Nottinghamshire County Council

Health Scrutiny Committee

Monday, 20 July 2015 at 14:00

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

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) 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:-

(3) 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 David Ebbage (Tel. 0115 977 3141) or a colleague in Democratic Services prior to the meeting.

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

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

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Monday 18 May 2015 at 2pm

Membership

Councillors

Colleen Harwood (Chairman)
John Allin
Kate Foale
Bruce Laughton
John Ogle
Jacky Williams

District Members

A	Glenys Maxwell	Ashfield District Council
A	Brian Lohan	Mansfield District Council
	David Staples	Newark and Sherwood District Council
A	Griff Wynne	Bassetlaw District Council

Officers

Sara Allmond	Nottinghamshire County Council
Martin Gately	Nottinghamshire County Council

Also in attendance

Joe Pigeon	Healthwatch Nottinghamshire
Barbara Brady	Public Health Consultant
Rick Dickinson	Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Simon Parkes	Newark & Sherwood Clinical Commissioning Group
Sue Bowler	Sherwood Forest Hospitals NHS Foundation Trust
Amanda Callow	Sherwood Forest Hospitals NHS Foundation Trust
Elaine Moss	Sherwood Forest Hospitals NHS Foundation Trust
Kerry Rogers	Sherwood Forest Hospitals NHS Foundation Trust

MINUTES

The minutes of the last meeting held on 23 March 2015, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Brian Lohan and Griff Wynne

DECLARATIONS OF INTEREST

There were no declarations of interest.

SHERWOOD FOREST HOSPITALS – REGULATORY UNDERTAKINGS

Kerry Rogers and Sue Bowler, Sherwood Forest Hospitals Trust introduced the report which provided monitoring information on financial position of the Trust. The compliance certificate for section 106 was predominately why the Trust was in special measures.

The Trust had intended to be further forward on closing the deficit at this point. There had been additional allowances included provision to change senior management. The Trust met Monitor regularly and an Inspector had been appointed who would monitor progress. An inspection by the Care Quality Commission (CQC) was also anticipated imminently.

The Trust had short and long term plans in place to deal with the deficit.

During discussion the following points were raised:

- The Trust had not given themselves enough slack in the plans to ensure that the plans did not go off track. A new delivery model was now in place along with a new manager to tackle situation.

- Some areas of the Trust were not coding cases correctly meaning that the mortality figures were not accurate. This meant that the Trust wasn't being paid for all of the work it was doing.

- The Trust were having to rely on agency staff due to not being able to recruit, however the Trust had more nurses now than the same time last year so there was successful recruitment. There were new recruitment and retention strategies in place so the use of agency staff was diminishing.

- The Trust had been very successful in recruiting consultants recently with a high calibre of candidates. However there were still vacancies and in winter there would be higher demand and therefore greater capacity needed.

- The Trust were concentrating on getting their own finances in order and all inefficiencies driven out before they considered looking at external finances.

- The Trust now had a realistic recovery programme in place.

- The Trust had a deficit of £30+ million including the PFI contract. At the end of the next five years the Trust would still be in deficit due to the scale of it. A single year plan would be ready in July and a five year plan ready in October.

- In relation to patient care, the Trust had been delivering the four access target for at least 10 weeks, where they had not been achieving for 18 months. The improvements had been delivered through successful partnership working. This included reducing the length of stays for under 14 days where the patient did not need to be in hospital.

A report would be brought to the September member with the one year plan for the Committee to scrutinise. A further report would then be brought after October with the five year plan.

The Chair thanked Kerry Rogers and Sue Bowler for their briefing.

CONSIDERATION OF DRAFT QUALITY ACCOUNTS: SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST AND DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST

Sue Bowler, Sherwood Forest Hospitals NHS Foundation Trust presented the draft quality accounts for Sherwood Forest Hospitals NHS Foundation Trust. The final draft was being gone through with the auditors regarding contents and accuracy.

During discussion the following points were raised:

- The committee noted the Trust's success in relation to pressure ulcers, as well as its own recognition that there was still a long way to go on the journey to improvement across a host of other indicators. However, the committee was pleased to see that quality and safety were still at the top of the Trust's agenda.

- The committee was cognizant that it was enormously difficult to institute the sorts of changes required and was pleased to hear that where the Trust had not hit targets (e.g. in relation to sepsis) it was not financially penalised by the commissioners; since this would have been very counter-productive. Instead, the money was reinvested within the Trust rather than being lost to the system.

- In relation to mortality rates, it was reassuring that the Trust was working closely with Bath University Hospital in order to learn how best to improve its performance. The committee praised this and hoped that the Trust would get help from other outside institutions where necessary in order to facilitate improvements.

- The Committee was concerned that the Trusts financial difficulties might be difficult to address. This was because of the heavy pressure of the Public Finance Initiative (PFI) agreement and because of the difficulties in staff recruitment which resulted in having to use expensive Agency or Bank Staff. The Committee hoped that support would be given to help hospitals recruit more people, especially mature entrants, locally."

It was agreed that the comments made by the Committee would be finalised and formally sent to the Trust for inclusion in the Accounts following agreement by the Chairman.

The Chair thanked Sue Bowler for her presentation.

Rick Dickinson, Doncaster and Bassetlaw Hospitals NHS Foundation Trust presented the draft quality accounts for Doncaster and Bassetlaw Hospitals NHS Foundation Trust. The draft accounts were circulated to members at the meeting.

During discussion the following points were raised:

- The Trust had not engaged effectively with the Health Scrutiny Committee for Nottinghamshire this year. The Trust did not send a representative to the Committee's March 2015 meeting to present its priorities. The Trust did not circulate its draft Quality Account to the committee in a timely fashion for consideration and comment.

- The committee hoped that there would be better lines of communication with the Trust in the coming year.

It was agreed that the comments made by the Committee would be finalised and formally sent to the Trust for inclusion in the Accounts following agreement by the Chairman.

The Chair thanked Richard Dickinson for his presentation.

MISDIAGNOSIS

Amanda Callow and Elaine Moss went through the presentation "delayed or missed diagnosis - scope, scale and system."

During discussion the following points were raised:

- There was no national reporting standard which made it difficult to compare data. There had however been studies which showed similar themes to the local study.

- Access to appointments at doctors surgeries was being looked at. It appeared to be variable. There was a need to build this into the commissioning of services. Some surgeries were trying alternative approaches such as a walk in service rather than appointments.

- The out of hours service provider CNCS was in special measures for Leicester and Leicestershire however in Nottinghamshire the extent of the difficulties was much less due to a stronger relationship with the company. The challenges in Nottinghamshire mainly related to being able to find enough doctors.

- Information sharing was a real problem. There had been discussions regarding this but there were legal issues, so a compromise had been agreed upon to encourage patients to opt in to their information being shared.

The Chair thanked Amanda Callow and Elaine Moss for their presentation.

PROTOCOL FOR RELATIONS BETWEEN HEALTH AND WELLBEING BOARD, HEALTHWATCH AND HEALTH SCRUTINY

Joe Pigeon, Healthwatch introduced the report which provided details of a protocol developed to set out the relationship between the Health and Wellbeing Board,

Healthwatch Nottinghamshire and the health scrutiny committees. The aim was to more clearly define the three bodies and how information would be shared between them. The report had also been to the Nottinghamshire Health and Wellbeing Board and the Healthwatch Board who both approved it.

The Healthwatch were considering looking at the following subjects for the forthcoming year:-

- Mental Health Crisis services for adults
- