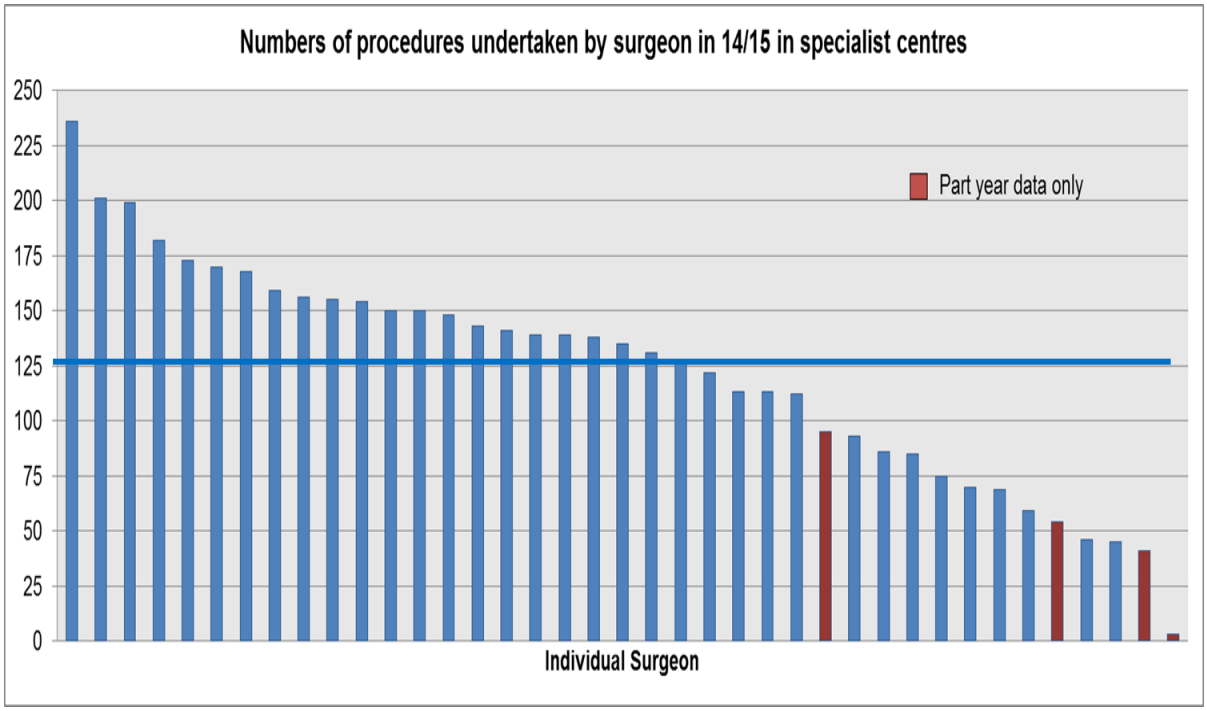
From the data supplied by the level 1 centres (figure 1 below) we can see that there are some surgeons whose activity levels fall below, and in some cases well below stated requirements. This is not just an issue for centres with low activity levels. It also occurs when centres have chosen to have too many practitioners or not to distribute activity in a way that achieves compliance with the standards. This needs to be urgently addressed by those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

Sometimes low activity was seen because of a change of staff, for example a cross-over between a retiring surgeon and their replacement. This is not considered a problem.

Taking the requirements for individual surgeon activity and for team size together, the implication of this is that in order to meet the standards each surgical centre will need a case load of at least 500 operations annually as a minimum. The Clinical Reference Group has previously advised that more than 500 cases would be needed at each centre because it would be operationally challenging to ensure that all surgeons reached the minimum activity required and every patient received their care from an appropriate surgeon if the unit's total activity was exactly 500 or only slightly above.

The evidence supplied shows that it is quite possible for surgeons to undertake 200 or more operations annually, emphasising the point that 125 operations per year is a minimum not a maximum. This is important in considering the efficient use of scarce resources as well as for consistency of outcome.

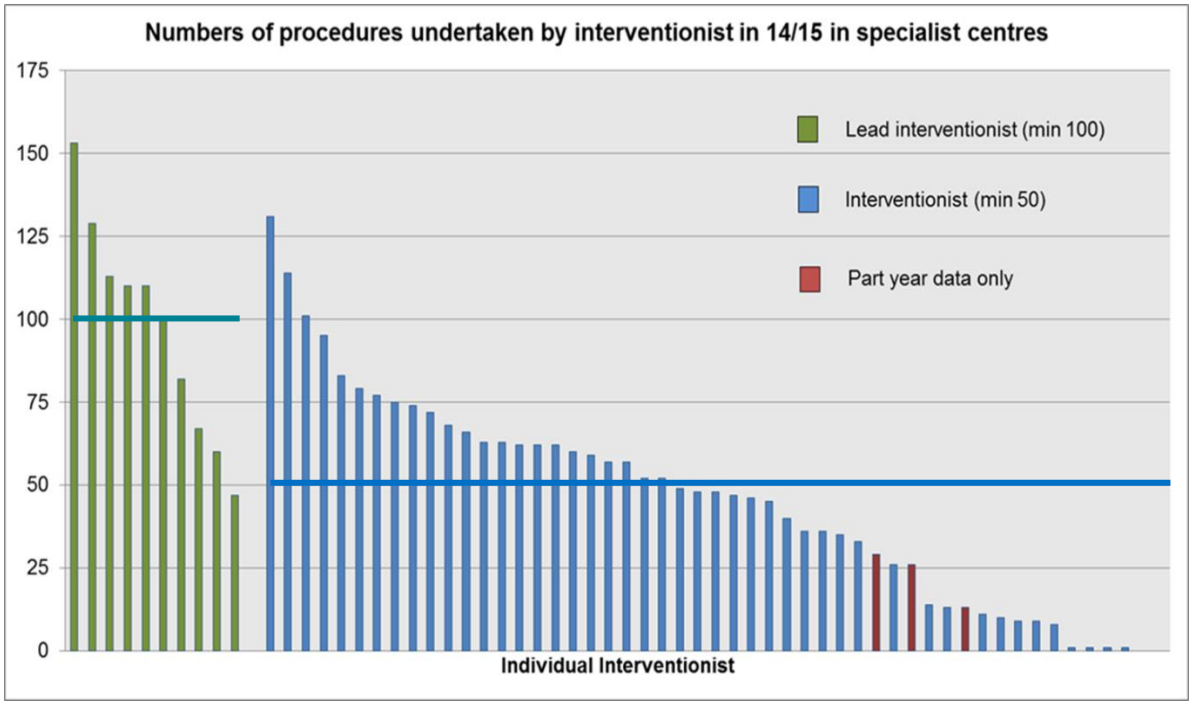
Figure 1: Number of procedures undertaken by individual surgeons in level 1 specialist surgical centres (2014-15)



From the data supplied by the level 1 centres[1] (see figure 2 below) we can see that these challenges are even more pronounced for interventional cardiology practice. There are many interventionists whose activity levels fall below, and in some cases well below, our requirement that lead interventionists undertake at least 100 procedures and other interventionists at least 50 procedures. As with surgery this results from a combination of factors including centres with too little activity, centres with too many practitioners and from poor distribution of activity within a centre. This needs to be urgently addressed by the centres concerned and NHS England regional commissioners will follow this up directly with the providers concerned.

[1] The individual interventionist activity numbers used here are those reported by each centre. Comparison with NICOR data shows that some of these include procedures which cannot be counted towards the volume required by the standards. While it is not possible from the data available to produce an absolutely definitive view of the number of procedures undertaken by each interventionist, whichever data source is used we see that a significant number of interventionists do not meet the minimum activity levels required by the standards. This is addressed in more detail in the individual centre reports.

Figure 2: Number of procedures undertaken by individual interventional cardiologists in level 1 specialist surgical centres (2014-15)



Ensuring there is 24/7 care and advice

The standards include adult care as well as children's services in order to ensure that excellent care is delivered to all age groups. Information from a number of centres showed that 24/7 care – both on-call and seven day working – is less robust for adult patients than for children. This needs to be addressed by those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

The evidence supplied revealed that in a number of centres clinicians are on more than one duty rota at the same time. The national panel considered that while there could be circumstances when it would be acceptable for a clinician to be on more than one rota, this was not always the case. The key test was the likelihood that being on one rota would prevent the clinician from discharging their duties on the other rota. The national panel had particular concerns about out of hours arrangements that would require a member of staff with responsibilities for patient care on one to site to leave that site to attend a CHD patient on a different site. The national panel considered that where these arrangements involved more than one organisation this added to the risk that duty doctors could be faced with conflicting priorities.

While all centres described arrangements to provide advice 24/7 to patients, families and other health professionals, only some described clearly how they made sure staff knew how to handle requests for information and advice. Similarly only some centres had systems in place that ensured those seeking advice (patients, their families and other health professionals) knew how to obtain it.

An age appropriate environment

Around 80% of procedures (surgery and interventional) are undertaken in children so it is important to provide their care in an age appropriate environment where paediatric CHD care is delivered alongside other paediatric services – on the same site and with the ability to meet challenging response times. The evidence supplied showed that this is challenging for providers that deliver paediatric CHD care from specialist hospitals mainly focussed on adult services.

Many centres also found it challenging to articulate how they provided an appropriate care environment for patients with physical and/or learning disability, suggesting that this is an area where sharing best practice could be helpful.

Governance and improvement

The development of formal network governance arrangements and oversight of level 2 centres undertaking interventional cardiology in adults with CHD is a new requirement and progress so far is patchy. There is more to do for providers in establishing these arrangements and for NHS England in establishing which centres will continue to practise at level 2.

Many centres were able to describe clinical governance, audit and improvement activities though evidence of learning and action resulting from this activity was sometimes not available. As networks develop we expect this area to improve as the standards require networks to develop a robust and documented clinical governance framework that includes clinical audit; regular network meetings to discuss patient pathways, guidelines and protocols, mortality, morbidity and adverse incidents.

4 Level 2 centres and occasional practice

The standards do not permit occasional and isolated practice (small volumes of surgery and interventional cardiology being undertaken in institutions that do not offer sufficient specialist expertise in this field). Occasional and isolated practice has been of particular concern to patients and their representatives.

Our analysis showed that surgery and interventional cardiology procedures in CHD patients may have been happening at a number of non-specialist centres. The standards only permit this to continue in very specific circumstances[2]. Most non-specialist centres were not expected to wish to meet these requirements.

We asked all these centres to confirm whether CHD procedures had taken place and if they had, either to cease occasional practice or to take steps to meet the requirements of the standards, including minimum volume requirements. Most providers confirmed that the apparent occasional practice revealed by analysis of HES data was due to coding errors. In other cases, the practice had already stopped or steps were being taken to move this activity to an appropriate level 1 or level 2 centre.

The issue has not yet been resolved at a number of providers, either because no response has been received or because an application to work as a level 2 Adult

[2] Closure of atrial septal defects (ASDs) by interventional cardiology at level 2 ACHD centres can continue providing individual operators meet minimum volume requirements and the centre meets all the level 2 ACHD standards.

CHD centre is unlikely to be agreed. These will be followed up by NHS England regional commissioners to ensure that occasional and isolated practice is eliminated.

Some centres confirmed that they wished to be considered as level 2 (specialist adult CHD medical centres). Centres wishing to work in this way were assessed at the same time as the level 1 centres against the corresponding standards.

The detailed assessment of each centre, based on the evidence submitted, and after the fact check process described above had taken place, is summarised here.

