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, 18 January 2017 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: 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), 1 Vacancy (Boston Borough Council) and 1 Vacancy (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
5	**Lincolnshire West Clinical Commissioning Group Update** *(To receive a report from Sarah Newton (Chief Operating Officer, Lincolnshire West Clinical Commissioning Group) which provides an update on the activities of Lincolnshire West Clinical Commissioning Group (LWCCG) and includes information on the lead commissioning arrangements undertaken by LWCCG; APMS (Alternative Provider of Medical Services) practices, financial and performance information; and patient engagement activity. Sarah Newton (Chief Operating Officer, LWCCG) and Dr Sunil Hindocha (Chief Clinical Officer, LWCCG) will be in attendance for this item)*	17 - 24
6	**Lincolnshire Sustainability and Transformation Plan - Finalising the Statement of the Health Scrutiny Committee** *(To receive a report from Simon Evans (Health Scrutiny Officer) which invites the Committee to consider the draft statement prepared following the discussions of the Committee at the extraordinary meeting held on 12 January 2017.* ***The draft statement, prepared on behalf of the Committee, will be circulated prior to the meeting****)*	25 - 26
7	**Congenital Heart Disease Services** *(To consider a report by Simon Evans (Health Scrutiny Officer) which provides the Committee with some points of clarification from University Hospitals of Leicester NHS Trust, including a letter from the Trust's Chief Executive, following the last meeting. Representatives from University Hospitals of Leicester NHS Trust will be in attendance)*	27 - 36
LUNCH 1.00PM - 2.00PM		
8	**Community Pharmacy 2016/17 and Beyond: The Final Package** *(To receive a report from Simon Evans (Health Scrutiny Officer) which provides information on how the Implementation of "Community Pharmacy in 2016/17 and Beyond: The Final Package" is impacting on local pharmacies. Steve Mosley (Chief Officer of the Lincolnshire Local Pharmaceutical Committee (LPC) will be in attendance for this item)*	37 - 62
9	**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)*	63 - 68

Tony McArdle
Chief Executive
10 January 2017

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
21 DECEMBER 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, T M Trollope-Bellew 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), Simon Evans (Health Scrutiny Officer), Sarah Furley (Programme Director, Lincolnshire Sustainability and Transformation Plan), Will Huxter (Regional Director of Specialised Commissioning (London), NHS England), Gary James (Accountable Officer, Lincolnshire East CCG), Dr Geraldine Linehan (Regional Clinical Director of Specialised Commissioning (Midlands and East), NHS England) and Andrew Morgan (Chief Executive, Lincolnshire Community Health Services NHS Trust)

County Councillors B W Keimach and R A Renshaw attended the meeting as observers.

51 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

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

The Democratic Services Officer reported that, since the last meeting of the Committee, two resignations had been received. Councillor Mrs L A Rollings had resigned from her position as the representative for West Lindsey District Council and Councillor G Gregory had also resigned his position as the representative for Boston Borough Council. Substantive replacements remained unconfirmed.

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor Mrs A White to the Committee in place of the current vacancy for West Lindsey District Council.

52 DECLARATIONS OF MEMBERS' INTERESTS

Councillor Mrs C A Talbot advised the Committee that she remained a patient of Nottingham University Hospitals NHS Trust but was also under the care of a team at United Lincolnshire Hospitals NHS Trust, which would be discussed under Item 6 – *Lincolnshire Sustainability and Transformation Plan.*

Councillor Mrs P F Watson advised the Committee that she was also a patient of United Lincolnshire Hospitals NHS Trust, which would be discussed under Item 6 – *Lincolnshire Sustainability and Transformation Plan.*

53 CHAIRMAN'S ANNOUNCEMENTS

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

i) Councillor Mrs Lesley Rollings and Councillor Gordon Gregory

The Chairman confirmed the two resignations from the Committee by Councillor Mrs Lesley Rollings and Councillor Gordon Gregory. On behalf of the Committee the Chairman asked that formal thanks be noted for their contribution to the activities of the Committee. It was also confirmed that, as reported, Councillor Mrs Angela White was in attendance as the representative for West Lindsey District Council. The Committee looked forward to each council confirming their permanent replacement representatives in due course.

ii) Dr Peter Holmes

It was reported that Dr Peter Holmes had resigned as the Chairman of the Lincolnshire East Clinical Commissioning Group Governing Body in order to focus on the management of his own Stuart House Surgery in Boston. The Chairman advised that she had written to Dr Holmes to thank him for his support of the activities of the Health Scrutiny Committee for Lincolnshire.

iii) Wainfleet GP Surgery Update

At the last meeting the Committee received information on how Lincolnshire East Clinical Commissioning Group had been providing support to Wainfleet Surgery, whose registration had been temporarily suspended by the Care Quality Commission (CQC).

On 7 December 2016, Lincolnshire East Clinical Commissioning Group advised that the two partners at the surgery would not be seeking re-registration with the CQC and, as a result, the CCG was now reviewing the options for GP provision in Wainfleet. The CCG was also seeking the views of patients, a part of its consideration of all available patients to acess services at another local practice.

iv) Arboretum GP Surgery Lincoln; Burton Road GP Surgery, Lincoln; Pottergate Surgery, Gainsborough; and Metheringham Surgery

On 28 November 2016, Lincolnshire West Clinical Commissioning Group announced that the Arboretum and Burton Road Surgeries in Lincoln, the Pottergate Surgery in Gainsborough and the Metheringham Surgery would all close on 7 January 2017. Lincolnshire West CCG had stated that the 11,000 patients across the four surgeries would have an alternative option within 0.2 miles of their existing surgery.

Lincolnshire West Clinical Commissioning Group had sought to secure a long-term provider to take over the management of the four practices but was unable to offer a contract to any of the bidders. Patients had until 7 January to register with a different GP practice. If patients did not register by that date, the CCG would automatically allocate those patients to a surgery on their behalf. If patients were unhappy with their allocated surgery they would still be able to choose an alternative at any time, based on where they lived and the practice boundaries within which they reside. An update report from Lincolnshire West Clinical Commissioning Group was expected at the Committee on 18 January 2017.

v) Working Group Meetings

On 20 December 2016, a working group meeting provided initial views on the United Lincolnshire Hospitals NHS Trust Five Year Strategy. The Chairman thanked Councillors S L W Palmer, Mrs S Ransome, Mrs J M Renshaw, Mrs S M Wray and Dr B Wookey for joining her at the meeting.

Nine councillors across two committees also wished to participate in the Delayed Transfers of Care Working Group. This working group would be discussed further as part of the Work Programme item but it was planned to arrange a meeting at the end of January/early February 2017.

vi) Lincolnshire Sustainability and Transformation Plan

The Lincolnshire Sustainability and Transformation Plan had been published on 6 December 2016. The County Council had considered and passed two motions on the STP and further information on the motions would be provided as part of item 6.

vii) Lincolnshire Sustainability and Transformation Plan and NHS Contracts

There had been some concern that the CCGs were required to sign two year contracts with their providers no later than 23 December 2016, prior to public consultation on services changes. CCGs and local providers were bound to meet the national framework which governed the timing of contracts. The Chairman reported that these contracts reflected the provision of services in line with the STP but only where this had already been agreed and where consultation was not required – for instance integrated working at neighbourhood level between GPs and community health services. The contracts were not specific in relation to potential changes to hospital services because the options for possible changes had not yet been agreed and had not been through formal public consultation yet. If there were service changes following consultation then the CCGs would go through the normal process of contract variation to reflect the new service provision.

viii) Grantham and District Hospital – Accident and Emergency Department

On 15 December 2016, the referral letter and accompanying statement was sent to the Secretary of State for Health on the overnight closure of Grantham and District Hospital's Accident and Emergency Department. As a first step, it was expected that the Secretary of State would seek initial advice from the Independent Reconfiguration Panel, an advisory non-departmental public organisation set up for this purpose. The Secretary of State would then take account of the initial advice from the Independent Reconfiguration Panel prior to making a decision on whether a full review would be required.

ix) Medicines Management – Outcomes of the Consultation

The four Lincolnshire Clinical Commissioning Groups had announced the outcomes of the Medicines Management consultation which closed on 18 November 2016. With effect from 12 December 2016, the four CCGs had approved restrictions on the prescribing of over-the-counter medicines for short term, self-limiting conditions, together with restrictions on prescribing baby milk, including specialist infant formula; and prescribing oral nutritional supplements in accordance with national guidelines.

The Clinical Commissioning Groups had also placed restrictions on prescribing gluten-free foods, with the exception of bread, flour and bread-mixes, which may be prescribed by GPs up to the recommended limits from Coeliac UK.

x) Non-Emergency Patient Transport

The four Lincolnshire Clinical Commissioning Groups announced that a new provider would take over the management of non-emergency patient transport across Lincolnshire: Thames Ambulance Service were to take over from the current provider, NSL, on 1 July 2017, following a procurement process. The service provided eligible patients non-emergency transport to hospital appointments, community surgery units and theatre slots and home again after they had been seen or discharged.

The scheme benefitted so many people across the county with around 200,000 journeys undertaken each year.

xi) Meetings

The Chairman reported that she had attended three briefing meetings from the management of the following organisations:-

- Lincolnshire West CCG – 2 December 2016;
- South Lincolnshire CCG – 14 December 2016; and
- St Barnabas Hospice – 20 December 2016

54 MINUTES OF THE PREVIOUS MEETING OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE HELD ON 23 NOVEMBER 2016

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 23 November 2016 be approved and signed by the Chairman as a correct record.

55 CONGENITAL HEART DISEASE SERVICES

Consideration was given to a report by Simon Evans (Health Scrutiny Officer) which provided details of a public consultation relating to decommissioning of congenital heart disease surgery from the East Midlands Congenital Heart Centre (formerly known as Glenfield Hospital).

Will Huxter (Regional Director of Specialised Commissioning (London)) and Dr Geraldine Linehan (Regional Clinical Director of Specialised Commissioning (Midlands and East) of NHS England were in attendance for this item.

On 21 July 2016 the Committee unanimously concluded 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. It also agreed that the Chairman would write to NHS England to outline the views of the Committee and to seek commitment to a full consultation.

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

- No final decision had been taken in regard to the future of University Hospitals of Leicester NHS Trust or any of the other congenital heart disease services in England;
- Information regarding consultation about the proposals would be communicated as widely as possible, well in advance of any consultation and NHS England would ensure that the consultation took account of those services which could be impacted by any change to CHD services, including paediatric intensive care and ECMO;
- NHS England confirmed that they were 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 in to 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 had been informed of these assessments at the end of June 2016 and advised that any necessary public involvement undertaken before services changes were implemented.

Individual assessment reports for 21 hospital trusts were published by NHS England on 13 September 2016 and were available at the following link:-

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

It was reported that NHS England had met with staff, patients and stakeholders of University Hospitals of Leicester NHS Trust to discuss the assessment of the Trust against the standards. Additionally, NHS England advised that extensive correspondence and discussions had taken place since that visit.

Blogs by Will Huxter had also been published on the NHS England website, the most recent of which, on 23 November 2016, indicated that consultation would not begin until early in 2017.

The Committee was advised that NHS England had made no final decision, that the proposal did not include closure of all services at University Hospitals of Leicester NHS Trust (UHL) and that some would remain. Information had been sought from the Trust about the impact of the proposals on all services including any financial implications.

In addition to work being carried out in relation to Congenital Heart Disease Services, a national piece of work was ongoing to look at paediatric and intensive care which would also be relevant to these proposals.

Additional capacity in all centres was also being considered and, despite the level of detail contained within the report, it was reported that the key challenge had been in relation to the level of surgical activity. It was suggested that surgeons at UHL had not met the minimum standard of 125 operations per surgeon (375 operations per year due to the requirement for three surgeons per operation) and that the Trust had also not provided any proposal to deliver this or the target expected by 2021.

It was acknowledged that patients accessed a range of services and it was proposed to have a specialist medical centre at Glenfield Hospital to provide care to a number of patients who did not require surgery or specialist care.

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

- It was reported that two providers in the country had not met the standard of 375 operations per year – Leicester and Manchester;
- NHS England needed to be confident that all services and providers would be able to meet all standards set although, as stated within the report presented, none of the current providers met every standard;
- UHL had provided a growth plan to NHS England which illustrated how the 2021 standard would be met by surgeons and included increasing the surgeons from three to four. The Committee asked what had been included in growth plans for other centres and was advised that other centres had not been required to produce a growth plan as they already met the surgical standard;

- It was reiterated that there was no financial motivation to spend less on Congenital Heart Disease services nationally and that all current providers, including UHL, had been asked for details of any financial impact that these proposals would have on their organisations;
- The Committee was extremely concerned that the lack of this type of centre within the East Midlands would be to the detriment of residents in the East Midlands and Lincolnshire in particular. The lack of a centre would result in high costs to families and, potentially, parents being unable to travel with their children to a centre so far away. Lincolnshire, simply, had no public transport, especially from the east coast of the county and families on low incomes generally had no car, were unable to afford taxi fares or bus/train fares to travel that great distance;
- It was acknowledged that other rural areas faced similar challenges, however NHS England was urged to undertake a quality impact assessment for the people of Lincolnshire and the East Midlands before making their final decision;
- The Committee asked why patients were being transferred to UHL when Birmingham was unable to cope with the pressure. It was suggested that the system was stretched overall but that specific issues could not be addressed. The benefit of larger centres was being considered to address capacity issues but the Committee remained unconvinced and requested that information be provided on why UHL was taking the additional patients from Birmingham;
- NHS England had adopted a standard that required a team of four surgeons, which would provide improved safety and outcomes for patients. Some surgeons were already undertaking over 200 procedures per annum, and it was thought sensible to have four surgeons at each unit undertaking a minimum of 125 procedures to enable improved outcomes and safety, as well as being able to manage the number of cases;
- The standards had been set at that level following a great deal of effort, consultation and agreement with a number of people to improve those standards. The Committee asked for details of the experts who sat on the panel to decide on this standard following the consultation exercise in 2014;
- The view of Healthwatch was that they accepted the standards from NHS England on the grounds of patient safety which was the overriding and essential issue, especially if the service was enhanced by having four surgeons instead of operating a 1 in 3 rota. However, Healthwatch was concerned that a decision may be made which NHS England may regret should the required standards be met and staff appointed at UHL in the next few years;
- Healthwatch also held the view that such great emphasis should not be put on travel distance as it was thought that people would travel any distance within the UK to ensure the right care for their child;
- It was confirmed that the standard set for surgical procedures of this type were counted when undertaken by surgeons in either an NHS or a private role as it was acknowledged that some surgeons did undertake private work in addition to NHS duties. The Committee requested the split between private and NHS surgical procedures for each surgeon. NHS England explained that individual

surgical data was held by the provider but that this would be sourced and provided to the Health Scrutiny Officer;

- The standards were nationally defined and set taking in to account the number of surgeons required to operate on a child's heart. The numbers were counted by a national database run by NICOR [National Institute for Cardiovascular Outcomes Research] which was considered to be the most equitable way of doing so;
- The Committee asked whether consideration had been given to setting a limit for patients travelling to access services, as it was suggested that the distance between parts of Lincolnshire and Birmingham was to o long for many Lincolnshire residents;
- It was asked if the input of social services in hospitals had been given any consideration following Birmingham Children's Services Department being put in special measures. The Committee was concerned that Lincolnshire children may become subject to care from that particular department as a result of receiving clinical care in Birmingham. NHS England advised that they were unsure if this had been considered, but would provide that information to the Health Scrutiny Officer;
- The Chairman requested that NHS England consider holding two or three public meetings in Lincolnshire for parents and other interested parties to attend. These should be held in East, South and Central Lincolnshire.

The Chairman invited colleagues from NHS England to come back to continue discussions on this item at the Committee's meeting scheduled for Wednesday 18 January 2017 and was keen that these discussions took place prior to the commencement of Purdah.

RESOLVED

1. That the report and contents be noted; and
2. That NHS England be requested to attend the meeting of the Health Scrutiny Committee for Lincolnshire on Wednesday 18 January 2017.

At 11.55am, the Committee was adjourned for a ten minute comfort break.

At 12.05pm, the Committee reconvened.

56 LINCOLNSHIRE SUSTAINABILITY AND TRANSFORMATION PLAN

Consideration was given to a report by the Health Scrutiny Officer which provided the Committee with the Public Summary Document of the Lincolnshire Sustainability and Transformation Plan (STP) and invited initial consideration of the content of the STP with a view to providing 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 CCG) and Sarah Furley (Programme Director, Lincolnshire Sustainability and Transformation Plan) were all in attendance for this item.

It was explained that each local NHS area was required to prepare a Sustainability and Transformation Plan (STP). The Lincolnshire STP was published on 7 December 2016 together with a public summary document. It was clarified that the STP was not a consultation document but a strategy document from which formal public consultations would be derived. These were expected to take place from May 2017 onwards.

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. Included in the guidance was a key requirement for each local NHS area to prepare an STP, the aim of which was to find out how health and care organisations could improve the health and wellbeing of their resident population whilst increasing the clinical and financial sustainability of local health and social care services.

In January 2016, 44 local STP 'footprints' were developed and the Lincolnshire STP covered Lincolnshire East, Lincolnshire West, South Lincolnshire and South West Lincolnshire Clinical Commissioning Group areas. It was confirmed that North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups were not included.

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

Considerable progress had been made in the development of the Lincolnshire STP which had built upon the work already underway in the county to devise a new model for health and care, through the Lincolnshire Health and Care Programme (LHAC). In addition, there had been discussion and input from Lincolnshire County Council officers, particularly in relation to how health and social care services could be better joined up; and how services in the community, which prevent ill health, could be improved.

A number of key stakeholders, including East Midlands Ambulance Service NHS Trust, Lincolnshire GPs, Lincolnshire pharmacies, key health providers outside Lincolnshire and local organisations from the public, private and voluntary sectors all contributed to the development of the plan. Healthwatch Lincolnshire also participated on the Stakeholder Board.

Seven health organisations led the work on the development of the STP:-

- 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; and
- Lincolnshire Partnership NHS Foundation Trust.

The Lincolnshire Health and Care (LHAC) programme was launched in 2013 as a result of organisations in Lincolnshire recognising that current services did not adequately meet the needs of residents. Due to growing demands and financial pressures it was clear that a change of direction was necessary and, as a result, all health and social care organisations collaborated for the first time to design a new model for health and care in Lincolnshire. This would then enable people to access the right services at the right time both now and in the future.

The announcement of the STP process delayed the public consultation on the LHAC programme, which was due at the end of 2015, as it was agreed that the LHAC work would become the clinical workstream of the STP programme. The LHAC emerging model of joined up care closer to home was the foundation for how STP partners envisage clinical services developing in the county and was aligned to the Five Year Forward View for the NHS. The scope of the STP, however, was broader and covered productivity and operational efficiencies including service procurement, best use of estates workforce development and technology innovation.

The vision of the Lincolnshire STP was based on a basic vision to achieve really good health for the people of Lincolnshire with support from an excellent and accessible health and care service delivered within the required financial allocation. The vision included the key priorities for the STP, noted below:-

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

The *LHAC Case for Change* document was published in June 2016 and set out the reasons why services needed to be changed in Lincolnshire. The document was developed with extensive engagement and discussion with staff and the public and an analysis of the evidence was done to ascertain how services were currently operating in the county. The findings were stark and it was clear that services were not always delivered to meet national standards for safety and quality.

The age and health profile of services and the increasing cost of care was making services unsustainable in their current form and Lincolnshire struggled to recruit the

relevant staff to enable all of its services to remain viable. This year alone an additional £60m was spent on health services than the amount of funding received.

The Committee was guided to page 82 of the full STP document as this provided further details on service reconfiguration arrangements including a schedule of service redesign options on pages 83 and 84.

The STP was emphasised as a dynamic strategy document and not a consultation document. The public consultation on service changes was due to commence in May 2017.

Statements and feedback on the Lincolnshire STP were welcomed and would be considered by the System Executive Team. Should the Committee choose to make a statement on the Lincolnshire STP at this stage, input into the formal consultation would still be possible.

Engaging Local People – A Guide for Local Areas Developing Sustainability and Transformation Plans stated that STPs should include engagement plans for both ongoing dialogue with stakeholders and for any formal public consultations required for major service changes.

The Chairman confirmed that the meeting of the County Council held on 16 December 2016 passed two motions in relation to this item:-

1. It was unanimously resolved that the County Council could not support the STP in its current form; and confirmed that the Council was prepared to work with all local NHS organisations to encourage them to adhere to and act upon the views which emerged from the public consultation; and
2. That the County Council confirmed that the Health Scrutiny Committee for Lincolnshire should scrutinise the likely impact of the proposals in the STP on different medical services in all parts of the county. The County Council unanimously agreed to set up a working group to consider the likely financial, and other impacts, of the STP on County Council services. This working group would then make recommendations to the County Council's Executive.

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

- NHS colleagues acknowledged the motions passed by the County Council, as noted above, and the risks involved in the delivery and implementation of the STP. However, it was clear that Lincolnshire needed a clear plan to ensure that NHS services within the county remained sustainable. All analysis undertaken to date had, regrettably, suggested that this would not be the case should services continue as it was currently;
- The Committee reflected on the proportion of GDP in the UK which would be allocated to health care. Any additional funding for health care would be welcomed by the NHS. At present, there remained pressure on Trusts to manage with the funding available;
- The Committee thought that the STP was too wordy and repetitive. It was acknowledged that the document was large but it was further explained that

the Full STP document had not been intended to be a public facing document and had been written to meet the requirements of NHS England;

- Home First was included as an initiative within the STP and it was explained that Home First placed as an emphasis on discharging patients to their own home, with intermediate care used only, when it was absolutely necessary, but it was acknowledged that Home First would place more demands on social care;
- Although not specifically mentioned within the document, NHS Colleagues had met with the Chief Executives of District Councils and it was confirmed that District Councils would be included in all discussions going forward;
- The voluntary sector had also been consulted but it was acknowledged that this was not sufficiently documented within the STP document;
- Although not always ideal for patients to opt to go out-of-county for hospital procedures it was acknowledged that in some cases this may be purely a geographical decision, based on how close the patients lived to the hospital;
- Mention was made to the closure of all neurology services within the county and that all new neurology patients were required to have treatment out-of-county. It was agreed that the provision of these types of services need to be available in-county;
- It appeared that the inclusion of end of life and palliative care was minimal within the STP. Although these services were incorporated elsewhere across the health community it was acknowledged that this could be made clearer, possibly by way of inclusion within a Frequently Asked Questions (FAQs) document;
- Care in the community had been launched in 1979, of which a number of aspects were not as successful as first thought. It was explained that a lot of the work in the community at that time was good work but that some could have been better. It was also difficult to compare the services provided then to that proposed now due to the significant advances made, especially within home technology;

At 1.00pm, Dr B Wookey (Healthwatch Lincolnshire) left the meeting and did not return.

- When asked the cost of producing the STP document, the Chairman reported that the cost incurred from the commencement of the LHAC to-date was £4.3m and that the cost of the PR to-date was £67k;
- It was confirmed that partners of the integrated transport pilot strived to reduce inequalities within the public transport and infrastructure of the county. It was hoped that, once mapped, school buses, NSL transport providers and on-demand buses could somehow amalgamate services as they currently used the same routes.

RESOLVED

1. That the report and contents be noted;
2. That the proposal for the Health Scrutiny Committee for Lincolnshire to provide a formal statement on the Lincolnshire Sustainability and Transformation Plan (STP) in advance of the formal public consultation be agreed;

3. To further discuss the details of the Lincolnshire STP and to draft a formal statement, as agreed in resolution number two above, the Committee resolved to hold an extraordinary meeting of the Heath Scrutiny Committee for Lincolnshire on Thursday 12 January 2017; and
4. That the draft statement of the Health Scrutiny Committee for Lincolnshire produced at the extraordinary meeting on 12 January 2017, as above, be tabled at the scheduled meeting of the Committee on Wednesday 18 January 2017 for approval.

57 WORK PROGRAMME

Consideration was given to a report by the Health Scrutiny Officer which gave the Committee the opportunity to consider its work programme for the coming months.

During consideration, the following amendments were proposed:-

1. Add Congenital Heart Disease (Update) to the work programme for the meeting of the Committee on 18 January 2017;
2. Cancel the meeting of the Committee scheduled for Wednesday 12 April 2017 due to the Purdah period as a result of the County Council elections in May 2017; and
3. Add an item to the work programme for a future meeting of the Committee to investigate the delay in patient access to GP appointments.

Previous discussions had resulted in the proposal to form a joint working group, with the Adults Scrutiny Committee, to consider the issues around Delayed Transfers of Care (DTOC). The Chairman explained that this issue was wider than originally anticipated due to the number of partners involved in this process. Due to the County Council elections it was proposed to hold one meeting to develop a framework for this work which could be commenced after the election. The Committee agreed with the proposal, the Health Scrutiny Officer was asked to identify a suitable date for a meeting of the working group.

RESOLVED

1. That the work programme, with the amendments noted above, be agreed; and
2. That a meeting be arranged for the Delayed Transfers of Care Working Group, to develop a framework for reviewing Delayed Transfers of Care.

The Chairman thanked the Committee for their tremendous support over the last few months and, in particular, Simon Evans (Health Scrutiny Officer) and Andrea Brown (Democratic Services) for their continued support.

The meeting closed at 1.20 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 Sarah Newton, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 January 2017**
Subject:	**Lincolnshire West Clinical Commissioning Group Update**

Summary:

This report provides the Health Scrutiny Committee for Lincolnshire with an update on the activities of Lincolnshire West Clinical Commissioning Group (LWCCG). It includes information on the lead commissioning arrangements undertaken by the LWCCG; APMS [Alternative Provider of Medical Services] practices, financial and performance information; and patient engagement activity.

Actions Required:

(1) To consider and comment on the information presented by Lincolnshire West Clinical Commissioning Group.

(2) To consider the outcomes of the procurement exercise undertaken by Lincolnshire West Clinical Commissioning Group in relation to the four APMS [Alternative Provider of Medical Services] practices.

1. **Background**

Lincolnshire West CCG (LWCCG) has a registered population of 234,594 patients, and is now in its fourth year of commissioning health services. Like many CCGs across the country we have experienced increasing demand for health care, particularly in respect of continuing health care, prescribing and hospital services. At a time of austerity in all public services, this is proving to be a particularly challenging time. It is clear that the CGG and the NHS generally is going to have to change and adapt in order to meet the needs of patients, and find ways to become more effective and efficient. We need to secure a sound future for the NHS locally and ensure that the needs of all patients continue to be

met in the most comprehensive and accessible way possible, whilst putting the NHS onto a more sustainable footing.

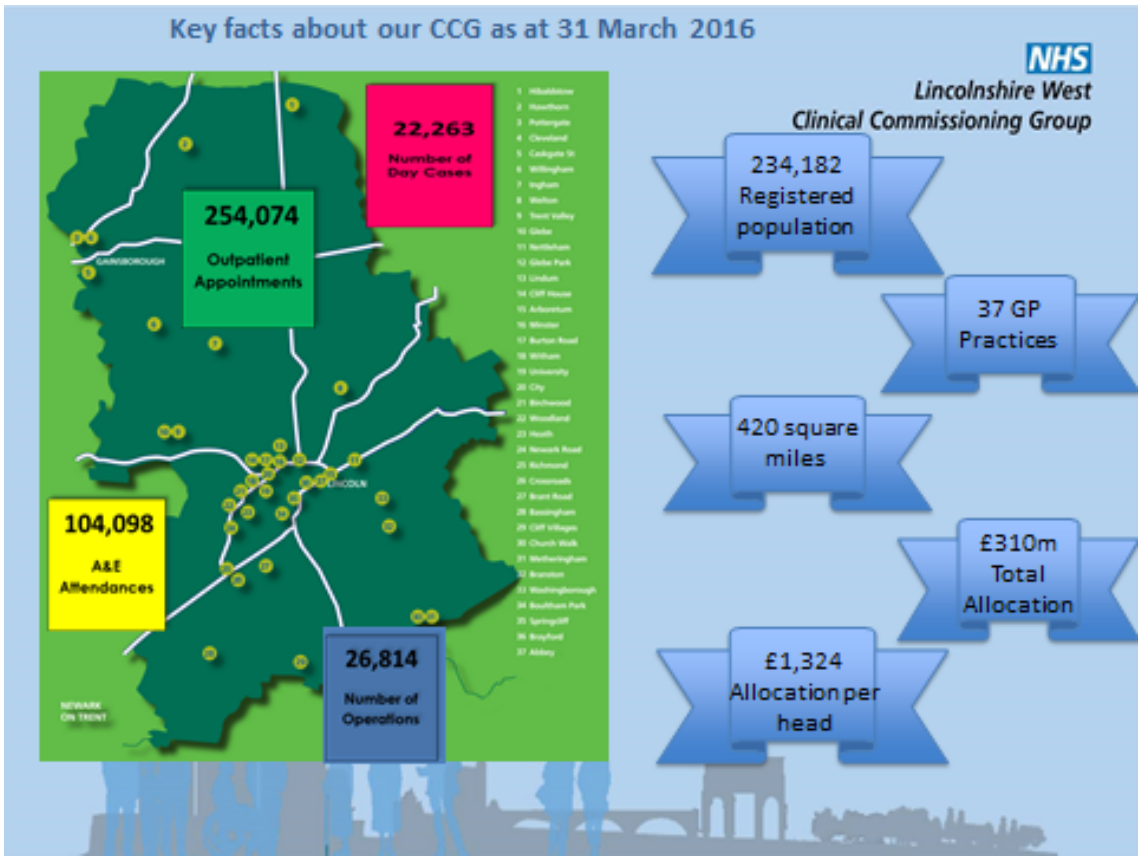

Figure 1 – Some key facts and figures for LWCCG

2. The Past Year in Commissioning

2.1. Primary Care

The CCG has fully delegated authority for Primary Medical (General Practice) services. The commissioning of GP services is managed through the Primary Care Co-commissioning Committee (PCCC) which is constituted to minimise any conflict of interest with GPs as members of the CCG, and includes as observers a representative from HealthWatch and the Health and Wellbeing Committee.

Alternative Provider Medical Services (APMS) Contracts

Primary care commissioning has been very challenging. When the CCG took on delegated responsibility for primary care commissioning in April 2015, five of our 37 practices were operated under Alternative Provider Medical Services (APMS) contracts.

The company running the University Practice APMS contract went into liquidation, (along with several other practices, outside our area) in March 2016. Following a successful procurement process the contract to run this practice was awarded to the Nottingham University Health Service, who are rated by the Care Quality Commission as Outstanding.

In July 2016 the CCG was given one month's notice by Universal Health, who held the remaining four APMS contacts (Burton Road Surgery, Lincoln; Pottergate Surgery, Gainsborough; Arboretum Practice, Lincoln; and Metheringham Surgery) that they were intending to apply for voluntary liquidation, and would therefore cease to provide services at the end of the month. The CCG secured the services of a Caretaker Manager for the practices, whilst a consultation process was undertaken and alternative long term providers were sought.

Despite a number of expressions of interest, only a single bid was received for three of the practices. The fourth practice Pottergate, received two bids. These bids were independently evaluated, and unfortunately neither bidder met the minimum criteria required to make a contract award. As there were no suitable providers, the Primary Care Commissioning Committee (PCCC) made the decision in November 2016 to close the practices.

Individual letters were sent to all adult patients registered at these practices informing them of the decision and identifying alternative practices where they could register. A helpline was set up and a number of drop in events were held to answer queries and help patients register with a new surgery. Alternative GP surgeries are situated within a quarter of a mile of each of the surgeries that are closing. The CCG has worked closely with receiving practices to support the transfer process, and ensure patients are able to continue to receive good quality primary care.

The four surgeries formally closed to patients on 13 January 2017. In order to ensure no patient was left without a GP, all patients who had not registered with an alternative practice by 6 January, have been written to and will be automatically registered with the GP practice closest to their existing GP practice. Patients are of course free to subsequently choose to register elsewhere.

2.2. Lead Commissioning Arrangements

During the last year the CCGs in Lincolnshire have reviewed the lead commissioning arrangements (the organisations that each CCG commissions on behalf of all Lincolnshire CCGs). LWCCG is now the lead commissioner for Lincolnshire Community Health Services, East Midlands Ambulance Service, Non-emergency patient transport, NHS 111 services and a number of other smaller contracts.

2.3. Achievements over the last 12 months

The CCG has worked hard over the year to improve the health of its resident population. The list below provides an indication of some of our achievements during this period.

- Commissioned a hospital liaison service for mental health, and funded a primary care service to help people with mental health problems attend health checks.
- Continued to develop our four neighbourhood teams and frailty pathways
- Delivered above average Bowel screening rates.
- Supported Primary Care International Recruitment Campaign, which has resulted

in a scheme to deliver 25 extra GPs to Lincolnshire

- Delivered a local target of 95% of practices having implemented a pre-diabetic register to support patients at high risk of developing type 2 diabetes to receive lifestyle support.
- Procured a new more comprehensive non-emergency transport service for Lincolnshire
- Launched consultation on over the counter medication and third party prescribing
- Supported the development of new Clinical Assessment Service
- Procured a new 111 service provider
- Improved dementia detection and support.
- Lead work to improve cancer pathways such as Find Out Faster cancer pathway.

3. CCG Finances

During 2015-16 the CCG received £310 million to commission healthcare. The largest expenditure (48%) is spent on buying services from Acute NHS trusts. 25% was spent on primary care, including prescribing costs, 10% on mental health, 7% on community services and 6% on continuing health care. Less than 2% was spent on corporate running costs. The CCG's spend on health care is shown in figure 2 below.

