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, 17 April 2019 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), Mrs K Cook, M T Fido, R J Kendrick, C Matthews, R A Renshaw, M A Whittington and R Wootten

District Councillors: P Gleeson (Boston Borough Council), C L Burke (City of Lincoln Council), Mrs P F Watson (East Lindsey District Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and P Howitt-Cowan (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interest**	
3	**Minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 20 March 2019**	3 - 20
4	**Chairman's Announcements**	21 - 24
5	**Update on Lincolnshire Partnership NHS Foundation Trust Services (including the Older Adults Mental Health Home Treatment Team)** *(To receive a report from Lincolnshire Partnership NHS Foundation Trust (LPFT), which provides the Committee with an update on the LPFT services. Jane Marshall, Director of Strategy LPFT and Chris Higgins, Director of Operations LPFT, will be in attendance for this item)*	25 - 30

Item	Title	Pages
6	**East Midlands Ambulance Service NHS Trust - Lincolnshire Division Update** *(To receive a report from the East Midlands Ambulance Service NHS Trust (EMAS), which updates the Committee on the following areas within the Lincolnshire Division: ambulance response performance information; handover delays at acute hospitals; collaboration with Lincolnshire Integrated Voluntary Emergency Service; the urgent care tier; the ambulance fleet; recruitment; blue light collaboration; and the transformation programme within the Lincolnshire Division. Mike Naylor, Director of Finance EMAS and Sue Cousland General Manager, Lincolnshire Division EMAS will be in attendance for this item)*	To Follow
7	**Implementing the NHS Long Term Plan: Proposals for Possible Changes to Legislation** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider its response to the NHS England's engagement document entitled: Implementing the NHS Long Term Plan – Proposals for Possible Changes to Legislation)*	31 - 66
8	**Health Scrutiny Committee for Lincolnshire - Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its work programme)*	67 - 72

Debbie Barnes OBE
Head of Paid Service
9 April 2019

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
20 MARCH 2019

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors Mrs K Cook, M T Fido, R J Kendrick, R A Renshaw, R Wootten and L Wootten.

Lincolnshire District Councils

Councillors P Gleeson (Boston Borough Council), C L Burke (City of Lincoln Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and P Howitt-Cowan (West Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Liz Ball (Executive Nurse, South Lincolnshire CCG), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Tim Fowler (Director of Commissioning and Contracting, Lincolnshire West CCG), Dr Neill Hepburn (Medical Director, United Lincolnshire Hospitals NHS Trust), Wendy Martin (Executive Lead Nurse and Midwife Quality and Governance, Lincolnshire West CCG), Michelle Rhodes (Director of Nursing, United Lincolnshire Hospitals NHS Trust), Kevin Turner (Deputy Chief Executive, United Lincolnshire Hospitals NHS Trust), Carole Pitcher (Primary Care Senior Contract Manager, NHS England – Midlands & East (Central Midlands)), Caroline Walker (Chief Executive, North West Anglia NHS Foundation Trust) and Jason Wong (Local Dental Network Chair, NHS England, Central Midlands).

County Councillor Dr M E Thompson (Executive Support Councillor for NHS Liaison & Community Engagement) attended the meeting as an observer.

86 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors C Matthews, M A Whittington and Mrs P F Watson (East Lindsey District Council).

It was noted that the Chief Executive, having received notice under Regulation 13 of the Local Government (Committee and Political Groups) Regulations 1990, had appointed Councillor M A Whittington to replace Councillor Mrs R H Trollope-Bellew on the Committee until further notice; and Councillor L Wootten had replaced Councillor M A Whittington for this meeting only.

An apology for absence was also received from Councillor Mrs S Woolley (Executive Councillor for NHS Liaison & Community Engagement).

87 DECLARATIONS OF MEMBERS' INTEREST

Councillor Mrs K Cook advised the Committee that she was a patient; and on the governing body of Lincolnshire Partnership NHS Foundation Trust.

88 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 20 FEBRUARY 2019

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held of 20 February 2019 be agreed and signed by the Chairman as a correct record.

89 CHAIRMAN'S ANNOUNCEMENTS

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

The Supplementary Chairman's announcements made reference to amendments to the Healthy Conversation 2019. The amendment headings were: Women's and Children Services, Engagement Events, Video Library, and Grantham A & E – Urgent Treatment Centre Proposal.

The Chairman invited the Committee to consider the establishment of a working group to look into item 4 (Proposed Changes to Legislation). The Committee agreed to consider this matter further at agenda item 12, Health Scrutiny Committee for Lincolnshire – Work Programme.

The Chairman confirmed that following the previous meeting, he had on behalf of the Committee written to the Rt Hon Theresa May, the Prime Minister, the Secretary of State for Health and Social Care, and to all Lincolnshire MP's expressing the Committees concerns. The Committee was advised that to-date an acknowledgment letter had been received from the Rt Hon Theresa May, the Prime Minister advising that a response would be received in due course.

RESOLVED

That the Chairman's Announcements presented as part of the agenda on pages 15 to 20; and the supplementary announcements circulated at the meeting be noted.

90 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - UPDATE ON CARE QUALITY COMMISSION INSPECTION

The Chairman welcomed to the meeting the following presenters from United Lincolnshire Hospitals NHS Trust:-

- Kevin Turner, Deputy Chief Executive;
- Dr Neill Hepburn, Medical Director; and
- Michelle Rhodes, Director of Nursing.

The Director of Nursing provided an update on United Lincolnshire Hospitals NHS Trust progress in response to the Care Quality Commission inspection.

The Committee was advised that the Trust had a Quality and Safety Improvement Plan (QSIP) in place which included twelve work programmes, with individual Executive Directors being responsible for each of the work programmes. It was noted that the QSIP was scrutinised on a weekly basis and was presented to the Quality Safety Improvement Board bi-weekly; and to the Quality Governance Committee (QGC) monthly, with escalations of issues being referred to the Trust Board via the QGC.

Detailed at Appendix A to the report was a Glossary of Terms; and Appendix B provided the Committee with an overview of progress made up to the end of January 2019.

It was reported that since the inspection in February 2018 measurable progress had been made in response to the CQC's immediate concerns, and that all twelve programmes were on track to deliver what had been agreed.

The Committee was advised that there were still some risks attached to the programmes and that everything was being done to mitigate those risks. The Committee noted that some significant work had been done relating to Children and Young People. The Committee was advised further that a senior nurse had been on secondment from Leicestershire to identify any gaps relating to provisions for children. It was reported that from the analysis of the data captured, a plan would be created which the Trust would be happy to share with the Committee (in approximately two months' time).

It was reported that all the posts had been filled within the Children and Young People Directorate; and that the new structure would take forward the work programme.

The Trust was pleased to advise the Committee that its hospital mortality rates had reduced significantly.

It was highlighted to the Committee that governance was still not as strong as it could be; and that governance procedures had been developing over the last year. The Committee was advised that when the new structure came in to force from start of April 2019, more governance arrangements would then come into place.

It was reported that the biggest clinical risk was the lack of staff at Pilgrim Hospital, Boston. The Committee was advised that on 25 February 2019 an unannounced visit had been made by the CQC to the Emergency Department at Pilgrim Hospital, Boston. The Committee was advised that the inspection report was not available yet, and that when it was it would be shared with the Committee. The Committee noted that the CQC had seen improvements, which confirmed what the Trust was experiencing.

It was highlighted that the main issue at the Emergency Department at Pilgrim Hospital, Boston was overcrowding, this was an issue the Trust was encountering on a daily basis, and one the Trust at the moment was unable to resolve. The Committee was advised that the Trust would keep the Committee informed of progress and the outcome of the CQC inspection.

During discussion, the Committee raised the following issues:-

- How the hospital mortality rates in the United Kingdom compared with the rest of the world. The Committee was advised that the methodology for the two most common hospital mortality rates related to the United Kingdom. For both the SHMI (Summary Hospital-level Mortality Indicator) and the HSMR (Hospital Standardised Mortality Ratio), confirmation was given that the indicators were re-based every year at 100, therefore every year the Trust needed to improve;
- One member expressed appreciation of the work done so far by the Trust and the continued improvements;
- The representative from Healthwatch advised that patients were still expressing concerns about the waiting times at A & E at Pilgrim Hospital, Boston; that patients were experiencing problems with appointments being cancelled and then being given several appointments on the same day; and also it was highlighted that Healthwatch had received a few comments on the level of care received as patients. The Trust was disappointed that some negative comments had been received and agreed to seek more information from Healthwatch outside the meeting. The Committee was advised that changes to appointments might be as a result of having to maximise the numbers of patients in a clinic, for example having to change an appointment time by 15/20 minutes. Trust representatives agreed to look into the issue. The Committee was advised that longer waiting times in A & E were replicated throughout England and were not just in Lincolnshire. It was reported that other initiatives were being developed to reduce the pressures on A & E, such as using GPs, pharmacies and the use of primary care streaming at the front of A & E departments. It was highlighted that whatever systems were put in place, the Trust always ensured that their priority was to ensure that patients were kept safe;

- A question was asked whether there were any plans to use capital funding to extend the facilities at Pilgrim Hospital. The Committee was advised that plans had been submitted as part of a county-wide NHS Capital Bid, which had not secured any funding;
- One member enquired as to what Intentional Rounding was? The Committee was advised that Intentional Rounding referred to nurses checking patients on their rounds every hour; this was a way of making sure the patient was well; and that there had not been any deterioration. It was noted that a Safety Huddle was when doctors, nurses etc., got together to share intelligence on patients in their care. The Committee noted that the introduction of both pilots had made significant differences on the wards; and in A & E Pilgrim Hospital, Boston. It was noted further that the processes would be embedded across the Trust;
- One member enquired what effect A & E pressures were having on patients. The Committee was advised that governance had been strengthened; and systems were in place where there were identified hotspots. Doctors and nurses now had better knowledge about working with children in A & E. The Committee were reminded that the full plan presented to the Committee previously detailed all the measures that were being put in place to improve the patient experience;
- The need for more preventative measures;
- The need to ensure that good news stories were celebrated and communicated better to the general public;
- Attendance at conferences to share best practice. Confirmation was given that staff were supported to attend conferences to develop best practice. The Committee was advised that best practice was shared across Trusts, for example with North Cumbria (an outstanding trust), which had resulted in learning on both sides. It was also highlighted that best practice was shared when staff attended conferences;
- The need to get the message out better regarding alternative provisions to attending A & E. Reference was also made to better publicity of the Advice App. It was also highlighted that there needed to be a generational health care shift; and
- A suggestion was made for the inclusion of the Grantham A & E into the system to help alleviate the peaks at Lincoln and Boston.

In conclusion, the Chairman on behalf of the Committee extended thanks to the three presenters for the considerable amount of work that had been done and for to the improvements that had been made so far. Thanks were also extended to NHS Staff for the brilliant job they were preforming.

RESOLVED

1. That the update and progress made in response to the CQC inspection report be noted.

2. That a further update on the United Lincolnshire Hospitals NHS Trust – Care Quality Commission Inspection be received by the Committee in three months' time, along with a copy of the updated RAG report.

91 CHILDREN AND YOUNG PERSONS SERVICES AT UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - UPDATE

Consideration was given to a report from the United Lincolnshire Hospitals NHS Trust, which provided an update on Children and Young Peoples Services. The report also provided the status of the Royal College of Paediatric and Child Medicine report and its relevance to the interim model.

Kevin Turner, Deputy Chief Executive and Dr Neill Hepburn, Medical Director were in attendance for this item.

The Committee was advised that the interim paediatric service model currently in place at Pilgrim Hospital, Boston had been introduced on 6 August 2018 was working well to address the significant challenges faced by the Children and Young People's Services. The Committee was reminded that the interim service comprised of an enhanced paediatric presence in the Pilgrim Hospital Emergency Department and an acute paediatric assessment unit with a twelve-hour length of stay; and outpatient clinics and surgery continuing at Pilgrim Hospital, Boston.

The Committee was advised that since the introduction of the dedicated ambulance transfer service, there had not been any instances where an ambulance had not been available to meet the needs of the service. Details of the transfers were shown on pages 30 and 31 of the report.

It was reported that since the introduction of the interim model at Pilgrim Hospital, there had been a significant improvement in throughput, as well as there being an improvement to the patient experience. It was highlighted that during the first 26 weeks of operation of the interim model, 1,869 patients had been seen in the paediatric assessment unit. A breakdown of the source of referrals was shown on page 32 of the report.

The Committee was advised that since the introduction of the interim model, no patient safety incidents had been experienced, or reported as a result of the change.

The Committee was advised further that staffing was still an on-going problem. It was noted that there had been a successful outcome from discussions with Health Education East Midlands to allow junior doctors to undertake additional locum work to fill some of the gaps in the rota. It was noted further that the recruitment of children's trained nurses continued to be a challenge. It was reported that a staff survey was to be undertaken in March to obtain the views of staff on the interim arrangements.

It was reported that risks were managed through the project risk register, a copy of which was attached at Appendix A to the report. It was highlighted that no incidents of patient harm had been reported.

