Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 12 January 2017**

Time: **10.00am**

Venue: **Edwards Room, County Hall, Norwich**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties who have indicated to the Committee Administrator, Timothy Shaw (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr R Bearman	Ms E Morgan	Norfolk County Council
Mr M Carttiss	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mr G Williams	*Vacancy*	North Norfolk District Council
Ms E Corlett	Ms S Whitaker	Norfolk County Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Dr K Maguire	Ms L Grahame	Norwich City Council
Mrs M Stone	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs S Weymouth	Mrs M Fairhead	Great Yarmouth Borough Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council

Mrs S Young Mr T Smith King's Lynn and West Norfolk Borough Council

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Tim Shaw on 01603 222948
or email timothy.shaw@norfolk.gov.uk

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1. To receive apologies and details of any substitute members attending

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 8 December 2016. (Page 5)

3. Members to declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter.

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects:

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role

- that of another public body of which you are a member to a greater extent than others in your ward.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4. **To receive any items of business which the Chairman decides should be considered as a matter of urgency**

5. **Chairman's announcements**

6. **10.10 – 11.45** **Community pharmacy** (Page 13)

Appendix A – Report from commissioners NHS England Midlands and East (East) (Page 18)

Appendix B – Report from Norfolk County Council Public Health (Page 23)

Appendix C – Report from the Local Pharmaceutical Committee (Page 24)

11.45 – 11.55 **Break at the Chairman's discretion**

7. **11.55 – 12.30** **Norfolk and Waveney Sustainability & Transformation Plan – NHOSC's comments** (Page 33)

To agree the committee's comments to the Norfolk and Waveney STP Executive Board following the meeting with representatives on 8 December 2016.

8. **12.30 – 12.40** **Forward work programme** (Page 37)

Glossary of Terms and Abbreviations (Page 40)

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Head of Democratic Services

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Date Agenda Published: 4 January 2017

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 8 December 2016

Present:

Mr R Bearman	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Ms E Corlett	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Dr K Maguire	Norwich City Council
Mrs M Stone	Norfolk County Council
Mr G Williams	North Norfolk District Council
Mrs S Young	King's Lynn and West Norfolk Borough Council

Also Present:

Michael Ladd	Member of Suffolk Health Scrutiny Committee
Bert Poole	Member of Suffolk Health Scrutiny Committee
Wendy Thomson	Managing Director of Norfolk County Council and the Lead for the N&W STP
Roisin Fallon-Williams	Chief Executive, Norfolk Community Health and Care NHS Trust
Oli Matthews	Head of Strategy and Business Development, Norfolk and Suffolk Foundation Trust
Jan McLachlan	NHS Norfolk Action Group
Heather Edmondson	NHS Norfolk Action Group
Susan Bourne	NHS Norfolk Action Group
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mr C Aldred, Mrs S Weymouth and Mr P Wilkinson.

2. Minutes

The minutes of the previous meeting held on 13 October 2016 were confirmed by the Committee and signed by the Chairman.

3. **Declaration of Interest**

3.1 There were no declarations of interest.

4. **Urgent Business**

There were no items of urgent business.

5. Chairman's Announcements

5.1 Film recording of the meeting

The Chairman pointed out that a member of the public would be taking a film recording of today's proceedings. This met with the Council's protocol on the use of media equipment at meetings held in public.

5.2 **Welcome to Mr Glyn Williams, North Norfolk District Council member of NHOSC**

The Chairman welcomed to the meeting Mr Glyn Williams who was attending his first meeting as the North Norfolk District Council member of the Norfolk Health Overview and Scrutiny Committee.

5.3 **Welcome to Mr Michael Ladd and Mr Bert Poole from Suffolk Health Scrutiny Committee**

The Chairman welcomed to the meeting Mr Michael Ladd, who represented the Kessingland and Southwold division on Suffolk County Council and was the Chairman of Suffolk Health Scrutiny Committee and Mr Bert Poole who represented the Oulton division on Suffolk County Council and was a member of the Suffolk Health Scrutiny Committee.

The Committee was informed that Mr Michael Ladd and Mr Bert Poole (together with Mrs Alison Cackett, the Waveney District Council Member of Suffolk Health Scrutiny Committee who had given her apologies) were invited to attend today's meeting to ask questions and make comments during the Norfolk and Waveney Sustainability & Transformation Plan (STP) item.

The Chairman added that the input of Mr Ladd and Mr Poole would be taken into account in any formal comments or recommendations that Norfolk Health Overview and Scrutiny Committee might wish to make to the STP Executive Board at this stage in the process. The Suffolk Councillors were not joining with the Committee in the formal sense of establishing a joint health scrutiny committee and they did not have voting rights at this meeting. That was not felt to be necessary at this stage because the STP was still a high level strategic plan and there were no specific proposals for substantial changes on the ground as yet.

6 **Norfolk and Waveney Sustainability and Transformation Plan**

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to the Norfolk and Waveney Sustainability and Transformation Plan (STP) which was being jointly developed by all the health and social care organisations in the area.

6.2 The Committee received a detailed presentation about the Sustainability and Transformation Plan (STP) for Norfolk and Waveney, which was submitted to NHS England in October 2016 (note: the STP timetable is listed in these minutes), along with a summary document "In Good Health - our proposals for changing health and social care in Norfolk and Waveney why health and social care services in Norfolk and Waveney needed to change", from Dr Wendy Thomson, Managing Director of Norfolk County Council and the Lead for the N&W STP. The presentation can be found on the County Council's committee pages website.

6.3 The Committee also received evidence from Mrs Roisin Fallon-Williams, Chief Executive, Norfolk Community Health and Care NHS Trust and Mr Oli Matthews, Head of Strategy and Business Development, Norfolk and Suffolk Foundation Trust.

6.4 In addition, the Committee heard from Michael Ladd and Mr Bert Poole, Members of Suffolk Health Scrutiny Committee (who were introduced at the start of the meeting) and three members of the public who, at the discretion of the Chairman, were allowed to make comments and raise questions about the STP.

