Nottinghamshire County Council

Nottingham City Council

Joint City / County Health Scrutiny Committee

Tuesday, 15 July 2014 at 10:15

County Hall, **County Hall, West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(2) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Julie Brailsford (Tel. 0115 977 4694) or a colleague in Democratic Services prior to the meeting.

(3) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
10 June 2014 at 10.15am

Nottinghamshire County Councillors

Councillor P Tsimbiridis (Chair)
Councillor P Allan
Councillor R Allan (substitute for Councillor Harwood)
Councillor R Butler
Councillor J Clarke
Councillor Mrs K Cutts MBE (substitute for Councillor Dr J Doddy)
A Councillor Dr J Doddy
Councillor J Handley
A Councillor C Harwood
Councillor J Williams

Nottingham City Councillors

Councillor G Klein (Vice- Chair)
Councillor M Aslam
A Councillor A Choudhry
Councillor E Campbell
Councillor C Jones
A Councillor T Molife
Councillor E Morley
Councillor B Parbutt

Also In Attendance

Julie Brailsford - Nottinghamshire County Council
Jane Garrard - Nottingham City Council
Martin Gately - Nottinghamshire County Council
Jane Kingswood - Healthwatch

CHAIRMAN AND VICE-CHAIRMAN

The appointment by the County Council of Councillor Parry Tsimbiridis as Chairman and Councillor G Klein as Vice-Chairman was noted.

MEMBERSHIP

The membership of the committee, as set out above, was noted.

MINUTES

The minutes of the meeting held on 13 May 2014 were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors E Campbell (other), A Choudhry (other), Dr J Doddy (other) and C Jones (other City C Business)

DECLARATIONS OF INTERESTS

None

INTOXICATED PATIENTS REVIEW FINAL REPORT

The Committee considered a report from the Chairman of Joint City and County Health Scrutiny Committee detailing evidence gathered by the study group on the impact of intoxicated parents on the Emergency Department of Nottingham University Hospitals. The following points were raised:

- Concern was expressed about the 50 prolific High Volume Service Users, the cost and the distress that intoxicated patients cause to other patients.

- The hospitals should start to keep a record of the patients admitted for a physical injury caused by being intoxicated.

- The perception that intoxicated patients are only a problem on Friday and Saturday nights but this is a constant problem 24 hours a day, seven days a week.

- The possibility of looking in to the scheme that Derby City Council have started regarding intoxicated patients based on a scheme that Cardiff Council have implemented in conjunction with the police.

- The Committee were pleased that the funding for the HVSU nurse post had been agreed for an additional year as the work done by Mr Davis proved that this role had helped reduce the HVSU's. It has not been confirmed yet that Mr Davis personally will continue in this role.

- The Committee would like to know to what extent the HVSU specialist nurse works with other agencies as there is value in multi-agency working.

The Committee agreed that the report including the additional comments raised should be sent to the Nottingham University Hospitals with a request for a report back in the autumn.

TERMS OF REFERENCE AND JOINT PROTOCOL

The report was noted by the committee.

WORK PROGRAMME

The Joint Health Scrutiny Committee was advised that the Work Programme is in a state of development. Items requested for the work programme included:

- Nottingham University Hospital Quality Account, environmental issues/waste stream and disposal of medical waste.

- Notts Healthcare Trust Quality Account, availability of beds and under pressure from CAMHS. Review to child and adolescent services.

The committee discussed the possibility of establishing study groups but it was decided all items should be brought to the main committee.

The meeting closed at 10.35am.

Chairman

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
15 JULY 2014
DEVELOPMENTS IN ADULT MENTAL HEALTH SERVICES
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

1. Purpose

To consider proposed changes to provision of adult mental health services in Nottingham and Nottinghamshire.

2. Action required

2.1 The Committee is asked to use the information to inform its questioning in relation to consultation by Nottinghamshire Healthcare NHS Trust and commissioners about proposed changes to adult mental health service provision.

3. Background information

3.1 Nottingham City Clinical Commissioning Group and Nottinghamshire Healthcare NHS Trust have advised of proposed changes to provision of adult mental health services as part of a wider transformation programme focused on reducing inpatient beds and improving community based provision.

3.2 The proposed changes include:

a) closure of A43 at Queens Medical Centre in January 2015
b) closure of A42 at Queens Medical Centre in March 2015
c) closure of inpatient rehabilitation beds at Enright Close, Newark in October 2014
d) improved community service provision, including enhanced Crisis Resolution and Home Treatment Service; a multi-disciplinary model of care; changes to care pathways; introduction of a ‘virtual ward’.

3.3 Representatives of Nottingham City and south Nottinghamshire Clinical Commissioning Groups and Nottinghamshire Healthcare NHS Trust will be attending the meeting to give a presentation outlining the proposed changes (attached) and discuss them with the Committee.

3.4 Councillors representing the Newark area have been invited to attend the meeting and contribute to discussion on the proposal to close Enright Close, Newark.

3.5 This Committee has statutory responsibilities in relation to substantial variations and developments in health services. While a 'substantial variation or development' of health services is not defined in Regulations, a key feature is that there is a major change to services experienced by patients and future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area. The Committee's responsibilities are to consider the following matters in relation to any substantial variations or developments that impact upon those in receipt of services:

a) Whether, as a statutory body, the relevant Overview and Scrutiny Committee has been properly consulted within the consultation process;

b) Whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation;

c) Whether a proposal for change is in the interests of the local health service.

3.4 Councillors should bear the matters outlined in paragraph 3.5 in mind when considering the proposals and discussing them with Nottinghamshire Healthcare Trust and commissioners.

4. List of attached information

4.1 The following information can be found in the appendices to this report:

Appendix 1 – Presentation on Adult Mental Health Service Transformation Programme from Nottinghamshire Healthcare NHS Trust

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

None

7. Wards affected

All

8. Contact information

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Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

ADULT MENTAL HEALTH

SERVICE TRANSFORMATION PROGRAMME

JOSC 15 July 2014

Local Services Transformation Programme 2014-2017

- Significant annual savings required of £4.3m for the next 2 years alone
- Major service redesign programmes planned with the focus on reducing inpatient beds and improving community based provision.
- This means new ways of working, doing things differently and being more efficient.
- Preventative & proactive approach to care.

Adult Mental Health 2014/2015

- Improve community services provision through the redesign programme taking place in the Directorate:
  - Emphasis on an MDT approach with wider use of disciplines
  - Pathways based services
  - Changes in use of nurses and Consultants
  - Efficiency work
- Reduction in 42 acute beds (staged 20 then a further 22 by early 2015) at QMC site
- Further reduction of inpatient residential rehab: closure of Enright Close Newark (24 beds)

Current Adult Inpatient Beds: Nottinghamshire

- Acute:
  - City/ S County: 106
  - Mansfield: 36
  - Bassetlaw: 24
- PICU: 15
- Inpatient rehab: 90
- Benchmarking data from the 2013 Mental Health Benchmarking Network covering 56 MH providers shows Nottinghamshire has a higher than average number of acute, PICU and rehab inpatient beds compared with the SHA & national average.

Closure of QMC Wards (1)

- To facilitate ward closures it is proposed that CRHT city & county south teams are enhanced & practices changed with more of a preventative focus.
- MDT model of care with a better skill mix
- 24/7 service including ability to provide care during the night
- Increased consultant availability over 7 days
- Improvements along the acute care pathway including meeting the requirements of the new Crisis Concordat for adult mental health
- Transitional funding for up to 2 years is requested to support the community service changes as this is a whole systems approach.

Closure of QMC (2) - Staffing Model (City & South County)

Currently	Proposed
Very high proportion of CPN's in both teams	Mixture of qualified staff including CPN's & OT's
Few support staff	More support workers including PSW's
Medical cover 9 – 5 weekdays	Psychology input
Telephone response at night	Introduction of NMP's
	Medical cover 7 days a week
	Staff available 24/7 to provide assessment & intensive home support

Closure of QMC Wards (3)

- Page 7 outlines the introduction of the “virtual ward” element into the enhanced CRHT ie a more preventative approach to care.
- There is more of a focus on the direct provision of family support interventions in the new model.
- The performance & quality outcome measurements to evidence whether the new service works are (in addition to those currently gathered):

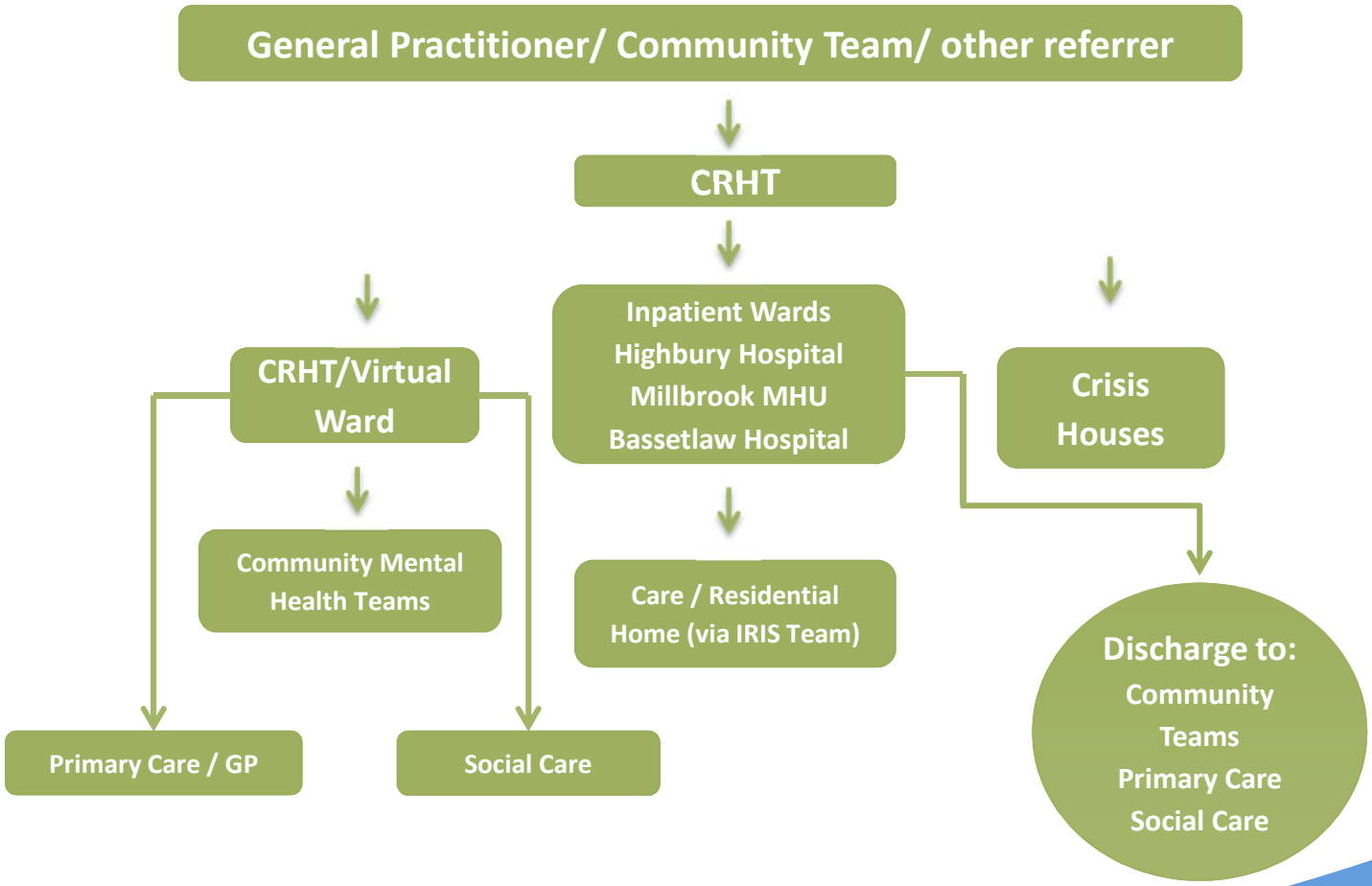
o Response rates for face to face assessments

o Reduction in admissions to MH acute beds

o No impact on out of area admissions/ risk share proposed around this

o Provision of NICE based treatments at home

Proposed Service Change Pathway



Wards at the QMC

Closure of Enright Close

- Following closures at MacMillan Close & Dovecote Lane it is proposed Enright follows by October 2014.
- A community rehab team (CRT) was established following the closure of MacMillan Close, in line with strategic intentions a similar proposal is being made for N&S as outlined in the paper.