	Green	**Green / Amber**	**Amber**	**Amber / Red**	**Red**
	Meets all the requirements as of April 2016.	Meets most of the requirements as of April 2016 and has good plans to meet the rest within max. 12 months.	Should be able to meet the April 2016 requirements with further development of their plans.	Does not meet all the April 2016 requirements and is unlikely to be able to do so.	Current arrangements are a risk.
North			Liverpool Heart & Chest		Blackpool; South Manchester
Midlands and East	Norwich & Norfolk*			Nottingham	Papworth
London					Imperial
South		Brighton	Oxford		

* Norwich & Norfolk was assessed as a medical only centre – it does not offer interventional ASD closures

NHS England's regional commissioners will discuss the arrangements at those providers assigned an amber/red or red rating with a view to ensuring that in future patients requiring ASD closure receive their care from an appropriate provider.

5 What happens next?

The issues we are grappling with are complex, but as commissioners we intend to see them through with a view to securing the best outcomes for all patients, tackling service variations and improving patient experience. That includes ensuring that all hospitals providing CHD care are able to meet the standards, or get as close as possible to them with satisfactory safeguards in place.

When we launched this assessment process with providers in December 2015 we advised them about how we intended to respond to the findings:

'…the outcome of the assessment may be one of the following:

- *NHS England continues to contract with a provider without conditions;*
- *NHS England will contract with a provider on the basis of a 'derogation' from the service specification (a time-limited agreement that providers can operate outside of the service specification, with an action plan to achieve compliance);*
- *If a provider does not meet the specification and is unlikely to be able to do so, we would need to discuss future service provision.'*

This report was considered by the Specialised Services Commissioning Committee (SSCC), a sub-committee of the NHS England Board, at the end of June. SSCC has recognised that the status quo cannot continue and that we need to ensure that patients, wherever they live in the country, have access to safe, stable, high quality services. SSCC also recognised that achieving this within the current arrangement of services would be problematic.

SSCC has determined that subject to appropriate public involvement and/or consultation, a change in service provision is appropriate and we expect that any such changes will be part of a managed process and that continuity of care for patients will be a high priority.

While the ability to meet the standards is an extremely important consideration as we seek to ensure that all patients benefit from the same high quality of care, it is not the only consideration. The NHS England board recognised this when it agreed the standards in summer 2015, setting out an intention to take into account and balance all the main factors, including: affordability; impact on other services; access; and patient choice; and not to treat the standards as though they existed in isolation.

Heart transplant services were not covered by the CHD standards as they have their own separate service specification. The national panel considered that the potential impact of any changes to CHD services on paediatric heart transplant and bridge to transplant services (which are only delivered by two providers - Newcastle and Great Ormond Street) would need careful consideration. In addition, adult CHD patients with end stage heart failure have limited access to heart transplant. The unit in Newcastle is recognised as delivering more care to this group than other adult heart transplant centres nationally.

For those providers where our assessment has shown that improvements are needed, we expect that agreed development plans and mitigations will become contractually binding by incorporation in provider Service Delivery Improvement Plans (SDIPs). NHS England regional service specialists will set out clearly the evidence required from providers to demonstrate that individual milestones of the agreed action plan have been met, and will meet with providers regularly to monitor progress, at least quarterly.

6 Ongoing approach to assuring standards compliance

We have a comprehensive process for ensuring that providers will meet all of the standards:

- CHD networks will be established with a specific focus on quality and improvement both operational (for example through the network MDT for rare, complex and

innovative procedures) and developmental (through network audit and improvement activities and clinical governance meetings). Patients and families will have an important role in the operation of the new CHD networks.

- Where providers need more support to achieve the standards we will facilitate arrangements to give access to support and advice from other providers. Where appropriate commissioners will provide project support.
- Our work with the CRG on the clinical dashboard and with NICOR on the national audit, and the new patient reported outcome measurement (PREM) tool we have commissioned will make available a much broader range of information about services to guide improvement activities and performance management.
- Regional commissioners will work through STPs and CCOGs to ensure that level 3 services are appropriately commissioned and play a full part in networks.

Meanwhile we are continuing to deliver a very active programme of work to support the implementation of the standards, including a new implementation group. This new group brings together clinicians from across the service with an interest in CHD, service and network managers, patients and their representatives and commissioners to work together on the challenges of meeting the whole span of standards, and to share best practice.

Hospital Trust: University Hospitals of Leicester NHS Trust

RAG RATING: Amber/Red

University Hospitals of Leicester has not demonstrated that it meets all of the requirements assessed and were considered unlikely to be able to meet requirement 2.1 (see below).

Meeting the requirements

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
1. Ensuring that paediatric cardiac / ACHD care is given by appropriate practitioners in appropriate settings.	1.1 All paediatric cardiac and adult CHD surgery, planned therapeutic interventions and diagnostic catheter procedures to take place within a Specialist Surgical Centre (exceptions for interventional and diagnostic catheters in adults noted below).	A9(L1) Paediatric; B8(L1) Paediatric; B12(L1) Paediatric; A9(L1) Adult; B8(L1) Adult; B12(L1) Adult	N	Y – acceptable plan provided	N

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
	1.2 All rare, complex and innovative procedures and all cases where the best treatment plan is unclear will be discussed at the network MDT.	B2(L1) Paediatric; B2(L1) Adult	Y	N	N
	1.3 All children and young people must be seen and cared for in an age-appropriate environment , taking into account the particular needs of adolescents and those of children and young people with any learning or physical disability.	C2(L1) Paediatric	Y	N	N
2. Ensuring that those undertaking specialist paediatric cardiac / ACHD procedures undertake	2.1 Congenital cardiac surgeons must be the primary operator in a minimum of 125 congenital heart operations per year (in adults and/or paediatrics), averaged	B10(L1)Paediatric; B10(L1) Adult	N	Y	Y

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
sufficient practice to maintain their skills	over a three-year period.				
	2.2 Cardiologists performing therapeutic catheterisation in children/young people and in adults with congenital heart disease must be the primary operator in a minimum of 50 such procedures per year (a minimum of 100 such procedures for the Lead Interventional Cardiologist) averaged over a three-year period.	B17(L1)Paediatric; B17(L1) Adult	N	Y – acceptable plan provided	N
3. Ensuring that there is 24/7 care and advice	3.1 Surgical rotas should be no more than 1 in 3.	B1(L1)Paediatric; B9(L1) Paediatric; B1(L1)Adult; B9(L1) Adult;	Y	N	N

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
	3.2 Interventional cardiologist rotas should be no more than 1 in 3.	B1(L1)Paediatric; B15(L1)Paediatric; B1(L1)Adult;	Y	Y	N
	3.3 Cardiologist rotas should be no more than 1 in 4.	B14(L1) Paediatric;	Y	N	N
	3.4 A consultant ward round occurs daily.	B1(L1)Paediatric; B1(L1)Adult;	Y	N	N
	3.5 Patients and their families can access support and advice at any time	B1(L1)Paediatric;	Y	N	N
	3.6 Medical staff throughout the network can access expert medical advice on the care of children with heart disease and adults with congenital heart disease at any time.	A10(L1) Paediatric; B14(L1) Paediatric; A10(L1) Adult;	Y	N	N

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
4. Ensuring that there is effective and timely care for co-morbidities	4.1 Specialist Surgical Centres must have key specialties or facilities located on the same hospital site. Consultants from the following services must be able to provide emergency bedside care (call to bedside within 30 minutes).	A21(L1)Paediatric; D1(L1) Paediatric; D2(L1) Paediatric; D3(L1) Paediatric; D4(L1) Paediatric; D5(L1)Paediatric; D6(L1) Paediatric; D7(L1) Paediatric; D8(L1) Paediatric; A21(L1)Adult; D1(L1) Adult; D2(L1) Adult; D3(L1) Adult; D4(L1) Adult; D5(L1) Adult; D6(L1) Adult; D7(L1) Adult;	N	Y	Y
	4.2 Key specialties must function as part of the multidisciplinary team.	A21(L1)Paediatric; D1(L1) Paediatric; D2(L1) Paediatric; D3(L1) Paediatric; D4(L1) Paediatric; D5(L1)Paediatric; D6(L1) Paediatric; D7(L1) Paediatric; D8(L1) Paediatric; A21(L1)Adult; D1(L1) Adult; D2(L1) Adult; D3(L1) Adult; D4(L1) Adult; D5(L1) Adult; D6(L1) Adult; D7(L1) Adult;	Y	N	N

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

Measure	Requirement	Related standards	Compliance demonstrated? (Y/N)	Development plan required?	Mitigation required?
5. Assuring quality and safety through audit.	5.1 Specialist Surgical Centres must participate in national audit programmes, use current risk adjustment tools where available and report and learn from adverse incidents.	A21(L1)Paediatric; F4(L1) Paediatric; F7(L1) Paediatric; F9(L1) Paediatric; A21(L1)Adult; F4(L1) Adult; F7(L1) Adult; F9(L1) Adult;	Y	N	N

Development plan and mitigation requirements

2.1 University Hospitals of Leicester initially reported a caseload of 321 procedures for 2015-16, an increase of 55 procedures compared with 2014-15. Validated numbers from NICOR are not yet available for this period; however, this is insufficient for three surgeons to meet the activity requirement. They currently have three surgeons who were not projected to achieve the required 125 operations in 2015/16 (122, 95, 43[1] projected procedures). University Hospitals of Leicester provided an updated figure for 2015/16 of 331 procedures but this is still insufficient for three surgeons to meet the activity requirement.

University Hospitals of Leicester is predicting that growth will continue as a result of:

- continuing to develop relationships with level 3 hospitals such as Kettering General Hospital, Peterborough City Hospital and Northampton General Hospital;
- delivering new outreach clinics; and
- expanding their estate, specifically expanding their outpatient department, moving and increasing accommodation for parents and carers, increasing office space for staff and increasing the paediatric cardiology bed provision to provide a short-stay area, cardiac high dependency beds and a separate facility for adolescents (this work is scheduled for completion in August 2016).

University Hospitals of Leicester also described the mitigation it currently has in place including:

- seeking support and advice in complex or unusual cases, particularly from colleagues at Birmingham Children's Hospital; and
- following MDT discussion they have been supported by one of the senior surgeons at Birmingham Children's Hospital on four occasions in the last year.

The panel was concerned about whether these plans were realistic as it is not possible to know if the recent growth will continue. University Hospitals of Leicester must develop a more detailed plan to ensure that all surgeons meet the required numbers during 16/17.

University Hospitals of Leicester must demonstrate that where its plan is based on changes in patient flows this includes agreements with the referring hospitals and the hospitals currently providing a service to that hospital. University

[1] Surgeon started operating in November 2015. A previous surgeon had also performed 61 procedures in 15/16 prior to stopping operating in October 2015.

Hospitals of Leicester must also monitor surgeon activity during 2016/17 and inform regional commissioners if at any point they consider it likely that one or more of their surgeons will not meet the requirement.

While the predicted growth may in time ensure that the 2016 requirement for a team of three surgeons can be supported, NHS England activity projections suggest that University Hospitals of Leicester will not achieve sufficient activity levels to meet the full requirement for a team of four surgeons by 2021.

2.2 University Hospitals of Leicester reported that it had performed 257 procedures in 2014-15 which would be enough for their interventionists to meet these requirements; however, recently provided figures from NICOR suggest a lower overall activity of 198 procedures (once all procedures which did not qualify had been removed). While NICOR reported activity varies from year to year subject to validation this suggests that University Hospitals of Leicester may be at the margins of having enough activity to meet the requirements for their proposed team of a lead interventionist who performs a minimum of 100 procedures and all interventionists to perform a minimum of 50 procedures for their proposed team of three interventionists. University Hospitals of Leicester must take steps to ensure that they consistently meet the required activity levels to provide sufficient procedures for all their interventionists to meet the required volume.

In order to meet these standards University Hospitals of Leicester plan to reduce the number of interventional cardiologists from seven to three with a fourth cardiologist focussing on EP and implants. The panel considered this an acceptable plan.

University Hospitals of Leicester implemented a 1 in 3 interventional cardiologist rota in April 2016. They must now develop plans to meet the 1 in 4 rota requirement from April 2017.

University Hospitals of Leicester also report an average of 32 procedures each year performed by other staff and trainees for 2013/16. This would appear to be in breach of standard A2(L1) which requires that all congenital cardiac care including investigation, cardiology and surgery, is carried out only by congenital cardiac specialists and standard B12(L1) which requires that all paediatric congenital cardiology must be carried out by specialist paediatric cardiologists (and the equivalent adult standard). The plan described above should address this issue.

University Hospitals of Leicester must take steps to manage interventional workload to ensure that all interventional is undertaken only by congenital

cardiac specialists, that all interventional cardiologists meet the required numbers during 16/17 and to monitor interventional activity and inform regional commissioners if at any point they consider it likely that one or more of their interventionists will not meet the requirement.

4.1 University Hospitals of Leicester does not have access to 24/7 bedside paediatric gastroenterology.

The panel was concerned about whether the proposed mitigations (24/7 support from general paediatrics and paediatric surgery based at Leicester Royal Infirmary to provide first line care for gastroenterological emergencies with next day advice from a paediatric gastroenterologist) were acceptable. The recruitment of an additional Consultant Paediatric Gastroenterologist was approved in May which they state will enable 24/7 30 minute to bedside paediatric gastroenterology care by the end of 2016.

4.1 University Hospitals of Leicester does not have vascular and interventional radiology services on site as required by Standard D7(L1)Adult.

The service is provided by Leicester Royal Infirmary with a site to site journey time under 30 minutes but evidence was not provided to demonstrate that this service is available 24/7 or of a commitment to 30 minute call to bedside care. The panel noted that this service is due to be moved to Glenfield Hospital in February 2017.

University Hospitals of Leicester must provide further evidence to demonstrate that this standard is met or that effective mitigations are in place. NHS England's regional commissioning team will review and agree the plans and monitor implementation of the plan.

Other requirements

1.1 University Hospitals of Leicester has reached an in principle agreement with Nottingham University Hospital that they will provide oversight of their activity as a Level 2 centre including ASD closures. A decision regarding Nottingham's continuation as a Level 2 centre is required prior to any decisions being made regarding the University Hospitals of Leicester proposals regarding its role in providing supervision. If this arrangement proceeds, University Hospitals of Leicester would need to provide additional information on their arrangements for overseeing ASD closures at Nottingham University Hospitals following their meeting which was held during April and July 2016. Regional commissioners would then determine whether any further plans or mitigations were required.

Paediatric Cardiac and Adult Congenital Heart Disease: Standards Compliance Assessment

4.1 University Hospitals of Leicester does not have paediatric surgery or gastroenterology located on site. While the 2016 requirements state that bedside care needs to be available within 30 minutes the standards require that by 2019 these services are co-located. University Hospitals of Leicester have made arrangements to meet the 2019 requirements through their building of a new children's hospital.

5.1 University Hospitals of Leicester working with Birmingham Children's and University Hospital Birmingham will also continue to develop their wider pan-midlands network in line with commissioner requirements due to be confirmed during 16/17.

Will Huxter Blogs on Congenital Heart Disease

Will Huxter, Regional Director of Specialised Commissioning, NHS England, has published the blogs on the NHS England website on the following dates:

13 September 2016

There has been much written about the proposals that we have made for CHD services and we thought it would be helpful to be clear on some of the facts.

First, no final decisions on CHD services have been made. Rather, following an assessment of current services based on information provided by current providers, NHS England has made a series of proposals about how services should be offered in the future. Final decisions on surgical services will not be made until we have carried out full public consultation.

We are now working with providers and stakeholders to explain and discuss our proposals, and to listen to concerns. This will help us to plan the consultation which we expect to launch later this year.

We expect the NHS England Board to make its decisions, following public consultation, in the first half of next year. But even when decisions have been made, services for patients will not change overnight. If the decision is to make changes like the ones proposed, it will be a steady and carefully planned transition of care and the CHD clinicians that you know will work to ensure care is transferred well. If you have any concerns about this please speak to your cardiologist.

While we are in the pre consultation phase we are responding to invitations from local authority Health and Wellbeing boards and Overview and Scrutiny committees, where we can talk through the proposals and answer any questions and we will continue to do this wherever we are able to. We are also planning to visit hospitals to discuss proposals with teams at the units.

We have updated the questions and answers page with questions that we have been asked and will continue to add questions and answers. One question we have been asked several times is who was on the panel that carried out the assessment. You can find that answer on our Q&A page, but in brief the assessments were made by a panel of made up of clinicians and patient representatives drawn from the Clinical Reference Group and the Programme of Care Board and commissioners drawn from NHS England's regional and national teams. Professor Kelly, the long serving chair of our clinicians' group was also part of the panel. I chaired it, in my role as the programme's SRO. See the full list of who was on the panel.

The reports of NHS England's assessment of each CHD centre (both level 1 and level 2) are now also available. These reports give the national panel's assessment of the evidence provided by the units for each of the requirements examined, which reflect 24 paediatric standards and the matching adult standards. These final reports take into account the comments from each provider organisation on the factual accuracy of its assessment, and so differ from the initial reports shared with

providers earlier in the process. Each report details whether the evidence provided shows that the requirement has been met, and then sets out what that provider needs to do to meet those standards that have not yet been met. Each unit is also given a summary rating. An overview of the assessment process, the findings and the ratings for every unit are described in the overview report of the national panel.

We want to reassure patients that published outcomes from all our current providers show that they are safe, but we believe that care can be improved and risks further reduced by ensuring that patients receive their care only from centres that meet the standards. Any changes made to any service will be made safely, and will be carefully managed with patients.

We are also planning for our next CHD Implementation workshop for the clinical and patient & public representatives who have been working on implementing the standards, which will be focusing on transition to adult services, psychological support, engaging young people and how we share best practice.

19 October 2016

I want to remind you about the reasons for us doing this work, and also inform you about developments in specific parts of the country. The driver for NHS England's work is simple – we want to ensure that every patient, who requires care for congenital heart disease, can be confident that that care is delivered from a centre that meets the national standards. These standards were developed by clinicians, patients, and other key stakeholders, and were the subject of rigorous public consultation, before being formally agreed by our Board in July 2015.

We know that implementation of these standards is critical if we are to provide the services our patients deserve. We know this, because stakeholders – including patient groups and families – have told us. We are strongly committed to ensuring that people with congenital heart disease have access to high quality, resilient services – achievement of the agreed national standards is the best way of securing this. However, any potential change will not happen overnight.

We are currently preparing for formal public consultation on our proposals. Commissioning decisions will not be made until spring, at the earliest, next year, and only after feedback received during that consultation has been considered. Any changes to current service provision will be carefully managed, and we will work with patients, and their clinical teams, to ensure that transition is as smooth as possible.

At the moment, we are meeting with providers across the country to discuss our proposals and their implications for individual hospital trusts. We have met with staff, patient groups and many others with an interest in the services, to answer questions; have visited existing facilities, to hear about plans for the future; and have sought to clarify some points where we needed further detail.

So far we have visited Great Ormond Street, the Evelina, University Hospitals Leicester, the Royal Brompton, Birmingham Children's Hospital, and Barts. We also have visits lined up at Newcastle, Alder Hey, Liverpool Heart & Chest Hospital, and

Central Manchester University Hospitals, with other hospital visits still to be arranged.

I would like to thank all of the providers who have hosted visits so far, in particular the clinical staff who have made time within their busy schedules to meet with us. We are in listening mode at the moment, and very open to debate and discussion. Since publishing our proposals in early July, we have dealt with almost 70 separate pieces of correspondence relating to our proposals, so if you do have any queries, please get in touch with us at england.congenitalheart@nhs.net

The discussions currently taking place with CHD providers are critical as there is still opportunity for providers to produce evidence, or come up with solutions, which will enable them to meet the CHD standards in full by the required timescales. This would influence what we finally consult on.

University Hospitals Leicester NHS Trust

We know that University Hospitals of Leicester NHS Trust has put into the public domain correspondence sent to NHS England. The letter relates to a number of questions which we put to the Trust, after our visit there on 16 September. In the interests of balance, it is important for people in Leicester, the wider East Midlands and beyond to understand the background to some of the questions we asked. There remain some fundamental areas where our assessment of the Trust's current position – based on the information provided to us by the Trust – shows that Leicester does not currently meet the national standards, and which it needs to address.

The national standards require a minimum of three consultant surgeons, each undertaking a minimum of 125 operations per year, averaged over the three years leading up to April 2016. Leicester has reported carrying out 331 cases in 2015/16, well short of the minimum requirement for 3 surgeons of 375 cases. The Trust has told us that it has one substantive consultant surgeon and two locums.

The national standard further requires four consultant surgeons, each undertaking a minimum of 125 cases per year, averaged over the three years leading up to April 2021 – which would require an increase of over 50% on the numbers achieved last year. University Hospitals Leicester has not yet provided us with a plan setting out how they would achieve the 500 cases required.

This is a really important standard for patients. We want patients to be confident that their surgery is being delivered by an expert in this field, who has the back-up of a team of fellow surgeons, to cover periods of annual leave, sickness and out-of-hours cover. On the basis of the information provided so far, we cannot guarantee that this is the case in Leicester.

The national standards also have requirements for particular clinical services to be located together on the same site, so that patients and their families can benefit from treatment from a team who know each other well, and which is able to respond in a joined up way at very short notice when required. University Hospitals Leicester has

not yet provided the information we require to demonstrate that these standards are met.

We will continue discussions with colleagues at University Hospitals Leicester, during this pre-consultation period, and will use this blog to share further information about any developments at Leicester or elsewhere as appropriate."

Will Huxter Blog - 23 November 2016

I want to use this blog to update you about the progress we are making in implementation of the nationally agreed standards for Congenital Heart Disease services, which were approved by our Board in 2015.

As you know, we are currently preparing for public consultation on our proposals about how CHD services might be configured in the future, in order to implement the standards across the country.

Since announcing our proposals in July, our regional and central teams have been working with providers to pin down exactly what is left to do to enable those who are almost there in meeting the standards, to achieve full compliance.

We have also been talking to those trusts which – on the evidence they have presented to us so far – look like they will be unable to meet the standards in full, within the required timescales as set out in the standards. These discussions, as you might imagine, are quite complex and involve a significant amount of back and forth between ourselves and the trusts in terms of information sharing.

It is really important that we give these discussions enough time to run their course, as some of the information received already during this pre-consultation period has the potential to alter the proposals which we will put forward for public consultation.

Given where we are in talking to a number of CHD providers, we have decided to enable talks to continue for a slightly longer period of time and will, therefore, launch public consultation in the New Year, and not before Christmas, as originally intended.

This will allow time for further discussions to take place, and will enable some of the providers to further refine and develop their plans for future service delivery – and for us to continue our pre-consultation engagement with patients, the public, clinicians, and other stakeholders. I will let you know via this blog once we have a definite date for consultation launch.

I will also give you more detail about some of the events that will be taking place during consultation. We are currently planning a mix of face-to-face and digital events, including webinars and Twitter chats, for those who are unable to travel to meetings, as well as some specific events for groups we think would be particularly affected by our proposals.