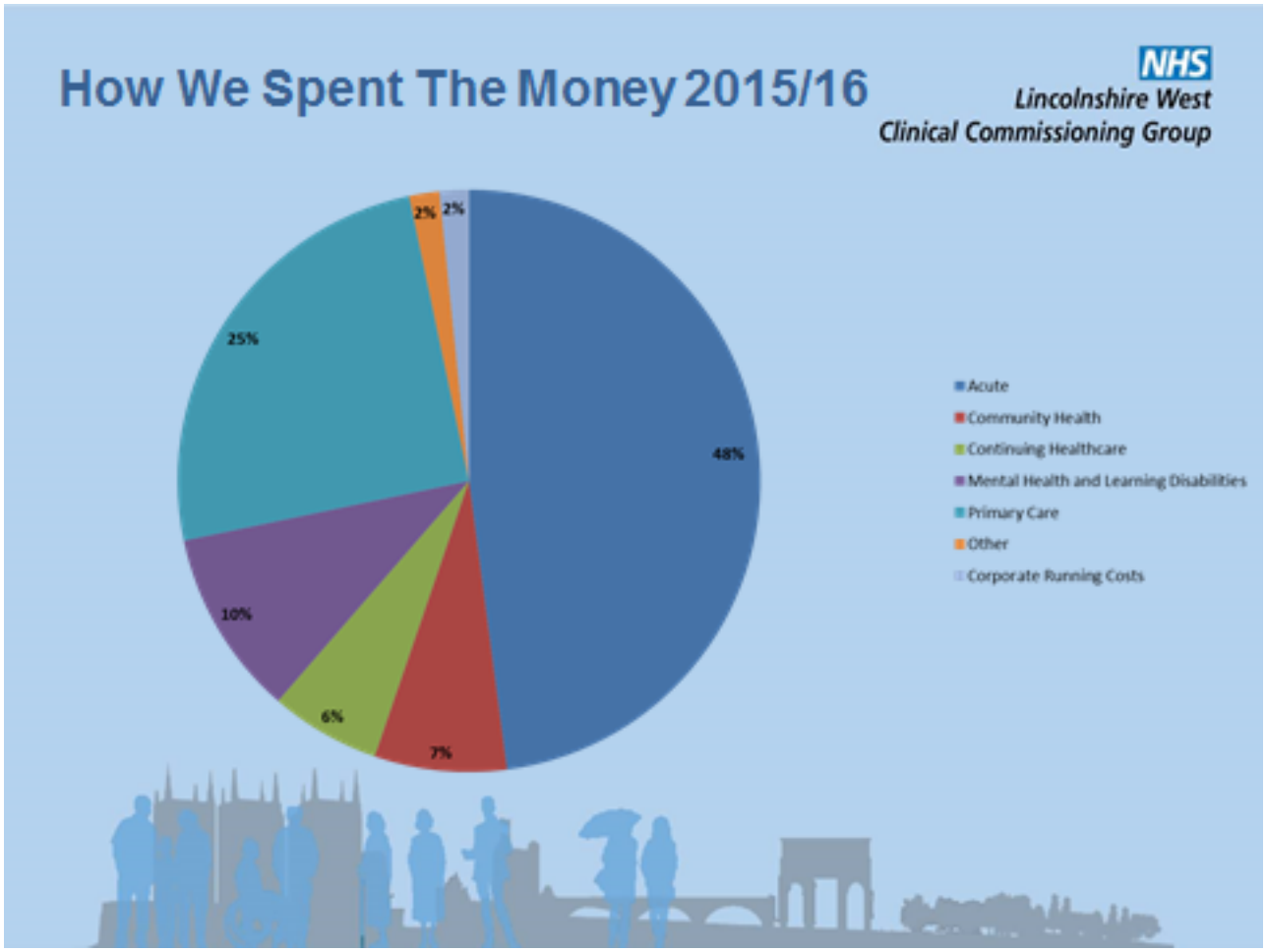

Figure 2 – Use of LWCCG Resources

The CCG received an increase in funding for 2016-17 but nevertheless increasing demand for services in a time of relative funding constraint is leading to some significant pressures on budgets. Pressure is particularly arising from the increases in prescribing costs, the costs of continuing health care (support packages for people being supported at home and in care homes with long term needs), and increased costs for mental health and acute hospital services.

The CCG is reacting to this pressure by taking measures to improve productivity and by focussing on services which are the highest priority. Obtaining value for its publicly funded budget is always a priority for a commissioner but at times of austerity it becomes even more important to ensure that every penny is being invested where it will bring the greatest benefit to patients.

Measures that the CCG is or has taken to manage the financial pressures include:

- Improving the cost effectiveness of prescribing by focussing on the best value medications such as generic rather than branded medicines, and changing to the most cost effective equivalent product
- Reducing expenditure on over the counter medications
- Stopping third party prescribing
- Seeking care in the most cost effective setting, for example in community surgical schemes rather than hospitals if possible
- Reviewing the clinical guidelines for procedures of low clinical value, to ensure compliance and that patients are receiving the most appropriate care at the most appropriate time

4. Performance of the CCG

CCGs are assessed through a performance framework of quarterly reviews and an annual summative conducted by NHS England. For 2015-16 LWCCG, in line with all CCGs in Lincolnshire, was rated overall as 'Requires Improvement'. The CCG performance on each of the assessment framework domains was:

Well Led:	Good
Delegated Functions:	Good
Finance:	Good
Performance:	Requires Improvement
Planning:	Requires Improvement

Overall 'Requires Improvement' was the commonest CCG rating nationally with 92 CCGs being assigned this outcome. The 'Performance' rating of the CCG framework principally refers to the performance of the system in meeting constitutional standards for patients.

Clinical priority baselines were published for the first time this year and for LWCCG these are shown in Figure 3. We are pleased with our 'Top Performing' rating for diabetes and 'Performing Well' ratings for maternity and mental health. Since these were published the CCG has worked hard to improve its dementia detection rates and can report these now meet national expectations. Significant improvements have also been made in respect of learning disabilities, where the number of patients in hospital has been significantly reduced. Whilst the CCG's one year cancer survival rates are

similar to national average, there are problems locally with cancer staging data, which is a measure of the degree of progression seen in a cancer at time of diagnosis. The CCG has led a number of pieces of work this year to improve patient cancer pathways, including action to reduce the referral to treatment times for upper and lower GI, and referral to diagnosis time for breast cancer.

NHS Lincolnshire West CCG					
Clinical Priority Area	**Overall Rating**	**Indicator Ratings**			
Cancer	Needs Improvement	**33.3%**	**76.5%**	**69.9%**	**88.2%**
		New of cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed	Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral	of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis.	of responses ,which were positive to the question "Overall, how would you rate your care?"
Dementia	Needs improvement	**64.5 %**		**77.8%**	
		Estimated diagnosis rate for people with dementia		of patients diagnosed with dementia whose care plan has been received a face-to-face review in the preceding 12 months	
Diabetes	Top performing	**39.7%**		**20.6%**	**43.8%**
		of diabetes patients have achieved all the NICE-recommended treatment targets		of people with diabetes diagnosed for less than a year who attended a structured education course	of GP practices that participated in the National Diabetes Audit
Learning Disabilities	Needs improvement	**69**		**25%**	
		Rate of inpatients per million GP registered adult population for each Transforming Care Partnership. CCGs are then assigned the score of the TCP they belong to		of people with a learning disability who are on the GP register and receiving an annual health check during the year. Measured as a percentage of the CCG's registered learning disability population	
Maternity	Performing well	**80.8**	**61.9**	**4.2**	**12.4%**
		The score out of 100 for women's experience of maternity services based on the 2015 CQC National Maternity Services Survey	The score out of 100 for choices offered to women in maternity services based on the National Maternity Services Survey	The rate of stillbirths and deaths within 28 days of birth per 1,000 live births and stillbirths, reported at CCG of residence level by calendar year.	of women who were smokers at the time of delivery
Mental Health	Performing well	**51.4%**		**50.0%**	
		of people who were initially assessed as "at caseness", attended at least two treatment contacts, are coded as discharged, and are assessed as moving to recovery		of people with first episode of psychosis starting treatment with a NICE-recommended package of care and treated within 2 weeks of referral	

Figure 3 LWCCG Clinical priority baselines

5. Patient engagement

Listening to the Patient Voice and having an effective Quality and Patient Experience Committee (QPEC) are of paramount importance to the CCG. The Quality and Patient

Experience Committee, (a subcommittee of the CCG Governing Body,) meets quarterly. The first part of the agenda is dedicated to listening to and hearing this voice through:-

- Reports on the results of Patient and Carer surveys;
- Listening Events;
- Healthwatch feedback
- Feedback from the CCG Patient Representatives who attend. (The Patient Representatives that attend are active members of the Committee and link back to the CCG Patient Council, which meets bi-monthly.)
- Feedback on consultations

In November 2016 a Stakeholder Communication and Engagement report was presented to the CCG Governing Body, which described the key achievements in the first half of the year. These included:

- Over 1,014 separate engagement interactions outside of "routine" business function
- 50 press releases, 98% of which were used by local media
- Increase in social media following by 67% (Twitter) & the launch of a new CCG Facebook page which reach an audience of 23,000 in October.
- National TV coverage of Diabetes Prevention Programme, regional TV coverage of new Find Out Faster cancer pathway, a monthly column in Lincolnshire Echo and Molly's Guide magazine and a regular slot on Siren FM including promoting mental health, diabetes, and cancer.
- The launch in September our new Health Involvement Network, giving even more opportunities for patients, groups and organisations to engage in the decision making of the CCG.

The last 12 months patients have been actively involved in decisions regarding the future. This included writing to all adult registered patients affected by APMS practice changes, enclosing a survey to seeking their views on future provision, holding drop in sessions, a county wide consultation on over the supply of counter medications, and involvement in the development of new care pathways.

6. System Leadership

LWCCG takes a leadership role across the county in a number of areas. In addition to our lead commissioning role for a number of contracts, we also provide the lead commissioning role for planned care and cancer across the County. In the STP and LHAC programs the CCG has led on Planned care and Cancer, Proactive care, Primary care and Estates.

7. Sustainability and Transformation Plans and Lincolnshire Health and Care Programmes

In partnership with other commissioners and providers across Lincolnshire LWCCG has been working on the Strategic Transformation Plan which incorporates the clinical redesign started in the Lincolnshire Health and Care (LHAC) programme. The Sustainability and Transformation Plan (STP) was submitted to NHS England (NHSE), and has been published.

It is important to note that the STP is not a draft plan it is a live document that will continue to evolve through the implementation of the two year operational plans. Any major change will only be made after full public consultation.

The critical steps include the Options Appraisal Event on 25 January 2017, Clinical Senate review on 20 February 2017 and the subsequent submission of the Pre Consultation Business Case to NHSE at the beginning of March 2017. The 12 week public consultation is likely to begin in May 2017

8. Conclusion

This is an extremely challenging period for the NHS in which we are seeing unprecedented levels of demand and a system that is struggling at times to meet constitutional standards. LWCCG continues to focus on the needs of its patients whilst understanding that this has to be done in the context of services that will work for Lincolnshire as a whole.

9. Consultation

There is no consultation required as part of this item.

10. 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 Sarah Newton Chief Operating Officer, Lincolnshire West CCG who can be contacted at sarah.newton@Lincolnshirewestccg.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:	**18 January 2017**
Subject:	**Lincolnshire Sustainability and Transformation Plan – Finalising the Statement of the Health Scrutiny Committee**

Summary:

On 12 January 2017, the Health Scrutiny Committee for Lincolnshire is due to consider the detail of the Lincolnshire Sustainability and Transformation Plan (STP) and provide its views and comments. These views and comments will be compiled into a draft statement, which the Committee will be invited to consider and approve as part of this item.

The draft statement, prepared on behalf of the Committee, will be circulated prior to the meeting.

Actions Required:

(1) To consider the draft statement prepared on behalf of the Health Scrutiny Committee for Lincolnshire on the Lincolnshire Sustainability and Transformation Plan, and subject to any amendments made by the Committee, to submit the statement as the Committee's initial response to the Lincolnshire Sustainability and Transformation Plan, prior to the full public consultation in May 2017.

1. Background

On 12 January 2017, the Health Scrutiny Committee for Lincolnshire is due to consider the detail of the Lincolnshire Sustainability and Transformation Plan (STP), focusing on the full STP document. As part of this consideration, the Committee is also requested to provide views and comments. Following 12 January, the views and comments made by the Committee will be compiled into a draft statement. The draft statement will be circulated to members of the Committee prior to this meeting for the Committee's consideration.

Both the full Lincolnshire STP document and the STP public summary document are available at the following link: -

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

2. Conclusion

The Committee is invited to consider the draft statement prepared on behalf of the Health Scrutiny Committee for Lincolnshire on the Lincolnshire Sustainability and Transformation Plan, and subject to any amendments made by the Committee, to submit the statement as the Committee's initial response to the Lincolnshire Sustainability and Transformation Plan, prior to the full public consultation in May 2017.

3. Consultation

The STP is not a consultation document in its own right. Formal public consultations on certain elements of the STP are expected from May 2017 onwards. The Committee is invited to provide initial feedback on the content of the STP. It is understood that all formal responses received on the Lincolnshire STP will be considered by the Lincolnshire System Executive Team.

4. 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 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:	**18 January 2017**
Subject:	**Congenital Heart Disease Services**

Summary:

On 21 December 2016, the Committee considered an item on Congenital Heart Disease Services. Two representatives from NHS England attended to provide information to the Committee. The two representatives were requested to attend this meeting to provide additional information and points of clarification. However, they are not available to attend. Any information received will be circulated to the Committee.

In the meantime some points of clarification have been provided by University Hospitals of Leicester NHS Trust, and the letter from the Trust's Chief Executive is enclosed. Representatives from the Trust are to attend the meeting.

The Committee is requested if it wishes to make any submission to NHS England in advance of the public consultation.

Actions Required:

(1) To consider any information received from the NHS England representatives, in relation to the questions raised by the Health Scrutiny Committee on 21 December 2016.

(2) To consider the information submitted by University Hospitals of Leicester NHS Trust – Letter from Chief Executive, John Adler, 1 January 2017 (Appendix A).

(3) To determine whether to make any submission to NHS England at this stage, in advance of the formal consultation phase.