Details relating to what had been learnt from complaints specific to the new paediatric model of care were shown on pages 36 to 38 of the report.

In conclusion, the Committee was advised that the interim model was addressing the difficulties and challenges caused by a shortage of doctors and nurses in the young people's services at Pilgrim Hospital, Boston; and that an update on the progress made on the recommendations following the Royal College of Paediatrics & Child Health report would be made available in due course.

During discussion, the Committee raised the following issues:-

- Some members were pleased that the international recruitment was seeing some results; and some improvements to the service;
- Concern was expressed to the distance some parents had to travel to visit their children. The Committee was advised that there had been a reduction in the number of children who had been admitted into hospital; and for those who were admitted, there was transport provision in place which was based on a set of criteria. It was highlighted that the Trust did not directly provide general transport support. The Committee noted that there was provision for families to stay with their children at the hospital. Reassurance was given that the number of referrals had reduced and those that were admitted were cared for in a safe environment;
- Clarification was sort with regard to the breakdown in the figures relating to the number of children who had been transferred; and whether more beds were needed to be made available at Lincoln County Hospital. Clarification was given to the figures detailed on page 31 of the report. The Committee was advised that if Lincoln did not have enough beds, on occasions patients had been transferred to Grimsby.
- Some concern was expressed relating to children being admitted on to an adult ward. The report advised the Committee that no children had been put on adult wards, against the child or parent/carer's wishes. Confirmation was also given that no children had been transferred to an adult ward from the assessment unit. The Committee was advised that the question would only be asked in respect of children 14, 16 and above, and with parental permission;
- One member enquired how the Trust was going to communicate to the people of Boston about the interim arrangements. The Committee was advised that the best promotion of the service was when the service worked for them. Acknowledgement was given that there was still some way to go, but it was an improving picture;
- Some concern was also expressed to the lack of public engagement. The Committee was advised that the Trust worked hard to engage with the local population. The Trust was advised that the public perception locally was that engagement was not happening. A suggestion was made that more publicity needed to done regarding engagement events;
- One member expressed concern that the consultant paediatric medical staff remained concerned about maintaining the safety of the middle grade medical rota. The Committee was advised that steps were being taken to mitigate the situation as the Health Education East Midlands had agreed to allow juniors to undertake additional locum work to help fill some of the gaps in the rota;

- Healthy Conversation 2019 exercise – One member highlighted that a proposal had been included for an urgent treatment centre at Stamford Hospital. A question was asked as to whether this would be from 8am to 8pm, or be 24 hours. The Committee was advised that conversations were starting to happen to help shape provision and that an acuity based model would be provided to support the engagement process;
- One member enquired when the Committee would receive an update on the progress with the action plan arising from the report by the Royal College of Paediatrics and Child Health. The Committee noted that the report was being complied and would be available to view shortly;
- A question was asked with recruitment remaining a major issue; had anything been done to help prospective employees for example directing them to housing, community and ethnic support groups and information about the area; and had the Trust considered offering more flexible working. Confirmation was given that HR had all the policies in place and that working flexibly was constantly being developed; and
- A further question asked was when an applicant declined a job offer, was feedback offered to identify the reasons why and was there any trends in those reasons. The Committee was advised that this data was captured. Normally, a declined application was because the applicant had received a better offer elsewhere.

The Chairman on behalf of the Committee extended thanks to the presenters for their attendance.

RESOLVED

1. That a copy of the updated report from the Royal College of Paediatrics and Child Health be received by the Committee at a future meeting.

2. That an update on Children and Young People's Services at United Lincolnshire Hospitals NHS Trust be received by the Committee in three months' time.

92 ARRANGEMENTS FOR THE QUALITY ACCOUNTS 2018-2019

The Committee gave consideration to a report from Simon Evans, Health Scrutiny Officer, which invited the Committee to consider its approach to the Quality Accounts for 2019 and to identify its preferred option for responding to the draft Quality Accounts.

Details of the options for handling Quality Accounts were shown on pages 127 to 129 of the report presented.

During a short discussion, the Committee agreed to pursue option 3A – Lincolnshire Based Provider with Quality Challenges and to include East Midlands Ambulance Service with United Lincolnshire Hospitals NHS Trust.

The Committee also agreed that a working group should be established and that the Health Scrutiny Officer would be contacting members of the Committee after the meeting asking for volunteers.

RESOLVED

1. That option 3A from Section 4 of the report be adopted as the Committees approach to Quality Accounts 2019 and that East Midlands Ambulance Service be added to that option.

2. That a working group be established for the Quality Accounts process for 2019; and that the Health Scrutiny Officer would be seeking volunteers from members of the Committee after the meeting.

93 UPDATE ON DEVELOPMENTS AT NORTH WEST ANGLIA NHS FOUNDATION TRUST

The Chairman welcomed to the meeting Caroline Walker, Chief Executive, North West Anglia NHS Foundation Trust, who provided a clinical and financial update for the North West Anglia NHS Foundation Trust.

The Committee was advised that the North West Anglia NHS Foundation Trust oversaw the running of Stamford and Rutland Hospital, Peterborough City Hospital and Hinchingbrooke Hospital in Huntingdon. The Trust also ran outpatient and radiology services at Doddington Hospital, Princess of Wales Hospital, Ely and North Cambs Hospital, Wisbech. The Committee was advised that the last two years had been challenging, as the Trust had only formed on 1 April 2017 and was then inspected by the Care Quality Commission in June/July 2018.

Details of the Care Quality Commission inspection at the Hinchingbrooke Hospital and Peterborough City Hospital were shown on pages 46 to 49 of the report presented. The published report from CQC in October 2018 gave the Trust the overall rating of 'Requires Improvement.' The Trust had been very disappointed with the rating. Prior to the report's publication, the Trust had responded to the draft CQC report with more than 100 pages of factual accuracy amendments, only to find that many of the inaccuracies were still published in the final report.

The Committee was advised that since the inspection, the Trust had resolved the 'must improve' actions; and the lessons learned from the recommendations were being applied across all the Trust's hospital sites. The Committee was advised further that work continued against a detailed action plan of remaining improvements against the said plan and that the plan was reviewed monthly. It was highlighted to the Committee that the plan had been submitted to the CQC on 3 December 2018 to show the Trusts compliance against key areas highlighted in their report.

It was reported that the Trust was continuing with its own CQC-style inspections of ward areas across all three acute sites to maintain assurance that services were consistently being run to a high standard of care. The Committee noted that the said in-house inspections were called CREWS (Caring, Responsive, Effective Well-led

and Safe). The Trust also had senior–level walkabouts across the hospitals to see first-hand improvements, and that these were led by the Chief Nurse.

The Committee was advised that the Trust was anticipating a re-inspection of services in the next few months.

It was reported that for 2017/18, the Trust had achieved its control total of £39.9m; and as a result had received a System Transformation Funding Budget of £5.7m. However, due to increasing cost pressures in 2018/19; at the end of the first quarter of the financial year 2018/19 the monthly spending rate was on course to be £10m higher than the control total set of £46.5m. It was highlighted that some of the increased spending had been the result of greater activity and additional staffing costs through agency and staffing banks. The Committee was advised that the Trust had seen increased activity from Lincolnshire which had resulted in extra bed capacity being needed. The Committee was advised further that by the end of the financial year the Trust would have a £15m overspend.

The Trust had also struggled with recruitment and currently had 100 doctor vacancies and 200 nurse vacancies. The Committee was advised along with other NHS organisations, the Trust had been taking note of national guidance and preparing for any potential impact of a 'no deal' exit from the European Union. The Trust had been working with its 500 highly valued EU staff on supporting their plans to settle in the United Kingdom and continue working for the NHS.

It was reported that the Trust had plans in place to meet the ambitions set out in the NHS Long Term Plan. The Trust was looking forward to working with partners, to turn the NHS Long Term Plan ambitions into real improvements in services for local people.

During discussion, the Committee raised the following points:-

- Page 48 - That Out Patients had not been rated. The Committee was advised this was because this was a Vanguard operation. It was noted that Vanguards had been introduced by the NHS to help develop better models of patient care;
- Private Finance Initiative (PFI) – One member asked how the Trust had been compensated for being a PFI hospital. The Committee was advised that the Trust received an element of support to cover its PFI costs. In addition, part of the deficit was as a result of late payments from other Trusts. The Committee was advised that the Trust engaged with the Department of Health and social Care regarding this issue. The Committee was advised that ambulances were bringing more patients from Lincolnshire to Peterborough City Hospital's A & E. Although this might only be one extra patient a day, these patients were often complex cases and as a result at about one patient a week, and often there was a strong possibility that the patient would be admitted. The Committee was advised further that the Trust received fantastic support from Lincolnshire Adult Care when patients were discharged. The Committee was surprised that more patients were being taken to Peterborough A & E, as this contradicted what the Committee

had previously been advised. The Committee was reminded that the patient had choice. When ambulances arrived with patients from Lincolnshire the handover was good. It was noted that sometimes it was the ambulance driver's choice, which at peak time caused an escalation. The Chairman advised the Trust that the Committee would be interested to see the numbers of patients coming from Lincolnshire. It was highlighted that the acute trusts needed to work together to plan and re-negotiate the contract for more activity going forward;

- Impact of TASL – The Committee was advised that TASL had caused the Trust to have some extra costs, however, these had improved. The Trust had spent several hundred thousand pounds on private ambulances. This had been caused by the way the NHS discharged. This had now been changed;
- One member asked whether the Trust had any views on the proposal for an urgent treatment centre at Stamford (part of the Healthy Conversation 2019). The Committee was advised that the Trust had been consulted on the proposal and that the Trust were fully in support of it as it supported other services already being provided at the Stamford Hospital. The Trust was unsure whether the provision would be 24 hours, or 8am – 8pm, and also whether it would be seven days a week or only Monday to Friday;
- A question was asked what impact the additional NHS funding would have on improving the Trust's deficit and improving services further. It was felt that the funding would not improve the Trust's deficit, but would have a positive impact on patients;
- The Committee was advised that the Trust was in deficit and was being charged interest on the money borrowed from the Government. The new money allocated should help reduce the deficit to £5m. It was being able cope with the cost of recruitment to meet need and investing in Neighbourhood Teams that was important going forward;
- In response to a question on whether the Children and Young People Services at Pilgrim Hospital, Boston was having on the Trust, the Committee was assured that this was not having a negative impact on the Trust; and
- It was also confirmed in response to a question that the Trust was spending a significant sum supporting non-emergency patient transport, as a result of the performance of the Thames Ambulance Service in Lincolnshire.

The Chairman extended thanks on behalf of the Committee to the Chief Executive of North West Anglia NHS Foundation Trust for her frankness and for the excellent report; and for the steps being taken to make the improvements raised by the CQC; and that the Committee requested a copy of the detailed recovery plan once it becomes available.

RESOLVED

1. That the Committee receives a copy of the detailed recovery plan in response to the Care Quality Commission's report, once it becomes available.

2. That the update report on the developments at North West Anglia NHS Foundation Trust be noted.

3. That the Committee receives details of the number of patients from Lincolnshire attending Peterborough City Hospital A & E, together with the number of admissions.

The Committee adjourned at 12.35pm and re-convened at 2.00pm.

Additional apologies for absence for the afternoon part of the meeting were received from Councillors M T Fido, R J Kendrick, P Howitt-Cowan (West Lindsey District Council) and Mrs R Kayberry-Brown (South Kesteven District Council) from 2.30pm.

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

94 NHS DENTAL SERVICES OVERVIEW FOR LINCOLNSHIRE

The Chairman welcomed to the meeting Carole Pitcher, Primary Care Senior Contract Manger, NHS England – Midlands and East (Central Midlands) and Jason Wong, Local Dental Network Chair, NHS England, Central Midlands.

In guiding the Committee through the report, reference was made to the local context with regard to commissioning and dental care services. It was reported that there were 71 contracts providing dental services in Lincolnshire, a breakdown of how these services were provided was shown on page 54 of the report.

It was highlighted that following the outcomes of the Oral Health Needs Assessment, agreement had been made for the commissioning of new contracts as part of the dental procurement programme to improve access to general dental services in priority areas. These were highlighted as being Boston, Lincoln, Sleaford and Spalding. Details of the Dental Procurement across Lincolnshire and Leicestershire were shown on page 60 of the report; and results of the procurement process were shown on page 61. It was highlighted that preferred bidders had not been identified for Louth and the Skegness/Spilsby areas as the bids evaluated had not met the financial sustainability requirements.

It was also highlighted that the new services identified for Boston, Spalding and Johnson Community Hospital had not commenced in January 2019, as originally planned. The Committee was advised that NHS England were disappointed not to have the new services in place for January 2019. It highlighted that the preferred bidders had been unable to find the workforce required to operate these services safely. The Committee was advised further that local providers in Spalding had confirmed that they were able to continue to provide urgent dental services as an interim measure; and two dental sessions a week were being provided from the Johnson Community Hospital Dental practice; and that this arrangement would run until January 2020. The Committee was advised that care taking options were currently being reviewed for the provision of NHS dental services in the Mablethorpe area.

It was reported that the NHS England Local Office had offered Lincolnshire dental providers the opportunity to bid for additional non-recurrent activity to improve access to NHS dental services, whilst longer term commissioning plans were considered. It was noted that the outcome had been the award of non-recurrent activity equating to an additional capacity for approximately 5,000 patients in Gainsborough, Skegness, Spilsby, Lincoln, Boston and Spalding. The Committee was advised that following the results of previous procurement, the Local Office was planning to re-procure the NHS dental services for Spalding, Boston, Louth, Spilsby/Skegness and Mablethorpe in 2019.

The Committee was advised that Lincolnshire did not have the number of dentists it required; and as a result steps were being taken to up skill the existing workforce. Details of dental foundation training were shown on page 57 of the report.

The Committee was advised that all dentists' delivering services as part of an NHS contract were required to be registered with the General Dental Council, and needed to be included onto the national performer list to ensure they were suitably qualified and trained to deliver NHS dental services.

The Committee was advised further that dental recruitment and retention nationally was an increasing pressure; and that NHS England and Local Dental Network (LDN) were exploring a number of options to develop a workforce strategy to improve recruitment and retention of the dental workforce in Lincolnshire. This work included flexible commissioning; peer mentoring schemes; increasing the number of foundation dentists, dental core trainees and leadership fellows in Lincolnshire; as well as considering whether a Dental School in Lincolnshire would assist in developing the local workforce.

During discussion, the Committee raised the following issues:-

- The difficulties residents were having in finding a dentist;
- The problems of the contracts from 2006; and the time constraints these imposed on dentists. The Committee was advised that the Contract reform focussed on activity delivery, and was not focussed on maintaining care. This had caused issues for the profession, but it was hoped that from 2020 once the core offer had been agreed, provision for Lincolnshire would improve;
- The problems of access to a dentist with Lincolnshire being such a rural County;
- Clarification was sort regarding current provision. Confirmation was given that Mablethorpe, Louth, and Boston had no routine dental provision, but there were practices in Boston accepting new patients, but there was no extra provision in Mablethorpe and Louth. It was also noted that some practices in Skegness were accepting patients;
- Contracts – Some concern was expressed to the fact that bidders were able to bid for a contract they were unable to provide; and that there was no period of notice. Confirmation was given that this was the case with some of the contracts. It was noted that some existing contracts from 2006 there was a requirement for three months' notice, which was not a long time to manage a

termination. It was highlighted that established practices in Mablethorpe had failed as they were unable to keep the workforce;

- One member enquired where residents could obtain information relating to the availability of dental services. The Committee was advised that information was contained on the NHS website;
- The need to promote dentistry as a profession more;
- The need to promote better with young children how important it was to look after their teeth;
- A question was asked how likely it was to have a Dentistry School in Lincolnshire. It was noted that in the East Midlands there was only one school in Birmingham. The Committee was advised that Private Dentistry Schools had been approached, a suggestion was made for the University of Lincoln to be approached; and
- The need for the Committee to highlight how ineffective the commissioning of Dental Services was across the country.

The Chairman on behalf of the Committee extended thanks to the two representatives and requested that an update should be received on the dental workforce strategy and plans for improving dental care in Spalding, Mablethorpe and County wide when available.

RESOLVED

1. That the NHS Dental Services Overview for Lincolnshire be received.

2. That the Committee receives an update when available on the dental workforce strategy; and plans for providing dental care in Spalding, Mablethorpe and County wide.

95 NON-EMERGENCY PATIENT TRANSPORT SERVICE - UPDATE

The Chairman welcomed to the meeting Wendy Martin, Executive Lead Nurse & Midwife, Lincolnshire West Clinical Commissioning Group (CCG) and Tim Fowler, Head of Contracting, Lincolnshire West CCG.

The report presented provided the Committee with the background surrounding Thames Ambulance Service Limited (TASL). The Committee was reminded that at the January 2019 meeting the CCG had stated that they would continue to work with TASL to address the earlier concerns raised by the Committee regarding TASL's unacceptable levels of performance and to the fact that the CCG were of the view that there would be an unacceptable level of risk of giving notice to exit the contract and move to a new provider at that time.

Representatives from TASL had then attended the February meeting of the Committee, at which disappointment had been expressed concerning the CQC results and to the lack improvement.

The Head of Contracting Lincolnshire West CCG advised that the CCG was working with other CCGs that commissioned TASL and NHS England to co-ordinate oversight of TASL's response to the findings of the CQC report.

The Committee was advised that following the publication of the CQC report the CCG had issued to TASL a Contract Performance Notice for breach of Service Condition 1.1 of their contract in that TASL had failed to deliver the Fundamental Standards of Care.

The Committee was advised that the CCG teams had recently undertaken quality visits to TASL sites in order to seek assurance that issues and requirements of the CQC report were being addressed. It was highlighted that these visits had observed improvements in training compliance, the use of equipment and some improvement in the visible cleanliness of vehicles. It was highlighted that the CCG still had concerns relating to journey planning, sharing of learning from complaints and incidents, reliability of Personal Digital Assistant devices and engagement between staff and senior management. The Committee was advised that these concerns had been raised with TASL, and TASL were developing actions to alleviate these issues.

Detailed at Appendix A to the report was a summary of the activity and KPI performance for the contract for the period up to January 2019 for the Committee to consider. The Committee was advised that call handling performance had exceeded the contract requirement of 80% and had achieved significant improvement from the December 2018 figure of 36%. It was highlighted that no other KPIs had been achieved for January, although improvement had been seen on the December position for seven of the remaining KPIs.

The Committee was advised that the decision by NHS Hull CCG to give one year's notice to TASL of the termination of their contract with the CCG would not adversely impact the Lincolnshire service; and that reassurance had been received from TASL to that effect.

In conclusion, the CCG confirmed that it would continue to address the concerns raised by the Committee with regard to the unacceptable level of performance by TASL. The CCG also reiterated that it was still of the opinion that there would be an unacceptable level of risk of giving notice to exit the contract and moving to a new provider at this moment in time.

A discussion ensued, from which the following points were raised:-

- The previous optimism the Committee expressed regarding the reinstatement of the voluntary car drivers;
- One member asked whether there were other providers available to be able to take on the service. The Committee was advised that what had to remain in mind was the service to patients; and that now was the wrong time to consider exiting the contract due to the unacceptable level of risk;
- Performance improvement – The Committee were reminded that TASL were not happy with the CQC report and had asked for the CQC to reassess them. It was highlighted that the CQC had agreed to reassess between now and the

summer; and the CCG was waiting to see that outcome. The CCG was continuing to work with other CCGs. The Committee was advised that the CCG at the time of the meeting had not received the February data. The CCG acknowledged that the performance was inadequate; and consideration was being taken if or when that exit should be implemented. One member asked whether there would be a point when that decision would be taken. The CCG advised that the concerns of the Committee were taken very seriously and that in the next two or three months a decision might be made;

- Procurement process - The CCG was asked whether during the procurement process due diligence had been taken, for example taking account of the CQC report on TASL's operations in Milton Keynes. The CCG advised that as soon as the CCG became aware of the report it had been shared with NHS England; and extensive monitoring had commenced; and
- Some concern was expressed as to how long the CCG should wait prior to any decision on the contract as the performance was not being achieved. The CCG appreciated the Committee's concerns and advised that there had to be a balance; as TASL might walk away from the contract; if that was the case the CCG would have to work with TASL on a planned exit and a contingency plan would have to come into operation. All things had to considered, but ultimately, what was best for the patient was the primary motivation.

The Chairman on behalf of the Committee thanked the two presenters for their frankness; and again raised the Committees disappointment in TASL's delivery of the NEPTS contract; and that the Committee wished it to be recorded that their recommendation was to end the contract as soon as possible; and that a further update should be received in three months' time.

RESOLVED

1. That the Non-Emergency Patient Transport Service update be noted.

2. That the disappointment of the Committee in TASL's delivery of the Non-Emergency Patient Transport Service contract be recorded.

3. That the Committee's recommendation to the CCG to give notice to terminate the contract as soon as strategically possible be recorded.

4. That a further update be received on the Non-Emergency Patient Transport Service in three months' time.

96 HEALTHY CONVERSATION 2019 - LISTENING AND ENGAGEMENT EXERCISE

The Health Scrutiny Officer presented a report for the Committee to consider and comment on the launch of the Healthy Conversation 2019 listening and engagement exercise.

The Committee was invited to look at the details summarised in pages 115 to 118 and to decide which elements would warrant looking at in further detail.

During discussion, the Committee raised the following points:-

- The possibility of having an informal group to look at the differences between Types 1 and 3 A & Es and Urgent Treatment Centres;
- The need for an informal workshop following the election to help any newly elected representatives;
- Thanks were expressed from some members to officers for their help and advice; to the members of the Committee for mutual respect and to the Chairman for chairing a meeting which at times had contentious areas of debate;
- The need to incorporate a geographical overview of the area covered by the proposed service;
- The need to include Sleaford, Spalding and Gainsborough when discussing emergency and urgent care, to ensure that the whole County was covered;
- The need to look at the quality of the Healthy Conversation 2019 website;
- Ensure that comments raised by the Committee were fed back in to the engagement exercise, and
- The need for members of the Committee to feed back their comments on engagement events.

RESOLVED

1. That the Committee notes:

   (a) The launch of Healthy Conversation 2019 listening and engagement exercise by the NHS in Lincolnshire on 5 March 2019;
   (b) That full public consultation will be undertaken by the NHS in Lincolnshire 'in due course' on any permanent substantial changes to health services.

2. That the Committee considers the following themes and topics in Healthy Conversation 2019, in the coming months:-

   - 15 May 2019 - Emergency and Urgent Care and Stroke Services;
   - 12 June 2019 – Women's and Children Services and Breast Services;
   - 10 July 2019 – Mental Health and Trauma and Orthopaedics; and
   - 18 September 2019 – Integrated Community Care and Haematology and Oncology.

3. That consideration be given to engagement arrangements at a future meeting, with a view to seeking assurance that efforts were being made to engage and involve as many people as possible, including 'hard-to-reach' and vulnerable groups.

97 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which enabled the Committee to consider and comment on the content of its work programme, to ensure scrutiny activity was focussed where it could be of greatest benefit.

The Committee gave consideration to the work programme as detailed on pages 132 to 133 of the report presented.

The Committee was invited to consider whether it wished to respond to item 4 – Implementing the NHS Long Term Plan – Proposals for Possible Changes to Legislation; and whether an informal working group should be established. The Committee agreed that the Health Scrutiny Officer should draft a response on behalf of the Committee and circulate to all members of the Committee for their comments.

RESOLVED

1. That the work programme be agreed subject to the inclusion of the items highlighted in minute numbers: 90 (1), (2); 91 (1), (2); 93 (1), (3); 94 (2); 95 (4); and 96 (2) and (3).

2. That the Health Scrutiny Officer should draft a response to the Implementing the NHS Long Term Plan – Proposals for Possible Changes to Legislation on behalf of the Committee and circulate to all members for their comments.

The meeting closed at 3.50 pm

Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 April 2019**
Subject:	**Chairman's Announcements**

1. Grantham A&E Overnight Closure - Referral to the Secretary of State for Health and Social Care

On 20 February, the Committee agreed that I should write to the Prime Minister on the overnight closure of Grantham A&E. On 29 March I received a letter from Stephen Hammond MP, the Minister of State for Health, which stated the following:

> *"Thank you for your correspondence of 26 February to the Prime Minister, and copied to Matt Hancock, about Grantham Hospital A&E Department. As the matter you raise concerns the NHS, your letter was passed to the Department of Health and Social Care. I apologise for the delay in replying.*
>
> *I appreciate your concerns about the future of the A&E Department and I would like to thank you for taking the time to raise them.*
>
> *The proposals for Grantham A&E are still under consideration by the Secretary of State. A decision will be published in due course, but until then itr would be inappropriate for the Department to comment.*
>
> *I am sorry I cannot be more directly helpful."*

2. United Lincolnshire Hospitals NHS Trust – Pilgrim Hospital Care Quality Commission Report

On 3 April 2019, the Care Quality Commission (CQC) published a report on the emergency department at Pilgrim Hospital, following an inspection on 25 February 2019. The CQC's own summary of its findings are reproduced in Appendix A to these announcements, with the full report is available at the following link:

https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ2145.pdf

3. The Sidings Medical Practice, Boston

On 2 April 2019, Lincolnshire East Clinical Commissioning Group (CCG) announced that following the retirement of Dr Peter Holmes from the Sidings Medical Practice in Boston, the CCG would be working closely with Lincolnshire Community Health Services NHS Trust (LCHS), who will be providing GP and other healthcare services to patients registered at the practice.

The support being provided by LCHS ensures continuity of services for patients at the Sidings. Patients will continue to access services in the same way and at the same location, supported by the staff at the practice, who will continue to provide care for patients as usual. The only change patients will see is that the two GP partners have now left the practice and LCHS will be providing support, including additional GPs and clinical staff, as required.

As commissioners of local GP services, Lincolnshire East CCG has stated that it is committed to providing the highest quality, safe care for the patients registered at the Sidings. This arrangement with LCHS will ensure patients can continue to access services at The Sidings as usual with no interruption to their care.

4. Clinical Commissioning Groups - Appointment of Single Accountable Officer

On 28 March 2019, the four Lincolnshire clinical commissioning groups (CCGs) confirmed the appointment of John Turner as their single accountable officer, with effect from 1 April 2019. The single accountable officer role will work across the four CCGs to ensure a joined-up approach to commissioning healthcare services for the population of Lincolnshire, and to support the closer integration of health and social care.

John Turner had been the accountable officer for South and South West Lincolnshire CCGs, and has also been the senior responsible officer for the Lincolnshire Sustainability and Transformation Partnership.

5. United Lincolnshire Hospitals NHS Trust - Recruitment of Chief Executive

The post of Chief Executive of United Lincolnshire Hospitals NHS Trust has been advertised recently with a closing date of 25 March 2019. Following a selection process throughout April, interviews for the final group of shortlisted candidates are due to take place in the week commencing 29 April 2019.

APPENDIX A

CARE QUALITY COMMISSION QUALITY REPORT ON PILGRIM HOSPITAL, BOSTON

On 3 April 2019, the Care Quality Commission (CQC) published its quality report on Pilgrim Hospital, Boston, following an inspection on 25 February 2019.

The key findings, as summarised by the CQC, are set out below:

"Our key findings were as follows:

- *The layout of ED was not suitable for the number of admissions the service received. During our inspection we saw significant overcrowding in the department. Throughout our inspection we saw patients being cared for on trolleys in the central area of the department and in the ambulance corridor as there were no free cubicles to use. This had not improved since our last inspection.*

- *Adults waited on average 81 minutes for treatment. This was against national standards of 60 minutes.*

- *Whilst the trust had a national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) in place, these were not always used as part of the triage process.*

- *The Royal College of Paediatrics and Child Health (RCPCH) says the initial assessment of children should be conducted by an appropriately trained nurse or doctor with paediatric competence. There was not always a paediatric competent nurse performing triage.*

- *We were not assured children would always be appropriately cared for in the department during 10pm and 10am. We asked the trust to provide us with evidence there was always a registered nurse with the appropriately level of competence to care for children during this time. We found not all shifts were appropriately covered.*

- *Flow concerns appeared to be 'normalised' and was considered to be a problem for the Emergency Department, not the wider trust.*

- *An Emergency Department risk tool gave an "at a glance" look at the number of patients in the department, time to triage and first assessment, number of patients in resuscitation, number of ambulance crews waiting and the longest ambulance crew wait. Whilst we saw this updated on a regular basis, we did not see, despite an 'extreme' score, actions taken resulting in an improvement in this position.*

- *We saw there were significant issues in relation to patient flow which led to crowding and patients receiving care in corridors. Patients were experiencing unacceptable waits. Whilst staff in the department followed the escalation*

policy, actions taken by others in line with the policy did not prove effective at restoring flow. The lack of effective actions resulted in handover delays, overcrowding and poor patient experience.

However:

- *At the time of this focussed inspection we observed part of one shift. There was good co-ordination between the doctor and nurse in charge.*

- *Staff at this inspection demonstrated a positive attitude towards their work and were working effectively together.*

- *Despite the challenges of the department, staff we spoke with were committed to doing the right thing for patients and wanted to deliver safe, effective and compassionate care.*

- *Since our last inspection the trust had implemented a dedicated frailty team based in the ED, which provided immediate review and care for patients who attended from care homes or where they needed input from older people specialists.*

- *At this inspection we found improvements in the management of patients who were at risk of deteriorating consciousness levels. We found staff were mostly monitoring these patients effectively. We also found improvements to triage times.*

- *There had been improvements in the provision of nursing staff for children at this inspection. Between 10am and 10pm there was at least one registered children's nurse present in the department responsible for the care and treatment of children.*

- *Staff mostly carried out assessments and delivered treatment with privacy, dignity and compassion during all our observations, including during handovers.*

- *There was a positive regard for patients who were distressed and calling out, we saw nursing and medical staff respond in a timely and appropriate way.*

- *Patients and relatives, we spoke with were mostly happy with their care and treatment. They said staff were kind and caring and they were doing their best.*

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Open Report on behalf of Lincolnshire Partnership NHS Foundation Trust (LPFT)

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 April 2019**
Subject:	**Update on Lincolnshire Partnership NHS Foundation Trust Services (including the Older Adults Mental Health Home Treatment Team)**

Summary:

Lincolnshire Partnership NHS Foundation Trust's has four older adult mental health inpatient wards. Two of these wards provide dementia care and two provide care for people with functional mental illness.

In October 2018 a twelve month project began to upgrade one of the two functional wards, Brant Ward at Witham Court in Lincoln, to create single en-suite bedrooms and improve the ward living spaces. Witham Court is the main centre for older adult mental health in Lincolnshire and has a firm place within the Trust's future strategy. The work on Brant Ward is considered to be a good investment in order to meet Care Quality Commission standards and to futureproof this valuable service.

To support the patients who would otherwise have been admitted to Brant Ward. The Trust set up a new older adult Home Treatment Team (HTT) to run whilst the estates work is being done. Six months into this project, the HTT is proving to be very successful and achieving excellent quality and financial outcomes.

Actions Required:

The Health Scrutiny Committee for Lincolnshire is asked to note the report and the progress made with the older adult Home Treatment service.

Background

The older adult Home Treatment Team (HTT) was set up to mitigate the temporary loss of Brant Ward, a functional mental health inpatient unit with 20 beds, in order that a full refurbishment of the unit could take place. Functional mental health conditions include, for example, people who are living with depression. This refurbishment is to improve the patient experience, providing single en-suite rooms for patients in light of recommendations made by Care Quality Commission around privacy and dignity.

The HTT is a community based service focussing on admission avoidance and supporting early discharge from hospital. The HTT became operational in October 2018; its operational hours are 8:00am-8:00pm Monday to Friday and 10:00am-6:00pm at weekends and public holidays.

Quality Impact of the Service

In the first five months of operation, the Home Treatment Team has demonstrated significant positive outcomes across three key areas:

1. Clinical effectiveness
2. Patient and carer experience
3. Patient Safety

Clinical Effectiveness

Admission Avoidance:

The primary objective for the Home Treatment Team was to provide alternative home based support for twenty patients with functional mental illness previously accessing inpatient beds at Brant Ward, Witham Court, Lincoln and to ensure more people do not have to travel out of Lincolnshire to access an inpatient bed. To date the service has been successful in delivering upon this key objective:

- Since commencement, the HTT have only admitted four patients into an inpatient bed.
- Only one older adult has been placed in an out of area mental health acute bed in the five months since HTT has been in place, compared to nine in the five months before HTT.
  There are currently no out of area older adult acute mental health placements.

Length of Stay:

Length of stay is accepted as a good indicator of successful care and treatment; a shorter length of stay coupled with a low readmission rate is an indicator of success. Since the commencement of the older adult Home Treatment Team and the temporary closure of Brant Ward there have been improvements in length of stay:

- The average length of stay for patients under the care of the HTT is 23 days. This is significantly lower than the length of stay of Brant Ward (pre-HTT) at 59 days.

- The average length of stay has also reduced on Rochford Ward, the remaining older adult functional mental health ward, where the hospital stay has reduced from an average of 76.2days to 45.2 days with HTT in place.
- Comparison of discharges from Rochford Ward show that discharges for the period October to December 2017 was twelve, versus 25 for the period October to December 2018 when the HTT was in place, representing a significant increase in discharge rate.
- No patient have been readmitted to an inpatient bed within 30 days of discharge from Rochford Ward since the HTT has been in place (30 days is an indicator of appropriate discharge).

Patient and Carer Experience

- There has been 100% patient satisfaction with the HTT. 73.91% of people reported that they were 'extremely likely' to recommend the service and 26.09% were 'likely' to recommend. Common feedback includes comments such as:

  "Thanks for coming. Excellent after care, couldn't have asked for better care"

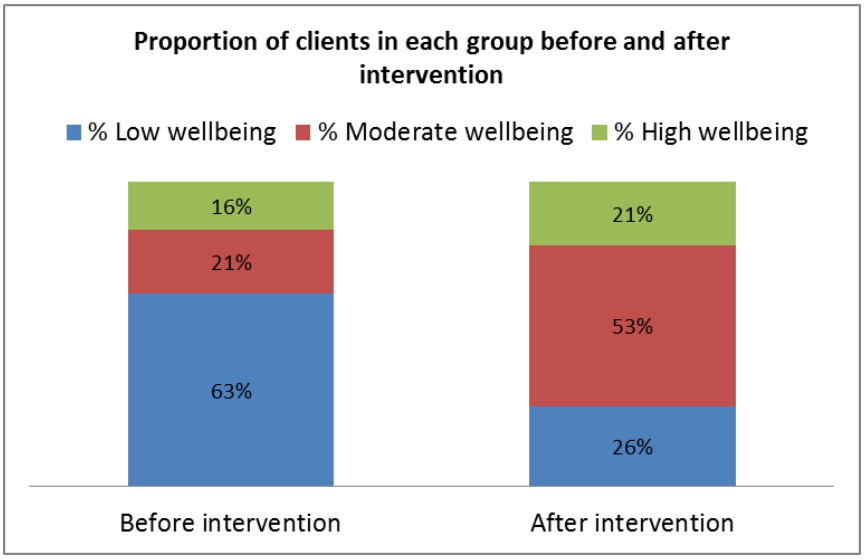
  "They have given me their time, they have listened, they have cared and have showing an understanding of my needs when I needed it most, a superb service"

  "Recommend the service and valued the service. Treated with respect and staff always listened"

  "Their experience shone through and their desire to help me was personal and so caring. They came up with wonderful practical ideas which were spot on to help! I know that this enabled me to make a much faster recovery that I would have done otherwise. I'm just so grateful that this service was available for me"

- Clinician Rated Outcome Measures (incorporating CGI-I: Clinical Global Improvement scale) have also shown high levels of clinical staff's satisfaction with patient condition on discharge from the service as well as 'very good' referrer satisfaction

- Using the validated tool 'Warwickshire Edinburgh Wellbeing Scale' (WEMWBS) the HTT is able to demonstrate a statistically significant improvement in the self-reported wellbeing of patients following HTT intervention. Less people report low wellbeing and more people report moderate and high wellbeing after HTT support (See chart below:



Patient Safety

Clinical Incidents (these can be all types of incidents most of which do not result in harm but are reported to ensure patients remain safe and lessons are learned):

- For the five months October 2018 to February 2019, there were five clinical incidents associated with the HTT. This compares with 123 clinical incidents associated with Brant Ward in the five months May 2018 to September 2018.
  The HTT has reported zero Serious Incidents since it became operational in October 2018.
  This demonstrates that the Home Treatment Team is managing clinical risk appropriately and effectively.

Use of Medication (working to reduce medication where patients do not need it):

- A review is currently underway to compare the use of medication in Brant Ward with levels being used through the Home Treatment Team. Early indications suggest a notable and positive reduction in prescriptions and use of psychiatric medications under the HTT model,

2. Conclusion

Lincolnshire Partnership NHS Foundation Trust (LPFT) is committed to a vision of providing care as close as possible to people's homes. For people living with mental health problems, their carers', friends and families we are keen to explore new ways of working to build resilience in communities. There is also a need to improve the quality of the physical environment for the wards that LPFT operates in order to protect patient dignity and privacy as they receive inpatient care and treatment.

Whilst upgrading Brant Ward, Lincoln, to meet these privacy and dignity standards (in which LPFT invested significant capital funds, the service took the opportunity to try out a pilot called the Home Treatment Team. The results of that service are described in this paper.

The Older Adult functional mental heath Home Treatment Team is proving to be very successful as an alternative to inpatient beds. In light of the success, the Trust will be engaging with patients and the public to explore support for retaining the HTT team when Brant Ward re-opens later this year following refurbishment.

Brant Ward, Lincoln will re-open to provide a ward for Older Adult care and treatment and the HTT team will also be in place to care for and treat people closer to home.

LPFT is very keen to share progress on the HTT team to demonstrate openness and transparency about the work we are doing to improve the services available for mental health patients in Lincolnshire.

3. Consultation

There are no issues for consultation arising from this report.

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 Jane Marshall, Director of Strategy, Lincolnshire Partnership NHS Foundation Trust, who can be contacted via Jane.Marshall@lpft.nhs.uk

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Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
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Open Report on behalf of David Coleman, Chief Legal Officer

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 April 2019**
Subject:	**Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation**

Summary

On 7 January 2019, NHS England launched the *NHS Long Term Plan*, with the support of the Secretary of State for Health and Social Care. Following this, on 28 February 2019 NHS England launched an engagement exercise on detailed proposals for possible changes to legislation. The launch of this engagement exercise was reported to the Health Scrutiny Committee for Lincolnshire on 20 March 2019, and the Committee agreed to make a response to the questions in the engagement exercise.

The full engagement document is attached to this report. An outline draft response is being prepared and will be circulated to members of the Committee.

The closing date for the submission of responses is 25 April 2019.

Actions Required:

(1) To consider a completed draft response to the questions in NHS England's engagement document entitled: *Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation.*

(2) Subject to any amendments proposed at the meeting, to approve a response to the questions in NHS England's engagement document entitled: *Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation.*

(Note: The completed draft response is being prepared.)

1. Background

NHS Long Term Plan

As reported to the Health Scrutiny Committee for Lincolnshire on 23 January 2019, the *NHS Long Term Plan* was launched by NHS England on 7 January 2019. The *Plan* contains extensive proposals for developing the NHS in England over the next ten years.

Chapter 7 of the *NHS Long Term Plan* focuses on the next steps, which includes the potential for changes to legislation. The *Plan* states that Parliament and the Government have both asked the NHS to make consensus proposals for how primary legislation might be adjusted to better support the delivery of the agreed changes set out in this *NHS Long Term Plan*. NHS England states that the *Plan* does not require changes to the law in order to be implemented. However, it is NHS England's view that amendments to the primary legislation would significantly accelerate progress on service integration; administrative efficiency; and public accountability. NHS England also recommends "changes:

- to create publicly-accountable integrated care locally;
- to streamline the national administrative structures of the NHS; and
- to remove the overly rigid competition and procurement regime applied to the NHS."

The launch of the *NHS Long Term* on 7 January 2019 was supported by the Secretary of State for Health and Social Care, whose statement in Parliament referred to organisations across the NHS (as well as local authorities) working more closely together so that they can focus on what patients need.

Relevant Extracts on Legislation Changes in the *NHS Long Term Plan*

Paragraphs 7.13 – 7.14 of the *NHS Long Term Plan* (published on 7 January 2019) refer to proposed changes to legislation and are reproduced below:

7.13. ***The changes set out in this Long Term Plan can generally be achieved within the current statutory framework, but legislative change would support more rapid progress.*** *The Acts of Parliament that currently govern the NHS give considerable weight to individual institutions working autonomously, when the success of our Plan depends mainly on collective endeavour. Local NHS bodies need to be able to work together to redesign care around patients, not services or institutions, and the same is also true for the national bodies. And the rules and processes for procurement, pricing and mergers are skewed more towards fostering competition than to enabling rapid integration of care planning and delivery.*

7.14. *In response to the formal request earlier in the year from the cross-party House of Commons Health and Social Care Committee and from the Prime Minister,* ***we have in discussion with NHS colleagues, therefore developed a provisional list of potential legislative changes for Parliament's consideration. These proposals are based on what we've heard from clinicians and NHS leaders, as well as national professional and representative bodies.*** *These proposals would:*

- ***Give CCGs and NHS providers shared new duties to promote the 'triple aim' of better health for everyone, better care for all patients, and sustainability, both for their local NHS system and for the wider NHS.*** *These statutory duties on CCGs and trusts would further support them to work in tandem with their neighbours for the benefit of their local population and wider NHS. These new reciprocal duties would also contribute to supporting our wider goal of securing a stronger chain of accountability for managing public money within and between local NHS organisations;*

- ***Remove specific impediments to 'place-based' NHS commissioning.*** *The 2012 Act creates some barriers to ICSs being able to consider the best way of spending the total 'NHS pound'. Lifting a number of restrictions on how CCGs can collaborate with NHS England would help, as would NHS England being able to integrate Section 7A public health functions with its core Mandate functions where beneficial;*

- ***Support the more effective running of ICSs*** *by letting trusts and CCGs exercise functions, and make decisions, jointly. This is simpler and less expensive than creating an additional statutory tier of bureaucracy. It would mean giving NHS foundation trusts the power to create joint committees with others. It would allow – and encourage – the creation of a joint commissioner/provider committee in every ICS, which could operate as a transparent and publicly accountable Partnership Board. To manage conflicts of interest, any procurement decisions – including whether to procure – would be reserved to the commissioner only;*

- ***Support the creation of NHS integrated care trusts.*** *Since the repeal of NHS trust legislation in 2012, the NHS has limited options if it wants to create a new NHS integrated care provider (ICP), for example to deliver primary care and community services for the first time under a single, streamlined ICP contract. Remedying this would both reduce administration costs and help with clinical sustainability. It should also be easier for proposed organisational mergers to progress, without diluting any of the current safeguards on frontline service changes;*

- ***Remove the counterproductive effect that general competition rules and powers can have on the integration of NHS care.*** *We propose to remove the Competition and Markets Authority's (CMA) duties, introduced by the 2012 Act, to intervene in NHS provider mergers, and its powers in relation to NHS pricing and NHS provider licence condition decisions. This would not affect the CMA's critical investigations work in tackling abuses and anti-competitive behaviour in health-related markets such as the supply of drugs to the NHS. We propose similarly dispensing with Monitor's 2012 Act competition roles, so that it could focus fully on NHS provider development and oversight;*

- ***Cut delays and costs of the NHS automatically having to go through procurement processes.*** *We propose to free up NHS commissioners to decide the circumstances in which they should use procurement, subject to a 'best value' test to secure the best outcomes for patients and the taxpayer. The current rules lead to wasted procurement costs and fragmented provision, particularly across the GP/urgent care/community health service workforce. This would mean repealing the specific procurement requirements in the Health and Social Care 2012 Act. We also propose to free the NHS from wholesale inclusion in the Public Contract Regulations. We would instead set out our own statutory guidance for the NHS to follow. At the same time, we propose to protect and strengthen patient choice and control, including through our wider programme to deliver personalised care;*

- ***Increase flexibility in the NHS pricing regime.*** *This would provide further flexibility in the setting of national prices, support the move away from activity-based tariffs where that makes sense, facilitate better integration of care and make it easier to commission Section 7A public health services as part of a bundle with other related services, on a nationally consistent basis;*

- ***Make it easier for NHS England and NHS Improvement to work more closely together.*** *We propose that as a minimum, NHS England and NHS Improvement should be free to establish a joint committee and subcommittees to exercise their functions, with corresponding streamlining of non-executive and executive functions.*

Proposals for Changes to Legislation

On 28 February 2019, NHS England followed up the *NHS Long Term Plan* with 'a call for views' on proposed amendments to the law, which are detailed in: *Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation.* This is attached as Appendix A to this report.

NHS England re-stated that it was possible to implement the *NHS Long Term Plan* without primary legislation, but legislative change could make implementation easier and faster. Local NHS bodies need to be better able to work together to redesign care around patients, and the same is also true for the national bodies. NHS England states that the rules and processes for procurement, pricing and mergers create unnecessary bureaucracy that gets in the way of enabling the integration of care.

Role of Health Overview and Scrutiny Committees

In relation to health overview and scrutiny committees, paragraph 69 of *Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation* makes reference to local authorities continuing to have the right to review and scrutinise the health service in their area and, where there is a substantial development or variation, there would continue to be an obligation on NHS bodies or heath service providers to consult with the local authority. This means none of the proposals would affect the role of this Committee.

2. Responding to the Questions in *Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation*

There are nine questions in NHS England's engagement document, which range from seeking views on the introduction of a general best value duty (question 2) to detailed changes to the 'double-delegation' of commissioning functions (question 8). The closing date for the submission of responses is 25 April 2019.

An outline draft response is being prepared and will be circulated to members of the Committee.

Response of the Health and Wellbeing Board

On 26 March 2019, the Health and Wellbeing Board considered *implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation* and agreed to make its own arrangements for making a response.

3. Conclusion

The Committee is being invited to consider a completed draft response to the questions in NHS England's engagement document entitled: *Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation.* Subject to any amendments proposed at the meeting, the Committee is also invited to approve its response to these questions.

4. Consultation

The Committee is being invited to consider and approve its response to the questions in NHS England's engagement document, entitled *Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation.*

5. Appendices – These are listed below

Appendix A	NHS England's engagement document entitled: *Implementing the NHS Long Term Plan - Proposals for Possible Changes to Legislation (published 28 February 2019)*

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

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Implementing the NHS Long Term Plan

Proposals for possible changes to legislation

Implementing the NHS Long Term Plan:

Proposals for possible changes to legislation

Engagement Document

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Introduction

We are inviting patients, NHS staff, partner organisations and interested members of the public to give us your views on potential proposals for changing current primary legislation relating to the NHS.

The success of the NHS Long Term Plan depends on our collective will to change the NHS for the better and improve services for everyone working in them and using them. Local NHS bodies need to be free to work together with partners, including local authorities, to plan and provide care around patients, not services or institutions, and the same is also true for our national organisations.

It's possible to implement the NHS Long Term Plan without primary legislation. But legislative change could make implementation easier and faster. Local NHS bodies need to be better able to work together to redesign care around patients, and the same is also true for the national bodies. And the rules and processes for procurement, pricing and mergers create unnecessary bureaucracy that gets in the way of enabling integration of care.

We outlined eight groups of suggested legislative changes in the NHS Long Term Plan and, as promised in the Plan, are now setting out further detail. It is based on what we've heard from patients, clinicians, NHS leaders and partner organisations, as well as national professional and representative bodies, and it is intended to better enable NHS organisations to work collectively. These proposals are designed to solve specific practical problems that the NHS faces and avoid creating operational distraction.

You can take part and ensure your voice is heard by completing the short survey which is available online at:
https://www.engage.england.nhs.uk/survey/nhs-long-term-plan-legislation/.

You can also provide more detailed feedback and comments through this online template for responses.

We want to hear from as many people as possible and intend to share the feedback we receive with the Parliamentary Health and Social Care Select Committee to inform their inquiries. We invite views by 25 April 2019. We encourage as many individuals as possible to complete the survey.

1. Promoting collaboration

1. We propose targeted changes to enable collaboration. The Health and Social Care Act 2012 formalised the role of the Competition and Markets Authority[1] (CMA) in reviewing certain NHS transactions and assigning new responsibilities to Monitor. Competition can in some circumstances help provide benefits to patients – for example in the supply of pharmaceuticals – and we therefore propose a more nuanced approach that gives due weight to collaboration. That is why we are proposing changes to both the CMA's and NHS Improvement's (Monitor) roles in respect of competition.

2. The CMA has powers to investigate alleged infringements of competition law and investigate particular markets if it sees issues for consumers with reducing competition. The CMA has used these powers to ensure that public interest has been an important part of regulating private companies in the health and healthcare market. We can see clear benefit in the CMA continuing this role.

3. However, the CMA's merger control regime applies to proposed NHS mergers involving NHS foundation trusts and the CMA has led a number of investigations into NHS provider mergers or acquisitions in recent years. Whilst it has approved all the mergers it has considered, with the one exception of its first investigation into the proposed merger between Poole Hospital NHS Foundation Trust and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, the investigations have been costly and time consuming for the organisations involved.

4. **We propose that the CMA's function to review mergers involving NHS foundation trusts should be removed.** Instead NHS Improvement would continue to review proposed transactions, including mergers or acquisitions, to ensure there are clear patient benefits**.**

5. NHS Improvement's primary role is to support improvement in the quality of care and use of NHS resources. In line with this, **we propose NHS Improvement's competition powers and duties should be removed.**

6. NHS Improvement (as Monitor) is responsible for setting conditions for those healthcare providers (including NHS foundation trusts and independent sector providers) that are required to hold an NHS provider licence. NHS Improvement (as Monitor) is also responsible, with NHS England, for the National Tariff Payment System, which governs the payments that NHS commissioners make for NHS-funded care (other than primary care). Under the 2012 Act, where a sufficient number of relevant bodies object to proposed licence conditions or the

[1] More information about the role of the CMA can be found here

proposed method for determining prices under the National Tariff Payment System, NHS Improvement must either refer the relevant proposals to the CMA or consult on a revised set of proposals. We consider that NHS Improvement – together with NHS England in the case of the National Tariff Payment System – should be able to reach final decisions on these matters without referral to a competition authority, provided it has consulted on the proposals and given proper consideration to any concerns that are raised.

7. **We propose that the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA should be removed.**

2. Getting better value for the NHS

8. In this section we propose targeted amendments to primary legislation to free the NHS from overly rigid procurement requirements. These would be replaced by a new best value test and stronger protection for patient choice.

9. Procurement of health care services in the NHS is carried out under two sets of regulations: the so-called section 75 regulations[2], made under powers in the Health and Social Care Act 2012, and the Public Contracts Regulations 2015, which implement EU rules on public procurement. The two sets of regulations overlap in terms of some of their requirements but following one of them does not automatically mean a commissioner is meeting the requirements of the other. Under the Public Contracts Regulations, contracts over a certain amount (£615,278 over the lifetime of the contract) need – with some limited exceptions – to be advertised and the applicable procurement procedures must be followed.

10. Current procurement legislation can lead to protracted procurement processes and wasteful legal and administration costs in cases where there is a strong rationale for services to be provided by NHS organisations, for instance to secure integration with existing NHS services. It also makes it more difficult for NHS organisations to ensure they are using their collective financial resources in the most effective way for local populations. Furthermore, the current legislation can discourage NHS organisations from collaborating to develop new models of care, in case this is challenged on the grounds of not treating all providers equally.

11. There should be a continued place for the use of competitive procurement, either by NHS commissioners or by integrated care providers, to bring in new capacity or innovative service models. To achieve best value commissioners should have discretion, subject to a best value test, as to when to seek interest from other potential healthcare providers, rather than arrange for NHS organisations to provide services.

12. **We propose that the regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed and replaced by a best value test.**

13. Requirements in relation to patient choice would continue under the separate regulations which currently impose requirements (‘standing rules’) on commissioners, as well as licence conditions for providers. We propose that the

[2] The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013.

power to set standing rules in primary legislation is explicitly amended to require inclusion of patient choice rights. The NHS Long Term Plan makes specific proposals to strengthen patient choice and control, including the roll out of personal health budgets. We anticipate these will be set out as additional requirements for commissioners under the standing rules.

14. **We also propose that arrangements between NHS commissioners and NHS providers are effectively removed from the scope of the Public Contracts Regulations and that NHS commissioners are instead subject to a new 'best value' test when making such arrangements, supported by statutory guidance.**

15. The new regime would allow NHS commissioners to choose either to award a contract directly to an NHS provider or to undertake a procurement process, with the clear aim of ensuring good quality care and value for money when designing local healthcare services. It would give commissioners freedom to engage widely with existing providers to design the model of care they want before awarding a contract, whether via a procurement process or otherwise. And it would allow them to choose how they oversee contracts with NHS providers and amend them as they see fit when healthcare needs change.

16. The key tests would be whether NHS commissioners were obtaining 'best value' from their resources in terms of the likely impact on quality of care and health outcomes, whether they were acting in the best interests of patients, and whether they were actively considering relevant issues in making any decisions, for example, the improvement progress a particular provider is making in tackling unwarranted lower outcomes than their peers.

3. Increasing the flexibility of national NHS payment systems

17. The National Tariff Payment System ('tariff') is a set of currencies (e.g. defined episodes of care), prices and rules governing the payments that NHS commissioners make to providers for NHS-funded healthcare (except for primary care services). It is intended to promote high-quality care and improve the efficiency with which services are provided. The tariff is set on an annual or multi-year basis.

18. The NHS Long Term Plan describes how we are already developing the tariff to support stronger collaboration and to provide shared incentives for commissioners and providers to improve quality of care and efficient use of resources, for instance the proposed move (subject to the outcome of the statutory consultation that closed on 21 February) from a 'cost per case' approach for paying for acute emergency care and instead using a much greater proportion of resources to recognise the fixed costs that hospitals incur in providing emergency care. Choice will still exist for elective care and money will need to continue to follow patients accordingly.

19. The tariff already offers significant flexibility to support new ways of delivering care. Providers and commissioners are able to agree local payment approaches, provided they are in the best interests of patients, promote transparency and result from engagement between providers and commissioners. However, we believe that legislative changes could help provide more flexibility in this respect.

20. **Specifically, we propose that legislation should:**
    - **allow national prices to be set as a formula rather than a fixed value, so that the price payable can reflect local factors;**
    - **provide a power for national prices to be applied only in specified circumstances, for example allowing national prices for acute care to cover 'out of area' treatments but enabling local commissioners and providers to agree appropriate payment arrangements for services that patients receive from their main local hospital in accordance with tariff rules;**
    - **allow adjustments to provisions within the tariff to be made (subject to consultation) within a tariff period, for example to reflect a new treatment, rather than having to consult on a new tariff in its entirety for even a minor proposed change.**

21. Currently, providers can in certain circumstances apply to NHS Improvement (as Monitor) to make local modifications to national prices. This is arguably out of keeping with the move to integrated care systems (ICSs) in which NHS

commissioners and providers take shared responsibility for managing their collective financial resources and agree how best to use those resources to improve quality and outcomes. **We propose that, once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed.** Commissioners and providers would continue to be able to agree local modifications to national tariff prices to reflect local circumstances.

22. It is not currently possible to set national tariff prices for ‘section 7A’ public health services commissioned by NHS England or Clinical Commissioning Groups (CCGs) on behalf of the Secretary of State. This has created difficulties where these services are part of a patient pathway for a particular service, for example, screening new-born babies’ hearing as part of their mothers’ maternity care.

23. Subject to proposals later in the document on the future arrangements for commissioning ‘section 7A’ public health services, to support integrated care **we propose that primary legislation should be changed so that the national tariff can include prices for ‘section 7A’ public health services.**

4. Integrating care provision

24. Health and care services for a local population are commissioned by different organisations and delivered by a range of separate provider organisations under different contracts, with different funding arrangements. Through the development of ICSs, those different commissioners and providers are increasingly coming together to plan services in a much more collaborative way. Some local health systems have expressed interest in going further and bringing some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget. They consider that this would enable them to make faster progress in developing integrated care for a local population, and provide stronger incentives and opportunities for provider organisations to prioritise action to prevent ill-health and improve population health.

25. In response to this, the NHS has developed the Integrated Care Provider (ICP) contract to enable the integration of services under a single contract. This could be for primary care and other community-based health services, potentially including public health and/or social care services, or it could also include acute hospital services. The ICP contract is a discretionary and flexible tool for local commissioners: it is for them to decide in the light of local circumstances whether to bring services together using ICP contracts and, if so, which services should fall within the scope of the contract.

26. The provider organisation that holds an ICP contract would not necessarily provide all the relevant services itself – it might well subcontract with other providers, such as local GP practices or voluntary sector organisations to provide some services. While the contract holder will continue to be accountable to commissioners, the ICP contract gives the contract holder overall responsibility for deciding how to use resources to improve quality of care and health outcomes for a defined population.

27. In some cases, it may be difficult for commissioners to identify an existing organisation that could take on responsibility for a contract of this kind. If, for instance, a group of local GP practices and a provider of community, mental health and/or hospital services wished to come together to become an integrated care provider, they might wish to establish a new NHS organisation that exists solely for the purposes of providing integrated care. The existing legislative framework does not, however, lend itself to these circumstances.

28. One way to overcome this challenge would be to give the Secretary of State clear powers to establish new NHS trusts for the purposes of providing integrated care. Taken together with the procurement changes proposed elsewhere in this document, this would also support the expectation in the NHS

Long Term Plan, and the Health and Social Care Select Committee's recommendation, that the ICP contract should be held by public statutory providers.

29. **We therefore propose that the law should be clarified so that the Secretary of State can set up new NHS trusts to deliver integrated care across a given area.** These 'integrated care trusts' would only be established where local commissioners wish to bring services together under a single contract, where there has been appropriate local engagement and where it is necessary to establish a new organisational vehicle for these purposes.

30. The resulting 'integrated care provider' would:
    - have a contractual duty to deliver and improve health and care for a defined population;
    - act as a provider of integrated care with the freedom to organise resources (money, staff, and facilities) across a range of health and care services, working – as appropriate – in conjunction with other local partners;
    - be run in a way that involves the local community and the full range of health care professionals, including GPs; and
    - be accountable to commissioners for its performance.

5. Managing the NHS's resources better

Establishing the best leadership and governance arrangements for local health services

31. NHS providers collectively deliver around £75bn of publicly funded services each year. In recent years, it has become increasingly common for NHS provider organisations to come together, through mergers or acquisitions, so that a single organisation can plan and deliver services better across multiple local sites. This can allow the NHS to manage its resources – its workforce, its buildings and other capital assets, its knowledge and insights – better, for instance by developing standardised approaches to service design and continuous quality improvement; improving approaches to recruiting, retaining and developing staff; and sharing back office and clinical support services.

32. Recent examples of trusts joining forces in this way include the former hospital trusts in Central Manchester and South Manchester (now Manchester University NHS Foundation Trust), the former trusts responsible for four hospital sites across Birmingham (now University Hospitals Birmingham NHS Foundation Trust) and the former hospital trusts in Ipswich and Colchester (now East Suffolk and North Essex NHS Foundation Trust). These and other similar developments are helping to ensure that services across the different sites managed by the unified trust remain clinically and financially sustainable, continuing to provide both efficient and high-quality care to local communities. In some cases, they are also providing the basis for 'group' models, where the headquarters of the unified trust develops more standardised approaches to service planning, workforce planning and corporate functions, avoiding duplication of effort across its sites. The clinical and managerial leadership in each of the constituent sites is able to focus more of its attention on the day-to-day running of services and strengthening links with its local community partners.

33. Although most recent developments have involved hospital trusts, the same approach can potentially bring comparable benefits for any area of NHS care and for integrated care.

34. Wherever possible, we would want local provider organisations and their system partners to agree where improvements of this kind are needed and how to take them forward. In some circumstances, however, such improvements could be frustrated by the reluctance of one local trust to consider such arrangements. Whilst NHS Improvement (exercising the powers of the Secretary of State) can direct NHS trusts in this respect, current primary legislation allows NHS Improvement to take equivalent action in relation to NHS foundation trusts only

in the extreme circumstances of trust special administration, in other words only where there is a serious failure or risk of failure.

35. **We are proposing that NHS Improvement should have targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits.** This provision would need appropriate safeguards. We propose specifically that NHS Improvement should have the power to direct NHS foundation trusts to:
    - enter into arrangements to consider and/or to prepare for a merger or acquisition with an NHS trust or another NHS foundation trust;
    - merge with an NHS trust or another NHS foundation trust; and
    - be acquired by another NHS foundation trust.

36. It is important to note that a merger of this kind brings about a change in the organisation that is accountable for providing local NHS healthcare services. This is distinct from any changes in how those local healthcare services themselves are organised. Decisions on any service changes remain a matter for local commissioners and providers and remain subject to a number of stringent tests, including strong patient engagement, preservation of patient choice, a clear clinical benefit and support from local clinical commissioners.

Improving planning of capital spending

37. The NHS Long Term Plan sets out the urgent need to invest in the buildings and facilities of the NHS, to meet the demands of a modern health service. This requires, among other changes, a more coordinated and collaborative approach to planning capital investment. Local health systems, particularly the emerging integrated care systems, are playing a growing role in coordinating decisions by local health bodies on priorities for capital investment and how to make more effective and efficient use of their physical assets in support of integrated care.

38. One of the current barriers to developing this more collective approach is that, whilst Parliament approves an annual financial envelope for capital expenditure across the Department of Health and Social Care and the NHS, there are no mechanisms to set capital spending for NHS foundation trusts. This leads to situations where, because of uncertainty or unpredictability associated with capital spending by foundation trusts, it becomes necessary to constrain or delay capital spending by non-foundation trusts that may be more urgent or address higher-priority needs. It limits the extent to which NHS Improvement can work with local health systems to help improve planning of capital spending for the benefit of patients. And it increases the risk that the Department and the NHS collectively could exceed the limits prescribed by Parliament.

39. **We are proposing that NHS Improvement should have powers to set annual capital spending limits for NHS foundation trusts, in the same way that it can currently do for NHS trusts**, in order to avoid NHS trusts being disadvantaged**.**

40. We recognise that the ability of foundation trusts to build up funding reserves (or in principle to borrow money, though in practice this is a much less used freedom) to allow additional capital investment is regarded as a helpful freedom, and we would want to avoid – where possible – cutting across these freedoms. The power to set annual spending limits would need to be exercised carefully and would not ultimately prevent foundation trusts from using funding reserves to support capital investment but would mean that they agree with NHS Improvement, working closely with local health systems, when to make large capital investments that might otherwise force other organisations to constrain high-priority investments or increase the risk of breaching the NHS's overall capital expenditure limits.

41. We intend to work closely with NHS Providers and other stakeholders in designing the detail of the provisions in this section.

6. Every part of the NHS working together

42. We want NHS organisations to work with each other – and with primary care networks, local government and other community partners – as ICSs to jointly plan and improve the way care is delivered. It is only through cross-organisational collaboration that providers and commissioners will be able to use their combined resources more effectively to improve quality of care and health outcomes and reduce inequalities.

43. Establishing ICSs as distinct, new organisational entities would involve a complex reassignment of functions that currently sit with CCGs and trusts. Instead, we believe there are a set of relatively straightforward changes to primary legislation which would remove barriers to collaboration and joint decision-making by letting trusts and CCGs exercise some functions, and make some decisions, jointly. This would be simpler and less expensive than creating new statutory bodies. It would complement the NHS Long Term Plan commitment to have ICS partnership boards that bring together commissioners, trusts, primary care networks, local authorities, the voluntary and community sector and other partners.

Joint committees of CCGs and NHS providers

44. Although current legislation allows CCGs and NHS providers (NHS trusts and foundation trusts) to work together informally, there are no powers for CCGs and NHS providers to set up joint committees to take joint decisions in the interests of their local population.