6.5 The following key points were noted:

- The Committee was informed that Sustainability and Transformation Plans (STPs) were being introduced across the country as a delivery mechanism for the NHS Five Year Forward View (5YFV).
- The purpose of the STP was to provide a focused strategy over five years (up to March 2021) to tackle the fundamental issues facing the local health and care system, resulting in an affordable, high quality service that was effective in meeting the needs of the local population into the future.
- The Norfolk and Waveney geographic 'footprint' was covered by a single STP, with the rationale being that it was important for the "footprint" to reflect the geography of the county of Norfolk as well as that of the Great Yarmouth and Waveney CCG area.
- Of the country's 44 STPs, only four (including that for the Norfolk and Waveney area) were led at Local Government level.
- The County Council was represented on the STP Executive Board by the Managing Director (who was the nominated lead for the Norfolk and Waveney STP), the Director of Public Health and the Acting Executive Director of Adult Social Services.
- Reference was made during the meeting to the fact that an integrated health and adult social care manager was a member of Norfolk Community Health and Care NHS Trust's Board. Members asked for consideration to be given to the suggestion that an integrated health and children's social care manager should also be included on the Norfolk Community Health and Care NHS Trust's Board.
- In reply to questions it was pointed out that the STP had not originally been written with the intention of it becoming a public document.
- A public report about the STP had, however, been presented to the County Council at its meeting on 17 October 2016.
- The County Council had endorsed the overall strategic direction of the Norfolk and Waveney STP and the key areas for change for submission to NHS England by the 21 October 2016 deadline and had supported the ongoing work with partners in moving to the next stages of detailed planning.
- The STP timetable was:
    - June 30 2016 – initial submission to NHS England
    - August 15 – KPMG engaged
    - October 7 – Publication of "In Good Health" and June submission

    - October 17 to 21 – Council, all Trust Boards, HWB and CCG Governing Body meetings
    - October 21 – Submission to NHS England
    - November to December – Wider engagement and detailed planning
    - November 24 – Submission of full draft 2017/18 to 2018/19 Operating Plans
    - December 23 2016 – Submission of final 2017/18 to 2018/19 Operating Plans and signed contracts
- It was pointed out that the Norfolk and Waveney STP documents could be found on the Healthwatch Norfolk website.
- Comments about how the STP should be developed and what might be included in it could be left on the Healthwatch Norfolk website until 22 January 2016.
- The public were also encouraged to make comments about the STP to their local County and District Councilors.
- Members were able to make detailed comments to Maureen Orr, Democratic Support and Scrutiny Team Manager.
- Local stakeholder meetings about the STP were being planned across the Norfolk and Waveney area and details would be posted on the Healthwatch website when they became available.
- Dr Wendy Thomson and Mrs Roisin Fallon-Williams outlined how health and social care partners in Norfolk and Waveney (including the Chief Executives of the Borough, City and District Councils) were defining the issues included in the STP, and the approaches that were being developed to tackle them.
- The Committee was informed that the STP would be a major strategic initiative that provided the "blueprint" for the development of services, but care was being taken to ensure that it developed alongside and enhanced the delivery of existing strategies (the Health and Wellbeing Strategy was one such example).
- In reply to questions, the speakers spoke about how the STP would not only build on the Health and Wellbeing strategies in Norfolk and Waveney but would also provide the basis for a focused approach to targeted health and social care interventions where they were considered to be most effective (for example, in providing a long term approach to issues of child obesity and support for children attending school with special educational needs; issues which Mr Ladd and Mr Poole regarded to be of the highest importance).
- It was suggested by Members of the Committee that the STP should be developed alongside other Central and Local Government and NHS strategies (such as the Government's plans for 7 day working in all sectors of the NHS and the operating plans of the NHS which were not directly a part of the STP).
- Breaking down barriers in the provision of care was seen by Members as fundamental to success, particularly between GPs and hospitals, physical and mental health and between health and social care.
- The co-location of health and social care staff in the west of the county was another example of the cooperation between health and social care that was currently being addressed.
- The financial position was such that the health and social care system could not be sustained without a significant shift to more efficient ways of delivering services.
- It was pointed out by the speakers that there would not be enough professional medical and care staff to meet the rising demand through the traditional services provided now, and the gap between the money available and the cost of providing NHS and social care in Norfolk and Waveney would

rise to just over £415m in five years' time unless something was done now to balance the 'whole system'.

- It was pointed out that NHS England was seeking bids to enable common elements of the STPs to proceed throughout the country.
- It was suggested by Members that in addition to looking to design the whole system approach around the amount of money that was available emphasis should be placed on the importance of lobbying Government at the political level for additional resources to fill funding gaps.
- Lobbying Government for legislative changes to support health and social care policies was also considered important, for example so that changes could be made in the trading practices of supermarkets that lead to improvements in lifestyle choices.
- It was suggested by Members that it might take significantly longer than the 5 year timescale of the STP before the fundamental changes that the STP intended to bring about were viewed by the public as a success or a failure.
- There were questions around how acute services would be able to continue to meet demand before the real improvements to the public's health materialised. There would for example be a time lag between investing in public health and actually improving health to the extent of being able to cut demand for acute beds by 35%.
- The speakers spoke about how primary care and community services (both health and social care) had little or no capacity as currently provided to meet expanding levels of demand.
- Demand, based on the health needs of the population, would grow significantly without intervention, with the population of over-85s forecast to rise significantly between now and 2021.
- Demographic factors drove demand for services for people with learning disabilities and physical disabilities and demand for these services, which involved complex care packages, was rising.
- The result was a health and care system that faced serious challenges in providing the best and most effective care to the population unless the situation was addressed as a "whole system" approach where both health and social care acted together.
- Across the "whole system" there were workforce challenges such as overall shortages of some specialist skills, difficulties in recruiting or retaining staff in some parts of the county, as well as fundamental challenges that arose from having to find new ways to tackle diabetes, reduce admissions to A and E and provide health and social care support in the home environment.
- It was pointed out that different commissioners and providers of services were currently working to different sets of standards and care protocols.
- Members asked to be provided with the details of where the public could find the Norfolk and Waveney CCGs' single set of commissioning intentions.
- It was pointed out that joint commissioning was not being considered at this stage in the STP process but could be considered for the future.
- In the meantime the STP would help provide a mechanism for new forms of working that mean staff in both organisations worked together closer than they had before.
- In order to make improvements in ICT shared services, a senior officer lead for the ICT elements of the STP was considered to be important.
- There was a recognition that people with mental health problems did not have access to health services on a parity with the population as a whole, resulting in significantly shorter life expectancy, and often inappropriate treatment. It was intended that, by integrating mental health services with other services, these inequalities would be addressed.

- Members said that providing greater public access to therapies that tackled mental health issues should be addressed as a strategic issue.
- It was pointed out that the STP aimed to support cultural/ social changes in society in relation to issues such as smoking and choice of food and drink and the need for exercise. The STP also recognised the importance of public open spaces in urban areas and the work of the Borough, District and City Councils.
- The speakers agreed that the reference in the STP to resilience training for staff should be carefully reworded so that it related to specific areas of staff retraining and was not seen as referring to the whole workforce.
- It was agreed that Mrs Lana Hempsall should be provided with information on progress with provision of housing with care on a site in Acle.
- It was pointed out that the impact of the STP on third sector organisations should not be lost.
- Heather Edmondson, a member of the public, spoke about how she considered five CCGs for Norfolk and Waveney to be wasteful and how money could be saved by having one commissioner for health services. She was concerned about the lack of focus on mental health in the plans to date. She considered it essential that safe crisis services were there across the county. She said that money saved from reducing CCGs could be used to fund the mind out-of-hours crisis line, and extend it to the whole of Norfolk and Waveney which saved money from 999 services and A&E.
- Susan Bourne, a member of the public and retired GP, spoke about the importance of maintaining good relations with NHS and social care staff.
- Jan McLacklan, a member of the public, spoke about the importance of maintaining good staff relations throughout health and social care and about not seeking answers by the privatisation of NHS services.
- In reply, the speakers said that they fully understood the importance of maintaining good staff relations and welcomed comments from anyone on how the STP could be improved. The STP included no mention of the privatisation of NHS services and there were no plans in that direction.
- The Chairman said that any specific proposals for substantial changes to health services that might emerge at a later date would be subject to consultation with health scrutiny in the usual way. Depending on the 'footprint' of the proposed change, they would be dealt with by Norfolk HOSC, Suffolk HSC or Great Yarmouth and Waveney HSC.

6.4 The Committee noted the information contained in the STP and that provided by the speakers during the meeting.

6.5 It was agreed that a report based on the comments made in today's meeting would be produced and circulated to NHOSC Members prior to submission to the STP Executive Board.

7. Forward Work Programme

7.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Team Manager, that set out a proposed forward work programme for the remainder of 2016/17.

7.2 The forward work programme was agreed with the addition of an update on the Department of Health's progress with the new Primary Care Education and Training Tariff to be included in the NHOSC Briefing in October 2017 (i.e. approximately a year after Members' informal meeting with Mr I Newton from the DoH).

7.3 Mr Kevin Maguire had further questions he wished to raise with Norfolk and Suffolk NHS Foundation Trust (NSFT) to seek clarification on the responses it provided in its letter of 28 October 2016 in response to questions raised following NHOSC on 8 September 2016. It was agreed that Mr Maguire and Ms Emma Corlett would provide more context on why it was important that further questions were raised with the NSFT.

7.4 It was also agreed that the additional questions to the NSFT would be circulated to NHOSC members before they were sent to the Trust.

Chairman

The meeting concluded at 13:10 pm

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Community pharmacy

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

NHS England Midlands and East (East) will attend to answer the committee's questions on local implementation of national reforms to the community pharmacy sector.

1. Background

1.1 In 14 April 2016 edition of the Norfolk Health Overview and Scrutiny Committee (NHOSC) Briefing Members received information from Norfolk Local Pharmaceutical Committee about government proposals for community pharmacy in England and the potential effect on services. It was suggested that as many as 3,000 pharmacies, a quarter of the pharmacies in England, could close. Given the concerns about the impact of the proposals on local people, NHOSC agreed to add the subject to its forward work programme for autumn 2016.

1.2 In September 2016 it was reported that the new Parliamentary Under Secretary of State at the Department of Health with responsibility for pharmacy intended to look again at the proposals for community pharmacy and that the plans would therefore not progress as soon as originally thought. NHOSC agreed to put the subject back to today's agenda.

2. Reforms to Community Pharmacy

2.1 The reforms to community pharmacy are taking place in the context of the £22bn efficiency savings that the NHS has to deliver by 2020-21. The Department of Health's (DoH) stated objective was to ensure that the expected efficiency savings in delivering community pharmacy services result in cost savings to the NHS while ensuring that patient health is not jeopardised, and minimising impacts on travel times to access community pharmacy services.

2.2 On 20 October 2016 the DoH published 'Community pharmacy in 2016/17 and beyond: final package', which explains the package of reforms, including changes to the community pharmacy contractual framework. The final package document, an impact assessment and other related documents are available via the link below:-
https://www.gov.uk/government/publications/community-pharmacy-reforms#history

2.3 The funding settlement announced for community pharmacy in England from 1 December 2016 represented a 4% reduction in funding in 2016-17 (in effect a 12% reduction in the final four months of 2016-17) and a further 3.4 % reduction in 2017-18. The final package document also included a range of changes affecting community pharmacy income including (in summary):-

- The proposed phasing out of the community pharmacies establishment payment by the end of 2019/20. Community pharmacies currently receive an establishment payment as long as they dispense above a certain prescription volume.

- A new Pharmacy Access Scheme (PhAS) to support access where pharmacies are sparsely spread and patients depend on them most. A pharmacy will be eligible for PhAS if it meets certain criteria, one of which is that it must be a mile away from its nearest pharmacy by road.

- A quality scheme which makes payments available to community pharmacies that meet certain quality criteria.

- Piloting of a national urgent medicines supply service, where people calling NHS 111 requiring urgent repeat medicines will be referred directly to community pharmacies.

- Future changes to some areas of the reimbursement of pharmacies for prescriptions.

- Work on introducing changes to regulations on market entry to prevent a new pharmacy stepping in straight away as a chain closes a branch or two pharmacy businesses merge and one closes.

- The intention to improve facilities for patients to order prescriptions digitally and to explore new terms of service for distance-selling pharmacies.

- Work to embed pharmacy into the urgent care pathway by expanding the services already provided by community pharmacies in England for those who need urgent repeat prescriptions and treatment for urgent minor ailments and common conditions.

There was no indication on funding for community pharmacy beyond 2018 and funding for the PhAS beyond 2018 is also uncertain.

2.4 The Department of Health's impact assessment says 'there is no reliable way of estimating the number of pharmacies that may close as a result of this policy'.

2.5 The subject of community pharmacy was debated in Parliament on 17th and 20th October 2016. The following links will take you to the Hansard records:-

https://hansard.parliament.uk/Commons/2016-10-17/debates/FBA2FB13-78EF-4A08-A0AE-A6E799D76DD1/CommunityPharmacies?highlight=Community%20pharmacy#contribution-240CE6F2-CFA4-49B7-B428-E290A7DF87C2

https://hansard.parliament.uk/search?searchTerm=community%20pharmacy

3. Purpose of today's meeting

3.1 Local NHS community pharmacy services are commissioned by the NHS England, not by local Clinical Commissioning Groups. NHS England Midlands and East (East) has provided the paper attached at **Appendix A** summarising the package of reforms, the rationale for making them, the process for implementing them in Norfolk and the implications for service users. Representatives of NHS England Midlands and East (East) will attend to answer Members' questions.

3.2 The Health and Social Care Act 2012 required Health and Wellbeing Boards to produce a Pharmaceutical Needs Assessment (PNA). The most recent PNA for Norfolk, published in 2015, is available on the County Council website:-
https://www.norfolk.gov.uk/what-we-do-and-how-we-work/policy-performance-and-partnerships/partnerships/health-partnerships/health-and-wellbeing-board/needs-assessments

The PNA concluded that the number and distribution of pharmaceutical service provision in Norfolk was adequate and there was no need for more pharmaceutical providers in the county. A key recommendation was that commissioners should continue to explore the potential sustainable services that could be commissioned from existing community pharmacies that would contribute to improving the health of Norfolk's population and / or that would contribute to reducing pressures elsewhere in the health system.

Norfolk County Council Public Health has a role in producing the PNA and has provided the paper attached at **Appendix B** regarding the process of predicting pharmaceutical needs and the relationship with the commissioners of NHS community pharmacy services. A representative from Public Health will attend the meeting to answer questions on the implications of the reforms in the light of the PNA.

3.3 Norfolk Local Pharmaceutical Committee (LPC) has provided the paper at **Appendix C** giving its perspective on the implications of the reforms and the Chief Officer of the LPC has been invited to attend the meeting.

A representative of Norfolk and Waveney Local Medical Committee (LMC) has also been invited to the meeting to give the GPs perspective on the community pharmacy reforms.

4. Suggested approach

4.1 After the representatives from NHS England Midlands and East (East), Norfolk County Council Public Health and the Norfolk Local Pharmaceutical

Committee have presented their reports, the committee may wish to discuss the following areas with them:-

(a) The Norfolk LPC says the community pharmacy reforms are likely to lead to pharmacies in Norfolk having to reduce staffing, cut opening hours and reduce the services offered, which would add to the pressure on GPs and hospitals. Has NHS England Midlands & East (East) conducted a local impact assessment regarding the potential effects on the wider health and care system in Norfolk?

(b) The Department of Health estimates that there was a rise of about 20% in the number of pharmacies it funded between 2003 and 2015 and it says that too many community pharmacies are too close to each other, with 40% located in clusters of three or more within a 10-minute walk of each other. Is the national pattern replicated in Norfolk? How much of the increase in pharmacy provision can be put down to increased demand within the healthcare system?

(c) It appears that less than one fifth of community pharmacies in Norfolk qualify for the Pharmacy Access Scheme (PhAS). Is the support under the PhAS scheme enough to ensure that these pharmacies are sustainable for the future?

(d) Norfolk and Waveney Sustainability & Transformation Plan (N&W STP) includes a priority project for 'Pharmacy support: employing pharmacists to work as part of the primary care team assisting with prescriptions, day-to-day medicine issues & consultations where appropriate'. How does this fit with the reforms to community pharmacy?

(e) One of the aims of the local healthcare system is to reduce the demand on NHS acute services. Do the commissioners consider that the reforms to community pharmacy will help achieve that aim?

(f) It is understood that changes to the community pharmacy contract have been made nationally, but do local commissioners (i.e. NHS England Midlands & East (East)) have flexibility to respond to identified local issues? (e.g. to allow PhAS funding for several pharmacies in a market town service a large rural area population as well as the town; to continue with the locally commissioned urgent medicines supply service rather than introduce the national one).

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Norfolk Health Overview and Scrutiny Committee
12 January 2017
Item no 6

Appendix A

Community pharmacy
NHS England

The NHS Five Year Forward View sets out a clear direction for the NHS, building on its strengths and rising to the challenges of the future. These include responding to changes in patients' health needs, expectations and personal preferences; rapid developments in treatment, technologies and care delivery; and transformational change through new models of care to improve patient outcomes.

There is general acceptance that there is real potential for far greater use of community pharmacy and pharmacists: in prevention of ill health; support for healthy living; support for self-care and long term conditions; medication reviews and as part of more integrated local care models. To achieve these aspirations, a more clinically focussed community pharmacy service is needed that is better integrated with other parts of primary care.

Following the announcement by the Department of Health of the Changes to the Community Pharmacy Contractual Framework for 2016-2018, the responsibility for implementation belongs to NHS England.

The primary objective is to increase the health gains realised from the NHS budget, by ensuring that expected efficiency savings in delivering community pharmacy services result in cost savings to the NHS that can be reinvested in Health services in other parts of the NHS - while ensuring that pharmaceutical services are not jeopardised, and minimising impacts on travel times to access community pharmacy services

The Department of Health has set the funding for community pharmacy at:-

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

This represents a 4% reduction in funding in 2016/17 followed by a further reduction in 2017/18 The Government believes those efficiencies can be made within community pharmacy without comprising the quality of services or public access to them. In some parts of the country there are more pharmacies than are necessary to maintain good access. 40% of pharmacies are in a cluster where there are three or more pharmacies within ten minutes' walk

As part of the contractual framework additional schemes are to be introduced

- Pharmacy Access Scheme
- Quality Payments Scheme
- NUMSAS (NHS urgent medicines supply advanced service)
- Pharmacy Integration Scheme

Author: Sharon Gray
Date: 3.01.2017

Pharmacy Access Scheme

The PhAS will be an additional monthly payment made to all pharmacies that are not in the top quartile by dispensing volume that are a mile or more from another pharmacy. These payments will mean that those pharmacies make a smaller efficiency saving than other pharmacies, 1% in 2016/17 and 3% in 2017/18. Pharmacies dispensing the largest prescription volumes (the top 25%) will not qualify for the scheme – these pharmacies are large businesses and are expect to continue to be viable in any case.

The PhAS has been designed to capture the pharmacies that are most important for patient access, specifically those pharmacies where patient and public access would be materially affected should they close. The PhAS takes isolation and need levels into account.

The scheme will include a review process to deal with any inaccuracies in the calculations, or any unforeseen circumstances affecting access; like a road closure. We will also review cases where there may be a high level of deprivation, and pharmacies are slightly less than a mile from another pharmacy, but critical to access. This review is being undertaken by the National Pharmacy Team and community pharmacies should apply directly to them using the well-publicised national process.

Quality Payments Scheme

In addition to this scheme Pharmacies will be able to apply to participate in a Quality Payments Scheme. Up to £75 million will be available for this in 2017/18 – this would equate to payments of up to 1.395 million to CP is Norfolk. The Quality Payments Scheme will reward community pharmacies for delivering quality criteria in all three of the quality dimensions: Clinical Effectiveness, Patient Safety and Patient Experience.

The payment will depend on how many of the quality criteria the pharmacy achieves. The criteria have been weighted based on an assessment of the challenge of achievement and the benefit to patients from doing so. The criteria have been weighted based on an assessment of the challenge of achievement and the benefit to patients from doing so with each criterion being allocated a number of ‘points’

The Pharmacy will need to demonstrate that it complies with the gateway criteria to allow it to participate in the scheme there will then be a maximum of 100 points available which will have a financial value to the pharmacy.

Gateway Criteria are:

- the contractor must be offering at the pharmacy Medicines Use Review (MUR)
- or New Medicine Service (NMS); or must be registered for NHS Urgent Medicine Supply Advanced Service Pilot; and
- the NHS Choices entry for the pharmacy must be up to date; and

- pharmacy staff at the pharmacy must be able to send and receive NHS mail (Note: For the April 2017 review, evidence of application for an NHS mail account by 1 February 2017 will be acceptable); and
- the pharmacy contractor must be able to demonstrate ongoing utilisation of the Electronic Prescription Service at the pharmacy premises.

Quality Indicators showing available points. It is expected that each point will be £62.00 in value.

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

NHS urgent Medicines supply advanced service (NUMSAS)

Requests for medicines needed urgently account for about 2% of all completed NHS 111 calls. These calls normally default to a GP appointment to arrange an urgent prescription and as a result block access to GP appointments for patients with greater clinical need.

Patients contacting NHS 111 to request access to urgently needed medicines or appliances will be referred to a pharmacy that is providing this service for assessment and potentially the supply of a medicine or appliance previously prescribed for that patient on a NHS prescription, where the pharmacist deems that the requirements of HMR are met, e.g. the patient has immediate need for the medicine or appliance and that it is impractical to obtain a prescription without undue delay

Pharmacy Integration Fund (PhIF)

The Pharmacy Integration Fund will support community pharmacy as it develops new clinical pharmacy services, working practices and digital platforms to meet the public's expectations for a modern NHS community pharmacy service.

It follows the announcement of the Department of Health's new Community Pharmacy Contractual Framework and associated funding, and comprises a package of proposals for 2016- 2018.

The aim of the PhIF is to support the development of clinical pharmacy practice in a wider range of primary care settings, resulting in more integrated and effective NHS primary care for patients.

In particular, the fund will drive the greater use of community pharmacists and pharmacy technicians in new, integrated local care models.

This will improve access for patients, relieve the pressure on GPs and accident and emergency departments, ensure best use of medicines, drive better value and improve patient outcomes.

The initial priorities for the PhIF are:

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

Norfolk

In Norfolk there are 148 Community Pharmacies of which 25 pharmacies are eligible for the PhAS Pharmacy Access Scheme. These 25 pharmacies will be serving patients in an area where they are the only pharmacy within a mile and they are not in the top 25% of dispensers. The pharmacy access scheme payment will enable the pharmacy to continue to support patients in its locality.

In addition all pharmacies will be eligible for the Quality payments Scheme if they are compliant with the gateway criteria.

Pharmacies will be able to participate in the NUMSAS

Implications for service users.

The Department of health is confident that the impact to service users should be minimal. The PhAS should protect smaller isolated rural pharmacies.

There is duplication of service provision, with some towns having many pharmacies within a short walk of each other. Removing this duplication will produce efficiency savings to the NHS enabling this funding to be used more effectively without reducing the service available to patients.

Norfolk Pharmaceutical Needs Assessment (PNA)

From 1 April 2013, every Health and Wellbeing Board in England has a statutory responsibility to publish and keep an up to date statement of the needs for pharmaceutical services for the population in its area, referred to as a PNA. This is the main reference document upon which commissioning of pharmaceutical services decisions are made, including the granting of NHS pharmaceutical services contracts.

The current Norfolk PNA was published in March 2015 and was produced for the Norfolk Health and Wellbeing board by a PNA Steering Group, with multi-agency membership, reflecting the whole system approach required to producing and maintaining a PNA.

The group consulted resident and provider opinion and related current provision of pharmaceutical services to various indicators of need such as health status and access to services. Provision of pharmaceutical services was assessed against the demographic and health needs of the population of Norfolk, including projections of future demographic growth calculated by the Office of National Statistics (ONS).

The Norfolk PNA serves several key purposes:

- It is used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements;
- It helps target services to the areas where they are needed and limit duplication of services in areas where provision is adequate;
- It informs interested parties of the pharmaceutical needs in Norfolk and enable work to plan, develop and deliver pharmaceutical services for the population; and
- It informs commissioning decisions by local commissioning bodies including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs).

The Norfolk PNA 2015 concluded that the number and distribution of pharmaceutical service provision in Norfolk was adequate.

It is a requirement to publish a revised assessment when significant changes to the need for pharmaceutical services are identified, unless this is considered a disproportionate response, or every 3 years whichever is sooner.

Norfolk Local Pharmaceutical Committee

Report to the Norfolk Health Overview & Scrutiny Committee: Community Pharmacy in 2016/17 and Beyond: Final Package

1) On 20 October 2016 the DH imposed new contract on community pharmacies in England, the details of which are here: https://www.gov.uk/government/publications/community-pharmacy-reforms#history

This report explains, from the perspective of providers, some more background to this, and discusses the implications for community pharmacies in Norfolk, and potential impact on services for patients.

2) **The Value of Community Pharmacy**

The challenges facing the NHS are indeed significant. The Government has stated a need to save £22bn in efficiency savings by 2020/21.

It is therefore right and fair that all services come under scrutiny, and their value to the NHS be examined.

A PricewaterhouseCoopers (PwC) report published in September 2016 found that community pharmacies contributed a net value of £3 billion to the NHS, public sector, patients and wider society in England in 2015 through just 12 of its services. http://psnc.org.uk/wp-content/uploads/2016/09/The-value-of-community-pharmacy-detailed-report.pdf

Breaking the combined contribution down into the areas which are benefitting, it was found that:

•The NHS received a net value of £1,352 million, including cash savings as a result of cost efficiencies, and avoided NHS treatment costs;

•Other public sector bodies (e.g. local authorities) and wider society together received over £1 billion through increased output, avoided deaths and reduced pressure on other services such as social care and justice; and

•Patients received around £600 million, mainly in the form of reduced travel time to alternative NHS settings.

Norfolk Local Pharmaceutical Committee
Chief Officer: Tony Dean M.R.Pharm S.
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We would suggest, therefore, that community pharmacies save money for the NHS and would highlight to your Committee the positive impact on the local (health) economy.

Since the DH letter of 17 December 2015, the Pharmaceutical Services Negotiating Committee (PSNC), our national representative body, has sought to engage with the DH on producing a strategy for the next 5 years which achieves the required savings without the need for direct cuts to community pharmacy funding. PSNC have proposed the "Community pharmacy forward View" http://psnc.org.uk/wp-content/uploads/2016/08/CPFV-Exec-Summary-Aug-2016.pdf

Despite this, the contract imposed in October 2016 appears not to have taken any of these constructive proposals into account, and the final package is practically identical to that laid out in December 2015.

We believe the DH strategy is flawed in many respects, in terms of the lack of credible impact assessment, absence of an evidence-based approach, unfounded assumptions around the current efficiency of community pharmacies and the lack of recognition that changes are required across the health system to properly integrate community pharmacy.

There has been no due process for public consultation at all.

It may be noted that a petition containing well over 2 million signatures was handed in to No.10 in June 2016, the largest ever petition on a healthcare matter. The Government appear to have ignored this entirely.

3) The Funding Cuts and the Underlying DH Policy

- The imposition will reduce funding from December 2016 to March 2017 by 12% on current levels, to set funding for this year at £2.687bn.
- The imposition reduces funding for 2017-18 by 7.4% on current levels, to set funding at £2.592bn for that year.
- **The Pharmacy Access Scheme** (PhAS) will go *some* way to protect a minority of pharmacies, though those included will still face 3% cuts for the rest of 2016-17 and 3% cuts in 2017-18. The scheme will be paid for from the funding for the community pharmacy contractual framework (CPCF). There is no security that the scheme will continue beyond 2018, meaning that even this minority of pharmacies can have no confidence in the future.

Only 32 of the 168 pharmacies in Norfolk will qualify for the scheme. This is due to the fact that that the main qualifying criterion is that a pharmacy must be a mile or more from the nearest other pharmacy (by road). The “last minute” insertion of a clause that may allow inclusion of pharmacies 0.8-1.0 miles from another in areas of high deprivation will, we assess, make little or no difference in Norfolk.

The “one mile” rule is a crude and arbitrary criterion which clearly takes no account of actual need, local patient demography (including those with protected characteristics) or the ability to travel, access to public transport etc. The presence of two or three pharmacies in a large market town means that none will qualify for the scheme, despite the fact that these pharmacies actually serve an extremely wide area in which there is no other provision. In our coastal areas these pharmacies also are needed to cope with a massive seasonal influx of visitors. There is no way a single pharmacy in any of these locations could cope with these pressures, yet such pharmacies are considered no differently by the DH from those in the very few significant clusters in some parts of the country to which the DH is so fond of referring.

The DH appears to justify the much of this harmful policy on the statement that “40% of pharmacies are located in clusters of 3 or more within a 10 minute walk of each other, and thus an assumption that many can be closed without impact. In Norfolk, anything like such clustering can only be seen in a very few places such as the centre of Norwich and a part of Great Yarmouth. In September 2016 Durham University produced a study showing that more pharmacies are found in areas with the greatest health inequalities compared with more affluent areas, which surely is where we need them? But this too has been ignored by the Government.

It is true that there has been an increase in the number of pharmacies in Norfolk between 2005 and 2015, and that this increase is relatively greater than the population increase over that time. This is largely due to a change in market entry Regulations in 2005-2012 (which were widely opposed at the time by our representative groups) which introduced “exemptions” to the entry requirements e.g. for pharmacies opening 100 hours per week or more and for distance-selling pharmacies. Those Regulations also increased the importance of patient choice, something which appears to have now conveniently have disappeared from DH policy.

In Norfolk, however, unlike in a very few places nationally, this has not lead to common “gross clustering”, with these new pharmacies opening in areas of high patient need and/or extending access in a beneficial way. Those who have invested in these new pharmacies did so in good faith response to a DH-lead strategy. That some of these are now apparently being vilified is patently unfair.

We have a process for assessing the need for pharmaceutical services which thence informs the market entry process. This is the Pharmaceutical Needs Assessment (PNA), produced every 3 years and endorsed by the Health and Wellbeing Board (HWB). The 2014 PNA for Norfolk concluded that the number and distribution of pharmaceutical service provision in Norfolk was adequate.

The DH arbitrary determination that up to 3,000 pharmacies can close without significant patient impact is not backed with any supporting evidence. Norfolk LPC would question where this now leaves the PNA? There seems little point in a detailed local process to determine need, when those pharmacies are then put at risk by a blanket policy to cut funding and aimed at reducing pharmacy numbers without any reference to that need? There is no evidence that those which may be forced to close in the longer term will be those least needed. It is obvious to most that greatest impact will be felt by the smaller independents, without access to economies of scale or vertically integrated models of operation.

If the aim is to rationalise the distribution of community pharmacies in a strategic way to ensure maximum value for money while maintaining access and services for patients Norfolk LPC would simply ask “How does this imposition secure that?”

This DH “strategy” takes no account of the practicalities of the pharmacy network and the investment needed in it. Should a pharmacy close, or indeed just reduce services, there are few places where the remaining pharmacies could cope due to premises restrictions etc. We do not have access to NHS capital grants/loans to invest in new premises and staff development. All investment must come from independent businesses having confidence in the future. This imposition destroys confidence- we simply do not know what is happening to funding after 2018, other than to expect further cuts. No business can strategically or significantly invest in this climate.

4) **The Impact in Norfolk**

What little impact assessment the DH has conducted indicates merely that "there is no reliable way of estimating the number of pharmacies that may close as a result of this policy". Norfolk LPC would endorse that. We simply do not know.

This will depend on many factors, but mainly on each Contractor's ability to cope with upcoming severe cash flow issues, and their ability to cut costs. In the longer term we suspect it will be the uncertainty around longer term funding which will prove most damaging. Should 3,000 pharmacies NOT be closed, are we to expect longer-term cuts until they do?

In the shorter term Norfolk LPC does not feel it is constructive to overstate the likelihood of immediate mass closures. Contractors have invested a great deal in their businesses and will take every measure possible before that happens.

Unfortunately that means that our Contractors are already taking other severe measures to protect their futures. Most or all have recruitment bans in place, and all are looking hard at staffing levels, and any discretionary spending such as investment in training, IT and premises.

Community pharmacies offer many "free" services for which they are not contracted or remunerated, such as delivery services, monitored dosage system provision etc. Some will have to restrict these.

Recruitment and overtime bans can only mean that there may be less staff available to serve patients. Longer waiting times in pharmacies would undoubtedly mean that other local medical services, Out of Hours, A&E etc. are put under greater pressure. Reduction in staffing levels may put Pharmacists under increasing pressure, and clearly this is not conducive to an improvement in safety and performance, though we would wish to reassure patients that safety is a constant priority and will remain so.

Many pharmacies are only contracted to open for 40 hours per week, but choose to open far longer for commercial reasons. It may be only natural for Contractors to look at the least viable of these "supplementary" opening hours and consider again the viability of opening some of these. Since this may include evening and weekend hours, the potential impact could be significant. Again, Norfolk LPC does not wish to overstate the likelihood of this in the very short term, but it is a risk.