1. Background

NHS England View

On 21 December 2016, Will Huxter, the Regional Director of Specialised Commissioning, NHS England (London Region), and Dr Geraldine Linehan, Regional Clinical Director of Specialised Commissioning, NHS England (Midlands and East Region) attended the Committee to provide information to the Committee on NHS England's reasoning for indicating that the East Midlands Congenital Heart Centre (EMCHC) would not meet the required standards for congenital heart disease surgery, with a view to decommissioning these services from the EMCHC.

Will Huxter and Dr Geraldine Linehan were requested to attend this meeting to provide additional information and further points of clarification. They have declined attendance owing to other commitments, but have indicated that they will provide written information on the information requested.

University Hospitals of Leicester NHS Trust View

In the meantime, the Chief Executive of University Hospitals of Leicester NHS Trust, John Adler, has written to the Chairman of the Committee, Councillor Mrs Christine Talbot. His letter, dated 1 January 2017, is attached at Appendix A to this report. Point 1(c) of the letter refers to treating information on the recruitment of staff confidentially, but it should be noted that University Hospitals of Leicester has now indicated that all the information in the letter can be published.

Timing of the Formal Consultation

The Chairman has written to NHS England to seek that they indicate the dates of the formal public consultation. Any responses received will be reported to the Committee.

2. Conclusion

The Committee is requested to consider any information received from the NHS England representatives, in relation to the questions raised by the Health Scrutiny Committee on 21 December 2016; and the information submitted by University Hospitals of Leicester NHS Trust (Appendix A).

The Committee is also invited to determine whether to make any submission to NHS England at this stage, in advance of the formal consultation phase.

3. Consultation

A formal public consultation is expected "early in 2017" and clarification has been sought from NHs England on when this consultation will take place. In the meantime, the Committee may wish to make a submission to NHs England in advance of the formal public consultation.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Letter from John Adler, Chief Executive of University Hospitals of Leicester NHs Trust to Councillor Mrs Christine Talbot, Chairman of the Health Scrutiny Committee for Lincolnshire - 1 January 2017

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

University Hospitals of Leicester NHS
NHS Trust

Leicester Royal Infirmary
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Cllr Christine Talbot
Lincolnshire Health and Scrutiny Committee

BY EMAIL

1st January 2017

Dear Cllr Talbot

Firstly, thank you for inviting us to attend the Lincolnshire Health and Scrutiny Committee meeting on the 21st December

On the **7th November** UHL sent a revised self- assessment of our ability to meet the standards to NHS England. Since our previous assessment, we are delighted to have made significant progress and feel confident that we now demonstrate compliance with all the standards, or can provide a robust plan showing how we will comply within the designated timeframes. Although our plans are not completely without risk, we are clear that the risks entailed in decommissioning our service are much greater.

I am therefore disappointed that on the **21st December** at your meeting, NHS England were still raising points against our compliance to the standards which we feel are very well covered in UHL's various responses, and that NHS England appear to have a very different interpretation to us on a number of other key points. As we were not able to respond in the meeting, and as requested, I have addressed each of the points raised with a summary of the point highlighted and provided more detail below.

Point 1

a) **375 cases this year -**This is not a requirement of the new cardiac review standards – the actual standard states 375 cases are required, averaged over three years from April 2016. East Midlands Congenial Heart Centre will achieve this standard in the required timescales

In our recent letter from NHS England dated 14th November 2016 they state that, *Standard 2.1 requires a team of at least 3 cardiac surgeons, each of whom must have been the primary operator in a minimum of 125 congenital heart operations per annum as at April 2016, **averaged over the previous 3 years** (and therefore averaged over that period a minimum of 375 cases per year for the team of surgeons as a whole is required).*

It is from this interpretation of the standard that NHS England is challenging our ability to meet the standard. We dispute the interpretation and implementation of the standard in this way; not least because it is both illogical and inequitable to enforce a standard retrospectively. Moreover, we believe this is the first occasion in which the word 'previous' has been included. Standard B9 (L1) and B10 (L1) both provide an "Implementation Timetable" of immediate for 3 surgeons and within 5 years for 4 surgeons.

This retrospective counting was not at any stage agreed by either the standards committee or indeed the wider sign off group. This standard is correctly interpreted as running prospectively from the time of implementation (1st April 2016) and the three years average should therefore be calculated forward from then.

When we look at the previous documentation, it is perfectly clear that up until now NHS England has always approached this on the basis that the three years were to run prospectively from April 2016 and this new interpretation is a change in tactics.

If we apply the interpretation of the standard in the way in which it was intended to be interpreted, then we are on track to achieve an average of 375 cases per annum over the three years averaged from April 2016. Our actual case load this year is likely to fall slightly short of the 375 number, but we have demonstrated through our growth analysis that we will be able to increase our numbers in 2017/18 and 2019/20 to ensure the three year average is met.

b) **500 cases by 2020 -** We provided a growth plan to NHSE on the 7th November that clearly shows that East Midlands Congenital Heart Centre will achieve the required 500 cases by 2020

We included in the submission, detailed in Appendix 1, a growth plan that clearly demonstrates us reaching 500 cases by 2020. This is based on our growth from the previous two years, population growth estimates taken from Office of National Statistics and a very cautious application of the additional referrals we believe we can generate from the on-going referral discussions with our network partners. Our network development plan is based on hospitals that we believe do not currently offer East Midlands Congenital Heart Centre as an option to their patients, despite it being the Level 1 centre closest to home, now starting to offer us as an option. This will only affect new patients unless existing patients choose to transfer to us. We believe this will take time to develop; we will need to demonstrate to the referring clinicians that we are able to match the level of service their patients currently receive. It is because of this we have been cautious in our expectations in the first two years.

This is a robust plan, backed up by our clinical and Executive teams speaking regularly to the network hospitals, and based on a very positive degree of traction recently, despite the on-going uncertainty facing the unit .

NHS England has not provided any explanation as to why they do not feel our plans are achievable. We have however had significant conversations and have started developing new referral pathways with a number of the Network Hospitals that show our plan is realistic. It would be helpful if NHS England more actively supported our network development, as we have repeatedly requested. They have declined thus far to do this, for whatever reason.

A point also has to be made in respect to the validity of the 500 cases being used as a measure. We agree that at the hospital level, the number of operations performed may be a rough starting point for an assessment of the volume of work if one can assume that the hospitals do the same range of complexity operations. There is no difference or acknowledgement made for operations that take 30 minutes vs. those that take 10 hours. East Midlands Congenital Heart Centre does very few of the least complex operations that constitute a large proportion of the surgical throughput of some other units.

NHS England commissioned the University of Sheffield to review the world research on the subject and then misrepresented their findings, as the principal author has made clear publicly. The ScHARR study found no convincing evidence that centres doing 500 operations a year provide any advantage over medium sized centres like our own.

c) **Surgeons -** The standards do not require surgeons to be employed in a substantive role and other centres also have consultants on locum contracts. It is usual practice to offer locum contracts to allow overseas consultants time to register with the GMC specialist register (a pre-requisite for a substantive post). In addition, on 2nd December we made a new substantive consultant appointment as well as an additional appointment from these interviews to allow service development and succession planning. Despite the adverse 'climate' we had nine high quality applicants for this post; perhaps demonstrating a significant degree of professional solidarity with, and faith in, EMCHC?

East Midlands Congenital Heart Service currently has three full time Consultant Congenital Cardiac Surgeons, therefore meeting the standard for 2016. Nowhere in the standards does it state that it is inappropriate to have a locum surgeon.

All our Congenital Cardiac Surgeons have completed specialist training programmes in Congenital Cardiac Surgery. One of our consultants is employed as a Locum Consultant by virtue of UK immigration and employment law, having been employed as a substantive Consultant Congenital Cardiac surgeon abroad with significant experience. He previously

worked in a similar role at Great Ormond Street from whence he came with a very favourable reference. He is now preparing his application to the GMC for inclusion on the specialist register; after which he can be considered for a substantive role. This is normal practice in NHS Trusts employing specialists from overseas and any perceived risk regarding the sustainability of this appointment has been mitigated by the Trust providing a long term Locum contract to cover the period until his registration process is complete.

The need to employ Locum surgeons from abroad can be explained by the pressures on paediatric cardiac surgery training.

To give you an idea of the extent of the issues, there were this year 70 applicants for 14 training posts in cardiac surgery. In other words, the CTS training programme was oversubscribed by 500%. Yet when it came to sub-specialism in paediatric cardiac surgery there was only 1 applicant for 3 places. This may be connected with the intense level of scrutiny which has been applied to the specialty over many years.

The interviews on December 2nd identified two candidates that the panel felt were of the required professional calibre to be appointed. We have therefore established an additional substantive surgical post in conjunction with Leicester University. This role will focus on service development and succession planning, and ensure the current solidity and outcomes of the team are retained as a new surgeon is introduced. Details of the two roles and the surgeons will be announced once the appointment has been finalised. We would be grateful if you could keep this information confidential until we have made our formal announcements.

In a letter to Mr Huxter on the 20th December we announced the two surgical substantive appointments. Despite a similar request to keep the appointments confidential, Mr Huxter chose to announce them at the meeting on the 21st December. He then went on to raise concern that the engagement of the fourth surgeon would further compromise our ability to meet the 125 caseload per surgeon standard. In our letter of the 20th December we made clear that;

'We can assure you that the surgical activity will be managed appropriately to maintain the required activity levels for each consultant. The additional appointment will allow us to focus on service development, mentoring, and succession planning; whilst ensuring the current solidity and outcomes of the team are retained as a new surgeon is introduced to it. This appointment will also offer us flexibility as our surgical numbers increase as per the growth plan we have submitted.'

We were therefore baffled as to why he felt the need to raise this concern, despite the explicit assurances within the letter. I will be raising the issue of breach of confidentiality separately with Mr Huxter.

Point 2 -

a) Network and out of area referrals are purely patient choice. We have a network development plan that will increase not decrease choice for patients. Our growth plan assumes that patients nearest to us will be offered the choice of Leicester but does not assume every patient will choose EMCHC. NHS England's plans will substantially reduce local patient choice.

The fact is that a number of hospitals within our catchment area, which see East Midlands based patients with CHD, have well established referral patterns to Great Ormond Street Hospital.

It is evident that NHS England assumes that by protecting the current referral pathways for the 150 surgical cases per annum who do not receive their surgery at EMCHC, they are in some way protecting patient choice. The reality is that this will deprive the thousands of patients in our area who currently are treated at EMCHC and are delighted with the quality of their care, of the right to choose to be treated in the hospital of their choice, nearest their home. They feel passionately about this.

It was evident from the meeting that journey time and cost, especially for those constituents who live in rural areas and are on a low income, is a key concern to your councillors. Our growth plan increases the choice for those patients to receive the highest quality service closest to home.

b) **Dr Geraldine Linehan GP commented on numerous occasions that patients want to experience care from someone with the best clinical expertise.** This is of course correct, and our surgeons have over fifty years' combined experience in congenital cardiac surgery. It is however the outcome of that surgery that is of greater relevance; the surgical outcomes at Glenfield Hospital exceed expectations in respect to deaths within 30 days following cardiac surgery

Our surgical outcomes, as illustrated in our latest quality report, (Appendix 2 page 20), show that our survival rate as adjusted by the PRAiS software (Partial Risk Adjustment in Surgery) is greater than the model predicts. In fact there have been four fewer deaths than would otherwise be expected over the three year period from 01/08/13 – 29/07/16. It is also not just the surgical experience that counts for outcomes; the whole team is crucial. East Midlands Congenital Heart Centre has some of the most experienced Cardiologists and Intensivists in the country and of course among the most ECMO experience in the world. So to question our service's 'expertise' against all evidence is inappropriate.

Due to the significant advances in Congenital Heart Disease surgery, any patient offered the choice of surgery at EMCHC or elsewhere in the UK would not be able to differentiate on outcome data alone, but would be able to assess the impact of being treated closer to

home, on the pastoral support they would receive, and the cost of travelling to and from the surgical unit.

Point 3 -

Only UHL and Manchester do not meet the 375 standard – the NICOR data for 2015/16 on the Nicor website shows that last year Alder Hey did 348 surgical cases, Newcastle did 328, and EMCHC did 326

The 2015/16 NICOR data can be found at https://nicor4.nicor.org.uk/chd/an_paeds.nsf/WSummaryYears?openview&RestrictToCategory=2015&start=1&count=500 .

Point 4 -

NHS England has no plans to close EMCHC. There will continue to be specialist medical services for CHD at Glenfield. On November 7th 2016 UHL submitted an impact assessment, of what services would not be able to be provided if Level 1 commissioning was removed. (Appendix 3 – impact assessment) This includes all invasive interventions and surgery.

Without the outcome of the independent reviews into PICU, ECMO, Paediatric surgery and transport, we were not able to clearly define the knock on effects across the wider paediatric specialisms, but it is the definite opinion of the clinicians responsible for delivering specialised services across the East Midlands, that very limited services would be able to be offered at UHL without the expertise and support of Cardiac Surgery. There will be a significant impact on experienced workforce, recruitment, retention, training and education.

In the meeting, Mr Huxter stated that the outcomes from the independent reviews would be incorporated into the post consultation decision making. We would strongly contest this as being transparent and fair, and feel this information is crucial for inclusion in the public consultation process.

Point 5 – Transition - extra capacity would be required elsewhere and that Birmingham had submitted funded plans to achieve this. Transition would take time 1-2 years to complete. The current capital availability within the NHS is very limited and it was confirmed at the last Cardiac Clinical Reference Group meeting, that there is no planned independent verification of how the additional capacity is going to be funded or provided.

The transition plans are solely dependent upon the three surgeons currently working at East Midlands Congenital Heart Centre staying with the centre during the transition period. In this scenario this may or may not be what happens so there is a high risk of service instability.

There is a lot of detail in this letter and the attachments; I hope the summary points will help you and your fellow councillors get a clear sense of our response to the points made by NHS England and be reassured that the apparent concerns they expressed about the service are unfounded. I have to confess to a level of frustration that NHS England continue to promote lines of argument which we have rebutted on several occasions. This suggests, at best, the lack of a genuinely open mind on their part.

Kind regards

Yours Sincerely

John Adler

Chief Executive

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:	**18 January 2017**
Subject:	**Community Pharmacy 2016/17 and Beyond: The Final Package**

Summary:

On 20 October 2016, the Government published *Community Pharmacy in 2016/17 and Beyond: The Final Package,* which set out the Government's response and decision on its consultation which closed on 26 May 2016, to which the Health Scrutiny Committee had responded on 27 April 2016.

Community Pharmacy in 2016/17 and Beyond: The Final Package is attached to this report. The report also includes the responses of the Local Government Association and three national pharmaceutical organisations to *Community Pharmacy in 2016/17 and Beyond: The Final Package*.

Steve Mosley, Chief Officer of the Lincolnshire Local Pharmaceutical Committee, will be in attendance to provide information on how the implementation of *Community Pharmacy in 2016/17 and Beyond: The Final Package* is affecting on local pharmacies.

Actions Required:

(1) To consider and comment on the *Community Pharmacy in 2016/17 and Beyond: The Final Package* and receive information on how its implementation is impacting on community pharmacies in Lincolnshire.

1. Community Pharmacy 2016/17 and Beyond – Final Package

On 20 October 2017, the Government published *Community Pharmacy in 2016/17 and Beyond: The Final Package*. The document is attached at Appendix A to this report.

2. **Responses of National Organisations to Community Pharmacy 2016/17 and Beyond: The Final Package**

This section of the report sets out the responses of several national organisations to *Community Pharmacy 2016/17 and Beyond: The Final Package.*

Response of the Local Government Association

On 20 October 2017, the Local Government Association issued the following response to *Community Pharmacy in 2016/17 and Beyond: The Final Package.*

"Councils want every local area to have a strong community pharmacy network, particularly those in deprived areas with the greatest health needs, or rural communities with the furthest distance to travel. It is important that government ensures this is delivered through the Pharmacy Access Scheme.

"Older and frail people rely on their local chemist not just as a place to get medicines, but as somewhere they can go to for informal health advice and information. If this lifeline was removed, it would mean more people having to potentially travel longer distances to GP surgeries and adding to existing pressures.

"We accept community pharmacies need to change, but instead of funding for them being reduced, we would like to see pharmacies playing a bigger role in providing public health services, alongside their important existing roles of supplying medicines. Additional investment in community pharmacies could improve the prevention of disease and help take the strain off the NHS and social care.

"Pharmacies also have an important place in our local economy. They are vital to ensuring diverse and vibrant high streets, which can otherwise be dominated by betting shops, fast food outlets and payday lenders. Losing our pharmacies could leave gaps in high streets that may never been filled."

Response of the National Pharmacy Association

The response of the National Pharmacy Association to Community Pharmacy 2016/17 and Beyond: The Final Package, which represents independent pharmacies, is set out below:

"The Government's approach shows a complete disregard for the community pharmacy sector and the wellbeing of patients. This is slap in the face for hardworking pharmacy teams and for concerned patients.

"Millions of worried patients have asked the Department of Health to think again. Politicians from all parties are against the cuts. It is abundantly clear that the current policy approach is flawed and universally unpopular.

"Yet elements within Government seem determined to press ahead with this damaging experiment, deaf to the nationwide protests. It is clear that they believe there are too many pharmacies and want closures. In the long run, thousands are at risk, unless there is a change of mindset and a change of direction amongst Ministers and officials.

“What concerns us most is the idea that still exists in parts of government and NHS which views pharmacy as merely a distribution point for medicines. Local pharmacies are so much more than that – they are a vital health and social care asset at the heart of communities.

“The Minister’s statement to MPs today that services will improve as a result of these massive cuts flies in the face of logic. The Government is not listening to the common sense arguments.

“But this is far from over. We will fight on in the light of today’s announcement. What gives us grounds for hope is the unprecedented level of public awareness and active political support that has been generated over the past months. This will form the basis of an ongoing effort to fundamentally shift the direction of government policy, so that pharmacies are seen as a solution to deep-seated problems in the NHS, not as a problem.

“Our most urgent task now is to defend against the most damaging potential consequences of the cuts. We owe it to the millions of patients who have supported us to continue to safeguard the pharmacy services they rely on.

“This issue goes far beyond the funding cuts imposed for 2016/18 and is ultimately about keeping the ‘community’ in community pharmacy. We want to engage in a programme of investment and improvement which builds on the strengths of our sector rather than seeks to dismantle it. The Government has said it wants to see pharmacies do more in urgent care and long-term conditions – now they must prove that they mean it, by changing course and investing in the sector for the long term.”

Royal Pharmaceutical Society

The Royal Pharmaceutical Society is the professional membership body for pharmacists and pharmacy in Great Britain. Its response to *Community Pharmacy in 2016/17 and Beyond: The Final Package* is as follows: -

"Community pharmacists will need support from the Royal Pharmaceutical Society and other organisations following the announcement by the Department of Health that they will reduce total funding for community pharmacy, both this year and next.

"The profession has spoken with one voice on this issue. We have consistently asked how the Government’s aspiration for the future of community pharmacy to be at the heart of the NHS can be squared with large reductions in funding.

"We recognise the NHS is under huge financial pressure, with colleagues in public health and hospitals at the sharp end of squeezed budgets too. There is a broader case for all of us in health to make about investment in a service that is dealing with unprecedented demand and expectations.

"Today we have heard more detail about the pharmacy access scheme, with some additional funding for pharmacies in deprived communities. It remains to be seen if this scheme will lessen the impact on opening hours and staffing levels in these vital community pharmacies.

"The pharmacy integration fund, originally set at £300 million over five years, has now been reduced to £42 million over 2 years, with years 3, 4 and 5 yet to be confirmed. We are committed to working with NHS England on best use of this fund but are dismayed there is now less certainly about the long term status of this work.

"We know that many pharmacists, whether they own a pharmacy or work for a pharmacy business will be hugely concerned about the future. We have been very clear about our opposition to funding reductions, but we know that the profession needs more from us at this time. The Royal Pharmaceutical Society will also make sure we offer pharmacists practical support to plan for the change that will begin on 1 December 2016."

Pharmacy Voice

Pharmacy Voice is an association of trade bodies which brings together and speaks on behalf of community pharmacy contractors. Its response to *Community Pharmacy in 2016/17 and Beyond: The Final Package* is as follows:-

"We have only just seen the Government's response to the PSNC today but, on first inspection, it doesn't appear that the Department of Health has been listening. We have spent the last 10 months explaining to them the value of community pharmacy, the pressure we take off other parts of the NHS and the money we save the Government by keeping patients out of GP surgeries and A&E.

"The public have made it clear to them that they expect their local pharmacies to expand their role in the community and MPs from every party have outlined how cuts will harm the interests of their constituents. Yet, despite this opposition, the Government appears hell-bent on pressing ahead with this incoherent, self-defeating and wholly unacceptable policy".

"Despite the announcement, Pharmacy Voice is determined to ensure the long-term sustainability of community pharmacy and vital patient care is not put at risk. We will now redouble our work to promote the positive vision set out in the Community Pharmacy Forward View and will work closely with national and local partners to demonstrate how implementing it can deliver savings and improve health across the country

"At the same time, we will build on the enormous good-will we have generated within Parliament, amongst the public and with NHS and Local Government colleagues in support of an expanded role for pharmacy within primary care and public health."

3. Previous Health Scrutiny Committee Consideration

On 20 April 2016, the Committee considered the consultation document on *Community Pharmacy in 2016/17 and Beyond* and received information from the Lincolnshire Local Pharmaceutical Committee.

Letter from the Chairman to the Secretary of State for Health

Following the meeting of the Committee on 20 April 2016, the Chairman submitted the following response to the Secretary of State for Health on behalf of the Committee: -

"I have been authorised by Health Scrutiny Committee for Lincolnshire to respond to the Community Pharmacy in 2016/17 and Beyond Proposals, as the Committee is concerned that these proposals could lead to 30 fewer community pharmacies in Lincolnshire. This reduction will lead to patients putting pressures on the NHS, either at GP surgeries, out-of-hours services or at Accident and Emergency.

"The Health Scrutiny Committee for Lincolnshire is concerned that the consultation on Community Pharmacy 2016/17 and Beyond was launched on 17 December 2015 and was in the form of a letter to the Pharmaceutical Services Negotiating Committee, which was copied to other national organisations. There was a complete failure on the part of your Department to involve or approach any local authority health overview and scrutiny committees or any health and wellbeing boards. In the case of the latter, I would draw your attention to their responsibility for developing and approving the local pharmaceutical needs assessments, which form the basis for decisions locally on where pharmacies may be established.

"There are 122 community pharmacies in Lincolnshire, serving a population of 740,000. As the county is rural in nature, 40 per cent of Lincolnshire residents are served by dispensing GP practices. As a result, the 122 pharmacies dispense approximately 50 per cent more prescription items than an average pharmacy in England. I understand that the proposed funding reduction via the drug tariff adjustment will have a more serious impact on Lincolnshire community pharmacies than the average pharmacy. I understand from information provided by the Lincolnshire Local Pharmaceutical Committee that the average financial impact for a community pharmacy in England will be approximately £14,500. I understand that for a pharmacy in Lincolnshire this impact could be as high as £22,000.

"According to Rt Hon Alistair Burt MP, the Minister of State for Community and Social Care, there are 11,674 community pharmacies in England. Mr Burt has estimated that between 1,000 and 3,000 pharmacies could close in England. If 3,000 pharmacies were to close, this would represent a reduction of 25 per cent. In Lincolnshire a 25 per cent reduction in the 122 community pharmacies would lead to the closure of 30 pharmacies, leaving only 82 pharmacies in the county.