45. **We propose that organisations should be given the ability to create these joint committees.** The new joint commissioner/provider committees would not do away with the existing responsibilities of CCGs and NHS providers. However, they would provide a mechanism for collective decision-making to agree local healthcare priorities and actions to address them and take a system-wide view on making the best use of their collective resources.

46. Taken with our proposals for new shared duties on NHS organisations to act in the wider interests of the health service, enabling CCGs and NHS providers to form committees would support the more efficient and effective functioning of ICSs.

47. The joint committees would be required to act openly and transparently and would need to work in a way that avoids conflicts of interests. For example, commissioners would not be able to delegate to joint committees decisions on purchasing services. **We are therefore seeking new provisions relating to the**

formation and governance of these joint committees and the decisions that could appropriately be delegated to them.

48. In the same way, it would be sensible to allow NHS providers to form their own joint committees (CCGs already have the ability to do so with other commissioners), which could include representation from other bodies such as primary care networks, GP practices or the voluntary sector. These committees could, for instance, bring local care providers together to set up clinical services networks, a single estates strategy or shared IT, HR and pharmacy services.

49. NHS commissioners or providers already have the ability to enter into partnership arrangements with local authorities (under section 75 of the NHS Act 2006), enabling them to establish joint committees and pool budgets across a variety of health functions. With local government, we will look at how existing provisions for joint working between local government and the NHS might be improved in the light of these proposed changes, including the ability for local authorities to be part of joint committees with NHS commissioners and providers, where this is locally agreed by all parties.

CCG governing bodies

50. One way of achieving improved joint working by commissioners and providers would be to remove restrictions that currently apply to certain members of CCG governing bodies.

51. Legislation gives CCGs a large degree of discretion as to the membership of their governing bodies, but – amongst other requirements – specifies that governing bodies must include a registered nurse and a doctor who is not a GP. Legislation further specifies that this nurse and doctor cannot work for a provider with which the CCG has commissioning arrangements.

52. It is inconsistent to allow GPs to sit on governing bodies but prevent the designated nurse and secondary care doctor from working for other local providers. We believe this rule is too limiting for CCGs to plan services effectively. There would be significant benefit from appointing clinicians from local providers to CCG governing bodies, so they can bring knowledge and insights from providing local hospital, community health or mental health services.

53. **We therefore propose that this restriction should be removed so as to allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers.**

54. We are confident that any conflicts of interest could be managed, in the same way we currently manage conflicts of interest arising from GP membership of governing bodies.

Joint appointments

55. Letting people hold joint roles across organisations is another way to foster joint decision making, enhance local leadership and improve the delivery of integrated care. They can also help to reduce management costs and engender a culture of collective responsibility across organisations.

56. Although it is possible to make joint appointments under the current legislation, organisations often face legal costs in seeking advice on what they can and cannot do, due to the ambiguity in the legislation, and can leave themselves open to challenge in the future for the appointments they make.

57. **We propose that express provision should be made in legislation to enable CCGs and NHS providers to make joint appointments.** Such a change would need to set out how conflicts of interests would be managed. This would help to reduce both unnecessary legal costs attached to making joint appointments, and the risk of subsequent challenge by others.

7. Shared responsibility for the NHS

58. The Acts of Parliament that currently govern the NHS give considerable weight to individual institutions working autonomously to provide or arrange care for specific groups of patients. However, the improvements in quality of care and health outcomes that are set out in the recently published NHS Long Term Plan rely on shared endeavour. Local NHS bodies, as well as local authorities, need to be able to work together to redesign care around the needs of patients and local communities, not services or institutions.

59. At present, NHS bodies are bound, rightly, by strong duties to provide or arrange high quality care and financial stewardship as individual organisations, and they have statutory duties to co-operate with one another when performing their functions. This is not enough on its own, however, to ensure that local health systems plan and deliver care across different organisational boundaries in ways that secure the best possible quality of care and health outcomes for local communities. Despite the duties of co-operation, organisations can still make isolated and disconnected decisions, rather than working together to consider the potential wider impact of organisational decisions on services and financial sustainability both in their local community and with neighbouring health systems. We believe therefore that NHS bodies should have shared responsibility for wider objectives in relation to population health and the use of NHS resources.

60. **We propose that a new shared duty should be introduced that requires those organisations that plan services in a local area (CCGs) and NHS providers of care to promote the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS.** The NHS will need to continue to be a full and active partner in Health and Wellbeing Boards.

61. These statutory duties would support local NHS bodies to work in tandem with their neighbours for the benefit of the local population and to collaborate with neighbouring health systems for the benefit of the wider NHS and the people it serves. They would also help with our goal of strengthening the chain of accountability for managing public money within and between NHS organisations.

62. The legal duties that currently apply to various bodies might need to be amended or extended to ensure they are consistent across all organisations and support this triple aim.

8. Planning our services together

63. Under current legislation, responsibility for planning and funding the provision of health services (commissioning) is split across different organisations: CCGs, NHS England and local authorities. This acts as a hindrance to integrating care for patients and making best use of public resources. Public health services (to help prevent ill-health), primary care, hospital care and specialist mental and physical healthcare are organised by different bodies. We want to join up the commissioning of these services but without creating the distraction of major organisational re-structuring.

64. We propose Parliament remove the legal barriers that limit the ability of CCGs, local authorities and NHS England to work together and take decisions jointly.

Joining up commissioning

65. NHS England has responsibility for commissioning a range of services: primary medical care, dental care, pharmaceutical and ophthalmic services, services for armed forces, and health services for prisons and the criminal justice system. We want the planning and funding of these services to be joined up with other local services.

66. An array of provisions already exists to enable CCGs and local government to work closely together to improve the health and wellbeing of their population through joint commissioning and joint provision. However, a number of legal barriers stand in the way of more joined-up NHS commissioning:

- NHS England currently has powers to delegate a range of its functions to CCGs. For example, over 90% of CCGs have delegated responsibility for commissioning primary medical care on behalf of NHS England. However, once NHS England has delegated a function to a CCG, that CCG cannot then enter into formal joint decision-making arrangements for that function with neighbouring CCGs or local government (as this would constitute unlawful ‘double delegation’).

- The Secretary of State currently arranges for NHS England to carry out certain public heath functions on his behalf – sometimes referred to as ‘section 7A’ services. These include: national screening for major diseases and immunisation programmes, and sexual assault referral services. Current legislation does not permit NHS England and one or more CCGs to commission these services jointly. This can make it harder for NHS England to take account of local issues. We believe NHS England should be able to work together with CCGs to commission these services. We are not proposing any change to the Secretary of State’s responsibilities in respect of

health protection. The NHS Long Term Plan raises the question as to what constitutes the best local arrangements for the commissioning of certain local services. These are out of scope for this document.

- Unless they are formally merged there are limits on the decisions that CCGs can make jointly.

67. To overcome these constraints, **we propose that NHS England should be given the ability to allow groups of CCGs to collaborate to arrange services for their combined populations. We also propose that CCGs should be able to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation', and that groups of CCGs should be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions.**

68. This would further empower CCGs to make joint decisions about planning and delivering care. NHS England would keep overall responsibility for these functions, but CCGs would have the freedom to work jointly with other CCGs to promote greater integration of local services. NHS England would be required to consult on any plans to delegate functions to CCGs.

69. Local authorities would continue to have the right to review and scrutinise the health service in their area and, where there is a substantial development or variation, there would continue to be an obligation on NHS bodies or heath service providers to consult with the local authority. The NHS and local authorities have extensive freedoms to work together jointly, including joint commissioning and budget pooling where this is locally agreed.

70. **We are also seeking to enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement or to delegate the commissioning of these services to groups of CCGs.**

Specialised services

71. NHS England is responsible for commissioning a range of specialised services. Many of these services form part of care pathways for patients that include services commissioned by CCGs or local authorities. For example, CCGs commission services for patients with kidney disease, NHS England for patients with kidney failure. This split in responsibilities can hinder efforts to organise care around the needs of patients.

72. It also makes it difficult to make decisions in the round based on the balance of investment between prevention of ill-health, care and support for people with

established but stable long-term health problems, and specialist treatment for people with serious complications in their health. We think there is a strong case for enabling CCGs to be more involved in decisions about specialised services and how they can be better integrated with local services. The only formal mechanism currently available is for the Secretary of State to re-designate services as not being within the scope of specialised services. However, this would not be appropriate for many services which need to be planned on a greater population footprint.

73. **We therefore propose that legislation is changed to enable NHS England to enter into formal joint commissioning arrangements with CCGs** including providing the ability to pool budgets.

9. Joined-up national leadership

74. The public see the NHS as an integrated service. Parliament expects the whole of the NHS to work together to make the best use of its collective resources for patients and the public. Health and care organisations are increasingly working together to improve care for their populations and want the national leadership to speak with a single voice. It is right that the national organisations of the NHS work more closely together.

75. As the organisations with most responsibility for setting the direction of and overseeing the NHS, NHS Improvement (technically comprising Monitor and the NHS Trust Development Authority) and NHS England are already working closely together to align what they do, provide more joined-up support for local health systems, and establish integrated teams to carry out most of their functions.

76. However, there are limits on how far NHS England and NHS Improvement can work together. For example, there is no provision to formally carry out functions jointly, there are constraints on sharing board members, and they have separate accountability arrangements to the Secretary of State. This causes unhelpful and cumbersome bureaucracy for both organisations.

77. **We propose that NHS England and NHS Improvement should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to Secretary of State and Parliament.** We believe this would enable NHS England and NHS Improvement to go further in:

    - speaking with one voice, setting clear, consistent expectations for providers, commissioners and local NHS health systems;
    - developing a single oversight and support framework for the NHS that supports integration and the best use of resources;
    - bringing together national programmes of work and key activities;
    - using their collective resources more efficiently to support local health systems.

78. **We propose that this should be achieved by:**

either

- creating a single organisation which combines all the relevant functions of NHS England and NHS Improvement (including Monitor and the TDA).

or

- leaving the existing bodies as they are, but provide more flexibility to work together, including powers to carry out functions jointly or to delegate or transfer functions to each other, and the flexibility to have non-executive Board members in common.

79. Both options would require changes to primary legislation.

80. At present, there are different legislative arrangements for the accountability between the Secretary of State and each of NHS England, Monitor and the Trust Development Authority. NHS Improvement is made up of the NHS Trust Development Authority, which is a Special Health Authority, and Monitor, which is a non-Departmental public body with a regulatory focus. NHS England is also a non-departmental public body. If a single body were created, accountability would need to be appropriately defined.

81. Other national Arm's Length Bodies (ALBs) play a vital role in supporting the health system. The Health and Social Care Select Committee has recommended that all national ALBs act in a more joined-up way, particularly on priority areas such as prevention of ill-health and workforce education and training. Responsibility for these issues sits in different organisations, specifically Public Health England and Health Education England.

82. **We propose legislative changes to enable wider collaboration between ALBs by establishing new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs**. This provision would require appropriate safeguards.

Next Steps

83. We hope to achieve broad support for these proposals and we want to hear from as many people as possible. A response to this document can be quickly completed by following this link: https://www.engage.england.nhs.uk/survey/nhs-long-term-plan-legislation/

84. It is also possible to submit more detailed comments via this link, once the short survey is complete. Or, if you prefer, we would be happy to receive views via e-mail at england.legislation@nhs.net or in writing to:

    NHS Legislation Engagement Survey
    Quarry House
    Quarry Hill
    Leeds
    West Yorkshire
    LS2 7UE

    A copy of the survey is attached to this document.

85. Alongside this, we will actively reach out to the NHS through our ongoing discussions on implementing the NHS Long Term Plan and will seek views at targeted events with partner organisations and interested bodies.

86. The engagement process on these proposals will run until 25 April 2019. Once all responses have been received and considered, we will publish a report which sets out the views received and makes firm recommendations for the Secretary of State.