That Norfolk LPC, with its unique access to the thoughts and plans of community pharmacy Contractors, cannot predict what the impact of the imposition will be merely underlines the fact that this is a dangerous

experiment by the DH with the provision of services much needed and valued by patients, if not our national commissioners.

5) **Quality Payments Scheme**

In principle we welcome the introduction of these quality measures. However, that pharmacies attaining 100% of all that is asked of them will still face substantial cuts to funding is clear. The funding attached to this is relatively low.

DH proposals for funding distribution, and substituting most of the current payments with a Single Activity Fee per item dispensed, are incompatible with supporting those pharmacies that do most to meet the needs of our communities. Overall there is a greater reliance on funding from dispensing volume under the new contract, which is wholly inconsistent with the stated direction we are being asked to take.

6) National Urgent Medicines Supply Service

Norfolk's 5 CCGs already commission a far superior service locally. This allows pharmacies to make NHS supplies to patients in urgent need who have run out etc. and cannot reasonably access medication via the normal route. This includes patients referred from 111 and, crucially, those presenting directly in a pharmacy. Around 90% of patients access the service directly via the pharmacy dealing with requests, meaning the overwhelming majority do not need to place burden on 111 services at all.

In the first 6 months of this year the local service saved 155 A&E attendances and 1,755 Out-of-Hours GP interactions.

We believe that, while a positive development in those parts of the country which have not had the foresight to commission a local service, for Norfolk the national scheme alone would represent a significant step backwards. Due to the need for a 111 referral, Pharmacists would be faced with having to explain to patients that they can only provide the NHS supply if the patient first contacts 111. This raises the unwelcome prospect of patients ringing 111 from the pharmacy. The role of 111 under the national scheme will merely be to check that the request does not include a controlled drug and thence to issue a reference number via email- in other words this will simply be an additional administrative function for 111 in Norfolk which they do not have at present due to our local scheme. We estimate this will result in at least an additional 4,000 calls to 111 in Norfolk per annum.

7) On-Line Pharmacy

The DH repeatedly refers to a desire to increase the use of online pharmacy services.

We already have many online pharmacies offering a full range of services, and indeed every pharmacy could develop its own on-line offer.

Currently, the overwhelming majority of patients prefer to access pharmacy services via bricks-and-mortar pharmacies. It is natural that, over time, use of online services will gradually increase. It is certain, though, as with all services, that a significant sudden shift to online access would have a significant impact on community pharmacies and their viability.

In a free and equal market community pharmacies are happy to develop their offering and compete with online services. We believe many will always prefer to have face-to-face contact and appreciate the relationship they have with a regular pharmacy and its staff.

What we suspect underlies this is a desire, among some in the DH, to develop a "two tier" system which will promotes the "Amazonisation" of pharmacy services, with online pharmacies operating under a separate and "cheaper" terms of service by not delivering the full range of services of a conventional pharmacy.

While this may seem attractive to some on superficial consideration, the availability of any such system would likely result in the blatant direction of patients to the lower-cost services by those commissioning pharmacy services, especially when this commissioning moves to more local groups faced with unattainable savings targets. That this would result in significant loss of local services, with all of their potential to make wider savings to the health economy, is clear. Experience tells us that commissioners will be prepared to ignore guidance on this, even if it increases overall national costs in the longer term, if it makes short-term local savings. This remains a significant threat to the future of community pharmacy services.

8) **"Pharmacy Support- Employing Pharmacists to work as part of the primary care team"**

On 13 October 2016, NHS England announced an increase in the budget for this pilot. The budget has increased from £15 million to £31 million. This will part-fund 403 new clinical pharmacist posts across 73 sites, covering 698 practices in England.

Norfolk LPC is supportive of the development of greater input by pharmacists into primary care, and we support in principle the initiative involving GP practice-employed pharmacists. Indeed, Norfolk LPC has actively assisted some pilot sites in Norfolk with the bid and recruitment processes.

What is of great concern, however, is that the Minister has repeatedly apparently confused this new role with that of a community pharmacist. There appears to us to be some underlying assumption that this role can mitigate the loss of community pharmacy services.

We would strongly challenge this. Even at the end of the three year pilot not all practices will have such a position, and even then the pharmacist will likely be shared across several small practices, or be just one body in a large practice. Such a pharmacist can only have a limited number of patient interactions each day. This capacity cannot compare with that of a local community pharmacy, often with several pharmacists and many highly trained support staff. If community pharmacy services are lost, massive additional burden will be placed on GP practices. The roles of practice pharmacist and the community pharmacist must be complementary, yet funding is apparently taken from the community pharmacy budget to pay for this initiative.

Community pharmacies offer long hours of availability, with six or seven day access. We would be interested to understand if pharmacists employed (and part-NHS funded) under this pilot are contracted to and routinely offer services in the evenings and at weekends? If they do not, we would perhaps question how this significant NHS expenditure on developing this role is consistent with the stated intention of the DH to ensure 7-day a week access to NHS services?

9) Minor Ailments Schemes etc.

Repeated reference has been made by the DH to an intention to expand services from pharmacies for those who need treatment for urgent minor ailments. What is has not done, unfortunately, is commission any such service or commit to doing so. In Scotland a highly successful service has been operating for many years, but we have no commitment to such a national service in England.

In 2003, it was found that 8% of emergency department consultations involve consultations for minor ailments, costing the NHS £136 million annually. Many of these attendees could have been treated through community pharmacy if a pharmacy service had been commissioned. One in five GP consultations are for minor ailments and by reducing the time spent by GPs on managing minor ailments, it would enable them to focus on more complex cases and could

reduce patient waiting times. A recent modelling analysis of the cost of a national minor ailments scheme in community pharmacies in England in 2011 showed that there was a significant cost saving. The Department of Health undertook a Partial Impact Assessment in 2008 which suggested that a saving of £300m could be made with wide-scale implementation of local services.

Despite the above, we understand that commissioning of such a service will be left to local commissioners, which will no doubt perpetuate the confused postcode lottery of service provision we currently see. This, unfortunately, in our view, again demonstrates the doctrine underlying all of the above- this is not about developing community pharmacy, this is about cuts without adequate consideration of the consequences or more positive alternatives.

Norfolk and Waveney Sustainability & Transformation Plan – NHOSC's comments

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The report of comments made by committee members on 8 December 2016 is presented for the committee's approval before submission to Norfolk and Waveney Sustainability & Transformation (N&W STP) Executive Board members.