"I would at this point draw your attention to provisions in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Under Regulation 23, when commissioners of NHS-funded services make a proposal for a substantial development of the local health service or a substantial variation in the provision of such service, they are obliged to consult with their local health overview and scrutiny committee. The Health Scrutiny Committee for Lincolnshire believes that a reduction 30 pharmacies would constitute a substantial development or variation. "I understand that as Secretary of State you are outside the ambit of these regulations, but I would

argue that if a local NHS commissioner were seeking a 25 per cent reduction in service, they would be required to present robust arguments to the Health Scrutiny Committee for Lincolnshire. The closure of 30 pharmacies in Lincolnshire will have an extensive impact on services available to Lincolnshire residents and would be a matter of utmost concern to the Health Scrutiny Committee for Lincolnshire.

"Furthermore, I understand that any pharmacy closures would not be planned or co-ordinated, but would depend on the financial viability of each pharmacy. Clearly a factor in this is the extent to which national chains would be able to absorb any reduced income. This option is not available to smaller independent pharmacies and they would be more likely to be affected. The piecemeal closure of pharmacies could lead to gaps in provision across the county, leaving communities without access to prescription medicine and professional advice.

"For those pharmacies that remain there will be pressures on staff and this could mean the pharmacies are less able to provide advice and support to patients. Without this, patients are more likely to seek appointments with GPs, out-of-hours services or attend Accident and Emergency.

"I would urge you to reconsider these proposals to ensure that local communities in counties such as Lincolnshire are not affected."

Response from Minister of State for Community and Social Care to the Chairman's Letter – 10 June 2016

On 10 June 2016, the Rt Hon Alistair Burt MP, the Minister of State for Community and Social Care responded as follows:

"Thank you for your letter of 11 May to Jeremy Hunt about community pharmacy services.

"I appreciate your concerns and I want to reassure you that the Government believes that community pharmacy is a vital part of the NHS. We need a clinically focused community pharmacy service that is better integrated with primary care and public health in line with the Five Year Forward View.

"Our proposals are about improving services for patients and the public, and about securing efficiencies and savings. A consequence may be the closure of some pharmacies but that is not our aim. We believe these efficiencies can be made without compromising the quality of services or public access to them.

"We are consulting on the introduction of a Pharmacy Access Scheme, which will provide more NHS funds to certain pharmacies, considering factors such as location and the health needs of the local population. The proposal is for a national formula to be used to identify those pharmacies that are the most geographically important for patient access.

"We are not able to assess which pharmacies may close because we do not know the financial viability of individual businesses nor the extent to which they

derive income from services commissioned locally by the NHS or local authorities, or have non-NHS related income.

"At the outset it was agreed that the Department of Health would lead the consultation rather than NHS England. We have been in discussion with the Pharmaceutical Services Negotiating Committee (PSNC), the body recognised under Section 165(1)(a) of the NHS Act 2006 as representing all community pharmacies providing NHS pharmaceutical services in England on changes to the contractual framework for 2016/17 and beyond. The PSNC is the body we are required to consult with on NHS community pharmacy funding. Alongside this, we have also engaged with other organisations including the Local Government Association and representatives of patient groups.

"I hope this reply is helpful, and I can assure you that your correspondence has been passed to the officials who are looking at the consultation response."

Chairman's Letter to the Minister of State for Community and Social Care – 21 June 2016

On 21 June 2016, the Chairman wrote to the Minister of State for Social Care, as follows: -

"I have advised the Health Scrutiny Committee for Lincolnshire of the proposed Pharmacy Access Scheme and the Committee hopes that the Scheme will protect pharmacies in rural areas, so that patients can avoid putting additional pressure on their local GP surgery, out-of-hours services or Accident and Emergency.

"I am grateful that you have confirmed that the Department of Health has fulfilled its statutory obligation by consulting with the Pharmaceutical Services Negotiating Committee and has further extended the consultation by involving other national pharmaceutical organisations and the Local Government Association. However, I would suggest that in future local authority overview and scrutiny committees are also directly consulted for their views on any such potential change in funding arrangements, as these could impact on local health provision.

"The Health Scrutiny Committee for Lincolnshire understands that community pharmacies are not commissioned in the same way as most other health services and the financial viability of each individual pharmacy largely determines whether a pharmacy might close or remain open. As I stated in my letter of 11 May 2016, this could lead to the piecemeal closure of pharmacies unless they are protected by the Pharmacy Access Scheme. Any gaps in provision across the county would leave communities without access to prescription medicine and professional advice.

"The Health Scrutiny Committee for Lincolnshire has asked me to reiterate its position that the closure of up 30 pharmacies in Lincolnshire would constitute a substantial development or variation in health service provision in the county. This is clearly outside the ambit of the health scrutiny regulations, as it would clearly be illogical for the Committee to refer Secretary of State's proposals to the Secretary of State himself. However, I would repeat my previous assertion

that if a local NHS commissioner were seeking a 25 per cent reduction in services, they would be expected to present robust arguments to their local health overview and scrutiny committee.

"I would strongly urge the Department to make sure that the Pharmacy Access Scheme ensures that rural areas are not left without community pharmacies. "

4. Conclusion

The Committee is invited consider *Community Pharmacy in 2016/17 and Beyond: The Final Package* and receive information on how its implementation is impacting on community pharmacies in Lincolnshire.

5. Consultation

A response was submitted on behalf of the Health Scrutiny Committee on 27 April 2016, and this item provides information on the outcomes of the consultation and the implementation of the Government's decision.

6. Appendices – These are listed below and attached at the end of the report

Appendix A	Community Pharmacy in 2016/17 and Beyond – Final Package *(Department of Health – 20 October 2016)*

7. 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

Department of Health

Community pharmacy in 2016/17 and beyond

Final package

October 2016

DH ID box
Title: Community Pharmacy 2016/17 and beyond: final package
Author: Directorate/ Division/ Branch acronym / cost centre Community Care/Medicines and Pharmacy/MPD/17060
Document Purpose: Policy
Publication date: October 2016
Target audience: Pharmacists, pharmacy technicians, pharmacy contractors, patients/public
Contact details: Pharmacy Team, 133-155 Wellington House Waterloo Road London SE1 6LH

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Contents

Executive summary

This document sets out the package of reforms that has been developed and approved by Department of Health Ministers, following consultation with the Pharmaceutical Services Negotiating Committee (PSNC) and other key stakeholders, including patient and public representatives. This included consideration of a set of alternative proposals put forward by the PSNC. We also received written responses from 126 organisations and individuals. These responses have been taken into account in the decision-making process.

1. The consultation process

1.1. The Government set out initial proposals for community pharmacy in 2016/17 and beyond in the open letter to the PSNC and other stakeholders on 17 December 2015. The consultation ended on 24 May 2016, although confidential discussions continued beyond that date.

1.2. Following considerations over the summer, the Government put revised proposals to the PSNC on 9 September 2016, and the PSNC issued their final response to the proposed package of measures on 13 October 2016.

1.3. This process has been led by the Department of Health, supported by NHS England. Given the context of the Spending Review 2015, and to facilitate a clear accountability framework, Department of Health Ministers have taken responsibility for implementing the proposals and so the implementing measures in the Drug Tariff will be determinations on behalf of the Secretary of State for Health.

1.4. The Government has endeavoured as far as possible to collaborate with the PSNC, as per our consultation model of engagement with them. On this occasion, agreement has not been reached.

2. Timetable for measures to be introduced

2.1. The Government intends to implement the funding changes from 1 December 2016, through amending the December Drug Tariff. Other elements of the package are also expected to be implemented in December, such as market entry regulation changes to facilitate the consolidation of pharmacies. Others are expected be introduced later, for example some changes to drug reimbursement.

3. Summary of measures being pursued

Funding settlement

3.1. The Government usually only announces one year settlements in relation to pharmacy remuneration. However, it is desirable that we offer a level of certainty and stability to pharmacy businesses, given the reduction in funding. As such, contractors providing NHS pharmaceutical services under the community pharmacy contractual framework (CPCF) will receive:

2016/17	£2.687 billion
2017/18	£2.592 billion

3.2. This represents a 4% reduction in funding in 2016/17 and a further 3.4% reduction in 2017/18.

3.3. Decisions relating to community pharmacy remuneration for 2018/19 and beyond will be subject of future consultation.

Fees and services

3.4. We are making the following changes to fees and allowances which will be reflected in the Drug Tariff from 1 December 2016:

- consolidating a range of fees into a single activity fee;
- phasing out establishment payments; and
- introducing a Pharmacy Access Scheme.

3.5. A quality payments scheme will also be introduced, with the first payments being made with the reconciliation payments in respect of April 2017 dispensed prescriptions.

3.6. In addition, NHS England will be commissioning a new urgent medicines supply pilot as an advanced service, which will require changes to Directions.

3.7. These changes are described in more detail below.

Single activity fee

3.8. The single activity fee will subsume a range of dispensing-related fees into one, simplified payment. This will include the following fees:

- the professional fee (also known as the dispensing fee);
- the practice payment;
- the repeat dispensing payment; and
- the monthly electronic prescription service (EPS) payment.

3.9. The one-off set-up payment for EPS release 2 will not be consolidated into this payment. This document should be treated as notice that the one-off set-up EPS release 2 payment will cease from April 2017.

3.10. The expected level of the single activity fee in the December Drug Tariff is £1.13 per item.

3.11. Additional fees paid for dispensing prescriptions for specific types of product such as unlicensed medicines, appliances, controlled drugs etc., will remain as separate fees.

Phasing out establishment payments

3.12. The single activity fee above will be implemented alongside the phasing out of establishment payments.

3.13. Community pharmacies currently receive an establishment payment as long as they dispense above a certain prescription volume. Currently, the payment starts at £23,278 per annum for pharmacies dispensing 2,500 items per month, going up to £25,100 per annum for pharmacies dispensing 3,150 or more items per month.

3.14. The establishment payment will be gradually phased out over a number of years.

3.15. On 1 December 2016 it will be reduced by 20% compared to 2015/16 levels (equivalent to a 6.7% reduction overall in 2016/17). By way of illustration, the top establishment payment of £25,100 per annum, equivalent to £2,092 per month, will reduce to £1,673 per month.

3.16. On 1 April 2017 it will be reduced by 40% compared to 2015/16 levels. By way of illustration, the top establishment payment will reduce to £1,255 per month.

3.17. It is proposed that the establishment payment will cease by the end of 2019/20. The phasing in future years beyond 2017/18 will be subject to future consultation.

Pharmacy Access Scheme

3.18. The Government believes efficiencies can be made within community pharmacy without compromising the quality of services or public access to them.

3.19. We are introducing a Pharmacy Access Scheme (PhAS) to support access where pharmacies are sparsely spread and patients depend on them most.

3.20. A pharmacy will be eligible for the PhAS if it meets all of the following three criteria:

- the pharmacy is more than a mile away from its nearest pharmacy by road;
- the pharmacy is on the pharmaceutical list as at 1 September 2016; and
- the pharmacy is not in the top quartile by dispensing volume.

3.21. Overall, 1356 pharmacies will receive funding from the PhAS on the basis of these criteria. On average, the payment received will equate to roughly £11,600 in 2016/17 and £17,600 in 2017/18. This is roughly £2,900 per month in 2016/17 and £1,500 per month in 2017/18. (Note that the monthly payment is higher in 2016/17 because the annual payment is split into 4 months (payments for December 2016 – March 2017) whereas the 2017/18 payment is split into 12 months.)

3.22. The exact payment a PhAS pharmacy will receive will be based on the funding it received in 2015/16. In addition, it will incorporate an efficiency saving, of 1% in 2016/17 and 3% in 2017/18. This efficiency saving is smaller than the saving made by pharmacies who do not qualify for the PhAS (which is 4.6% in 2016/17 and 8.3% in 2017/18).

3.23. The scheme will run from 1 December 2016 to 31 March 2018. During this time, eligibility will be fixed to the pharmacies that are deemed eligible in the list published on the 20 October 2016. This is because our aim is to offer community pharmacies greater certainty for a longer period than a one year deal would provide. However, for pharmacies which consider they should be added to the list, a review mechanism will be in place, to allow flexibility for extenuating circumstances that merit consideration.

3.24. A document outlining the technical workings of the scheme and the list of eligible pharmacies is published alongside this document.

Quality payments scheme

3.25. A quality scheme will be introduced. Up to £75 million will be available for this in 2017/18. What is not paid out as part of the quality scheme will be paid out in other fees and allowances. It will be funded from the overall funding for 2017/18 of £2.592 billion.