NHS Legislation Survey

Available online here: https://www.engage.england.nhs.uk/survey/nhs-long-term-plan-legislation/

[MANDATORY]	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Should the law be changed to prioritise integration and collaboration in the NHS through the changes we recommend?	☐	☐	☐	☐	☐

[OPTIONAL]		**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Promoting collaboration	• Do you agree with our proposals to remove the Competition and Markets Authority's functions to review mergers involving NHS foundation trusts?	☐	☐	☐	☐	☐
	• Do you agree with our proposals to remove NHS Improvement's powers to enforce competition?	☐	☐	☐	☐	☐
	• Do you agree with our proposals to remove the need for contested National Tariff provisions or licence conditions to be referred to the CMA?	☐	☐	☐	☐	☐
2. Getting better value for the NHS	• Do you agree with our proposals to free up procurement rules including revoking section 75 of the Health and Social Care Act 2012 and giving NHS commissioners more freedom to determine when a procurement process is needed, subject to a new best value test?	☐	☐	☐	☐	☐
3. Increasing the flexibility of national payment systems	• Do you agree with our proposals to increase the flexibility of the national NHS payments system?	☐	☐	☐	☐	☐
4. Integrating care provision	• Do you agree that it should be possible to establish new NHS trusts to deliver integrated care?	☐	☐	☐	☐	☐
5. Managing the NHS's resources better	• Do you agree that there should be targeted powers to direct mergers or acquisitions involving NHS foundation trusts in specific circumstances where there is clear patient benefit?	☐	☐	☐	☐	☐
	• Do you agree that it should be possible to set annual capital spending limits for NHS foundation trusts?	☐	☐	☐	☐	☐
6. Every part of the NHS working together	• Do you agree that CCGs and NHS providers be able to create joint decision-making committees to support integrated care systems (ICSs)?	☐	☐	☐	☐	☐
	• Do you agree that the nurse and secondary care doctor on CCG governing bodies be able to come from local providers?	☐	☐	☐	☐	☐
	• Do you agree that there should be greater flexibility for CCGs and NHS providers to make joint appointments?	☐	☐	☐	☐	☐
7. Shared responsibility for the NHS	• Do you agree that NHS commissioners and providers should have a shared duty to promote the 'triple aim' of better health for everyone, better care for all patients and to use NHS resources efficiently?	☐	☐	☐	☐	☐
8. Planning our services together	• Do you agree that it should be easier for NHS England and CCGs to work together to commission care?	☐	☐	☐	☐	☐
9. Joined-up national leadership	• Which of these options to join up national leadership do you prefer? a) combine NHS England and NHS Improvement b) provide flexibility for NHS England and NHS Improvement to work more closely together c) neither of the above			☐ ☐ ☐		
	• Do you agree that the Secretary of State should have power to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs, with appropriate safeguards	☐	☐	☐	☐	☐

[Optional]
Detailed comments

If you have any specific comments or additional information to provide, please provide in the relevant text box.

1. **Promoting collaboration.** This includes the following proposals:
    a. Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts
    b. Remove NHS Improvement's competition powers and its general duty to prevent anti-competitive behaviour
    c. Remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA

2. **Getting better value for the NHS.** This includes the following proposals:
    a. Revoke regulations made under section 75 of the Health and Social Care Act 2012 and repeal powers in primary legislation under which they are made, subject to a new best value test
    b. Remove arrangements between NHS commissioners and NHS providers from the scope of the Public Contracts Regulations, subject to a new best value test

3. **Increasing the flexibility of national NHS payment systems**. This includes the following proposals:
    a. Remove the power to apply to NHS Improvement to make local modifications to tariff prices, once ICSs are fully developed
    b. Enable the national tariff to include prices for 'section 7A' public health services
    c. Enable national prices to be set as a formula rather than a fixed value, so prices can reflect local factors
    d. Enable national prices to be applied only in specified circumstances
    e. Enable selected adjustments to tariff provisions to be made within a tariff period (subject to consultation)

4. **Integrating care provision.** Enable the Secretary of State to set up new NHS trusts to provide integrated care.

5. **Managing the NHS's resources better.** This includes the following proposals:
   a. Give NHS Improvement targeted powers to direct mergers involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits
   b. Give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts

6. **Every part of the NHS working together.** This includes the following proposals:
   a. Enable CCGs and NHS providers to create joint committees
   b. Give NHS England powers to set guidance on the formation and governance of joint committees and the decisions that could appropriately be delegated to them
   c. Allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers
   d. Enable CCGs and NHS providers to make joint appointments

7. **Shared responsibility for the NHS.** Create a new shared duty for all NHS organisations to promote the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS

8. **Planning our services together.** This includes the following proposals:
   a. Enable groups of CCGs to collaborate to arrange services for their combined populations
   b. Allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'
   c. Enable groups of CCGs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions
   d. Enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement, or to delegate the commissioning of these services to groups of CCGs
   e. Enable NHS England to enter into formal joint commissioning arrangements with CCGs for specialised services

9. **Joined up national leadership.** This includes the following proposals:
   a. Bring NHS England and NHS Improvement together more closely, either by combining the organisations or providing more flexibility for them to work closely together
   b. Enable wider collaboration between ALBs

Beyond what you've outlined above, are there any aspects of this engagement document you feel have an impact on equality considerations?

Other comments?

Name……

In what capacity are you responding? [Please tick]

Academic institute	**[ ]**
Charity, patient representative organisation or voluntary organisation	**[ ]**
Clinical Commissioning Group	**[ ]**
Clinician	**[ ]**
Commercial organisation	**[ ]**
Family member, friend or carer of patient	**[ ]**
General Practitioner	**[ ]**
Healthcare professional	**[ ]**
ICS/STP representative	**[ ]**
Independent provider organisation	**[ ]**
Industry body	**[ ]**
Local authority	**[ ]**
Member of the public	**[ ]**
NHS foundation trust	**[ ]**
NHS national body	**[ ]**
NHS non-clinical staff	**[ ]**
NHS trust	**[ ]**
Patient	**[ ]**
Professional representative body	**[ ]**
Regulator	**[ ]**
Think tank	**[ ]**
Trade Union	**[ ]**
Other [Please specify]……	**[ ]**

Are you responding on behalf of an organisation? Y [ ] / N [ ]

Organisation name……

Email……..

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 David Coleman, Chief Legal Officer

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 April 2019**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary:

This item enables the Committee to consider and comment on the content of its work programme, which is reviewed at each meeting of the Committee so that its content is relevant and will add value to the work of the Council and its partners in the NHS. Members are encouraged to highlight items that could be included for consideration in the work programme.

Actions Required:

To review, consider and comment on the work programme set out in the report.

1. Work Programme

The items listed for today's meeting are set out below: -

17 April 2019 – 10 am	
Item	*Contributor*
Update on Lincolnshire Partnership NHS Foundation Trust Services (including the Older Adults Mental Health Home Treatment Team)	Jane Marshall, Director of Strategy, and Chris Higgins, Deputy Director of Operations, Lincolnshire Partnership NHS Foundation Trust
East Midlands Ambulance Service NHS Trust - Lincolnshire Division Update	Mike Naylor, Director of Finance, East Midlands Ambulance Service NHS Trust Sue Cousland, General Manager – Lincolnshire Division - East Midlands Ambulance Service NHS Trust

17 April 2019 – 10 am	
Item	*Contributor*
Implementing the NHS Long Term Plan: Proposals for Possible Changes to Legislation – Draft Response of Health Scrutiny Committee	Simon Evans, Health Scrutiny Officer

Planned items for the Health Scrutiny Committee for Lincolnshire are set out below:

15 May 2019 – 10 am	
Item	*Contributor*
Healthy Conversation 2019: Urgent and Emergency Care	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Healthy Conversation 2019: Stroke Services	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Healthy Conversation 2019: General Progress Update	John Turner, Accountable Officer, Lincolnshire CCGs.
Clinical Commissioning Group Management Arrangements	John Turner, Accountable Officer, Lincolnshire CCGs.

12 June 2019 – 10 am	
Item	*Contributor*
Healthy Conversation 2019 Women's and Children's Services	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Healthy Conversation 2019 Breast Services	Representatives from the Lincolnshire Sustainability and Transformation Partnership
United Lincolnshire Hospitals NHS Trust: Women and Children's Services Update	Senior Management Representatives from United Lincolnshire Hospitals NHS Trust
United Lincolnshire Hospitals NHS Trust: Care Quality Commission Update	Senior Management Representatives from United Lincolnshire Hospitals NHS Trust
Non-Emergency Patient Transport	Tim Fowler, Director of Contracting, Lincolnshire West Clinical Commissioning Group Mike Casey, Director of Operations, Thames Ambulance Service

10 July 2019 – 10 am	
Item	*Contributor*
Healthy Conversation 2019 – Mental Health	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Healthy Conversation 2019 – Trauma and Orthopaedics	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Winter Resilience – Review of 2018-19	To be advised
General Practice – Access and Demand	Dr Kieran Sharrock, Medical Director, Lincolnshire Local Medical Committee

18 September 2019 – 10 am	
Item	*Contributor*
Healthy Conversation 2019 – Haematology	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Healthy Conversation 2019 – Oncology	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Delivery of the NHS England National Cancer Strategy in Lincolnshire - Update	To be advised

16 October 2019 – 10 am	
Item	*Contributor*
Healthy Conversation 2019 – Grantham Acute Medicine	Representatives from the Lincolnshire Sustainability and Transformation Partnership
Healthy Conversation 2019 – General Surgery	Representatives from the Lincolnshire Sustainability and Transformation Partnership

<u>Items to be Programmed</u>

- Developer and Planning Contributions for NHS Provision
- Joint Health and Wellbeing Strategy Update
- CCG Role in Prevention
- Lincolnshire Sustainability and Transformation Plan / Acute Services Review – Formal Consultation Elements

Appendix A to the report sets out the previous work undertaken by the Committee in a table format.

Conclusion

The Committee's work programme for the coming year is set out above. The Committee is invited to review, consider and comment on the work programme and highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

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, Health Scrutiny Officer, who can be contacted on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
AT-A-GLANCE WORK PROGRAMME

	2017						2018											2019				
KEY ✓ Substantive Item α Chairman's Announcement Planned Item	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec	23 Jan	20 Feb	20 Mar	17 Apr	15 May
Meeting Length - Minutes	170	225	185	170	205	230	276	280	270	230	244	233	188	280	160	275	185	200	150	265		
Cancer Care																						
General Provision																✓						
Head and Neck Cancers														α					α			
Care Quality Commission																						
General																			α			
Clinical Commissioning Groups																						
Annual Assessment														α								
Lincolnshire East																✓						
Lincolnshire West															✓							
South Lincolnshire																	✓					
South West Lincolnshire																	✓					
Community Maternity Hubs								α														
Community Pain Management												α								α		
Dental Services							✓		α								α	α		✓		
GPs and Primary Care:																						
Extended GP Opening Hours								α			α				α							
GP Recruitment			α		α																	
Lincoln GP Surgeries		α		α																		
Lincoln Walk-in Centre		✓	α	✓		✓		✓			✓											
Louth GP Surgeries		α	α																			
Out of Hours Service														α								
Sleaford Medical Group									α													
Spalding GP Provision														α								
Grantham Minor Injuries Service												α	✓	α								
Health and Wellbeing Board:																						
Annual Report												α										
Joint Health and Wellbeing Strategy		✓						✓														
Pharmaceutical Needs Assessment					✓		✓															
Health Scrutiny Committee Role	✓																					
Healthwatch Lincolnshire											α		α		α							
Lincolnshire Community Health Services NHS Trust																						
Care Quality Commission													α		α							
Learning Disability Specialist Care				✓									✓									
Lincolnshire Sustainability & Transformation Partnership / Healthy Conversation 2019																						
General / Strategic Items				✓			✓				α	✓	α	✓			✓		✓	✓		
GP Forward View										✓												
Integrated Community Care										✓						✓						
Mental Health								✓							✓	α						
NHS Long Term Plan																α	✓	✓	✓			
Operational Efficiency									✓													
Stroke Services																						
Urgent and Emergency Care									✓							✓						

	2017						2018												2019				
KEY ✓ Substantive Item α Chairman's Announcement Planned Item	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec	23 Jan	20 Feb	20 Mar	17 Apr	15 May
Lincolnshire Partnership NHS Foundation Trust:																							
General Update / CQC		✓																α				
Older Adults Services																					✓	
Psychiatric Clinical Decisions Unit							α															
Lincolnshire Reablement & Assessment Service																	α					
Local Government Elections																			α			
Louth County Hospital														α	✓		α					
Northern Lincolnshire and Goole NHS Foundation Trust			α												α			α				
North West Anglia NHS Foundation Trust							✓									α				✓		
Organisational Developments:																							
CCG Joint Working Arrangements													✓	α				α					
Integrated Care Provider Contract														α	✓								
National Centre for Rural Care													α					α					
NHSE and NHSI Joint Working												α						α					
Lincoln Medical School			α														α						
Patient Transport:																							
Ambulance Commissioning			✓																				
East Midlands Ambulance Service			✓		α					✓	α	α	α	✓		α	α				✓		
Non-Emergency Patient Transport						✓	α	✓	✓	✓		✓	α	✓	α	α	✓	✓	✓	✓			
Sleaford Ambulance & Fire Station											α		α										
Public Health:																							
Child Obesity												α	α										
Director of Public Health Report												✓											
Immunisation					✓																		
Influenza Vaccination Programme																	α						
Pharmacy			α																				
Renal Dialysis Services														✓									
Quality Accounts	✓								✓											✓			
United Lincolnshire Hospitals NHS Trust:																							
A&E Funding		α																					
Introduction	✓																						
Care Quality Commission		✓										α	α	✓				✓	α	✓			
Children/Young People Services											✓	✓	✓	✓		✓	α	✓		✓			
Financial Special Measures			α		✓					✓													
Grantham A&E			✓				✓	α						α	α	α		✓	✓				
Orthopaedics and Trauma												α		α					α				
Stroke Services																		α					
Winter Resilience					α	✓	α	α			✓				✓								