Financial Context

QMC/CRHT

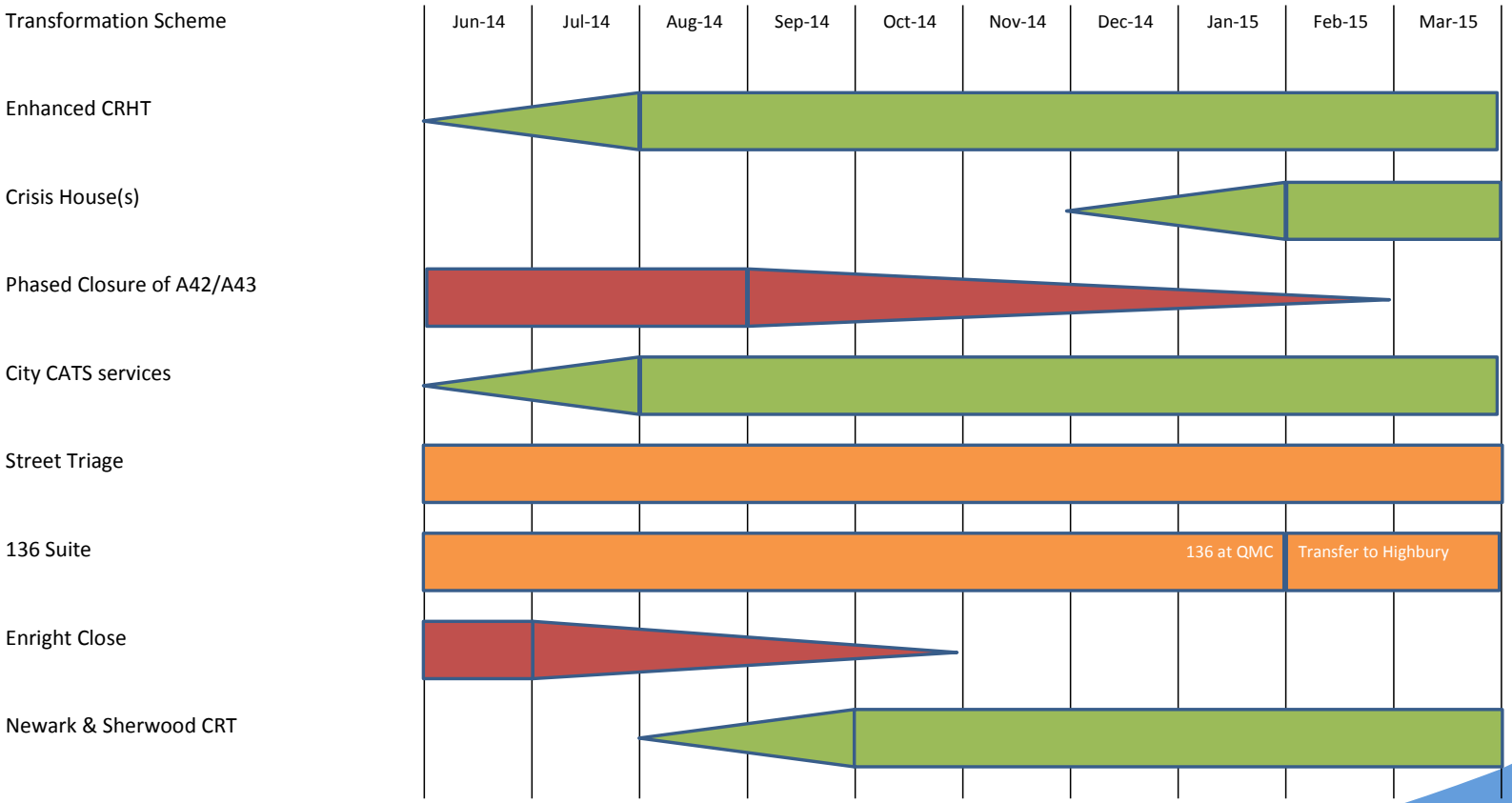
- Current Direct Cost: £5.2m
- Direct Cost Savings upon QMC Ward Closures: £3.0m
- Proposed Additional Direct Cost Requirements:

1. *CRHT* [enhanced]; £965,356k
2. *Community Team enhancement – costs to be confirmed but 500k estimated*
3. *Provision of third sector operated crisis house- 500k estimated.*

Enright

- Current Direct Cost: £929k
- Proposed Direct Cost: £433k
- Savings: £496k

AMH Transformation Programme
Implementation Timeline 2014/15



JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
15 JULY 2014
MENTAL HEALTH SERVICES FOR OLDER PEOPLE
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

1. Purpose

To consider information about developments in mental health services for older people in Nottingham and Nottinghamshire.

2. Action required

2.1 The Committee is asked to use the information provided to scrutinise developments in mental health services for older people and determine whether any further scrutiny is required.

3. Background information

3.1 The Executive Director for Local Services, Nottinghamshire Healthcare NHS Trust will be attending the meeting to update the Committee on developments in mental health services for older people in Nottingham and Nottinghamshire.

4. List of attached information

4.1 The following information can be found in the appendix to this report:

Appendix 1 – Paper from Nottinghamshire Healthcare NHS Trust

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

None

7. Wards affected

All

8. Contact information

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Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

MHSOP Proposal of Ward and Community Development

July 15 2014

Simon Smith Executive Director of Local Services

Bestwood ward is a 20 bed organic assessment ward and Daybrook ward is a 20 bed functional ward based at the St Francis Unit (Nottingham City Hospital)

The wards receive patients from Nottingham City, Nottingham North & East, Nottingham West and Rushcliffe CCGs

In line with national policy and local commissioning intentions, MHSOP proposes closing these wards and replacing them by expanding the community model of care supporting older people to remain within their homes

This change constitutes the third stage of implementing service transformation across MHSOP, where bed based provision is re-engineered into community focused models of care – Friary & A23 have previously been successfully re-modelled

As at 03 July 14 there were 20 patients on Daybrook ward and 7 on Bestwood ward with a total of 29 empty beds across MHSOP services

Key Reasons for the re-provision of Daybrook & Bestwood wards are:

- Independent EMPACT Bed Utilisation Review 2012 indicated 54% of organic assessment beds were being used inappropriately
- The EMPACT review also highlighted 25% of functional admissions did not require admission and could have been managed in an alternative setting. Once admitted, alternative levels of care i.e. step down provision, was often cautiously introduced (56%)
- Patients from the city disproportionately over occupy existing beds. They make up 11% of the over 65 population and account for 28% of bed days

- Supports NICE guidance for people with organic and functional mental illnesses and inpatient admission by having a stepped care approach and a focus on person centred care

- Implement recommendations for required bed numbers for Nottinghamshire's population projected for 2023/24 which equates to 44 organic and 49 functional beds based on national benchmarking data

- Based on the evidence presented there is a need for a skilled multidisciplinary workforce working in a variety of services with different intensities of care provision

- In their place NHT will extend the community model of care for the CCGs who access these wards. The priorities for the savings made for the ward closures are:

  - Wards to be efficient in assessing, formulating, treating and discharging patients to the appropriate next setting with a focus on psychological approaches to care
  - Enhancing Intensive Recovery Intervention Service teams over 7 days / week with qualified staff available at weekends for both organic and functional patients between 7am and 10pm
  - Enhancing dementia outreach services to manage patients within care homes to reduce admission to the wards
  - Expanding AMH crisis services to include older people between 10pm and 7am

Intensive Recovery Intervention Services (IRIS)

- Is a secondary mental health service delivered within community settings, usually this will be the person's home
- Is time-limited (12 weeks), person centred and according to assessed treatment needs for up to four visits per day by one or two workers
- Operates a flexible 7 days/week, between 7.00 am to 10.00 pm to meet client need
- Provides an urgent referral response within 24 hours
- Operates an open access referral process with inclusive eligibility criteria across health and social care

- Ensures effective care planning and co-ordination with seamless handover to mainstream services
- Avoids admission to, and facilitates timely discharge from, hospital (both general and specialist mental health) through active intervention and rehabilitation. This is evident from the city bed occupancy data
- Reduces the demand for acute beds, both medical and mental health
- "*All the carers that came were very pleasant, helpful and supportive. They made sure I was safely secured in my home at night."* (Service User: Patient Opinion Re: Mansfield and Ashfield IRIS team)

Consultation/Meetings to Date

- 17.12.2013: Business Planning and Involvement Meeting
- 22.04.2014: Business Planning and Involvement Meeting
- 13.05.2014: Meetings with patients on Daybrook ward with the Involvement team
- 23.05.2014: Meeting with staff members on Bestwood ward
- 12.06.2014: Meeting with carers & relatives of patients on both wards with the Involvement team.
- Planned consultations with BME and hard to reach groups July 2014
- Staff consultation: July 2014.

Conclusion

- Unnecessary hospital admissions are not in the best interests of those with organic or functional mental illnesses nor their carers and can have a long term impact on people's abilities to recover and return home
- It is widely acknowledged that there are lower treatment costs through services such as IRIS as opposed to inpatient care. An equivalent service for city residents will be introduced
- This is a service which reports very high service user and carer satisfaction
- The MHSOP directorate is asking for your support with this proposal

MENTAL HEALTH SERVICES FOR OLDER PEOPLE

PROPOSAL OF WARD AND COMMUNITY DEVELOPMENT IN MHSOP

1. Executive Summary

Bestwood and Daybrook Wards are provided by Nottinghamshire Healthcare NHS Trust (NHT) within the Mental Health Services for Older People directorate (MHSOP). The wards are based at the St Francis Unit (Nottingham City Hospital) in Nottingham city and have 20 beds on each ward, providing organic and functional assessment respectively for older people. These wards receive patients from Nottingham City CCG, Nottingham North and East CCG, Nottingham West CCG and Rushcliffe CCG.

In line with national policy, and in response to local commissioning intentions, NHT will consult on the re-provision of these wards, and in their place provide a community model of care which supports older people to remain within their homes wherever possible. This particular change constitutes the third stage of implementing service transformation across MHSOP, where bed based provision is re-engineered into community focused models of care.

Over the last five years the Mental Health Services for Older People directorate has developed services in line with best practice, QIPP and CIP requirements. This has resulted in numerous small changes to the service. There has also been investment in parts of the service which has led to significant change. These include Intensive Recovery Intervention Service teams (IRIS) in County and Bassetlaw, Memory Assessment Services, Dementia Outreach Team (in the City locality) and Dementia Outreach Service (County including Bassetlaw). However, more fundamental systematic changes to the model MHSOP provides have been identified by the directorate to meet the increased demand for the service in line with the importance of person centred care, recovery and risk enablement, that have led to less of an emphasis on inpatient care.

The fundamental principles of a future service model[1] are:

1. The service will provide care for those of any age with dementia and those over 65 with moderate and severe functional mental health conditions. (NB for people with a primary learning difficulties diagnosis who present with dementia, their care will continue to be provided by specialist services with advice provided via Working Age Dementia Services as required).

[1] The fundamental principles of a future service model for MHSOP closely links into the Guidance for Commissioners of Older People's Mental Health Services (May 2013), meeting nine of the ten key messages for commissioners. Report available at http://www.jcpmh.info/good-services/older-peoples-services/

2. The focus will be on managing people within the community rather than inpatient care.

3. The services will be provided with an ethos of positive risk taking and recovery focused care, reducing dependency on services.

4. Functional services will be equivalent to those provided in Adult Mental Health for people of working age but will meet the specific needs of older adults.

5. Services will be aligned to their primary care physical health counterparts to ensure the holistic management of patients.

6. The service will continue to need a stock of organic assessment and treatment beds to assess and treat the most complex patients.

7. The service will continue to need a stock of functional assessment and treatment beds specifically for older people with severe functional illness and those with co morbid physical frailty.

8. The wards should remain separate in their function; i.e. organic or functional not a combination.

9. An average length of stay will be agreed for each type of ward.

10. Services will not be closed without alternatives being secured, in place and functioning.

This service change has been agreed in principle by commissioners and this paper has been developed to outline the alternative service model that will be provided in response to the closure of the two wards. This paper is in addition to papers already presented to commissioners via QCRM. **It should be noted that for longer term demand and capacity for the City and the whole of the County the Community Development plan, as listed below should be negotiated.**

This paper forms part of a suite of documents which should be considered in conjunction.

1. MHSOP clinical strategy.
2. MHSOP recovery and risk enablement strategy.
3. Community development plan
4. In-patient development plan.
5. DICU Evaluation paper, including responses to commissioner queries.
6. EMPACT bed utilisation review.
7. Organic bed clinical model.
8. Functional bed clinical model.
9. Integrated CMHT operational procedure (to be developed).
10. Medical workforce model and plan (to be developed.
11. Day Services update (to be developed.
12. Service re-design and implementation plans (x 2).
13. Service redesign workforce plan.
14. Service modelling papers (x 2).
15. Care homes currently served by the Dementia Outreach Service.

1. Context for Service Change

The key reasons for the re-provision of Daybrook and Bestwood Wards and in their place providing a community model of care are:

- To implement the recommendations for required bed numbers for Nottinghamshire's population projected for 2023/24[2] which equates to 44 organic and 49 functional beds
- The independent EMPACT Bed Utilisation Review 2012 indicated 54% of organic admissions were to support breakdowns in care at home, rather than evidence based clinical need for admission. Furthermore, length of stay in organic assessment beds was extended by up to 60% due to lack of alternative and more clinically appropriate provision within the community.
- The EMPACT review also highlighted 25% of functional admissions did not require admission and could have been managed in an alternative setting. Once admitted, alternative levels of care, i.e. step down provision, was often cautiously introduced (56%). There is a lack of clinically appropriate provision within the community (25%), which inappropriately impacts on lengths of stay for these patients.
- Supports NICE guidance for people with organic and functional mental illnesses and inpatient admission by having a stepped care approach and a focus on person centred care.
- Based on the evidence presented there is a need for a skilled multidisciplinary workforce working in a variety of services with different intensities of care provision.

In light of this NHT is proposing the closure of Bestwood and Daybrook Wards based at St Francis Unit Nottingham City Hospital. NHT will consult on the re-provision of these wards, and in their place provide a community model of care for the CCGs who access these wards, which supports older people to remain within their homes wherever possible.