1. Background

1.1 On 8 December 2016 Norfolk Health Overview and Scrutiny Committee (NHOSC) received the N&W STP, a summary called 'In Good Health - Our proposals for changing health and social care in Norfolk and Waveney' and a presentation from the Managing Director of Norfolk County Council, who is the N&W STP lead. The Managing Director was joined at the meeting by Chief Executive of Norfolk Community Health and Care NHS Trust and the Head of Strategy and Business Development, Norfolk and Suffolk NHS Foundation Trust, to answer questions from Members and comment on points raised by members of the public.

1.2 At the end of the discussion NHOSC agreed that a report based on the comments made in the meeting would be produced and circulated to NHOSC Members prior to submission to the STP Executive Board.

1.3 Bearing in mind that the STP engagement process runs until 22 January 2017, the Chairman and Vice Chairman of NHOSC agreed subsequently to the meeting that the report of comments would be brought to committee today for final approval before submission to the STP Executive Board.

2. Action

2.1 NHOSC is asked to approve the report of comments to the Executive Board of Norfolk and Waveney Sustainability & Transformation Plan, which is attached at Appendix A.

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or 0344 800 8011 (Textphone) and we will do our best to help.

Norfolk Health Overview and Scrutiny Committee (NHOSC)

Report of NHOSC members' comments on Norfolk and Waveney Sustainability & Transformation Plan, 8 December 2016

On 8 December 2016 Dr Wendy Thomson, Managing Director of Norfolk County Council and lead for Norfolk and Waveney Sustainability & Transformation Plan (N&W STP) and Roisin Fallon-Williams, Chief Executive of Norfolk Community Health and Care NHS Foundation Trust attended NHOSC to present N&W STP, answer questions and receive comments. Oli Matthews, Head of Strategy and Business Development, Norfolk and Suffolk NHS Foundation Trust, joined them at the table to answer questions specifically on mental health issues.

NHOSC agreed that comments made by members during the meeting would be sent to the STP Executive Board in the form of a report, based on the minutes of the meeting.

NHOSC members' comments were as follows:-

1. The STP should be developed alongside other Central and Local Government and NHS strategies (such as the Government's plans for 7 day working in all sectors of the NHS and the operating plans of the NHS which were not directly a part of the STP).

2. Breaking down barriers in the provision of care is fundamental to success, particularly between GPs and hospitals, physical and mental health and between health and social care.

3. In addition to looking to design the whole system approach around the amount of money that was available, emphasis should be placed on the importance of lobbying Government at the political level for additional resources to fill funding gaps.

4. It might take significantly longer than the 5 year timescale of the STP before the fundamental changes that the STP intended to bring about are viewed by the public as a success or a failure.

5. There are questions around how acute services will be able to meet demand before the real improvements to the public's health materialise and the economic modelling that has been done around early intervention strategies.

6. Providing greater public access to therapies that tackle mental health issues at an early stage should be addressed as a strategic issue.

7. The reference in the STP Workforce workstream to resilience training for staff should be explained so that its connection to the NHS Five Year Forward View is understood and it is not seen as referring to the whole workforce.

8. The impact of the STP on third sector organisations should be recognised.

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED
Members are asked to suggest issues for the forward work programme that they would like to bring to the committee's attention. Members are also asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the briefings, scrutiny topics and dates below.

Proposed Forward Work Programme 2017

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
23 Feb 2017	Continuing healthcare in Norfolk – an update on the implementation and evaluation of the new policy introduced by North Norfolk, South Norfolk, Norwich and West Norfolk CCGs.	
6 Apr 2017	Children's mental health services in Norfolk – scrutiny of the service after a full year of operation following the Local Transformation Plan changes IC24's NHS 111 and GP out of Hours Service in central and west Norfolk – an update from IC24 and Norwich CCG, further to the NHOSC meeting on 14 April 2016.	
25 May 2017		

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

Provisional dates for report to the Committee / items in the Briefing in 2017

Provisional – 26 Oct 2017 – Ambulance Response and Turnaround Times in Norfolk - on 13 Oct 2016 NHOSC received a report from the East of England Ambulance Service NHS Trust and the Norfolk & Norwich University Hospitals NHS Trust. Agreed that it *may* wish to look at the subject again in a year's time.

26 Oct 2017 – *In the NHOSC Briefing* – Introduction of the Primary Care Education and Training Tariff – update from Mr I Newton, Department of Health (follow up to Members' informal meeting with Mr Newton on 29 Sept 2016).

Members serving on Task & Finish Groups

Task & finish group	Membership	Progress
Children's Services Committee Task & Finish Group Review Review of access to support and interventions for children's emotional wellbeing and mental health	**From NHOSC** Mrs M Stone (appointed 14 April 2016) Ms E Corlett (Chairs the T&F Group and joined NHOSC subsequent to its establishment)	The group expects to report to CS committee on 24 January 2017.

Main Committee Members have a formal link with the following local healthcare commissioners and providers:-

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr David Harrison)
South Norfolk	-	Dr N Legg (substitute Mrs M Stone)
Gt Yarmouth and Waveney	-	Mrs M Stone (substitute Mrs M Fairhead)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Mrs M Stone (substitute Ms E Corlett)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Mrs M Stone)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Stone)
James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred (substitute Mrs M Stone)

Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Stone)

Norfolk Health Overview and Scrutiny Committee 12 January 2017

Glossary of Terms and Abbreviations

5YFV	NHS Five Year Forward View – published in October 2014, the 5YFV set out how NHS services needed to change in the following five years
A&E	Accident and emergency
CCG	Clinical Commissioning Group
CP	Community pharmacy
CPCF	Community pharmacy contractual framework
DoH / DH	Department Of Health
GP	General practitioner
HMR	Human Medicines Regulations 2012
IC24	Integrated Care 24 (a not for profit social enterprise organisation providing GP out of hours and NHS 111 services in Norfolk)
ICT	Information and communication technology
KPMG	A global network of professional service firms providing audit, tax and advisory services
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
MUR	Medicines Use Review
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS E M+E(E)	NHS England Midlands & East (East)
NHOSC	Norfolk Health Overview and Scrutiny Committee
NMS	New Medicine Service
NSFT	Norfolk and Suffolk NHS Foundation Trust
NUMSAS	NHS urgent medicines supply advanced service
N&W STP	Norfolk and Waveney Sustainability & Transformation Plan
OSC	Overview and Scrutiny Committee
PhAS	Pharmacy Access Scheme
PhIF	Pharmacy Integration Fund
PNA	Pharmaceutical Needs Assessment
PwC	Pricewaterhouse Cooper – a multinational professional services network (auditing, accountancy, etc.)
STP	Sustainability and Transformation Plan
T&F	Task and finish