NHS England

Briefing for local government on proposed changes to NHS Specialist services for people with Congenital Heart Disease

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Commissioning Operations**	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

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Additional Circulation List	
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Contact Details for further information	Congenital Heart Disease Programme NHS England Skipton House, 80 London Road, London SE1 6LH england.congenitalheart@nhs.net www.england.nhs.uk

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BRIEFING FOR LOCAL GOVERNMENT ON PROPOSED CHANGES TO NHS SPECIALIST SERVICES FOR PEOPLE WITH CONGENITAL HEART DISEASE

Version number: 1

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Prepared by: Will Huxter

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Contents

1 Executive summary

In July 2015, the NHS England Board agreed new standards and service specifications for congenital heart disease (CHD) services, with the expectation that in future all providers would meet the standards, leading to improvements in service quality, patient experience and outcomes. NHS England is the direct commissioner of CHD services, as prescribed specialised services.

The standards are based on a three tier model of care with clear roles and responsibilities (and standards) for each tier. Networks will help local services to work closely with specialist centres, to ensure that patients receive the care they need in a setting with the right skills and facilities, as close to home as possible. The three tiers are:

- ***Specialist Surgical Centres (level 1)***: These centres will provide the most highly specialised diagnostics and care including all surgery and most interventional cardiology.
- ***Specialist Cardiology Centres (level 2)***: These centres provide specialist medical care, but not surgery or interventional cardiology (except for one specific minor procedure at selected centres). Networks will only include level 2 centres where they offer improved local access and additional needed capacity.
- ***Local Cardiology Centres (level 3)***: Accredited services in local hospitals run by general paediatricians / cardiologists with a special interest in congenital heart disease. They provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from the Specialist Surgical Centre, allowing more care to be given locally.

The Board agreed a go-live date of April 2016 for implementation of the new standards, embedded in contracts with providers, with a standard specific timetable to achieve full compliance.

The Board agreed proposals for commissioning the service and endorsed initial work with providers to develop proposals for ways of working to ensure the standards would be met.

Work with providers commenced in April 2015, culminating in submission of proposals in October 2015. Seven submissions were received, some from networks based on a single surgical centre, others from new multi-centre networks.

The proposals were comprehensively assessed by a commissioner led panel, with clinician and patient/public representation. The panel advised that certain standards were considered particularly important determinants of service quality and safety:

- All surgeons should be part of a team of at least four, with an on-call commitment no worse than 1:3 from April 2016 and that each surgeon must undertake at least 125 operations per year. From April 2021 the aim is a minimum 1:4 rota.
- Surgery must be delivered from sites with the required service interdependencies.

The assessment was discussed at NHS England's Executive Group Meeting (EGM) in December 2015. EGM accepted the panel's assessment that, taken together, the provider proposals did not provide a national solution; giving more time would not yield a different outcome; and that developing a national solution would require significant support and direction by NHS England. EGM agreed that action should be taken to ensure that the April 16 standards were met as soon as possible, with immediate action to ensure that appropriate short term mitigations are put in place in the meantime to provide assurance of safety. This approach was endorsed by the Specialised Services Commissioning Committee (SSCC) at its meeting in February 2016.

2 The Assessment

2.1 The Assessment Process

A process to assess compliance with selected standards was launched in January 2016. It focused on 24 paediatric standards (and the matching adult standards) most closely and directly linked to measurable outcomes (including the surgical and interdependency standards previously highlighted by SSCC) and to effective systems for monitoring and improving quality and safety.

Providers of CHD services were asked to evidence their compliance with the 2016 standards. While the focus was on the 2016 standards, NHS England also took account of the ability of providers to reach the 2021 standards.

Where standards were not met providers were asked to provide plans to achieve the standards and the mitigating actions they proposed to take to provide assurance of the safety and quality of services until all the standards were met. An acceptable development plan was considered to be one than gave a high degree of assurance (in the view of NHS England) that the standard would be met within 12 months of the standard becoming effective on 1 April 2016.

The process was based on NHS England's standard approach when introducing a new service specification for any specialised service.

Our initial assessment showed that additional information would be needed in order to complete the process. This was requested from all the hospitals involved in March 2016 to make sure that every hospital had the opportunity to supply all the relevant information before we completed our assessment. We gave initial feedback on the findings of the first round at a meeting with clinicians on 18 March, and explained why further detail was being requested. These additional returns were assessed in April 2016.

Each set of returns was initially evaluated at a regional level by the NHS England specialised commissioning team, followed by a national panel to ensure a consistency of approach. The national panel brought together NHS England staff from both national and regional teams with representatives from the Women and Children's Programme of Care Board and the Congenital Heart Services Clinical Reference Group to provide wide ranging and senior clinical advice and patient and public perspectives.

The panels were asked to concentrate on this assessment of compliance rather than trying to answer the question 'what should NHS England do?' The driver for this work has been to ensure delivery of the standards.

2.2 Outcome of Assessment Process

All the providers were assessed against the standards, and rated on a scale from Green (meeting all the requirements as of April 2016) through to Red (current arrangements are a risk). The national panel report is available on the NHS England website:

https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/.

3. Proposals for change

In line with these assessments, NHS England has set out decisions that it is minded to take in relation to congenital heart disease services, subject to the outcome of public consultation. No decisions have been taken at this time. The full text of the announcement is available on the NHS England website: https://www.england.nhs.uk/2016/07/chd-future/

In summary we are proposing that in order to ensure that every patient benefits from services that meet the agreed standards that in future specialist surgical (Level 1) services for patients with congenital heart disease will be provided at:

- Alder Hey Children's Hospital NHS Foundation Trust and Liverpool Heart and Chest Hospital NHS Foundation Trust
- Birmingham Children's Hospital NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust,
- Great Ormond Street Hospital for Children NHS Foundation Trust and Barts Health NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Newcastle Hospitals NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust

Subject to further discussions with the relevant Trusts, local authorities and public consultation, specialist surgical (Level 1) services for patients with congenital heart disease would no longer be provided at:

- Central Manchester University Hospitals NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- Royal Brompton & Harefield NHS Foundation Trust

Specialist medical services may be retained in Leicester and Manchester.

We are also proposing that in order to ensure that every patient benefits from services that meet the agreed standards, that in future specialist medical (Level 2) services for patients with congenital heart disease will be provided at:

- Brighton and Sussex University Hospitals NHS Trust
- Norfolk & Norwich University Hospitals NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust

Subject to further discussions with the relevant Trusts, local authorities and patient groups, specialist medical (Level 2) services for patients with congenital heart disease would no longer be provided at:

- Blackpool Teaching Hospitals NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Nottingham University Hospitals NHS Trust
- Papworth Hospital NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust

4. Engagement, public consultation and scrutiny

NHS England has committed to full public consultation on its proposals for change in relation to level 1 congenital heart disease surgical centres. This will be for a period of 12 weeks, and will be led nationally with regional support.

Prior to the launch of public consultation, NHS England will undertake engagement with affected Trusts, local authorities, patient groups and other stakeholders. Pre-consultation engagement will include an assessment of the potential impact on other services within the Trust in the event that the proposals are approved.

Proposed changes at aspiring level 2 congenital heart disease centres are not considered to meet the threshold for 'substantial variation' because of the small number of patients affected. NHS England will work with affected hospitals and patient groups to plan and manage the changes needed. These changes are not expected to have any impact on other services in these hospitals.

We intend to work most closely with those authorities closest to the hospitals potentially affected by change. Other authorities that consider the proposals to represent a substantial change for their residents may wish to be involved in these arrangements either before or during formal consultation. We would be supportive of the development of joint scrutiny arrangements.

We will provide further briefings or attend H&WB or OSC meetings on request (please see contact details below).

5. Timescale

Subject to advice from OSCs and others during our pre-consultation engagement, NHS England's high level timetable is as follows:

- Pre-consultation engagement: this has now started
- Public consultation: minimum 12 weeks, starting in the autumn (date to be confirmed following pre-consultation engagement)
- Review of the outcome of consultation: Spring 2017
- Final decisions: late Spring/early Summer 2017

Implementation of the final decisions: Summer 2017 onwards (with an appropriate transition plan for patients and staff).

6. Next steps

Keep in touch with NHS England's work via Will Huxter's blog available on the NHS England website: https://www.england.nhs.uk/commissioning/spec-services/npc-crg/chd/blogs/

Contact the team; request a more detailed briefing or attendance at a HWBB or OSC, or to request an email alert when a new blog is issued: england.congenitalheart@nhs.net

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

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 December 2016**
Subject:	**Lincolnshire Sustainability and Transformation Plan**

Summary:

Each local NHS area is required to prepare a Sustainability and Transformation Plan (STP). On 7 December 2016, the Lincolnshire STP was published, together with a public summary document. The STP is not a consultation document, but a strategy document, from which formal public consultations will be derived. Formal public consultations are expected to take place from May 2017 onwards.

The public summary document of the Lincolnshire STP is attached at Appendix A to this report. The full Lincolnshire STP is available online at the following link:

http://lincolnshirehealthandcare.org/en/stp/

The purpose of this item is for the Committee to give initial consideration to the contents of the STP, and to consider how the Committee will make its response as part of the engagement phase of the STP. This could include the possibility of holding a special meeting of the Health Scrutiny Committee in January 2017.

The following will be attending the meeting to present the STP and respond to questions from the Committee:

- Andrew Morgan, Chief Executive, Lincolnshire Community Health Services NHS Trust
- Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group
- Sarah Furley, Programme Director, Lincolnshire Sustainability and Transformation Plan.

Actions Required:

(1) To give initial consideration to the Lincolnshire Sustainability and Transformation Plan (STP).

(2) In the light of the fact that the STP is not a consultation document, to determine whether to provide a formal statement on the Lincolnshire STP, in advance of the formal public consultation, which is expected from May 2017 onwards.

(3) If the Committee determines to provide a formal statement on the Lincolnshire STP in advance of the formal public consultation, to consider how it wishes to do so, including the possibility of holding a special meeting of the Committee during January 2017.

1. Background

Requirement for a Sustainability and Transformation Plan

On 22 December 2015, *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21* was published by several national NHS organisations, including NHS England and NHS Improvement, who are the main regulators for health care. A key requirement in this guidance was that each local NHS area would prepare a Sustainability and Transformation Plan (STP). The aim of the STP process was to see how, by working together, health and care organisations could improve the health and well-being of their resident population and increase the clinical and financial sustainability of local health and social care services. In addition, each STP was required to provide evidence of how it would contribute to the delivery of the *NHS Five Year Forward View*, which sets out the national direction for health and care in the country.

As a first step in January 2016, 44 local STP 'footprints' were developed. The Lincolnshire STP covers the Lincolnshire East, Lincolnshire West, South Lincolnshire and South West Lincolnshire Clinical Commissioning Group areas. It does not include North Lincolnshire or North East Lincolnshire Clinical Commissioning Group areas, which is covered by the Coast, Humber and Vale STP.

Draft STPs were submitted in June and September 2016 and an updated plan, following feedback from these submissions, was submitted on 21 October 2016, for further review by NHS Improvement and NHS England.

Developing the Lincolnshire STP

Considerable progress has been made this year to develop the Lincolnshire STP, building on the work which was already underway in the county to come up with a new model for health and care through the Lincolnshire Health and Care Programme (LHAC). Through the LHAC programme, Lincolnshire's clinical leaders have worked to identify the main challenges faced by the health and care system for Lincolnshire, and potential solutions. In developing the STP, short term opportunities to improve

cost effectiveness of services were also explored, as well as options to create a sustainable Lincolnshire care model for 2020 and beyond.