3.26. There will be two review points during the year, at which quality payments can be claimed:

- end of April 2017; and
- end of November 2017.

3.27. Payments due from each review point will be paid as part of the full value of services for that month, i.e. payment from April's review point will be paid at the end of June/beginning of July. There will potentially be a further 'reconciliation payment' made with the full value of services for March 2018, if there is money remaining from the £75 million.

3.28. To qualify for payments, pharmacies will have to meet four gateway criteria[1]:

- provision of at least one specified advanced service; and
- NHS Choices entry up to date; and
- ability for staff to send and receive NHS mail; and
- ongoing utilisation of the Electronic Prescription Service.

3.29. Passing the gateway criteria will not, in and of itself, earn a quality payment for the pharmacy. Quality payments will depend on how many of the quality criteria the pharmacy meets.

3.30. Pharmacies passing the gateway will receive a quality payment if they meet one or more of the criteria listed in the table below. The criteria have been weighted based on an assessment of the difficulty of achieving them and the benefit to patients from doing so, with each criterion being designated a number of 'points'.

[1] We are still working through the detail of this and may need to introduce some flexibility depending on availability, for example of NHS Mail 2.

Domain	Criteria	Number of review points at which it can be claimed	Points at any one review point	Total points over the two reviews points
Patient Safety	Production of a written report that demonstrates evidence of analysis, learning and action taken in response to near misses and patient safety incidents, including implementation of national patient safety alerts and having shared learning	One	20	20
Patient Safety	80% of registered pharmacy professionals have achieved level 2 safeguarding status for children and vulnerable adults within the last two years	Two	5	10
Patient Experience	Results of patient experience survey from the last 12 months published on the pharmacy's NHS Choices page	One	5	5
Public health	Healthy Living Pharmacy level 1(self-assessment)	One	20	20
Digital	Demonstration of having accessed the summary care record and increase in access since the last review point	Two	5	10
Digital	NHS111 Directory of Services entry up to date at review point	Two	2.5	5
Clinical Effectiveness	Asthma patients dispensed more than 6 short acting bronchodilator inhalers without any corticosteroid inhaler within a 6 month period are referred to an appropriate health care professional for an asthma review.	Two	10	20
Workforce	80% of all pharmacy staff working in patient facing roles are trained 'Dementia Friends'	Two	5	10
			Total number of points	100

3.31. The number of points that each pharmacy can qualify for over the two reviews is 100. However, three of the quality criteria (which account for 45 points between them) only need to be met once and therefore can only be claimed at one of the two review points.

3.32. At each review point, in order to receive payment where the gateway criteria and some or all quality criteria have been fulfilled, pharmacies will need to make a declaration to the NHS Business Services Authority (NHS BSA) using the approved form.

3.33. Payments will be made to eligible contractors depending on how many criteria they have met (and therefore how many 'points' they achieved). We expect the value of each point to be set at £64. This is set at a level that would deliver £75 million assuming 100% of pharmacies achieved all 100 points. However, in reality it is unlikely that all pharmacies will achieve all of the quality criteria across the two review points. Therefore, after the two review points, there will be a reconciliation process, at which the remaining funding will be divided between qualifying pharmacies based on the number of points they have achieved over the two review points. This reconciliation payment will not have to be claimed and will be paid with the full value of services payment for March 2018 (i.e. end of May/beginning of June).

3.34. To ensure the overall amount earned by one contractor for quality payments remains proportionate, a cap of £128 per point will be allowed in totality including the reconciliation payment. To reach the cap would require less than 50% of pharmacies achieving less than 50% of the quality criteria. Any funding remaining after the reconciliation payment will be paid through other fees and allowances to pharmacy contractors.

3.35. Further guidance on quality payments will be available by 1 December 2016.

Urgent medicines supply pilot scheme

3.36. NHS England will be piloting a national urgent medicines supply service, where people calling NHS 111 requiring urgent repeat medicines will be referred directly to community pharmacies. The service specification and further guidance for this will be published by 1 December, 2016. This will be funded from the Pharmacy Integration Fund, i.e. in addition to the £2.687 billion for 2016/17 and £2.592 billion for 2017/18.

3.37. The aim is for the NHS BSA to start registration for the service from December 2016.

3.38. The urgent medicines supply pilot scheme forms part of the overall work of NHS England to embed pharmacy into the NHS urgent care pathway. This is described in more detail in the Pharmacy Integration Fund section below.

Changes to reimbursement

3.39. Whilst for the majority of prescriptions, the reimbursement, margin and apportionment arrangements work well; there are some areas which could be improved. There are a number of drug reimbursement proposals that the Department of Health and PSNC have been working on. These include:

- 'non Part VIII' products, i.e. products with no reimbursement price listed in Part VIII of the Drug Tariff;
- changes to Category M for certain generic medicines to better reflect their market price;
- changes to the margin survey to account for multiple suppliers for Non Part VIII products and Category C products;
- 'splitting the discount'- to reflect that in general generic medicines have increased margin over brands; and
- changes to the way Category A prices are set.

3.40. However, some of these changes are dependent on further work with other parts of the supply chain, and some are easier to put in place than others. We will continue to progress those outlined above during the course of the two year settlement and introduce as appropriate. Non Part VIII and changes to category M for certain generic medicines are likely to be the first to be put in place.

3.41. The Department of Health is committed to progressing all the elements listed.

Changes to market entry to facilitate the consolidation of pharmacies

3.42. As part of the consultation on community pharmacy 2016/17 and beyond, the PSNC proposed changes to pharmaceutical services regulations to prevent a new pharmacy stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes.

3.43. We propose to make regulations which provide some protection for two pharmacies that choose to consolidate on a single existing site, where this does not create a gap in provision. Subject to the usual Ministerial and Parliamentary approvals our aim is for the changes to come into force in December.

Modernising the service

3.44. As we set out in the letter on 17 December 2015, we also want to take steps to improve the prescription ordering journey to maximise patient choice and convenience.

3.45. We recognise the changing expectations of patients and the public with respect to digital technologies in all walks of life and want to ensure those expectations are met. The Secretary of State announced a range of measures in September to improve digital NHS services for patients and – in keeping with that – we will continue to pursue our aims of improving the journey for patients ordering prescriptions digitally.

Later changes

3.46. We recognise that there are different types of community pharmacy providers and, as part of our initial proposals, we set out our intention to explore new terms of service for distance-selling pharmacies in recognition of their different service offering.

3.47. This will be the subject of further consultation with the PSNC.

4. Other decisions relating to Drug Tariff determinations

4.1. There will also be amendments to the Drug Tariff to set out the arrangements for:

- submitting and payment for electronic prescriptions; and
- payment for batches lost in transit from the pharmacy to the NHS BSA.

4.2. There will be consequential and updating amendments to the monthly claim form (the FP34C).

4.3. The PSNC will be given the opportunity to comment on the drafting in the usual way.

5. What is not being pursued that was included in the original 17 December 2015 letter

5.1. We will not be implementing any specific new measures with regards to prescription duration as part of this package.

6. Pharmacy Integration Fund

6.1. To support the transformation outlined in the NHS' Five Year Forward View, a new Pharmacy Integration Fund (PhIF) was announced in the 17 December 2015 open letter. NHS England is responsible for the allocation of the PhIF.

6.2. The aim of the PhIF is to support the development of clinical pharmacy practice in a wider range of primary care settings, resulting in a more integrated and effective NHS primary care patient pathway. In particular, the PhIF will drive the greater use of community pharmacy, pharmacists and pharmacy technicians in new, integrated local care models.

6.3. This will improve access for patients, relieve the pressure on GPs and accident and emergency departments, ensure optimal use of medicines, drive better value, improve patient outcomes and contribute to delivering a seven day health and care service.

6.4. The initial priorities for the PhIF are:

- the deployment of clinical pharmacists and pharmacy services in community and primary care settings, including groups of general practices, care homes and urgent care settings such as NHS 111; and
- the development of infrastructure through the development of the pharmacy professional workforce, accelerating digital integration and establishing the principles of medicines optimisation for patient-centred care.

6.5. All programmes will be informed by ongoing stakeholder engagement and patient and public involvement.

6.6. Beginning in December 2016, NHS England will be working to embed pharmacy into the NHS urgent care pathway by expanding the services already provided by community pharmacies in England for those who need urgent repeat prescriptions and treatment for urgent minor ailments and common conditions.

6.7. This will be piloted in two work streams to run in parallel from December 2016 to April 2018:

- an urgent medicines supply service – as outlined earlier. This will involve a direct referral from NHS 111 to community pharmacies. This will speed up access for those needing urgent repeat prescription medicines because they will no longer need a GP out-of-hours appointment, and it will route patients away from A&E who might otherwise attend to request

urgent medicines. The aim is to manage more efficiently the approximate 200,000 calls per year to NHS 111 for urgent repeat prescription medicines. The usual NHS prescription charges and exemptions will apply to this service;

- urgent minor illness care - from December 2016 to April 2018, NHS England will test the technical integration and clinical governance framework for referral to community pharmacy from NHS 111 for people who need immediate help with urgent minor ailments where this is appropriate for community pharmacy. This will develop an evidence-based, clinical and cost effective approach to how community pharmacists and their teams contribute to urgent care in the NHS, in particular making the referral of people with minor ailments from NHS 111 to community pharmacy much more robust. Minor ailments services are already commissioned by clinical commissioning groups (CCGs) across many parts of the country and ultimately NHS England will encourage all CCGs to adopt this joined-up approach by April 2018, building on the experience of the urgent and emergency care vanguard projects to achieve this at scale.

6.8. From January 2017 NHS England will start to evaluate both urgent care elements to assess the impact on the national urgent and emergency care system. The PhIF will be the resource to support the development and evaluation of the pilots.

6.9. NHS England is planning to publish further details about the PhIF in October 2016.

6.10. In addition to the urgent care work streams, this will include a workforce development package for community pharmacy professional teams, deployment of pharmacy teams into care homes, and development of the pharmacist role in integrated urgent care clinical hubs, such as NHS 111.

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:	**18 January 2017**
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

18 January 2017		
Item	**Contributor**	**Purpose**
Lincolnshire West Clinical Commissioning Group Update	Dr Sunil Hindocha, Chief Clinical Officer, Lincolnshire West Clinical Commissioning Group Sarah Newton, Chief Operating Officer Lincolnshire West Clinical Commissioning Group	Status Report
Community Pharmacy 2016/17 and Beyond	Steve Mosley, Chief Officer, Lincolnshire Local Pharmaceutical Committee	Update Report
Congenital Heart Disease Services	Simon Evans, Health Scrutiny Officer	Update Report
Lincolnshire Sustainability and Transformation Plan – Finalising the Committee's Response	Simon Evans, Health Scrutiny Officer	Consultation

15 February 2017		
Item	**Contributor**	**Purpose**
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 (LIVES)	Update Report
United Lincolnshire Hospitals NHS Trust - Pharmacy Services	Colin Costello, Director of Pharmacy and Medicines Optimisation, United Lincolnshire NHS Trust	Update Report

15 February 2017		
Item	**Contributor**	**Purpose**
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
Transforming Care: Community Learning Disabilities Support: Long Leys Court	To be confirmed	Consultation
NHS Improvement – Improving NHS in Lincolnshire	To be confirmed.	Status Report
United Lincolnshire Hospitals NHS Trust – Care Quality Commission Inspection Report	To be confirmed.	Update Report

15 March 2017		
Item	**Contributor**	**Purpose**
St Barnabas Hospice	Chris Wheway, Chief Executive, St Barnabas Hospice	Update Report
Joint Strategic Needs Assessment	Alison Christie, Programme Manager (Health and Wellbeing) Public Health Division, Adult Care and Community Wellbeing, Lincolnshire County Council David Stacey, Programme Manager (Strategy and Performance), Public Health Division Adult Care and Community Wellbeing,	Update Report

15 March 2017		
Item	**Contributor**	**Purpose**
	Lincolnshire County Council	
Obesity in Children and Adults	To be confirmed	Update Report
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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