The priorities for the savings made from the ward closures:

- Staffing the remaining wards to be efficient in assessing, formulating, treating and discharging patients to the appropriate next setting with a focus on psychological approaches to care

- Enhancing community services over 7 days / week to provide intervention from state registered staff at a weekend for both organic and functional patients

The paper also considers reinvestment is required, outside of the service redesign, into:

- Enhancing dementia outreach services to manage patients within care homes to reduce admission to the wards

2. Current & Proposed Inpatient Configuration

The key aim is to significantly reduce unnecessary admissions, and therefore fundamental changes are required. At present inpatient beds within the MHSOP directorate are spread across four sites; Bassetlaw District General Hospital, Millbrook Unit, Nottingham City Hospital and Highbury Hospital (Table 1):

Table 1

Functional		**Organic**	
Ward B1	5 beds	Ward B1	10 beds
Daybrook Ward	20 beds	Bestwood Ward	20 beds
Cherry Ward	20 beds	Amber Ward	20 beds
Kingsley Ward	15 beds	Silver Birch Ward (DICU)	20 beds
Total	**60 beds**	**Total**	**70 beds**

Proposed bed numbers on closure of Bestwood and Daybrook wards:

Functional		**Organic**	
Kingsley Ward	20 beds	Amber Ward	15 beds
Cherry Ward	20 beds	Silver Birch Ward (DICU)	20 beds
Ward B1	5 beds	Ward B1	10 beds
Total	**45 beds**	**Total**	**45 beds**

3. Organic Wards Service Model and Staffing

The new service model proposes three organic wards; Amber, Silver Birch and B1 Wards, providing a total of 45 beds. The community model plans to utilise IRIS teams to gate-keep ward admissions. All admissions, other than referrals by DOT, MHA Assessments and RRLP will go through IRIS to ensure all alternatives to an admission to an acute ward have been considered. It is expected that the number of people admitted to hospital beds will reduce due to better and increased support within the community, improved gate-keeping and only patients with complex presentations of dementia will be admitted (PBR cluster 20). These are people with dementia who are having significant problems in looking after themselves and whose behaviour challenges their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high-risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down. In recognition of this Amber Ward will be converted in to a second Dementia Intensive Care Unit (DICU). At present Ward B1 will continue to operate as an assessment ward and will be able to transfer its more complex patients to both of the DICU wards. This may be reviewed.

A recent review of the DICU (Dementia Intensive Care Unit) identified its evident success in managing dementia with associated challenging behaviour. These include: length of stay reduced by 65%, only 2 failed discharges, reduced use of anti-

psychotics as a result of enhanced access to psychology, nurse/psychology led care and discharge as well as access to dementia outreach services.

In future the referral pathway into Silver Birch and Amber Wards will only be for the most complex patients with a wide range of health, social and behavioural needs. Patients who traditionally may have been admitted to inpatient care will be assessed and treated by the enhanced community services identified in the community services model.

The DICU model aims to achieve a 12 week assessment and treatment pathway. This includes assessment and treatment of patients using a multidisciplinary approach to identify patients' physical and psychological needs to ensure that individuals are placed within the least restrictive environment on discharge. This approach includes the use of standardised clinical assessment materials, access to psychology, occupational therapy, physiotherapy and speech and language therapy, and a structured and individualised activities programme. Regular case formulation sessions will be held on the ward to discuss clinical cases and reflect on best practice. The enhanced staffing levels will ensure the optimum intervention and length of stay for the patients.

In summary the previous 60 dementia beds (Bestwood, Amber and Silver Birch wards) will be reduced to 35 (Amber and Silver Birch wards) and will only be used for people in PbR cluster 20. Both remaining wards (Silver Birch and Amber) will be DICU wards. The loss of 25 beds across the system will mitigate the current under activity on the existing DICU. On the basis that demand for dementia beds will continue to grow at the predicted rate future activity for this ward has been established at 85% occupancy in line with national good practice. MHSOP will continue to monitor and improve length of stay via operational meetings which will change from their current structure to reflect the patient pathway.

Staffing: Amber and Silver Birch Wards (Ward B1 will remain unaffected)

Staffing	Amber (15 beds)			Silver Birch (20 beds)		
Ward Manager	1.0			1.0		
Deputy Ward Manager	1.0			1.0		
Nursing staff	E	L	N	E	L	N
	2	2	1	2	2	1
HCA	3	3	2	4	4	3
Activity Coordinator (M- F)	0.8			1.0		
Environment Care Coordinator (M-F)	1.0			1.0		
Ward Clerk (25 hours per week) (M- F)	0.5			0.5		

Currently there is 1.0 wte 8a Psychologist on Silver Birch. The intention is for this role to work across both Amber and Silver Birch and have additional support from a 1.0 wte band 4 psychology assistant also working across both wards.

4. Functional Wards Service Model and Staffing

The new service model proposes three functional wards; Cherry, Kingsley and B1 Wards, providing a total of 45 beds, as opposed to existing 60 beds. The community model plans to utilise IRIS teams to gate-keep ward admissions. All admissions will be facilitated through IRIS to ensure all avenues other than admission to an acute ward have been considered. Patients admitted through MHA assessments and RRLP will be directly admitted to inpatient wards. It is expected that the number of people admitted to hospital beds will reduce due to better and increased support within the community, improved gate-keeping and only patients with complex presentations of depression, various anxiety disorders and psychosis will be admitted. Patients who traditionally may have been admitted to inpatient care will be assessed and treated by the enhanced community services identified in the community services model.

Patients referred to Kingsley, Cherry and B1 Wards will continue to receive high levels of specialist and on-going clinical interventions from a wide range of healthcare professionals so that higher complex needs can be managed. All three wards will be multidisciplinary in approach and treatment will be person-centred and psychologically based.

In line with the introduction of PbR only patients assessed to be the cluster pathways outlined in the table below will be admitted and this will determine their treatment timescales;

Non-Psychotic Inpatient Admissions	
Cluster 5	This group of patients will be severely depressed and/or anxious and/or other. They will not present with distressing hallucinations or delusions but may have some reasonable beliefs. They may often be at high risk for non-accidental self-injury and they may present safeguarding issues and have severe disruption to everyday living.
Cluster 6	Patients with moderate to severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc where extreme beliefs are strongly held, some personality disorders and enduring depression.
Cluster 8	This group of patients will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependant engagement and often hostile services.
Psychosis Inpatient Admissions	
Cluster 13	These patients will have a history of psychotic symptoms which are not controlled. They will present with severe to very severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.
Cluster 14	These patients will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

Cluster 15	This group of patients will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present, It is likely that this group will present a risk of non-accidental self injury and have disruption in many areas of their life.
Cluster 16	These patients have enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles and co-existing problem drinking or drug-taking. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.
Cluster 17	This group of patients have moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable and engage poorly with services.

Discharge planning will commence from admission to the ward through the development of the appropriate care plan with the patient and carer as appropriate. Discharges from inpatient wards will be to the most appropriate community teams based on patient need. This will be facilitated at the earliest clinically appropriate stage by IRIS teams.

MHSOP will continue to monitor and improve length of stay, allowing Kingsley, Cherry and B1 Wards to provide a high quality inpatient assessment facility. That is; able to assess and treat the more complex patients presenting with severe depression, various anxiety disorders and psychosis on functional wards, with less acute patients being treated at home or in care homes. In recognition of having the most complex patients being admitted into inpatient wards, the increase in the number of beds at Kingsley ward and to continue to provide high quality services to patients, staffing levels will need to be enhanced.

Staffing: Cherry and Kingsley Wards (Ward B1 will remain unaffected)

Staffing	Cherry (20 beds)			Kingsley (20 beds)		
Ward Manager	1.0			1.0		
Deputy Ward Manager	1.0			1.0		
Nursing staff	E	L	N	E	L	N
	2	2	1	2	2	1
HCA	3	2	2	3	2	2
Activity Coordinator (M – F)	1.0			1.0		
Environment Care Coordinator (M-F)	0.6			0.6		
Ward Clerk (25 hours per week) (M- F)	0.5			0.5		

N.B. Cherry and Kingsley ward there will be 5 days (Mon-Fri) extra shift (mid/twilight or late as required) and for Cherry ward two further shifts (Tue and Fri) for ECT days at Band 5 level.

Psychology intervention is currently provided by the Consultant Clinical Psychologist to the functional wards, in order to move to a more psychologically focused service an additional 0.5 WTE clinical psychology post will be recruited to.

5. AHP and Medical Staffing enhancements to wards

Allied Health Professionals

Occupational therapy (OT) and Physiotherapy (PT) are essential to support ward staff in assessment, formulation, treatment and discharge planning as part of a multi-disciplinary team.

At present the wards in the south of the county have a dedicated inpatient therapy team and those at Millbrook have had an in-reach service from the CMHT with an additional preceptorship occupational therapist. An inpatient therapy team will be developed which would provide consistent input across all wards. The skill mix for this would be:

Role	Current	Proposed	Difference
Band 6 OT	1.0	1.0	0
Band 5 OT	1.0	1.6	0.6
Band 6 PT	0.8	0.8	0
Band 5 PT	1.5	1.5	0
Band3Therapy Assistant	1.72	2.0	0.28

This represents an increased cost of £25 000 which would equate to each ward having access to 0.65 wte OT, 0.57wte PT and 0.5 Therapy TI.

Medical

Increased consultant psychiatry sessions will be provided to the remaining wards from the current inpatient psychiatry establishment. This will support both increased clinical complexity and reduced length of stay. The frequency of patient reviews would be increased to accommodate increased clinical need as well as a focus on reviewing treatment and discharge planning. Daybrook and Bestwood wards currently have 8 psychiatry sessions and these sessions will be re-allocated. Silver Birch will be allocated 6 additional sessions and 2 sessions will be allocated to the Millbrook Unit covering Amber and Kingsley wards.

6. Re-investment planning

MHSOP will reinvest into:

1. Increased staffing levels and multi-disciplinary working for the remaining wards to mitigate increased clinical complexity, reduce length of stay and increase throughput with a focus on psychologically appropriate treatments.

2. Enhancing community services over 7 days / week to provide intervention from state registered staff at a weekend for both organic and functional patients who have increased risks
3. Enhancing dementia outreach services to manage patients within care homes and thereby reduce organic admission to the wards

Direct budgets for Bestwood and Daybrook wards total £2.1m. In order to enhance the staffing levels on the remaining wards and re provide an alternative level of care for patients who would usually access these wards £1.321m is the amount of reinvestment required. Future optimum staffing levels for community services as the population increases can be seen in the Community Development Plan.

7. Clinical Benefits

Inappropriate admissions and increased lengths of stay in hospitals are not in the best interests of people with organic and moderate to severe functional illness. Protracted lengths of stay increase the risk of infection, boredom, depression, frustration and a loss of independence and confidence.[3] Furthermore the service model proposed meets objectives 9 and 11 of the Dementia Strategy 2009[4] by improving intermediate care services for people with dementia and improved quality of care for people with dementia in care homes. MHSOP will continue to provide high quality care to people with organic and moderate to severe functional illness, but in a more appropriate care setting. The care delivered will be based on person centred, risk enablement and recovery principles in line with those developed as part of the PbR care pathways.

8. Reinvestment into Remaining Inpatient Wards

The costs associated with the enhanced ward model is described below:

Ward	Current budget (£000)	Proposed cost (£000)	Difference (£000)
Amber (to DICU)	730	863	133
Silver Birch	1,141	1,107	-34
Band 4 Psychology DICU 1.0wte	0	26	26
Kingsley	734	862	129
Cherry	828	908	80
Band 8a Psychologist functional 0.5 wte	0	27	27
Enhanced AHP	0	25	25
Total	3,433	3,815	386

[3] Ready to go? Planning the discharge and transfer of patients from hospital and intermediate care 2010, http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/EastMidlands/PandEI/Ready_to_Go_-_Hospital_Discharge_Planning.pdf.

[4] Dementia Strategy: Living well with dementia: A National Dementia Strategy https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy)

9. Reinvestment to community services from ward closures

Prior to the closure of A23, Bestwood Ward was the receiving ward for organic assessment patients from City and Nottingham North and East. A23 was the receiving ward for organic patients in Nottingham West, City South and Rushcliffe. The reinvestment into community services from this closure are continuing to be negotiated.

The number of functional beds in the south of the county has remained the same until this planned closure of Daybrook ward. Therefore it is suggested that the reinvestment from the closure of Daybrook ward is divided between City, Rushcliffe, Nottingham West and Nottingham North and East.

Each CCG will now be taken in turn regarding suggested community reinvestment: in response to the ward closures. Appendix 3 contains the longer term investment for the four CCGs required to respond to the increasing demand from the changing demographics.

All costings are 2 points below top of scale and include non pay.

10. Rushcliffe (Daybrook)

Assuming the level of reinvestment from the closure of A23 is as anticipated the next priority is to enhance dementia outreach staffing as well as nursing staff and CSW capacity within IRIS (for the additional functional patients that would need frequent nursing interventions as an alternative to admission). This would be the minimum reinvestment required to support the ward closures.

Role	Service	Proposed Additional WTE	Proposed cost (£000)	Activity
CPN Band 6 CSW	IRIS IRIS	0.50 1.00	24 29	210 840
OT Band 6	DOS	0.60	26	252
Support worker Band 3	DOS	1.00	26	588
Grand Total		**2.10**	**104**	**1890**

11. Nottingham North and East (Gedling and Hucknall) (Bestwood and Daybrook)

There are a large number of care homes in the Nottingham North and East locality, especially in the Hucknall area. The service is currently stretched across 711 nursing/care home beds. An increase in the Dementia Outreach staffing levels is recommended as below to support the closure of Bestwood Ward. An increase in staffing in the IRIS team would be required to support the closure of both wards to provide 7 day / week qualified clinician cover and extra CSW capacity.

Role	Service	Proposed Additional WTE	Proposed cost (£000)	Activity
CPN band 6	DOS	0.50	25	300
OT band 6	DOS	0.60	26	252
Support worker band 3	DOS	1.00	26	588
Band 6 CPN/OT/PT	IRIS	2.16	102	907
Assistant Practitioner band 4 CSW band 3	IRIS IRIS	1.00 1.00	33 29	588 840
Grand Total		**6.26**	**241**	**3475**

This would be the minimum reinvestment required to support the ward closures.

12. Nottingham West (Broxtowe) Daybrook only

Assuming the level of reinvestment from the closure of A23 is as anticipated the next priority is to increase the current state registered IRIS staffing compliment to achieve 7 day cover as well as increase the CSW capacity.

Role	Service	Proposed Additional WTE	Proposed cost (£000)	Activity
Band 6 CPN/OT/PT Band 3 CSW	IRIS IRIS	1.30 1.00	61 29	546 840
Grand Total		**1.30**	**90**	**1386**

13. City (Daybrook and Bestwood)

City Dementia Outreach Team has had increased investment in the last financial year and further investment has been agreed in principle for the team to cover all City CCG patients in dementia registered care homes including those out of area.

The key area to address in the City is the lack of an alternative to inpatient care for people living in their own homes. This is reflected by the higher than anticipated admission rate for City patients. They make up 11.3% of the over 65 population in Nottingham and Nottinghamshire however account for 27.7% of occupied bed days.

Some intermediate care services are provided by CityCare for the City CCG. The criteria for the service are different to that in IRIS and it is rare that patients from MHSOP services meet the service criteria and are accepted by the team. The team provides care for people with up to moderate dementia - it does not take people with moderate to severe functional mental health problems or complex dementia. This has a significant impact on avoiding a mental health admission or expediting a mental health discharge in the city locality, as reflected in the occupied bed days above.

It is crucial that this is resolved if the proposed bed reductions are to succeed, as with the beds closed it will be both impossible to maintain and treat people in their own homes or admit them. There are two possible options:

1. Align the existing service model to that in the county e.g. acceptance criteria and length of service intervention time (city is currently 6 weeks and county 12 weeks). This will require an increase in capacity to accommodate new activity or a reduction in services that are currently provided. It will additionally require significant and extensive skilling up of staff to deal with the complete range of complex mental health problems other than dementia and complex/challenging dementia.

2. Or; create a team based on the county model (NHT preferred option). Additional investment of £500k would be required to establish one team which replicates services provided to Nottingham North and East. This would be insufficient to fully cover the city area but would allow for up to 30 people (dependent on need) to be treated in their own homes.

However, until this issue is resolved the principle that City and Nottingham North and East currently access Daybrook and Bestwood the amount to be reinvested from the closure of the wards should match that of Nottingham North and East which is £241 000. City funding from the closure of A23 in 2013 also remains to be re-invested.

14. WAD investment

Over time the entry pathway into services for Working Age Dementia Diagnostics across all CCGs has been in need of review in order to continue to provide the commissioned level of service. Working Age Dementia services are consistently facing pressure given the historic under estimation of the number of referrals that the team would receive, and also increasing pressures to accept patients with substance misuse related cognitive symptoms such as Korsakoff's.

As part of the service re-design planning the directorate was asked by commissioners to review the existing WAD service provision and identify the additional resource required to meet the growing demand. This information is presented below and related only to the existing service; it does not incorporate costs for alcohol related memory impairment which would require additional financial investment.

There have been capacity issues in the WAD assessment and diagnostic service since its inception. Over the 4 years it has been running there have been on average 216 referrals for individuals who will require at least a first assessment and follow up appointment. The diagnostic service currently has available:

- 120 new assessment appointments.
- 288 follow up appointments.

However based on this the referral rate of 216/year the diagnostic service requires:

- 216 new assessment appointments.

- 353 follow up appointments (this includes 216 follow up appointments, 88 post diagnostic appointment (2nd follow up), 22 further follow ups to review due to poor tolerance of medication, 27 repeat assessment appointments).

This shortfall in the number of available appointments is demonstrated by the long waiting times to an initial assessment appointment. The current waiting time for an initial appointment is 14 weeks. In order to reduce waiting times and increase capacity to match the demand the recommendation is for further investment to recruit the following staff:

Role	Band	Wte
Advanced Practitioner	7	1.0
Psychology Assistant	4	1.0
Admin	2	0.5
Grand Total		**2.5**

The costing of this investment is **£95,177** based at top of scale and including non pay. The division of this cost between CCGs would need to be agreed as the service is Nottingham and Nottinghamshire wide.

WAD Occupational Therapy

The OT staffing level in county and Bassetlaw has been inadequate. The current model for each areas is 0.2 wte OT and 0.2 wte OT TI. All the OT posts have had extremely high turnover with difficulty in retaining staff who are working in a different locality each day. Due to this the posts have been regularly vacant. The recommendation is to therefore have 0.5 wte of each role in each locality (in this instance seeing Mansfield and Ashfield as two localities). This will both meet the demand, retain the specialism of WAD and also retain staff in these important roles. The recommended skill mix by team based on the city model rather than using population data is:

Role	Band	Wte
CPN	6	0.5
OT	6	0.5
Therapy TI	3	0.5

The investment needed to achieve this level of service and support MHSOP in retaining experienced OTs would be:

Locality	OT (band 6)	OTTI (band 3)
Bassetlaw	0.3	0.3
Mansfield and Ashfield	0.6	0.8
Broxtowe	0.3	0.3
Gedling and Hucknall	0.3	0.3
Rushcliffe	0.3	0.3
Newark and Sherwood	0.3	0.3

8

The costing of this investment is **£161,396** based at top of scale and including non pay.

15. Key Performance Indicators

Key Performance Indicators would include:

- Positive service user feedback and satisfaction with services
- Positive carer/family feedback and satisfaction with services
- All services users to have a recovery focused and risk enablement care plan, crisis and contingency plans in place
- Reduced length of stay in MHSOP inpatient wards
- Reduced re-admissions to inpatient wards
- Increased number of patients being seen by MHSOP services

16. Proposed New Model of Activity

Based on 85% bed occupancy across all functional and organic wards (90 beds), the proposed annual occupied bed days is 27, 923 against a current plan of 39,115.

Service	**Cost £000**
Enhancement of Inpatient Wards to achieve higher intensity intervention and higher throughput	386
Rushcliffe	104
Nottingham City	500 *
Nottingham West (Broxtowe)	90
Nottingham North & East (Gedling & Hucknall)	241
Total:	**£1,321**

Activity differences:

Inpatient OBD reduction	11 192
Community activity increase	12 837 *

* Based on same level of reinvestment/activity in IRIS as in Nottingham North and East as served by Daybrook and Bestwood Wards)

A re-investment in the direct cost of 63% would generate an **increase in activity of at least 14%**.

By addressing the alternatives to admission in the city theoretically **16.4% of its occupied bed days could be saved**.

Since the EMPACT study was conducted IRIS services have been established in all county areas which are having an impact on preventing admission and reducing length of stay:

MHSOP Median LOS for 14 June 2012= 52 days
MHSOP Median LOS for 14 June 2013= 43 days
MHSOP Median LOS Jan – Mar 2014 = 38 days

All these factors are supportive of reducing the bed numbers. Further calculations can be seen in Appendix 2.

17. Summary

Recent experience clearly indicates that investment into community services for older people has been successful in helping people stay at home. Furthermore, it rates more highly on quality for patients and carers than inpatient care, and has improved patient outcomes.

This paper provides an outline for the initial changes in response to the ward closures and costs. It should be noted that continuing demographic changes will increase the demand for MHSOP services over time. Further investment will be required to continue to develop alternatives to inpatient admission (i.e. IRIS) and ensure the capacity to respond in a timely manner to referrals to prevent the escalation of the situation to a crisis and the need for a higher level of services in all localities

Over time the entry pathway into services i.e. Memory Assessment, Working Age Dementia Diagnostic and Community provision and CMHT will require ongoing review in order to provide this function. The details recommended for future community services can be found in the Community Development Plan.

Working Age Dementia (WAD) services are consistently facing pressure given the historic under estimation of the number of referrals that the team would receive, and also increasing pressure to accept patients with substance misuse related cognitive symptoms such as Korsakoff's. This paper has outlined the increase in capacity needed to maintain an appropriate level of service should the commissioners wish to invest new money into this service.

The directorate is conscious that the re-investment sums have not yet been agreed by commissioners and would recommend should further funding be available WAD is specifically supported as a priority for new community investment.

Andrea Ward
General Manager
MHSOP

Dr Ola Junaid
Clinical Director
MHSOP

March 2014

With acknowledgement to Helen Smith and Satwant Kaur, Project Managers, as principal authors of the paper.

N.B. Redundancy costs from ward closures and start up costs for any newly created services are not included in this report

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
15 JULY 2014
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST PERFORANCE AGAINST FOUR HOUR EMERGENCY ACCESS TARGET
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

1. Purpose

To consider the performance of Nottingham University Hospitals NHS Trust against the operational standard for Accident and Emergency (95% of patients seen and admitted, transferred or discharged within four hours) and action that is being taken to improve performance.

2. Action required

2.1 The Committee is asked to use the information provided to scrutinise the action being taken by Nottingham University Hospitals NHS Trust to improve performance against the four hour emergency access target; and determine whether any further scrutiny is required.

3. Background information

3.1 There is a national operational standard for Accident and Emergency that 95% of patients are seen and admitted, transferred or discharged within four hours.

3.2 Over the last year there have been increasing reports at a national level about pressures on the urgent and emergency care system and the impact this has had on the ability to meet the national standard. In response NHS England requested that Urgent Care Boards were established around each A&E Department to oversee the development of an urgent recovery programme to improve standards; and work towards a medium and longer term response. The Committee has previously heard about the work of the Greater Nottingham Urgent Care Board.

3.3 Nottingham University Hospitals NHS Trust (NUH) hasn't met the 95% target since October 2013 and overall for 2013/14 achieved 93.3% against the 95% standard. Data presented to the Trust Board in June showed that NUH performance between March and June 2014 was one of the worst compared to peer trusts. The Trust has identified a number of factors affecting the ability to meet this target including capacity within

the Emergency Department, an increase in patients needing to be admitted, bed availability and recruitment challenges.

3.4 The Executive Lead for Operations and Deputy Director of Operations will be attending the meeting to give a presentation (attached) on work taking place to improve the timeliness of emergency care.

4. List of attached information

4.1 The following information can be found in the appendix to this report:

Appendix 1 – Presentation 'Improving the timeliness of emergency care' from Nottingham University Hospitals NHS Trust

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Reports to and minutes of meetings of the Joint Health Scrutiny Committee held on 10 September 2013 and 11 February 2014

Performance Report to Nottingham City Clinical Commissioning Group on 26 March 2014

Integrated Performance Report to Nottingham University Hospitals NHS Trust Board on 26 June 2014

7. Wards affected

All

8. Contact information

Jane Garrard, Overview and Scrutiny Review Co-ordinator
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

Improving the timeliness of emergency care

Jenny Leggott, Executive Lead for Operations
Nikki Pownall, Deputy Director of Operations

15 July 2015

To cover:

- Performance
- 3 key issues
- Improvement plan

Performance

- 13/14: 93.3% Vs 95% national standard

- 14/15 (Quarter 1): 87.59%

3 key issues

1. Capacity & flow
2. Workforce
3. Environment

CAPACITY & FLOW

Capacity at QMC

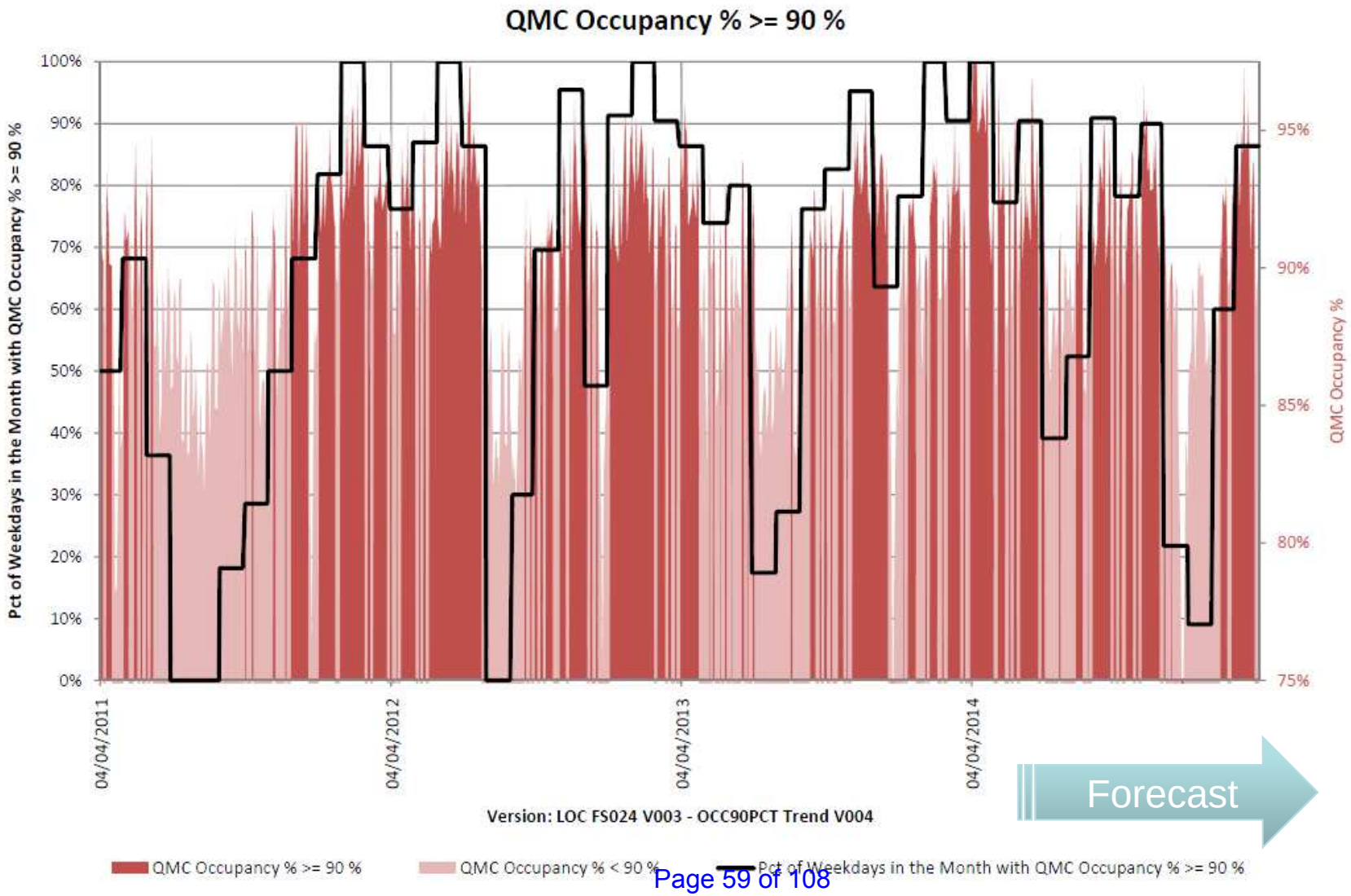
- Since winter, QMC has been operating at near-full capacity
- To get flow, we need a bed occupancy of < 90%

Factors:

1. 1.8% increase in patients >65 being admitted
2. Length of stay for these patients is 8.4 days Vs 7.5 days the previous year

QMC bed occupancy by day (where occupancy >90%

Nottingham University Hospitals NHS
NHS Trust



Forecast

We are here for you

More beds are needed

- We are working with our partners to ensure patients are transferred from acute care to community care in a timely way
- More beds are needed at NUH and in the community ahead of the coming winter
- Bed modelling shows we need 41 extra beds at NUH (QMC and City) to meet demand
- We have plans to open these beds by October, subject to recruitment

WORKFORCE

Recruitment

- We have staffing challenges

- Medical pressures: ED & Acute Medicine
- Nursing shortages: across NUH

- We take a proactive approach to nursing recruitment, including overseas recruitment

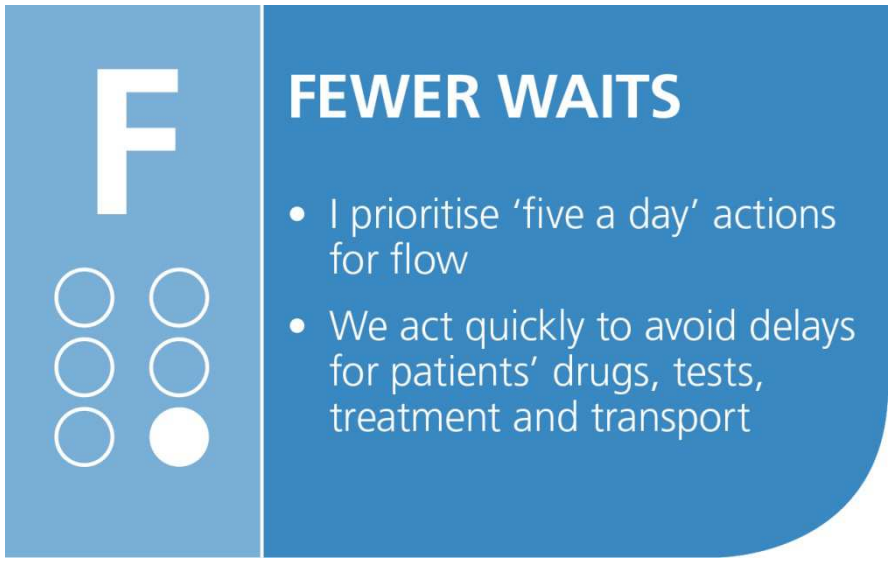
ENVIRONMENT

Environmental challenges

- ED was designed for 350 patients a day. We now regularly see over 550 patients daily
- Overcrowding in majors area (area 3, where our poorly patients are seen before being admitted to hospital)
- Insufficient cubicle capacity to assess and treat patients
- We have plans to review the environment and increase capacity this winter and beyond - including:
  - Opening 6 extra integrated assessment unit spaces and 9 extra cubicles at the end of 2014/early 2015

IMPROVEMENT PLANS

14/15 quality priority



- Quality Account
- Patient feedback & inconsistent performance has informed where we need to do better in 14/15
- We are determined to consistently achieve the 95% emergency access standard

Better for You Programme of Work

- **Emergency Department**
  - Rapid assessment & treat (4 trials complete)
  - Time to be seen by a Doctor
  - Streaming trials (ENP front door, see & treat and divert where possible)
  - Pace setter trials (Junior Doctor productivity)
  - Collaborative work with acute medicine on clinical use of Acute Medical Receiving Unit

- **Acute Medicine**
  - Improvement projects leading to 30-40% same-day discharges
  - New App under development to improve navigation
  - Ambulatory care improvements, including surgical pathway
  - GP slots through Nottingham Emergency Medical Service (NEMS)

Better for You Programme of Works

- **Healthcare of Older People**
  - Peer review of patients with length of stay > 20 days
  - Rehabilitation pathway to City Hospital
  - Dementia Care Pathway
  - Buddying scheme with high performing wards
  - Discharge Lounge projects
- **Simple & supported discharge**
  - Pharmacy-led transcription (invested in 9 additional Pharmacists)
  - Real-time monitoring across the system (go live July 2014)
- **Acting on learning from 'Perfect Week' June 2014**
  - Emergency Care Intensive Support Team (ECIST) running further rapid improvement week (September 2014)

QUESTIONS

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

15 July 2014

Agenda Item: 7

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

NEW HEALTH SCRUTINY GUIDANCE

Purpose of the Report

1. To introduce the new guidance on Health Scrutiny issued by the Department of Health.

Information and Advice

2. Last month, the Department of Health issued guidance to support Local Authorities and their partners to deliver effective health scrutiny. The guidance is intended to provide an up-to-date explanation and guide to implementation of the regulations under the National Health Service Act 2006 governing the local authority health scrutiny function. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations which came into force on 1st April 2013. The duties in the Regulations are aimed at supporting local authorities carrying out the local authority health scrutiny function.

3. The regulations describe the arrangements for Joint Health Scrutiny on page 17 at paragraph 3.1.16 and mention discretionary Joint Health Scrutiny Committees for the purpose of dealing with health issues that cross local authority boundaries. In addition, 3.1.17 also makes reference to mandatory Joint Health Committees where more than one local authority health scrutiny function needs to be consulted in relation to substantial reconfiguration proposal. It is anticipated that for Nottingham City and Nottinghamshire, this committee will fulfill both the discretionary and mandatory roles.

4. At this stage, Members are invited to note the new guidance. Officers supporting the Joint Health Committee will develop a detailed briefing on the issues raised by the guidance and bring this back to the committee in the autumn.

5. The new guidance is attached as an appendix for information.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the new guidance.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Department of Health

Local Authority Health Scrutiny

Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

June 2014

Title: **Local Authority Health Scrutiny:** Guidance to support Local Authorities and their partners to deliver effective health scrutiny
Author: SCLGCP/PCLG/18280
Document Purpose: Guidance
Publication date: June 2014 To be reviewed in June 2015
Target audience: • Local Authorities • Local Government Association • Health and Wellbeing Boards • Clinical Commissioning Groups • NHS trusts (acute, community, mental health) • NHS England • Healthwatch
Contact details: Local Government Team Department of Health Room 330, Richmond House 79 Whitehall London SW1A 2NS

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Local Authority Health Scrutiny

Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

Prepared by the People, Communities and Local Government Division of the Department of Health.

Contents

Key messages

- The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function.

- Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration - and in making recommendations about how it could be improved.

- At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service ("relevant NHS bodies and relevant health service providers"[1]) and in testing this information by drawing on different sources of intelligence.

- Health scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

- Effective health scrutiny requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local Healthwatch.

- In the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although health scrutiny functions are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends.

- Furthermore in the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

[1] In this guidance, "health service commissioners and providers" is a reference to:
a) certain NHS bodies, (i.e. NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) and
b) providers of NHS and public health services commissioned by NHS England, clinical commissioning groups and local authorities.
Each of these is "a responsible person", as defined in the Regulations, on whom the Regulations impose certain duties for the purposes of supporting local authorities to discharge their health scrutiny functions.

- Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.

- Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible. If external support is needed, informal help is freely available from the Independent Reconfiguration Panel (IRP)[2] and/or the Centre for Public Scrutiny[3]. If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals.

- In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.

- Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny. Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings. This will be in line with the new transparency measure in the Local Audit and Accountability Act 2014 and will allow local people, particularly those who are not present at scrutiny hearing-meetings, to have the opportunity to see or hear the proceedings.

[2] Independent Reconfiguration Panel website: www.ipanel.org.uk/view.asp?id=0
[3] Centre for Public Scrutiny website: www.cfps.og.uk

1. Introduction

This guidance is intended to support local authorities, relevant NHS bodies and relevant health service providers in discharging their responsibilities under the relevant regulations; and thereby supporting effective scrutiny. The guidance needs to be conscientiously taken into account. However, the guidance is not intended to be a substitute for the legislation or to provide a definitive interpretation of the legislation. Only the courts can provide a definitive interpretation of legislation. Anyone in doubt should seek legal advice.

1.1 Background

1.1.1 The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services. For some time, local authority overview and scrutiny[4] of health has been an important part of the Government's commitment to place patients at the centre of health services. It is even more important in the new system.

1.1.2 Health scrutiny is a fundamental way by which democratically elected local councillors are able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account. To this end, it is essential that health scrutiny functions are also carried out in a transparent manner, so that local people have the opportunity to see and hear proceedings, in line with the new transparency measure in the Local Audit and Accountability Act 2014. Local government itself is making an even greater contribution to health since taking on public health functions in April 2013 (and will itself be within the scope of health scrutiny). Social care and health services are becoming ever more closely integrated and impact on each other, with the result that scrutiny of one may entail, to a certain extent, scrutiny of the other. In many cases, health scrutiny reviews will be of services which are jointly commissioned by the NHS and local government.

1.1.3 Within the NHS, there has been increasing emphasis on the need to understand and respond to the views of patients and the public about health and health services: the NHS Constitution, the Government's Mandate to NHS England and the NHS Operating Framework together provide a strong set of principles underpinning the NHS's accountability to the people it serves. Responding positively to health scrutiny is one way for the NHS to be accountable to local communities.

1.1.4 This is an important and challenging time for local authority scrutiny of the health service in England. The wider context includes huge financial pressures on the public services and the challenges of an ageing society in which more people are living for longer with illness and long-term medical conditions and disability. The NHS and local government are operating in a completely new health landscape underpinned by new legislation; with care commissioned and, in many cases, potentially delivered, by more and varied organisations. New health scrutiny legislation permits greater flexibility in the way that local authorities discharge their health scrutiny functions. Local government is working ever more closely with the NHS through health and wellbeing boards, taking a holistic view of the health, public health and social care system.

[4] Referred to as 'review and scrutiny' in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

1.1.5 At the same time, the whole health and care system and the public accountability mechanisms that surround it are grappling with the implications of the Francis inquiry into the shocking failure of care at Mid-Staffordshire NHS Trust. Among many other recommendations, the Francis report says that:

- The Care Quality Commission should expand its work with overview and scrutiny committees.
- Overview and scrutiny committees and local Healthwatch should have access to complaints information.
- The "quality accounts" submitted by providers of NHS services should contain observations of commissioners, overview and scrutiny committees and local Healthwatch.

1.1.6 Following the Francis report and recommendations, the role and importance of effective health scrutiny will become more prominent. The Francis inquiry increased expectations for local accountability of health services. It is expected that health scrutiny will develop working relationships and good communication with Care Quality Commission local representatives, NHS England's local and regional Quality Surveillance Groups as well as with local Healthwatch. While there is no legislative stipulation as to the extent of support that should be made available for the health scrutiny function, the health and social care system as a whole will need to think about how the function is supported nationally, regionally and locally to enable the powers and duties associated with the function to be exercised appropriately.

1.2 Purpose of guidance

1.2.1 It is against this background that this guidance has been prepared. It is intended to provide an up-to-date explanation and guide to implementation of the regulations under the National Health Service Act 2006 governing the local authority health scrutiny function. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Regulations"), which came into force on 1st April 2013[5]. They supersede the 2002 Regulations under the Health and Social care Act 2001[6]. The Regulations have implications for relevant NHS bodies and relevant health service providers, including local authorities carrying out the local authority health scrutiny function[7], health and wellbeing boards and those involved in patient and public engagement activities. The duties in the Regulations are aimed at supporting local authorities to discharge their scrutiny functions effectively. Failure to comply with those duties would place the relevant NHS body or relevant health service provider in breach of its statutory duty and render it at risk of a legal challenge.

1.2.2 This guidance is, therefore, of relevance to:

- Local authorities (both those which have the health scrutiny functions and district councils).
- Clinical commissioning groups (CCGs).
- NHS England.

[5] References to numbered Regulations throughout this guide are to the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013.
[6] These had effect as if made under the National Health Service Act 2006.
[7] The health scrutiny function is conferred on the152 councils with social services responsibilities.

- Providers of health services including those from the public, private and voluntary sectors.
- Those involved in delivering the work of local Healthwatch.

The guidance should be read alongside other guidance issued by the Department of Health and NHS England, such as the guidance on the NHS duty to involve[8], and guidance for NHS commissioners on the good practice principles and process for planning of major service change.

1.3 Scope of the Regulations

1.3.1 The Regulations explained in this guidance relate to matters relating to the health service, i.e. including services commissioned and/or provided by the NHS as well as public health services commissioned by local authorities. This includes services provided to the NHS by external non-NHS providers, including local authorities (this is discussed in more detail in section 3).

1.3.2 The NHS Constitution, the Mandate to NHS England, and the NHS Outcomes Framework provide a set of guiding principles and values for the NHS which indicate that the NHS is not just a sickness service, but is there to improve health, wellbeing and to address health inequalities: "to pay particular attention to groups or sections of society where improvement in health and life expectancy are not keeping pace with the rest of the population[9]". The Mandate makes clear that one of NHS England's priorities should be a focus on "preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health[10]". Since the creation of the health scrutiny functions under the Health and Social Care Act 2001, local authority scrutiny committees have prioritised issues of health improvement, prevention and tackling health inequalities as areas where they can add value through their work. In their reviews, local authorities have looked at the wider social determinants of health and health inequalities, not least because of local government's own contribution through the whole range of its services.

1.3.3 NHS services can themselves impact on health inequalities and general wellbeing of communities, for example, by improving access to services for the most deprived and least healthy communities. Moreover the Department of Health has always advised and local authorities have recognised that the best use of their health scrutiny powers will depend on scrutiny extending to health issues, the health system and health economy rather than being limited to services commissioned or managed by the NHS or local authorities.

1.3.4 The duties of health service commissioners and providers under the Regulations apply to NHS commissioners and to providers of health services as part of the health service, including NHS bodies and local authorities, as discussed below. However, local authority health scrutiny committees have often drawn on their wider powers to promote

[8] http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf
[9] NHS Constitution, *The NHS belongs to us all*, March 2013: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf
[10] The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015, p8: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf

community wellbeing to carry out overview and scrutiny of a range of health issues which go beyond NHS services. In the new health landscape, public health is a responsibility of local government and health and wellbeing boards provide strategic leadership of the health system through partnership, with a specific duty to encourage integrated working across health and social care. We can expect an increasing number of services to be jointly commissioned between local authorities and the NHS. Any health scrutiny exercise may therefore include reviewing the local authority's own contribution to the health of local people and the provision of health services, as well as the role of the health and wellbeing board, and of other agencies involved in the health care of local people.

1.3.5 Responses to matters that are scrutinised may therefore be the responsibility of a number of stakeholders. In this light, the power to scrutinise the health service should be seen and used in the wider context of the local authority role of community leadership and of other initiatives to promote and facilitate improvement and reduce inequalities. In the context of the NHS reforms, this includes:

- A greater emphasis on involving patients and the public from an early stage in proposals to improve services.
- The work of health and wellbeing boards as strategic bodies bringing together representatives of the whole local health and care system.
- The work of other relevant local partnerships, such as community safety partnerships and partnerships with the community and voluntary sectors.

1.3.6 The new legislation in the 2012 Act lays increased emphasis on the role of patients and the public in shaping services. This is recognised in the introduction of local Healthwatch organisations and their membership of health and wellbeing boards. The Regulations make provision about the referral of matters by local Healthwatch to local authority health scrutiny. This is discussed in section 3 below.

1.3.7 Section 2 below outlines those aspects of the health scrutiny system that remain the same for each of the key players: local authorities, the NHS and the patient and public involvement system. Section 3 discusses in detail what has changed following the new legislation for each of these key players and how the changes should be implemented. Section 4 discusses the important issue of consultation on substantial reconfiguration proposals (i.e. proposals for a substantial development of the health service or for a substantial variation in the provision of such service). Section 5 provides references and links to relevant additional documents.

2. What remains the same following the new legislation?

2.1 For local authorities

2.1.1 Under the Regulations, local authorities in England (i.e. "upper tier" and unitary authorities[11], the Common Council of the City of London and the Council of the Isles of Scilly) have the power to:

- Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services.
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:

    - The consultation has been inadequate in relation to the content or the amount of time allowed.
    - The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
    - A proposal would not be in the interests of the health service in its area.

(In the case of referral, the Regulations lay down additional conditions and requirements as to the information that must be provided to the Secretary of State – these are listed in section 4.7 below.)

2.1.2 As previously, executive members may not be members of local authority overview and scrutiny committees, their sub-committees, joint health overview and scrutiny committees and sub-committees. Overview and scrutiny committees may include co-opted members i.e. those who are not members of the relevant local authority (for example, co-opted members of overview and scrutiny committees of district councils or representatives of voluntary sector organisations). Co-opted members may not be given voting rights except where permitted by the relevant local authority in accordance with a scheme made by the local authority[12].

[11] i.e. county councils, district councils other than lower-tier district councils and London Borough councils. However, in general, health scrutiny functions may be delegated to lower-tier district councils (except for referrals – see regulations 28 and 29) or their overview and scrutiny committees, or carried out by a joint committee of those councils and another local authority.

[12] Section 9FA of and Schedule A1 to the Local Government Act 2000, Regulations 5 and 11 of the Local Authorities (committee system) (England) Regulations 2012, and Regulation 30 of the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013.

2.1.3 The position of councils which have returned to a committee system of governance is discussed in section 3 below.

2.1.4 The position in relation to these matters remains following the new legislation, but the legislation is extended to cover additional and new organisations and diverse local authority arrangements, as described in section 3 below.

2.2 For the NHS

2.2.1 Regulations under the Health and Social Care Act 2001 created duties on the NHS which mirror the powers conferred on local authorities. These duties are carried forward into the new legislation, and require the NHS to:

- Provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny (section 3 lists all those now covered by this requirement).
- Attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny.
- Consult on any proposed substantial developments or variations in the provision of the health service[13].
- Respond to health scrutiny reports and recommendations: NHS service commissioners and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request. This applies to requests from individual health scrutiny committees or sub-committees, from local authorities and from joint health scrutiny committees or sub-committees.

2.2.2 These duties remain in place, and (following the abolition of PCTs and Strategic Health Authorities) now apply to CCGs; NHS England; local authorities as providers of NHS or public health services; and providers of NHS and public health services commissioned by CCGs, NHS England and local authorities. Additional responsibilities are described in section 3 below.

2.3 For patient and public involvement

2.3.1 Legislation has created a number of far-reaching requirements on the NHS to consult service users and prospective users in planning services, in the development and consideration of proposals for changes in the way services are provided and in decisions affecting the operation of those services.

2.3.2 For NHS trusts, the duty as to involvement and consultation is set out in section 242 of the 2006 Act (as amended by the Health and Social Care Act 2012). The public involvement duties of NHS England and of CCGs are set out in sections 13Q and 14Z2 respectively of the 2006 Act. These are separate duties from those set out in the Regulations discussed here. Together they add up to a web of local accountability for health services.

2.1.1 The Health and Social Care Act 2012 introduced local Healthwatch to represent the voice of patients, service users and the public; and health and wellbeing boards to promote partnerships across the health and social care sector. The Regulations set up formal relationships between local Healthwatch and local authority health scrutiny, to ensure

[13] Subject to exceptions as set out in the 2013 Regulations.

that the new system reflects the outcomes of involvement and engagement with patients and the public, as described in section 3 below.

3. Changes arising from the new legislation

3.1 Powers and duties – changes for local authorities

Councils as commissioners and providers of health services

3.1.1 As commissioners or providers of public health services and as providers of health services to the NHS, services commissioned or provided by local authorities are themselves within the scope of the health scrutiny legislation.

3.1.2 To that end local authorities may be bodies which are scrutinised, as well as bodies which carry out health scrutiny.

3.1.3 The duties which apply to scrutinised bodies such as the duty to provide information, to attend before health scrutiny and to consult on substantial reconfiguration proposals will apply to local authorities insofar as they may be "relevant health service providers"[14].

3.1.4 Being both scrutineer and scrutinee is not a new situation for councils. It will still be important, particularly in making arrangements for scrutiny of the council's own health role, to bear in mind possible conflicts of interest and to take steps to deal with them.

Councils as scrutineers of health services

3.1.5 The Local Government Act 2000 (as amended by the Localism Act 2011) makes provision for authorities:

- To retain executive governance arrangements (i.e. comprising a Leader and cabinet or a Mayor and cabinet).
- To adopt a committee system of governance.
- To adopt any other form of governance prescribed by the Secretary of State.

3.1.6 Health scrutiny arrangements will differ in some respects depending on the system that the council chooses to operate. Most importantly:

- Councils operating executive governance arrangements are required to have at least one overview and scrutiny committee. In this case, the scrutiny is independent of the executive.
- If a council adopts a committee system, they can operate overview and scrutiny committees if they choose, but are not required to do so.

3.1.7 At present, most local authorities are retaining executive governance arrangements. For those councils moving to a committee system, a further discussion of the differences and implications for health scrutiny is included on page 16 below.

3.1.8 Generally health scrutiny functions are in the form of powers. However, there are certain requirements under the Regulations as follows. Local authorities on whom health scrutiny functions have been conferred should:

- Have a mechanism in place to deal with referrals made by Local Healthwatch organisations or contractors[15].

[14] See section 244 of the NHS Act and Regulation 20 of the 2013 Regulations for the meaning of "relevant health service provider".

[15] See Regulation 21 of the 2013 Regulations.

- Have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals. Such responses could be made through the full council, an overview and scrutiny committee with delegated powers from the full council, a joint overview and scrutiny committee or a committee appointed under s101 of the Local Government Act.
- Councils also need to consider in advance how the members of a joint health scrutiny committee would be appointed from their council where the council was required to participate in a joint health scrutiny committee with other councils to respond to substantial reconfiguration proposals covering more than one council area.

Conferral of health scrutiny function on full council

3.1.9 The National Health Service Act 2006, as amended by the Health and Social Care Act 2012, confers health scrutiny functions on the local authority, as distinct from any overview and scrutiny committee or panel within the local authority section 244 (2ZD). This new provision is designed to give local authorities greater flexibility and freedom over the way they discharge health scrutiny functions. The full council of each local authority will determine which arrangement is adopted. For example:

- It may choose to continue to operate its existing health overview and scrutiny committee, delegating its health scrutiny functions to the committee.
- It may choose other arrangements such as appointing a committee involving members of the public and delegating its health scrutiny functions (except the function of making referrals) to that committee.
- It may operate its health scrutiny functions through a joint scrutiny committee with one or more other councils.

3.1.10 As indicated above local authorities may delegate their health scrutiny functions under section 101 of the Local Government Act 1972 but are not permitted to delegate the functions to an officer (Regulation 29).

3.1.11 Executive members of councils operating executive governance arrangements (that is a Leader and cabinet or a Mayor and cabinet) may not be members of local authority overview and scrutiny committees or of their sub-committees or of joint health overview and scrutiny committees and sub-committees.

3.1.12 Overview and scrutiny committees are a proven model offering a number of benefits that other structures may not, including having a clear identity within the local authority, political balance and, in many cases, an established reputation within the local community for independence and accessibility.

Delegation of health scrutiny function by full council

3.1.13 The legislation enables health scrutiny functions to be delegated to:

- An overview and scrutiny committee of a local authority or of another local authority (Regulation 28).
- A sub-committee of an overview or scrutiny committee (Local Government Act 2000).
- A joint overview and scrutiny committee (JOSC) appointed by two or more local authorities or a sub-committee of such a joint committee.
- A committee or sub-committee of the authority appointed under section 102 of the Local Government Act 1972 (section 101 of the Local Government Act 1972) (except for referrals).
- Another local authority (section 101 of Local Government Act 1972) (except for referrals).

3.1.14 Local authorities may not delegate the health scrutiny functions to an officer – this option under the Local Government Act 1972 is disapplied (disallowed) by Regulation 29.

3.1.15 If a council decides to delegate to a health scrutiny committee, it need not delegate *all* of its health scrutiny functions to that committee (i.e. it could retain some functions itself). For example, it might choose to retain the power to refer issues to the Secretary of State for Health as discussed below. Equally, it might choose to delegate that power to the scrutiny committee.

Joint health scrutiny arrangements

3.1.16 As before, local authorities may appoint a discretionary joint health scrutiny committee (Regulation 30) to carry out all or specified health scrutiny functions, for example health scrutiny in relation to health issues that cross local authority boundaries. Establishing a joint committee of this kind does not prevent the appointing local authorities from separately scrutinising health issues. However, there are likely to be occasions on which a discretionary joint committee is the best way of considering how the needs of a local population, which happens to cross council boundaries, are being met.

3.1.17 Regulation 30 also requires local authorities to appoint joint committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals (referred to below as a mandatory joint health scrutiny committee). In such circumstances, Regulation 30 sets out the following requirements (see section 4 on consultation below for more detail).

- Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation.

3.1.18 These restrictions do not apply to referrals to the Secretary of State. Local authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so. If a local authority had already appointed a discretionary committee, they could even delegate the power to that committee if they choose to.

3.1.19 If the local authority has delegated this power, then they may not subsequently exercise the power of referral. If they do not delegate the power, they may make such referrals.

3.1.20 A situation might arise where one of the participating local authorities had delegated their power of referral to the joint committee but not the other(s). In such a case a referral could be made by: the JOSC or any of the authorities which had not delegated their power of referral to the JOSC, but not the authorities which had delegated their power of referral to the JOSC.

Reporting and making recommendations

3.1.21 Regulation 22 enables local authorities and committees (including joint committees, sub-committees and other local authorities to which health scrutiny functions have been delegated) to make reports and recommendations to relevant NHS bodies and health

service providers. The following information must be included in a report or recommendation:

- An explanation of the matter reviewed or scrutinised.
- A summary of the evidence considered.
- A list of the participants involved in the review or scrutiny.
- An explanation of any recommendations on the matter reviewed or scrutinised.

3.1.22 A council can choose to delegate to an overview and scrutiny committee (including joint committee, sub-committee or another local authority) the function of making scrutiny reports and recommendations to relevant NHS bodies and health service commissioners. Alternatively, a council can choose to delegate only the function of *preparing* such reports and recommendations, and retain for itself the function of actually *making* that report or recommendation. The latter approach would give the full council the opportunity to endorse the report or recommendation before it was sent to the NHS.

3.1.23 Where a local authority requests a response from the relevant NHS body or health service provider to which it has made a report or recommendation, there is a statutory requirement (Regulation 22) for the body or provider to provide a response in writing within 28 days of the request.

Conflicts of interest

3.1.24 Councils should take steps to avoid any conflict of interest arising from councillors' involvement in the bodies or decisions that they are scrutinising. A conflict might arise where, for example, a councillor who was a full voting member of a health and wellbeing board was also a member of the same council's health scrutiny committee or of a joint health scrutiny committee that might be scrutinising matters pertaining to the work of the health and wellbeing board.

3.1.25 Conflicts of interest may also arise if councillors carrying out health scrutiny are, for example:

- An employee of an NHS body.
- A member or non-executive director of an NHS body.
- An executive member of another local authority.
- An employee or board member of an organisation commissioned by an NHS body or local authority to provide services.

3.1.26 These councillors are not excluded from membership of overview and scrutiny committees, and, clearly, where the full council has retained the health scrutiny function, they will be involved in health scrutiny. However they will need to follow the rules and requirements governing the existence of interests in matters considered at meetings. Where such a risk is identified, they should consult their monitoring officer for advice on their involvement.

Councils operating a committee system

3.1.27 Councils which have returned to a committee system under the Local Government Act 2000 may or may not have retained a council-wide overview and scrutiny function. If they have retained such function, they will be able to delegate their health scrutiny functions to overview and scrutiny committees in the same way as those councils operating executive arrangements that have executive and scrutiny functions.

3.1.28 Councils with a committee system that have not retained a council-wide scrutiny function will need to decide what to do about their health scrutiny functions. The health scrutiny function is conferred on the full council but delegation to a committee, joint committee, sub-committee or another local authority is permitted (except in the case of referrals in relation to which delegation under section 101 of the Local Government Act 1972 is not permitted). Therefore such a council might retain health scrutiny functions or delegate these to a committee, joint committee or sub-committee (or indeed to another council or its overview and scrutiny committee).

3.1.29 In deciding how to operate a health scrutiny function, councils operating a committee system will need to consider issues of potential conflicts of interest. Like upper tier and unitary councils, they will need to have a health and wellbeing board whose work will be within the scope of health scrutiny insofar as it relates to the planning, provision and operation of the health service. They may also have a health and social care committee or a stand-alone health committee which makes decisions about the commissioning of public health services. A conflict might arise where, for example, under a committee system, the members of any committee of the council which is taking commissioning decisions on public health services, are also members of its health scrutiny committee or where a health and social care committee of a council operating a committee system is also acting as a health overview and scrutiny committee. The solution might be to have a separate health overview and scrutiny committee, with different members.

3.1.30 Regardless of the governance arrangements being operated by a council, the health scrutiny function may not be delegated to an officer (Regulation 29).

The role of district councils

3.1.31 As previously, under the new Regulations (Regulation 31), district councillors in two tier areas, who are members of district overview and scrutiny committees, may be co-opted by the upper tier county council onto health overview and scrutiny committees of those councils or other local authorities. Such co-option may be on a long term (i.e. for the life of the overview and scrutiny committee or until the county council decides) or ad hoc basis (i.e. for review and scrutiny of a particular matter) (Regulation 31).

3.1.32 District councillors in two tier areas may also (Regulation 30 read with the Local Government Act 2000) be co-opted onto joint health scrutiny committees between the upper tier county councils and other local authorities.

3.1.33 District councillors in two tier areas may also be on joint health scrutiny committees of the relevant district council and the upper tier county council (Regulation 30).

3.1.34 Many county councils have taken the opportunity to co-opt district councillors onto their scrutiny committees, as district councillors bring very local knowledge of their communities' needs and may also provide a useful link to enhance the health impact of district council services. Health and wellbeing strategies in two-tier areas are likely to include reference to the role of district councils in improving health and reducing inequalities, for example through their housing and leisure functions. As health and wellbeing boards' functions including their strategies (insofar as related to the planning, provision and operation of the health service) will be within the scope of health scrutiny, this provides an additional reason for considering the co-option of district councillors.

3.2 Powers and duties – changes for the NHS

Extension of scope of health scrutiny

3.2.1 A significant change for the NHS in the new health landscape is the extension of certain duties in the Regulations to cover providers of health services (commissioned by NHS England, CCGs or local authorities) who are not themselves NHS bodies. Together with relevant NHS bodies these are known as 'responsible persons' in the legislation and these include:

- CCGs
- NHS England
- Local authorities (insofar as they may be providing health services to CCGs, NHS England or other local authorities).
- NHS trusts and NHS foundation trusts.
- GP practices and other providers of primary care services (previously not subject to specific duties under health scrutiny regulations as independent contractors, they are now subject to duties under the new Regulations as they are providers of NHS services).
- Other providers of primary care services to the NHS, such as pharmacists, opticians and dentists.
- Private and voluntary sector bodies commissioned to provide NHS or public health services by NHS England, CCGs or local authorities.

3.2.2 Under the Regulations, 'responsible persons' are required to comply with a number of duties to assist the health scrutiny function. These duties are underpinned by the duty of co-operation which applies between the NHS and local authorities under section 82 of the NHS Act 2006 which requires them, in exercising their respective functions, to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

Required provision of information to health scrutiny

3.2.3 Regulation 26 imposes duties on 'responsible persons' to provide a local authority with such information about the planning, provision and operation of health services in the area of the authority as it may reasonably require to discharge its health scrutiny functions. All relevant NHS bodies and health service providers (including GP practices and other primary care providers and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority) have a duty to provide such information.

3.2.4 In addition, the duty of candour under the NHS Standard Contract is also relevant in relation to the provision of information to patients generally.

3.2.5 The type of information requested and provided will depend on the subject under scrutiny. It may include:

- Financial information about the operation of a trust or CCG, for example budget allocations for the care of certain groups of patients or certain conditions, or capital allocations for infrastructure projects, such as community facilities.
- Management information such as commissioning plans for a particular type of service.
- Operational information such as information about performance against targets or quality standards, waiting times.

- Patient information such as patient flows, patient satisfaction surveys, numbers and types of complaints and action taken to address them.
- Any other information relating to the topic of a health scrutiny review which can reasonably be requested.

3.2.6 Confidential information that relates to or identifies a particular living individual or individuals cannot be provided unless the individual or individuals concerned agree to its disclosure. However, the information can be disclosed in a form from which identification is not possible. In such a situation, health scrutiny bodies (i.e. councils or council health overview and scrutiny committees or sub-committees carrying out delegated health scrutiny functions) can require that the information be put in a form from which the individual cannot be identified in order that it may be disclosed.

3.2.7 In some cases, information, such as financial information, may be commercially sensitive. In such cases, it may be possible for health scrutiny to receive this information in confidence to inform, but not be directly referred to in, its reports and recommendations.

Required attendance before health scrutiny

3.2.8 Members and employees of a relevant NHS body or relevant health service provider have a duty to attend before a local authority when required by it (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions. This duty now applies to all those listed at the beginning of this section. So, for example, if a local authority were to require the attendance of a member of a CCG, or of a private company commissioned to provide particular NHS services, it could do so under the Regulations. Bodies, the employees or members of which are required to attend by local authority health scrutiny, are expected to take the appropriate steps to ensure the relevant member or employee complies with this requirement[16].

3.2.9 As regards the attendance of particular individuals, identification of the appropriate member or employee to attend will depend on the type of scrutiny review being undertaken and its aims. By way of example, where the local authority has required attendance of a particular individual, say the accountable officer of a clinical commissioning group, and it is not practicable for that individual to attend or if that individual is not the most suitable person to attend, the CCG would be expected to suggest another, relevant individual. Thus, in such situations, both the local authority and the commissioner or provider (as the case may be) would be expected to co-operate with each other to agree on a suitable person for attendance and, in doing so, to act reasonably at all times.

Responding to scrutiny reports and recommendations

3.2.10 Depending on the topic being reviewed, reports and recommendations by local authority health scrutiny bodies may be made to any of the relevant NHS bodies or health service providers covered by the legislation (and, in the case of health scrutiny by a body to which the function has been delegated, to the delegating authority e.g. the relevant local authority or in the case of a sub-committee appointed by a committee, that committee or its local authority).

[16] The meaning of 'member' is given in section 244 of the NHS Act 2006 and includes people who are members of committees or sub-committees of CCGs who are not members of the CCG, directors of NHS trusts and directors and governors of NHS foundation trusts. They also include directors of bodies which provide health services commissioned by NHS England, CCGs and local authorities.

3.2.11 Relevant NHS bodies and health service providers to which a health scrutiny report or and recommendation has been made must by law, if a response is requested, respond within 28 days of the request. Reports and recommendations are expected to be based on evidence. Respondents should take the evidence presented seriously, giving a considered and meaningful response about how they intend to take forward reports or recommendations. Meaningful engagement is likely to lead to improvements in quality and access to services.

3.2.12 Many local authorities, as part of their work plan, return to completed scrutiny reviews after a certain period – usually 6 months or a year – to find out whether and how their recommendations have been implemented and how they have influenced improvements. Relevant NHS bodies and health service providers to whom scrutiny reports have been presented should be prepared for this kind of follow-up and be able to report on progress and improvements resulting from scrutiny reviews.

3.3 Powers and duties – referral by local Healthwatch

3.3.1 Local Healthwatch organisations and contractors have specific roles which complement those of health scrutiny bodies. For example, they can “enter and view” certain premises at which health and social care services are provided. This can enable local Healthwatch to act as the “eyes and ears” of patients and the public; to be a means for health scrutiny to supplement and triangulate information provided by service providers; and to gain an additional impression of quality of services, safety and issues of concern around specific services and provider institutions. Health scrutiny bodies and local Healthwatch are likely each to benefit from regular contact and exchange of information about their work programmes. It may also be helpful in planning work programmes, to try to ensure that certain aspects are aligned. For example, if a health scrutiny body is planning a review of a certain service, it might be useful if local Healthwatch plans to visit the service in a timely way to inform the review.

3.3.2 Local Healthwatch organisations and their contractors carry out certain statutory activities including that of making reports and recommendations concerning service improvements to scrutiny bodies. This would cover the provision of information and the referral of matters relating to the planning, provision and operation of health services in their area (which could potentially include concerns about local health services or commissioners and providers) to local authority health scrutiny bodies.

3.3.3 Regulation 21 sets out duties that apply where a matter is referred to a local authority by a local Healthwatch organisations or contractors. The local authority must:

- Acknowledge receipt of referrals within 20 working days.
- Keep local Healthwatch organisations (or contractors as the case may be) informed of any action it takes in relation to the matter referred.

4.Consultation

4.1 The context of consultation

4.1.1 The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public. Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS's public involvement and consultation duties as these are separate. The NHS should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed.

4.1.2 The backdrop to consultation on substantial reconfiguration proposals is itself changing. The ideal situation is that proposals for change emerge from involving service users and the wider public in dialogue about needs and priorities and how services can be improved. Much of this dialogue may take place through representation of service users and the public on health and wellbeing boards and through the boards' own public engagement strategies. With increasing integration of health and care services, many proposals for change may be joint NHS-local authority proposals which may have been discussed at an early stage through the health and wellbeing board. Health scrutiny bodies should be party to such discussions – local circumstances will determine the best way for this to happen. If informally involved and consulted at an early enough stage, health scrutiny bodies in collaboration with local Healthwatch, may be able to advise on how patients and the public can be effectively engaged and listened to. If this has happened, health scrutiny bodies are less likely to raise objections when consulted.

4.1.3 NHS England has published good practice guidance for NHS commissioners on the planning and development of proposals for major service changes and reconfigurations. The guidance is designed to support commissioners, working with local authorities and providers, to carry out effective service reconfiguration in a way that puts quality of care first, is clinically evidence-based and which involves patients and the public throughout. It is intended to be used as a reference guide to help develop and implement plans in a clear and consistent way. The guidance is available at:

http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

4.2 When to consult

4.2.1 Regulation 23 requires relevant NHS bodies and health service providers to consult a local authority about any proposal which they have "under consideration" for a substantial development of or variation in the provision of health services in the local authority's area. The term "under consideration" is not defined and will depend on the facts, but a development or variation is unlikely to be held to be "under consideration" until a proposal has been developed. The consultation duty applies to any "responsible person" under the legislation, i.e. relevant NHS bodies and health service commissioners which now come under the scope of health scrutiny as described above.

4.2.2 As previously, "substantial development" and "substantial variation" are not defined in the legislation. Many local authority scrutiny bodies and their NHS counterparts have developed joint protocols or memoranda of understanding about how the parties will

reach a view as to whether or not a proposal constitutes a “substantial development” or “substantial variation”. Although there is no requirement to develop such protocols it may be helpful for both parties to do so. The local authority may find a systematic checklist, of the kind often contained in such protocols, useful in reaching a view about whether a proposed development or variation is substantial and, for example, NHS commissioners may find it helpful in explaining to providers what is likely to be regarded as substantial.

4.3 Who consults

4.3.1 In the case of substantial developments or variation to services which are the commissioning responsibility of CCGs or NHS England, consultation is to be done by NHS commissioners rather than providers i.e. by the relevant CCG(s) or NHS England. When these providers have a development or variation “under consideration” they will need to inform commissioners at a very early stage so that commissioners can comply with the requirement to consult as soon as proposals are under consideration.

4.4 Timescales for consultation

4.4.1 The Regulations now require timescales to be provided to health scrutiny bodies and to be published by the proposer of substantial developments or variations, (Regulation 23). When consulting health scrutiny bodies on substantial developments or variations, a relevant NHS body or health service provider is required by the Regulations to notify the health scrutiny body of the date by which it requires the health scrutiny body to provide comments in response to the consultation and the date by which it intends to make a decision as to whether to proceed with the proposal[17]. These dates must also be published. This is so that local patients and communities are aware of the timescales that are being followed. Any changes to these dates must be notified to the relevant health scrutiny body and published. Constructive dialogue between relevant NHS bodies and health service providers on the one hand, and health scrutiny bodies on the other, when communicating on timescales for comments or decisions in relation to substantial developments or variations should help ensure that timescales are realistic and achievable.

4.4.2 It is sensible for health scrutiny to be able to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion.

4.5 When consultation is not required

4.5.1 The Regulations set out certain proposals on which consultation with health scrutiny is *not* required. These are:

- Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might for example cover the situation where a ward needs to close immediately because of a viral outbreak) – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this.

[17] Government guidance on consultation principles was published in July 2012 (see references).

- Where there is a proposal to establish or dissolve or vary the constitution of a CCG or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.
- Where proposals are part of a trusts special administrator's report or draft report (i.e. when a trust has financial difficulties and is being run by an administration put in place by the Secretary of State) – these are required to be the subject of a separate 30-day community-wide consultation.

4.6 Responses to consultation

4.6.1 Where a health scrutiny body has been consulted by a relevant NHS body or health service provider on substantial developments or variations, the health scrutiny body has the power to make comments on the proposals by the date (or changed date) notified by the body or provider undertaking the consultation. Having considered the proposals and local evidence, health scrutiny bodies should normally respond in writing to the body undertaking the consultation and when commenting would need to keep within the timescale specified by them.

4.6.2 Where a health scrutiny's body's comments include a recommendation and the consulting organisation disagrees with that recommendation, that organisation must notify the health scrutiny body of the disagreement. Both the consulting organisation and the health scrutiny body must take such steps as are reasonably practicable to try to reach agreement. Where NHS England or a clinical commissioning group is acting on behalf of a provider, in accordance with the Regulations, as mentioned above, the health scrutiny body and NHS England or the CCG (as the case may be) must involve the provider in the steps they are taking to try to reach agreement.

4.6.3 Where a health scrutiny body has not commented on the proposal or has commented but without making a recommendation, it must notify the consulting organisation as to its decision as to whether to refer the matter to the Secretary of State and if so, the date by which it proposes to make the referral or the date by which it will make a decision on whether to refer the matter to the Secretary of State.

4.7 Referrals to the Secretary of State

4.7.1 Local authorities may refer proposals for substantial developments or variations to the Secretary of State in certain circumstances outlined below. The circumstances remain largely the same as in previous legislation.

4.7.2 The new Regulations set out certain information and evidence that are to be provided to the Secretary of State and the steps that must be taken before a referral can be made. On receiving a referral from a local authority, overview and scrutiny committee, joint committee or sub-committee, the Secretary of State may ask for advice from the Independent Reconfiguration Panel (IRP), an advisory non-departmental public body. The new Regulations do not affect the position of the IRP. The IRP will undertake an initial assessment of any referral to the Secretary of State for Health where its advice is requested**.** It may then be asked to carry out a full review. Not all referrals to the Secretary of State for Health will automatically be reviewed in full by the IRP – this is at the Secretary of State's discretion. The IRP has published a summary of its views on what can be learned from the referrals it has received and the reviews it has undertaken from the perspective both of the NHS and of health scrutiny. The IRP also offers pre-

consultation advice and support to NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change - including advice and support on methods for public engagement and formal public consultation.

Relevant NHS bodies, health service providers and local authority scrutiny may also find it helpful to read its report on the *Safe and Sustainable* review of children's heart surgery, the first national reconfiguration proposal referred to the IRP, whose recommendations were accepted by the Secretary of State (see references).

4.7.3 The powers under the previous Regulations to refer matters relating to NHS foundation trusts to Monitor have been removed, as this was not considered appropriate to the role of Monitor and the new licensing regime.

Circumstances for referral

4.7.4 The circumstances for referral of a proposed substantial development or variation remain the same as in previous legislation. That is, where a health scrutiny body has been consulted by a relevant NHS body or health service provider on a proposed substantial development or variation, it may report to the Secretary of State in writing if:

- It is not satisfied with the adequacy of content of the consultation.
- It is not satisfied that sufficient time has been allowed for consultation.[18]
- It considers that the proposal would not be in the interests of the health service in its area.
- It has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

4.7.5 However, there are certain limits on the circumstances in which a health scrutiny bodies may refer a proposal to the Secretary of State.

In particular, where a health scrutiny body has made a recommendation and the relevant NHS body or health service provider has disagreed with the recommendation, the health scrutiny body may not refer a proposal unless:

- it is satisfied that reasonably practicable steps have been taken to try to reach agreement (with steps taken to involve the provider where NHS England or a CCG is acting on the provider's behalf) but agreement has not been reached within a reasonable time; or
- it is satisfied that the relevant NHS body or health service provider has failed to take reasonably practicable steps to try to reach agreement within a reasonable period.

In a case where a health scrutiny body has not commented on the proposal or has commented without making a recommendation, the health scrutiny body may not refer a proposal unless:

- It has informed the relevant NHS body or health service provider of-
  - its decision as to whether to exercise its power of referral and, if applicable, the date by which it proposed to exercise that power, or
  - the date by which it proposes to make a decision as to whether to exercise its power of referral.

- In a situation where it informed the relevant NHS body or health service provider of the date by which it proposed to decide whether to exercise the power of referral, it has made that decision by that date and informed the body or provider of the decision.

[18] The referral power in the context of inadequate consultation only relates to the consultation with the local authority, and not consultation with other stakeholders.

Who makes the referral?

4.7.6 Where a local authority has a health overview and scrutiny committee (e.g. under section 9F of the Local Government Act 2000, as amended by the Localism Act 2011) as the means of discharging its health scrutiny functions, the health overview and scrutiny committee may exercise the power of referral on behalf of the local authority where this has been delegated to it. The power of referral may also be delegated to an overview and scrutiny committee of another local authority in certain circumstances (Regulation 28). Where a local authority has retained the health scrutiny function for the full council to exercise, or where it has delegated some health scrutiny functions, but not the power of referral to a committee, the full council would make the referral.

4.7.7 Where a local authority has established an alternative mechanism to discharge its health scrutiny functions, such as delegation to a committee, sub-committee or another local authority under section 101 of the Local Government Act 1972, the referral power cannot be delegated to that committee, sub-committee or other local authority but must instead be exercised by the local authority as a function of the full council (or delegated to an overview and scrutiny as above, although local authorities would need to consider the appropriateness of separate delegation to an overview and scrutiny committee in such circumstances)[19].

4.7.8 Where a local authority is participating in a joint overview and scrutiny committee (JOSC) (see pages 14-15), who makes the referral will depend on whether the power to refer has been delegated to the joint committee or retained by the local authority.

4.7.9 The following applies to both discretionary joint committees (i.e. where councils have chosen to appoint the joint committee to carry out specified functions) and mandatory joint committees (i.e. where councils have been required under Regulation 30 to appoint a joint committee because a local NHS body or health service provider is consulting more than one local authority's health scrutiny function about substantial reconfiguration proposals):

- Where the power to refer has been delegated to the joint committee, only the joint committee may make a referral.
- Where the power to refer has not been delegated to the joint committee, the individual authorities that have appointed the joint committee (or health overview and scrutiny committees or sub-committees to whom the power has been delegated) may make a referral.

4.7.10 In the case of either mandatory or discretionary JOSCs, where individual authorities have retained the power to refer, they should ensure that they are in a position to satisfy the relevant requirements under Regulation 23 to include certain explanations and evidence with the referral. They should also ensure that they can demonstrate compliance with the conditions set out in Regulation 23(10), bearing in mind that in the case of a mandatory JOSC, only that JOSC may make comments to the consulting body and that, where the JOSC makes a recommendation which is disagreed with by the consulting body, certain requirements have to be satisfied before a referral can be made.

Information and evidence to be sent to Secretary of State

[19] See Regulation 29.

4.7.11 When making a referral to the Secretary of State, certain information and evidence must be included. Health scrutiny will be expected to provide very clear evidence-based reasons for any referral to the Secretary of State. These requirements are new since the previous Regulations, so they are given here in full. Referrals must now include:

- An explanation of the proposal to which the report relates.
- An explanation of the reasons for making the referral.
- Evidence in support of these reasons.
- Where the proposal is referred because of inadequate consultation, the reasons why the health scrutiny body is not satisfied of its adequacy.
- Where the proposal is referred because there was no consultation for reasons relating to safety or welfare of patients or staff, reasons why the health scrutiny body is not satisfied that the reasons given for lack of consultation are adequate.
- Where the health scrutiny body believes that proposals are not in the interests of the health service in its area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area.
- An explanation of any steps that the health scrutiny body has taken to try to reach agreement with the relevant NHS body or health service provider.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has been made.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has not been made, or where no comments have been provided on the proposal.

4.7.12 The terms of reference of the IRP, in assessing proposals and providing advice to the Secretary of State, are to consider whether the proposals will provide safe, sustainable and accessible services for the local population. Referrals to the Secretary of State and information provided by consulting bodies when consulting health scrutiny will, therefore be most helpful if they directly address each of these issues.

5. References and useful links

5.1 Relevant legislation and policy

- Department of Health (2013), *The NHS Constitution: the NHS belong to us all*: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

- Department of Health (2012), *The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf

- Government guidance on consultation principles (2012): https://www.gov.uk/government/publications/consultation-principles-guidance

- Health and Social Care Act 2001, sections 7 – 10: http://www.legislation.gov.uk/ukpga/2001/15/contents

- Health and Social Care Act 2012, sections 190 – 192: http://www.legislation.gov.uk/ukpga/2012/7/contents

- Local Government Act 2000: http://www.legislation.gov.uk/ukpga/2000/22/contents

- The Localism Act 2011: http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted

- National Health Service Act 2006, sections 244 – 245: http://www.legislation.gov.uk/ukpga/2006/41/contents

- Statutory Instrument No. 2013/218 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: http://www.legislation.gov.uk/uksi/2013/218/contents/made

5.2 Useful reading

- Centre for Public Scrutiny (2013): *Spanning the system: broader horizons for council scrutiny* (based on health scrutiny work on the health reforms in 14 local authority areas)*:* http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L13_19_CfPSspanning_the_system__web.pdf

- Centre for Public Scrutiny (2012): *Local Healthwatch, health and wellbeing boards and health scrutiny: roles, relationships and adding value:* http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_693_CFPS_Healthwatch_and_Scrutiny_final_for_web.pdf

- Centre for Public Scrutiny (2011), *Peeling the Onion,* learning, tips and tools from the DH-funded Health Inequalities Scrutiny Programme: http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf

- Centre for Public Scrutiny (2007): *Ten questions to ask if you're assessing evidence:* http://www.cfps.org.uk/publications?item=209&offset=150

- Independent Reconfiguration Panel (2010): *Learning from Reviews:* http://www.irpanel.org.uk/lib/doc/learning%20from%20reviews3%20pdf.pdf

- Independent Reconfiguration Panel (2013): *Advice on* Safe and Sustainable *proposals for children's heart services*: http://www.irpanel.org.uk/lib/doc/000%20s&s%20report%2030.04.13.pdf

- Institute of Health Equity (2008), *Fair Society, Healthy Lives* (the Marmot report): http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

- LGA and ADSO (2012), *Health and wellbeing boards: a practical guide to governance and constitutional issues*: http://www.local.gov.uk/c/document_library/get_file?uuid=ca8437aa-742c-4209-827c-996afa9583ca&groupId=10171

- NHS England's guidance on the duty to involve (2013): *Transforming Participation in Health and Care* - http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

- NHS England (2013): *Planning and Delivering Service Change for Patients* - http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

15 July 2014

Agenda Item: 8

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents.

3. The draft work programme for 2014-15 is attached as an appendix for information.

4. It had been hoped that Members would receive a briefing on NHS 111 performance at this meeting, but the relevant officers were not available to attend. This item has therefore been scheduled for the September meeting.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the draft work programme for 2014-15.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Joint Health Scrutiny Committee 2014/15 Work Programme

10 June 2014	• **Intoxicated Patients Study Group** To consider the report and recommendations of the Intoxicated Patients Study Group • **Terms of Reference and Joint Protocol**
15 July 2014	• **Developments in Adult Mental Health Services** To receive information about developments in adult mental health services (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **NUH Performance Against Four Hour Emergency Department Waiting Time Targets** To receive the latest performance information (NUH) • **New Health Scrutiny Guidance** To receive briefing on the new Department of Health guidance on Health Scrutiny
9 September 2014	• **Greater Nottingham Urgent Care Board** To consider the progress of the Greater Nottingham Urgent Care Board (Nottingham City CCG lead) • **Patient Transport Service** To consider performance in delivery of Patient Transport Services (Arriva/ CCG lead) • **NUH Pharmacy Data** Information received as part of ongoing review • **NHS 111 Performance** To receive the latest update on workforce change implementation (Nottingham City/Nottinghamshire County CCG)

14 October 2014	• **Intoxicated Patients Review** To consider the response to the recommendations of this review (NUH)
11 November 2014	• **Update on joint working to improve care for frail older people** To review progress in how partners are working together to improve the care of frail older people (Nottingham City CCG, Nottingham City Council, Nottinghamshire County Council, Nottingham University Hospitals)
9 December 2014	• **Approach to Child and Adolescent Mental Health Services** Initial Briefing (Nottinghamshire Healthcare Trust)
13 January 2015	• **NUH Environment & Waste** Initial Briefing (Nottingham University Hospitals)
10 February 2015	
10 March 2015	
21 April 2015	

To schedule:

- NHS 111 – to consider outcomes of GP pilot and performance following workforce changes
- Response to recommendations from the Intoxicated Patients Review
- Report and recommendations of the Pharmacy Review
- Nottingham University Hospital Maternity and Bereavement Unit
- Health Scrutiny Guidance
- 24 Hour Services
- Outcomes of primary care access challenge fund pilots

Visits:

- EMAS
- Urgent and Emergency Care Services (various date

Study groups:

- Quality Accounts
- Waiting times for pharmacy at Nottingham University Hospitals NHS Trust