In addition, there has been discussion and input from Lincolnshire County Council officers, in particular around how health and social care services can be better joined up; and how services in the community, which prevent ill health, can be improved. Other key organisations have also fed into the development of the Plan like the East Midlands Ambulance Service NHS Trust, key health providers outside Lincolnshire, Lincolnshire GPs and pharmacies and local organisations from the public, private and voluntary sector that provide relevant services that support wellbeing in the community. Healthwatch Lincolnshire participate on the stakeholder board.

The work to develop the STP has been led by Lincolnshire's seven health organisations which are:

- Lincolnshire West Clinical Commissioning Group
- Lincolnshire East Clinical Commissioning Group
- South West Lincolnshire Clinical Commissioning Group
- South Lincolnshire Clinical Commissioning Group
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust

Lincolnshire Health and Care and Its Relationship to the STP

The Lincolnshire Health and Care (LHAC) programme was launched in 2013 as result of organisations in Lincolnshire recognising current services did not adequately meet the needs of residents. Due to growing demands and financial pressures it became clear that doing nothing about the issue was simply not an option. Because of this, all the health and social care organisations collaborated for the very first time to attempt to tackle the problems and to design a new model for health and care in Lincolnshire enabling people to access the right services at the right time now and in the future.

The primary focus of the LHAC programme has been clinical quality and safety, ensuring resources are deployed as effectively as possible to deliver services which people want and need and which are sustainable for future generations. Resources are staff, money and our NHS buildings.

The LHAC programme was about to go to public consultation at the end of 2015, but the announcement of the STP process delayed this. It was agreed that the LHAC work would become the clinical work stream of the STP programme. The LHAC emerging model of joined up care, closer to home is the foundation for how STP partners see clinical services developing in the county and is aligned to the national Five Year Forward View for the NHS. However, the scope of the STP is broader. It covers things like productivity and operational efficiencies ranging from how services are procured to how estates are best used, the development of the workforce and technology innovation.

Publication of the STP

The Lincolnshire STP was published on 12 December 2016, together with a public summary document, which is attached at Appendix A to this report. The full STP document is available at the following link: -

http://lincolnshirehealthandcare.org/en/stp/

The STP is not a consultation document, but a strategy document, from which formal public consultations will be derived. Formal public consultations are expected to take place from May 2017 onwards.

Lincolnshire STP Vision

Lincolnshire's STP is based on a simple vision – to achieve really good health for the people of Lincolnshire with support from an excellent and accessible health and care service delivered within our financial allocation. The vision for the STP was published in August 2016. The vision includes the key priorities for the STP, which are:

- Spend more money on keeping people well and healthy
- Support people to take more responsibility for their care and increase the number of people who use personal health budgets for their health and care
- Reduce the number of people needing to be admitted to hospital and instead provide care in the community through joined up neighbourhood care teams
- Have a network of small community hospital facilities and urgent care centres to work with neighbourhood teams
- Have a small number of specialised mental health inpatient facilities to provide support to neighbourhood care teams and community hospitals
- Have a smaller acute hospital sector providing emergency and planned care with specialist services for things like heart attacks and strokes and maternity and children's services
- Have a consistent approach for which patients can be referred for treatment to hospital, based on evidence of what has the best results for patients
- Improve the effectiveness and safety of services so patients have a better experience and we meet all national standards for care

LHAC Case for Change Document

In June 2016, the *LHAC Case for Change* document was published, which was circulated to members of the Health Scrutiny Committee. This document set out the reasons why services need to change in Lincolnshire and was developed following extensive engagement and discussion with staff and public and analysis of the evidence for how services currently operate in the county. The findings are stark. It is clear that services are not always delivered that meet national standards for safety and quality. The view from the public was mixed – while many reported good quality care from excellent and compassionate staff this was not a consistent picture. Time and again, people mentioned the difficulty in getting appointments, the long waits for referrals and how disjointed services often are for people with multiple needs. There

were also reports of poor quality care and poor patient experience with an overstretched workforce struggling to meet the rising demand for care.

The age and health profile of services and the increasing cost of care is making the way services currently operate unsustainable for the future. Lincolnshire cannot get the staff to enable all its services to remain viable – there are several hundred vacancies for both general and specialist staff and this means our workforce is overstretched. Lincolnshire also relies on temporary or agency staff which is very costly and reduces the quality of care delivered to patients. There is considerable duplication between different organisations and agencies in the county which is both wasteful and disjointed, with poor communication and often duplication and inefficiency. This year alone £60m more was spent on health services than the amount received in funding.

The Next Steps and Actions by the Committee

The STP is not a consultation document. It has been emphasised that it is a dynamic strategy document, and there is a strong commitment to listening to and reflecting on all comment and feedback received on the STP's content. The next steps in the STP process are outlined on page 24 of the public summary document in Appendix A (and detailed on page 114 of the full STP). It should be stressed that full public consultation on service changes is due to begin in May 2017.

Page 82 of the full STP document provides further details on service reconfiguration arrangements, and a schedule of service redesign options is set out on pages 83 and 84 of the full STP. It is stated on page 84 that formal public consultation will begin in May 2017.

Statements and feedback on the Lincolnshire STP are welcome at any time and would be considered by the System Executive Team. Prior to May 2017, the Committee may determine to make a formal statement on the STP, in advance of the formal public consultation. If the Committee chooses to make a response at this stage, it would still be in a position to exercise its statutory functions and make a response to the formal public consultation during the summer of 2017.

If the Committee chooses to make a statement on the Lincolnshire STP in advance of formal public consultation, it will need to consider how it will do this and by what date. A potential option may be a special meeting during January.

Engagement – National Guidance

On 15 September 2016, *Engaging Local People - A Guide for Local Areas Developing Sustainability and Transformation Plans* was published by NHS England, NHS Improvement and four other national NHS organisations. This guidance stated that STPs should include engagement plans for both ongoing dialogue with stakeholders and for any formal public consultations required for major service changes. Copies of the guidance were circulated to members of the Committee.

2. Conclusion

The Health Scrutiny Committee for Lincolnshire is invited to give initial consideration to the Lincolnshire Sustainability and Transformation Plan (STP). In the light of the fact that the STP is not a consultation document, the Committee is requested to determine whether it wishes to provide a formal statement on the Lincolnshire STP, in advance of the formal public consultation, which is expected from May 2017 onwards.

3. Consultation

The STP is not a consultation document. Formal public consultations are expected from May 2017 onwards. As an initial step the Committee is invited to consider if it wishes to make a statement on the Lincolnshire STP, in advance of the formal public consultation. It is understood that all formal responses received will be considered by the Lincolnshire System Executive Team.

Page 24 of the STP Summary Document (Appendix A) states that a full public consultation is expected in 2017 on proposals covering urgent and emergency care and maternity and children's care in particular, but more work is needed to finalise the options before formal consultation. There is a commitment to listen to all contributions and use these contributions to influence the decisions made.

Page 82 of the full STP provides further details on service reconfiguration arrangements, and a schedule of service redesign options is set out on pages 83 and 84 of the full STP. It is stated on page 84 that formal public consultation will begin in May 2017.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Sustainability and Transformation Plan – Public Summary Document

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk










Lincolnshire Sustainability and Transformation Plan

Public Summary

Contents

An update on our new five year Plan for health and care services in Lincolnshire

Health and Care Services in Lincolnshire are changing.

Lincolnshire health and care organisations have been working together on a new 5 year Plan – it is called our Sustainability and Transformation Plan (STP). We want to make sure that services are safe and effective. We want every pound we spend on services in the county to make a real difference for Lincolnshire residents.

This document is a summary of our Plan. It sets out how care in Lincolnshire will be provided differently by 2021. It explains what the benefits will be for Lincolnshire residents. It also describes how we will continue talking and listening to residents and staff as we finalise this Plan and take it forward.

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Chief Executive
Lincolnshire Community Health Services NHS Trust

Lincolnshire Community Health Services NHS
NHS Trust

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Clinical Chief Officer
Lincolnshire West Clinical Commissioning Group

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1

Why do our health and care services need to change?

Our health and care staff work really hard to provide excellent care. However, the quality of services in Lincolnshire is not always as good as it could be.

Lincolnshire residents have told us they think services need to change.

Many people say it can be really hard to get an appointment with their GP, particularly if they want to see a specific doctor. Patients are travelling too far to hospitals for care that could be delivered by their GP, at home or in their community. It also takes too long to get people home from hospital and there can often be delays before people are discharged. For people who have long term conditions like heart disease, diabetes or breathing difficulties, care is often very disjointed, with many different professionals providing care without talking to each other.

We know that ***over 2,000 planned operations are cancelled every year.*** This can be difficult and upsetting for patients. Over 50% of people needing operations have their operations outside of Lincolnshire. ***We also know that we don't meet some of the key NHS standards, such as making sure no one has to wait longer than four hours in A&E.*** We don't work efficiently and there is duplication, for example with tests or assessments being repeated.

On top of this,

we are spending £60 million more each year than we have in funding

We spend too much money on treating people in hospital rather than providing support in the community to prevent people needing hospital care.

In Lincolnshire we have an ageing population ***the number of people aged over 75 set to double in the next 20 years*** We also have lots of people with poor health and many who have several different illnesses at the same time. Lincolnshire's residents are spread thinly over a huge area. This means that it can be difficult to provide a fully staffed service when the numbers of people being seen and treated are low.

We don't have enough doctors and nurses in Lincolnshire across health and care. There's also a national shortage of nurses and doctors in specialities such as emergency medicine, radiology, and paediatrics (children's health). This leaves staff overstretched and we have to rely on temporary staff which can be expensive and not good for patient care.

2
Process

Over the past nine months, Lincolnshire's health and care organisations have been looking at how we can:

- improve the wellbeing of our population
- provide better quality care and
- deliver services within our budget over the next five years.

Our Plan is built on, and includes, the work we've been developing for over 3 years through the Lincolnshire Health and Care programme. We know there are difficult decisions to make about how services are provided. But if we don't change things then our health and care system will buckle under the pressure.

Who has worked on this Plan?

Our Plan covers health and care services. NHS organisations in Lincolnshire have taken the lead on the Plan, in particular the changes to Healthcare services. Lincolnshire County Council has given advice about how social care can link up with health services. The Council has also helped develop ideas for how support services in the community can best keep people well and healthy and prevent them going into hospital when they don't need to. We have also listened to the feedback from our public and talked to lots of organisations from the voluntary, public and independent sectors which provide vital services in our communities. We've made sure we talk to health organisations over our borders too so that our Plans are coordinated.

This Plan is an opportunity to improve and transform the way our health and care services work. Now we want to hear views from the public, patients and staff about this Plan. This Plan is our final draft but is not set in stone. Many of our proposals are still at an early stage and need to be further discussed, tested and developed. Some changes will need to go through a full public consultation. Plans are now clear enough that we can talk in detail to the public to get their views and input. Over the next 6 months we will be holding a range of events where people can come and hear about the Plan and share thoughts and ideas on how we take it forward. If you are interested in finding out more or getting involved please email lhac@lincolnshireeastccg.nhs.uk or call 01522 718051

To view the full Plan please go to www.lincolnshirehealthandcare.org/stp

3

What you've told us so far

We've been out talking to the public for the last 3 years to get their views about our services. We've heard from over 18,000 people during this time. The key issues that have been raised are:

- The difficulty in getting a GP appointment and waiting times for referrals for things like tests, operations and assessments
- The need for services to be more joined up – people are frustrated with having to repeat their healthcare stories several times to different professionals. Communication needs to improve between professionals and care for patients with lots of different conditions must be coordinated better.
- Not knowing where to go for support and difficulty in accessing a service, often because of the distance to travel
- Wanting services to be as close to home as possible although it was understood that it is not possible to have all services available close to home, all the time
- The importance of services being safe and good quality for all people in the county

Some parts of our Plan are already starting to deliver the changes that patients and staff have said they want to see.

The graphic below sets out how some of the feedback from public and stakeholder engagement has directly influenced our Plan:

You Said	We Did
Services are confusing – it's not always easy to know where to go when you have a crisis	Developed the Clinical Assessment Service to deliver one route via 111 for those with urgent care needs who will be directed immediately to the most appropriate place for their needs
Why can't it be more joined up for those receiving care from a number of different places	Developed the Care Portal as our technology solution allowing instant access to a patient's records Designed integrated neighbourhood care teams to ensure a joined up service
I don't want to repeat myself all the time	Developed the Care Portal to ensure better communication between health and care professionals to deliver better care to the patient
I want to be at the centre of my care	Finalised the Self-Care Strategy with a number of initiatives to empower people to take more control over their own health and wellbeing
I don't know where to go for support in the community	Community Directory of Service up and running, provided by Lincs2Advice – online/telephone access to a wide range of local services with information on opening times, eligibility, access etc
I want services as close to home as possible with improved access	Developed Integrated Neighbourhood Care Teams; proposals for moving care from an acute to community setting; improvement plans to deliver GP FYFV to include 7 day access;
For mental health, I want to be treated at home or in my local community	Proposals in development for a community model of care in mental health and more acute mental health beds in county for those who need inpatient care
I want to have confidence that I will receive high quality, safe services	Proposals in development around a number of options to improve clinical services through hospital reconfiguration
I want to be engaged and involved in decisions about changing health and care services	Engagement with over 18,000 people; engagement plan developed for further engagement and involvement in the future; website fully operational with information about LHAC and the STP

4

Lincolnshire's vision for health and care

Our vision is to achieve really good health for the people of Lincolnshire by 2021 with support from an excellent and accessible health and care service with the money we have available.

To make this happen we will:

Spend more money on keeping people well and healthy, providing tools and support for people and communities to make healthy choices and take more control over their care; this will improve their quality of life and reduce the number of people dying from diseases that could be prevented

Support people to take more responsibility for their care and increase the number of people who use personal health budgets for their health and care

Reduce the number of people needing to be admitted to hospital and instead provide care in the community through joined up neighbourhood care teams; join up physical and mental health, and health and social care; care will be genuinely closer to home and if people do need to be in hospital, we will get them home quickly

Have a network of small community hospital facilities and urgent care centres to work with neighbourhood teams; these will provide support for tests and x-rays, outpatient appointments with doctors and other health professionals and a limited number of beds

Have a small number of specialised mental health inpatient facilities to provide support to neighbourhood care teams and community hospitals

Have a smaller acute hospital sector providing emergency and planned care with specialist services for things like heart attacks, strokes, maternity and children's services; have better links between expert hospital doctors and professionals in the community

Have a consistent approach for which patients can be referred for treatment to hospital, based on evidence of what has the best results for patients; improve the care experience for people with particular diseases such as diabetes or cancer, making sure care is joined up and waiting times are reduced;

Improve the effectiveness and safety of services so patients have a better experience and we meet all national standards for care

How will this be different for patients?

They know who their GP is but are likely to have initial consultations with a range of primary care and community based health and care staff. This will often be by phone or using new telemedicine technology (this allows patients to receive care from doctors or specialists far away without the patient having to travel to visit them). They find they don't need to explain their health and care issues in detail more than once.

Residents take more responsibility for their own health, both in managing long term conditions such as high blood pressure and in making healthy lifestyle choices to keep fit and well.

They can access their records via the Care Portal to assist them with caring for themselves if they have long-term conditions like high blood pressure or breathing difficulties.

For ongoing health and care issues, their main contact may well be their GP. They can expect that most diagnostic tests and specialist consultations are done locally. If they need specialist emergency or planned care, they may need to travel to an acute hospital but can return to their own community very quickly.

They find that all those caring for them are well trained and motivated, working effectively with their colleagues, and that their care is delivered in comfortable surroundings. They can access the right service first time and consistently receive good quality, safe care wherever they live in the county.

5

Improved wellbeing for all

By 2021 individuals, carers, families and communities will be able to take control of their own care. They will have access to the information, knowledge, skills and resources needed to prevent ill-health and improve and maintain health and wellbeing.

We know that as many as 300 deaths could be prevented in Lincolnshire by 2021 if we provide support so that people can make healthier lifestyle choices.

We will spend more money on keeping people well and healthy for longer. We know that as many as 300 deaths could be prevented in Lincolnshire by 2021 if we provide support so that people can make healthier lifestyle choices. Our focus will be on helping people who are overweight and who are smokers.

We will also work with our staff to make sure that every time they come into contact with a patient or service user they can provide information and support about healthy lifestyle choices.

- We are already part of the National Diabetes Programme which provides 9 month intensive lifestyle support to those at risk of diabetes – over 500 people were referred in the first four months of the programme which started in July 2016. This programme is vital as we have a very high level of diabetes in the county.
- We now have a community directory of services in place to link residents to a wider network of activities to improve wellbeing and reduce isolation and inactivity.
- We are also looking at how we can work with the public to make sure that people use services appropriately – for instance pharmacies can offer to review medication or provide advice which might mean someone doesn't need to see a doctor.

6

More care out of hospital in your home and community

By 2021, people will be supported close to their homes and only need to go to hospital for specialist treatment or emergencies. Social care and health services will be fully joined up. There will be much better relationships with local charities and independent organisations which provide such crucial care and support services to many people in our communities.

We will provide care closer to home so that fewer people have to be admitted to hospital. We know that hospitals are not always the best place for people to be, particularly older people who can lose their independence and their mobility very quickly if they are in a hospital bed.

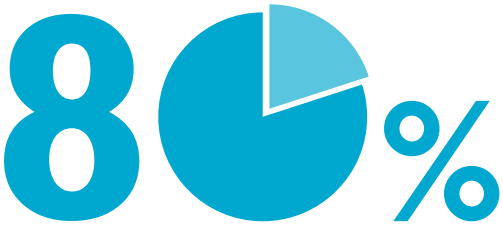
We will bring together doctors, nurses, mental health practitioners, social care professionals, therapists and other community based professionals to work as one team in a neighbourhood, linking in with wider services and support.

Our Plan includes proposals for 7 day a week access to GP services. Our GP surgeries will work together in larger groups to provide access to a range of services. These will be delivered by a wider workforce including pharmacists, physiotherapists, doctors and nurses. This will mean that patients will be able to get an appointment more easily and more services currently provided in a hospital setting will be available locally. This would include things like getting antibiotics through a drip or follow up appointments following sprains or breaks. Although GPs are currently over stretched, we are making good progress in recruiting new GPs to the county.

We are working with groups and organisations in Lincolnshire's communities to get people out of hospital as soon as possible.

NHS bodies and local councils will continue to work closely together to meet the demand for care home places and home support in a timely manner. More funding will also be provided for transitional care services. These services ensure support for people who have been in hospital or need some limited observation because they are frail or have just had an operation.

Staff in nursing and residential care homes will be treated as vital members of the wider integrated team, having immediate access to shared care plans. They will have a more proactive role in the care of their residents.



Over 80% of people with complex needs already have an identified case manager to help them to move back home after a hospital stay.

Vera's story

Vera is an 89 year old widow with a small family. She is very independent and copes well on her own, despite falling and breaking her leg a few years ago. Vera's daughter-in-law helps with daily tasks but lives 25 miles away. Vera has a cleaner and a 'Piper' alarm she can press to summon help if she needs it. She has some long term health problems including arthritis, anaemia and kidney problems and sees her GP and a hospital doctor regularly for her care. Over the last 6 months she has been struggling to get about and needs help going to the bathroom. Vera wants to stay at home in her council house in the small village where she lives, despite her health getting worse.

In July, she had a fall and was not found for 12 hours. She was taken to hospital where she was found to have a urinary tract infection and an infection in her leg. She stayed in hospital 2 weeks and then had a week in a community hospital to prepare for going home. She was discharged home with some support but her family were not involved in this decision and were concerned. A week later she fell again and had another 2 weeks in hospital. She lost weight and struggled with getting out of bed. She had a further 2 and a half weeks in a community hospital, put on weight and was sent home with carers coming in to help her. 10 days later she fell again and the ambulance came out but they did not take her to hospital as she wanted to stay at home. She was taken to hospital the next day because she was in pain and they found she had a broken hip and had a mild heart attack. She had a hip operation and is still in hospital.

Throughout this time the complications of the system and Vera's wish to return home has led to decisions being taken without a plan involving her family. Organisations supporting Vera have not been joined up. The GP is not involved. Over the last 10 weeks, Vera has lost her independence and now needs significant care for the time she has left.

In the future Vera will:

- Be well known to the team in her GP surgery who will have been regularly supporting her for the last 5 years to manage her long term health conditions
- Have a care plan that is agreed with Vera and her family and sets out what help she needs to stay safely at home, before she actually needs it
- Have wider support from a joined up Neighbourhood Care Team with professionals who work together to support Vera and help her link up with wider community services to keep her active
- Be pulled from hospital much earlier after her first hospital visit and be taken home to manage her urinary infection in the community, so she would not lose her independence

7

Mental health, learning disabilities and autism

By 2021, people will get the right support in the right setting provided by mental health services which are fully joined up with physical health and with care services.

Much work has already been done to improve mental health services and transform care for people with learning disabilities. We have a new community model of services for people with learning disabilities which meets the new national standards. For most people with learning disabilities this means support at home or in their community rather than having to be in an inpatient bed. We have improved support for people with autism and introduced a new service which provides more support for those with mental health needs who are in hospital.

We will improve community mental health services to make sure they are joined up with neighbourhood care teams and wider community services. We will improve our new crisis support service in the community so that we can respond rapidly to people in crisis and, where possible, avoid them being admitted as an inpatient.

We will have more psychiatric intensive care beds in Lincolnshire for those people who need to be in an inpatient facility – at the moment 305 people are placed in beds outside of Lincolnshire for their care.

We will improve the mental health support provided for people with conditions like cancer. We will look at improving the quality of services for our Older Adults and develop plans for a new community based service. This will mean fewer older adults need to be in an inpatient bed. As part of the development of our new learning disability community service, we will be consulting with the public on the closure of Long Leys Court which is our Learning Disability Unit. Long Leys Court has been temporarily closed since June 2015.

Paul's story

Paul is in his mid-20s, works in IT and lives with friends in Lincoln. He starts to feel unwell with back pain and general illness and he struggles to cope at work. He visits his GP a few times and is sent for physiotherapy. He continues to be in pain and regularly calls out the ambulance. He can't manage to keep working and falls out with his flatmates – he moves back home with his parents. He can't find a new job and has a breakdown. His GP thinks he might have epilepsy and he is referred to a mental health team but they send him back to his GP. He is passed back and forth between the GP and the mental health team 4 or 5 times and he also regularly takes himself to A&E but they send him back to his GP.

He eventually has a crisis and is put on medication but he doesn't take this properly and his behaviour becomes really challenging. He is not assessed again by the mental health team but goes on a waiting list for an occupational therapist. His family eventually call the police as he is behaving in a way that puts them at risk of harm. The police take him to A&E but there is no mental health support and he is sent home. His family call the mental health crisis team and after 36 hours they come and do an assessment. They suggest a rehab unit but leave without any plans in place for when he can go. He collapses in a fit and his family call the crisis team again. They finally agree that he needs to go into an acute mental health bed and he agrees. However, they can't find one available. Eventually he is sent to a unit 60 miles from home. He spends 6 weeks there and then is moved to a local rehab unit where he is still an inpatient. He has seen an occupational therapist but is waiting for more psychological assessments.

In future Paul will:

- Have a joined up service from physical and mental health professionals in the community with a single assessment and general support to help him stay in his job
- Be able to get specialist help more quickly
- Get support which means he will not reach a crisis point
- Have access to a crisis team 24 hours a day if he needs it
- Have support if he attends A&E from mental health specialists
- Be able to access inpatient beds in Lincolnshire if he needs to be admitted to a hospital bed

8

Improved care for women, babies and young children

By 2021, women will have choice about their pregnancy and births and mothers, babies and young children will be well supported with an excellent standard of care. Services will be safe, high quality and sustainable.

Our maternity services for Lincolnshire will be safe, personalised, kind, professional and family friendly. We will ensure that every woman has access to clear information so that she can take decisions about her care and has the confidence that support will be tailored to her and her baby's needs.

We want to provide more choice to women about the place and type of birth they want. We are looking at offering women a range of options for their births including a consultant-led service, mid-wife led services and home births. At the moment we do not offer midwife led services.

The way services are provided for mothers, babies and children in the county needs to change.

We have 5,500 births a year across our two hospital sites (Lincoln and Boston).

This low number of births makes it difficult to make sure that the staff have the right clinical experience and it is hard to recruit enough staff to work on two sites. For specialist children's care (paediatrics) this is even more difficult because there is a national shortage of doctors and nurses.

Currently all babies born under 29 weeks go out of county (either before birth or after birth) because the premature baby service is not able to provide suitable numbers of trained doctors and nurses to meet the national standards. We regularly do not have enough children's doctors on our sites to meet the national safety recommendations for staffing. Even if we had more money, it is likely that we would not be able to recruit enough staff to keep services as they are.

We need to ensure services are safe. We will be putting forward proposals next year which are likely to include options to centralise some elements of maternity and children's services, as well as an option to keep consultant led births on two hospital sites. In particular, it is likely that emergency children's surgery will need to move to a single hospital site. However, we have not finally agreed our options and need to test them with clinical experts to ensure that they are safe before we consult formally with the public. We look forward to talking to women and their families about these options.

9

Services in an emergency which are safe and easy to access

By 2021, people will be able to access services for urgent care quickly and easily. When they need emergency care, they will experience excellent care from highly qualified staff. Care will meet all national standards for quality and safety.

When there is an emergency, we need to ensure we have skilled staff who can provide high quality care. For urgent care, we know that the public often find it hard to know where to go for help. We are already taking steps to change this. We will make sure that people's needs are met in the right way, at the first contact, without having to travel far unless it's really necessary.

Our new Clinical Assessment Service takes calls from NHS 111, low priority 999 calls and calls direct from GPs and Care Homes. The service has a team of clinical staff who can see a patient's records and make a decision about the most appropriate place for their care.

40% of people who go to A&E in Lincolnshire leave without the need for any treatment. This shows us that A&Es are not always being used for emergencies. Our plans are to provide a network of Urgent Care Centres which will be able to see and treat the majority of urgent care patients. This will reduce the pressure on A&E and should lead to fewer people being admitted to hospital.

We will consult with the public next year on options for emergency and urgent care provision in the county.

This will include proposals for Grantham hospital. Currently, Grantham hospital does not meet the Level 2 Critical Care standards and does not take a large amount of emergencies such as stroke, major heart attack, head injury or trauma.

The A&E is also currently temporarily closed between 6.30pm and 9am, with an out of hours service operating from the hospital. We are still developing plans for Grantham, listening to views from the local Grantham community and from our clinical staff and looking at national standards and guidance. Any changes will have an impact on our other hospital sites, and on Peterborough hospital, so it is important that we make the right decision.

In Lincolnshire, the population is spread over a large area and we have a shortage of skilled staff. We know it is vital to bring together our key specialist services onto fewer sites if we are to have sufficiently skilled staff seeing a high number of complex cases.

Our Heart Centre in Lincoln is an example of where we have brought care onto a single site. The Centre now has some of the best results in the country with better survival rates for those people who have a heart attack or cardiac arrest.

We are considering whether we may need to bring our hyper-acute stroke services onto a single site in order to improve the recovery and survival rates for people who suffer with a stroke.

Evidence shows that having the first 72 hours after a stroke in a hyper-acute unit can massively improve your chance of recovery.

We do not have a good record of providing this and too many of our stroke patients do not receive this care.

It is likely we will consult the public on proposals for how we maintain stroke services on two sites but with a dedicated hyper-acute stroke facility. We may also want to move our emergency vascular surgery site to make sure it is located in Lincoln, close to our Heart Centre.

We know that the public have concerns about services moving further away from where they live. However, a poor service that is very close to home is not an alternative to a high quality service that is a bit further away but is accessible.

Bob's story:

Bob is in a nursing home as he is frail and vulnerable; he has had a stroke so can't move the left side of his body and can't speak very clearly. His wife visits him every day and takes him home for a few hours a day so they can spend time together.

Bob arrives by hospital transport for an outpatient's appointment; he is cold and poorly dressed on a very cold day. His wife meets him at the hospital and is concerned he is very quiet. He warms up and seems better but the hospital doctor is worried about him going back to the nursing home in hospital transport. His wife offers to take him back in her adapted car. The doctor calls the Nursing Home to say Bob seems unwell and asks that his wife gets help getting him in from the car. The Nursing Home are defensive about Bob's health and condition and do not agree to help his wife. To add to his wife's stress, her car has a parking ticket. She had parked in the disabled bay with her blue badge but hadn't realised she needed to pay.

The next day Bob is back in A&E as he has a problem with his catheter (that helps him go to the loo). He is eventually taken to Boston because there is no one to deal with it in Lincoln after midday. He spends 5 hours in Boston A&E but becomes too ill to have his problem seen to. He is admitted into a bed and his wife spends 4 days and nights with him sleeping on the floor beside his bed. His previous Nursing Home won't take him back because he has different care needs and he dies 24 hours after leaving hospital in a different Nursing Home.

In future Bob will:

- Be able to have support in his Nursing Home for simple issues like changing his catheter
- Have doctors give advice on the care he needs via the new Clinical Assessment Service which means a senior doctor can speak to his care home directly
- Have a care plan put together by Bob, his wife, his GP and the team in his Nursing Home which means he avoids going into hospital
- Be shown compassion and support, both for him and his wife
- Be supported to die in the place of his choice

10

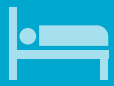
Effective support for planned operations or treatment

By 2021, people will have a good experience when they go for treatment or an operation and will be well supported to access care which makes a positive difference to their lives.

We understand that many patients might choose to have their care delivered out of county because it is more convenient, but we think that more people would choose to have planned treatment in Lincolnshire ***if the experience and quality of the service was improved. We want to make sure that when people need planned operations or treatment, they are well supported and their care is delivered in a joined up way.*** We will reduce the number of cancelled appointments and operations by making sure that beds for planned operations are protected and not used for emergency care. We will also make sure that things work more efficiently and people's experience is improved.

We have to make sure we refer people for operations when they are most ready to benefit and only when they really need an operation. This might mean that someone would need to have physiotherapy first, or try exercise or medication, before we would agree to do an operation.

We know that many aspects of planned care which are carried out in hospitals could be done by a GP or in a community based service closer to home. We are already looking at some conditions such as diabetes to see if we can make changes to deliver support closer to home. We will make sure people don't have to wait so long for tests, assessments and treatment. Our new Care Portal will mean that tests are not duplicated as we will be able to see patients' full medical records more easily. It can be dangerous for your health to have unnecessary tests.



We carry out too many operations that do not improve people's lives and in some cases cause greater problems so doing the right thing at the right time is a key part of our plan.

We are looking at which planned care services should be delivered on which of our hospital sites. We currently provide some services from more than one site. This makes it hard to attract staff, keep up professional skills and make sure that we have enough staff working to cover all the appointments. As with the changes to the Lincolnshire Heart Centre, we think there would be benefits in bringing together some services onto a single site to make it a Centre of Excellence.

11

Making sure we make best use of every pound we spend in Lincolnshire

By 2021, we will spend our allocated budget on services that deliver good value and support good health and care for the people of Lincolnshire.

We currently receive funding of £1.2 billion pounds to spend on health services in Lincolnshire. At the moment, we spend more money each year than we have actually got

this year alone we will have spent over £60 million more than we have.

Increasing demands on our health and care services and increases to the cost of healthcare mean that, ***if we do nothing, we will have a £182 million shortfall by 2021.***

Our Plan sets out how we will bring our finances back into balance by 2021.

The table right shows where we have identified savings that can be made. In addition to these savings we have assumed that we will receive £52m of national funding in 2020/21.

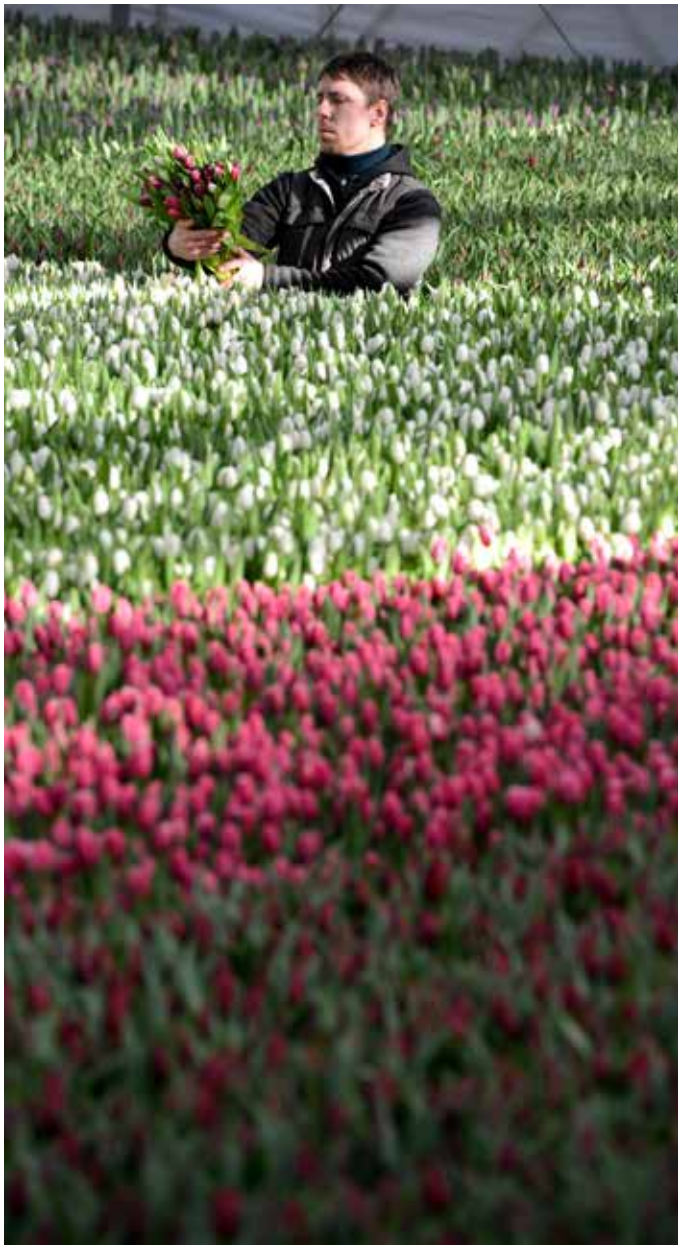
Theme	Objective	Savings
Changing the way services are delivered	• Making sure our services deliver national standards • Improving safety and quality • Having the right skills in our workforce and enough staff • Preventing people going to hospital • Having a joined up service where staff work together more effectively • Bringing together some services onto fewer sites	£30m
Making the most of our resources	• Reducing duplication (like doing x-rays or assessments twice) • Making better use of physical space (like our community hospitals) • Increasing local capacity so that more patients have a choice of services in Lincolnshire	£14m
Operational efficiency	• Spending less on senior managers • Spending less on agency staff and temporary staff • Using technology like the Care Portal to save time and effort and improve patient care • Being smarter in the way we buy goods and services • Reducing costly duplication between different organisations	£62m
Changing the roles and skills in our workforce	• Having the right workforce to deliver the care we need • Helping our workforce work more productively • New roles and career pathways • Managing the increase in pay • Creating an engaged and innovative workforce	£18m
Decisions about how we spend our money	• Spending money on things that deliver better value and outcomes for the people of Lincolnshire • Making sure we do what works and reflects best evidence	£6m
Total Savings		£130m
Additional Transitional Funding	Lincolnshire is due to receive £52m national funding	£52m
Final Total		£182m

We need to ensure that all of the £1.4 billion we will be spending by 2021 delivers services that make a positive difference to the health and care of our population. This will only be possible if we change the way we provide services as set out above.

This Plan needs to balance the books, as well as improving the quality of care and the health and wellbeing of our population. Not all of our initiatives will save money – some may even cost more. Many of the reasons that we might want to change the way we provide services, such as having a single site for hyper-acute stroke care, are focused on providing better quality care and saving lives, not saving money. We believe that our Plan can be delivered if we start working together as one health and care system not as lots of different organisations and we've already made a positive start in doing so.

The table below illustrates where we currently spend our money and where we will be spending our money in 2021. The overall amount we spend will be increasing but we will prioritise investment into primary care and community services.

	2016/17	**2020/21**	**Movement**
Primary Care (ie GPs and other services) excluding Prescribing	120.1m	145.6m	+25.6m
Prescribing	147.2m	166.9m	+19.7m
Community Services including care packages for complex needs (CHC)	169.2m	200.8m	+31.6m
Mental Health Services	95.5m	110.0m	+14.5m
General Hospital Services	528.2m	543.8m	+15.5m
Specialist Services (Hospital and Other)	169.0m	198.4m	+29.4m
Other Expenditure	20.5m	29.9m	+9.4m
Administration	16.4m	12.1m	-4.3m
	1266.0m	**1407.5m**	**141.5m**



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A 21st Century approach to care

By 2021, we will have the right workforce, buildings, transport and IT infrastructure to support a high quality health and care service.

The table above shows that many of the savings will come from changing the way health and care organisations work. This is a really important part of our plan.

Many of the projects and plans we have in place to work more effectively together and spend money more efficiently are in line with advice and recommendations from Government, for example:

- Reducing how much money we spend on management in the health system
- Having a single team for things like information and technology (IT) and human resources (HR) rather than lots of teams across the different Lincolnshire health organisations
- Reducing the money we spend on prescribing medication in line with evidence and best practice and avoiding waste

Our workforce: We have detailed plans in place to make sure we have the right skills in our workforce. Many of these plans include looking at new roles which don't exist at the moment and thinking about how different professionals can develop skills to provide care in a different way. A good example of this is Advanced Nurse Practitioners who can do a lot of the work that a GP currently does, or Pharmacy technicians who could also support patients with their medication. Our Plans provide greater opportunity for our current workforce to develop their careers in Lincolnshire.

For those people who want to work in health and care in Lincolnshire this is an exciting time. We will need all the skills and expertise that we currently have, but our Plan shows that if we change how we work, by 2021 we will probably have a slightly smaller workforce. This doesn't mean we'll be making anyone redundant as we have an older workforce that is likely to shrink as people retire.

Making better use of our buildings: We have looked in detail at all the buildings we have and how they are used. Our Plan includes:

- Making better use of our space, including getting rid of buildings or estate that is not used
- Looking at upgrading properties which are in a poor state of repair and, if this is not possible, moving the location of some services to a more fit for purpose building

Looking at building some new facilities, for instance an Urgent Care Centre at the front of Lincoln and Boston hospitals. This is dependent on us being able to get capital funding and we are looking into this now

Where services will be moving location in order to make better use of space or move to a more appropriate site we will fully engage with the public and look at how easy it is to get to any new location for the people using the service.

Supporting people to access services: We know that it is often difficult for people to travel to access services in our very rural county. Over 55,000 households in Lincolnshire do not own a car or a van. Many people who are disabled struggle to use our public transport system which is spread thinly across the county and often runs infrequently. We are committed to making it easier for people to access our services, particularly where we may be changing the location of where services are provided. We are looking at possible transport solutions and how technology can help to reduce the need for staff and patients to travel.

Using technology to deliver better care: We have a really detailed plan for how we will use new technology to improve the way health and care services are delivered. Here are some of the projects that are already underway:

- The Care Portal: a technology solution which enables a professional involved in your care to pull up information from all your care records, with your permission, to see a complete picture of your care. It means patients won't have to repeat themselves and doctors can see test results, past treatment, medication and care plans before they make a decision about your care. This is a really exciting development and will save time and improve a patient's experience. It could also save lives in an emergency situation. Next year, we are hoping to give the public access to their own records too via the Portal.
- Telehealth – there are lots of different devices and equipment which we can use which will allow people to manage their own condition better.
- Skype – we have talked to the public about whether they would be happy to speak to a doctor, nurse or other professional on the phone or over the internet using things like Skype, if it meant they could get advice or support more quickly. Some people do not like this idea but many people would be happy with this approach.

Summary and next steps: We believe that Lincolnshire is a fantastic place to live and that we can work together to transform the way people manage their own health and care, and access services to support them. By 2021, the balance between hospital and out of hospital care will have moved significantly. Care in the community rather than admissions to hospital will be the norm for most people apart from those who really need specialist or emergency hospital care. This will feel very different for people who use our services and for our staff and we will need people to behave in a different way.

We do not underestimate the challenges of delivering this plan. We appreciate that there are some hard choices to make if we want high quality care that is as accessible as possible in our rural county but can still be delivered by our workforce with the money we have.

We won't be changing everything all in one go. There are some things that we can do immediately like the work on our Neighbourhood Care Teams. This is already being developed by staff, care workers, professionals and local organisations who are working on the ground to find new, better ways of joining up care.

We'll be updating you regularly on our progress and you can check the website www.lincolnshirehealthandcare.org for more information.

There will be more opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change. We expect a full public consultation in 2017 on proposals covering urgent and emergency care and maternity and children's care in particular but more work is needed to finalise our options before we formally consult the public. We are committed to being as inclusive and open as possible. We will listen to all contributions and use these contributions to influence the decisions we make.

This Plan is likely to change and develop over time. We look forward to your input and involvement to give us the best chance of making this transformation of health and care in Lincolnshire a success.

For more information or to get involved email us at lhac@lincolnshireeastccg.nhs.uk

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

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 December 2016**
Subject:	**Work Programme**

Summary:

This item invites the Committee to consider and comment on its work programme.

Actions Required:

To consider and comment on the content of the work programme.

1. The Committee's Work Programme

The work programme for the Committee's meetings over the next few months is attached at Appendix A to this report, which includes a list of items to be programmed.

Set out below are the definitions used to describe the types of scrutiny, relating to the proposed items in the work programme:

Budget Scrutiny - The Committee is scrutinising the previous year's budget, the current year's budget or proposals for the future year's budget.

Pre-Decision Scrutiny - The Committee is scrutinising a proposal, prior to a decision on the proposal by the Executive, the Executive Councillor or a senior officer.

Performance Scrutiny - The Committee is scrutinising periodic performance, issue specific performance or external inspection reports.

Policy Development - The Committee is involved in the development of policy, usually at an early stage, where a range of options are being considered.

Consultation - The Committee is responding to (or making arrangements to respond to) a consultation, either formally or informally. This includes pre-consultation engagement.

Status Report - The Committee is considering a topic for the first time where a specific issue has been raised or members wish to gain a greater understanding.

Update Report - The Committee is scrutinising an item following earlier consideration.

Scrutiny Review Activity - This includes discussion on possible scrutiny review items; finalising the scoping for the review; monitoring or interim reports; approval of the final report; and the response to the report.

In considering items for inclusion in the Committee's work programme, Members of the Committee are advised that it is not the Committee's role to investigate individual complaints or each matter of local concern.

2. Conclusion

The Committee is invited to consider and comment on the content of the work programme.

3. Consultation

There is no consultation required as part of this item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health Scrutiny Committee Work Programme

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

Chairman: Councillor Mrs Christine Talbot
Vice Chairman: Councillor Chris Brewis

21 December 2016		
Item	**Contributor**	**Purpose**
Congenital Heart Disease Services	Will Huxter, Regional Director of Specialised Commissioning (London), Congenital Heart Disease Programme Implementation	Consultation
Lincolnshire Sustainability and Transformation Plan	Andrew Morgan, Chief Executive, Lincolnshire Community Health Services NHS Trust Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group. Sarah Furley, Programme Director, Lincolnshire Sustainability and Transformation Plan.	Consultation

18 January 2017		
Item	**Contributor**	**Purpose**
NHS Improvement – Improving NHS in Lincolnshire	To be confirmed.	Status Report
United Lincolnshire Hospitals NHS Trust - Pharmacy Services	Colin Costello, Director of Pharmacy and Medicines Optimisation, United Lincolnshire NHS Trust	Update Report
Transforming Care: Community Learning Disabilities Support: Long Leys Court	To be confirmed	Consultation
Lincolnshire West Clinical Commissioning Group Update	To be confirmed.	Status Report
Community Pharmacy 2016/17 and Beyond	To be confirmed.	Update Report

18 January 2017		
Item	**Contributor**	**Purpose**
United Lincolnshire Hospitals NHS Trust – Care Quality Commission Inspection Report	To be confirmed.	Update Report

15 February 2017		
Item	**Contributor**	**Purpose**
St Barnabas Hospice	Chris Wheway, Chief Executive, St Barnabas Hospice	Update Report
East Midlands Ambulance Service	Blanche Lentz, Lincolnshire Divisional Manager, East Midlands Ambulance Service NHS Trust	Update Report
LIVES [Lincolnshire Integrated Volunteer Emergency Services]	Nikki Silver, Chief Executive Officer, Lincolnshire Integrated Volunteer Emergency Services	Update Report
Butterfly Hospice	Andrew Morgan, Chief Executive, Lincolnshire Community Health Services NHS Trust Sarah McKown, Head of Clinical Service, Lincolnshire Community Health Services NHS Trust Clare Credland, Integrated Clinical Services Lead, Lincolnshire Community Health Services NHS Trust	Update report
South West Lincolnshire CCG Update	To be confirmed	Update Report

15 March 2017		
Item	**Contributor**	**Purpose**
Obesity in Adults and Children	To be confirmed	Update Report
South Lincolnshire Clinical Commissioning Group	To be confirmed	Update Report

15 March 2017		
Item	**Contributor**	**Purpose**
Lincolnshire East Clinical Commissioning Group	To be confirmed	Update Report

For more information about the work of the Health Scrutiny Committee for Lincolnshire please contact Simon Evans, Health Scrutiny Officer, on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

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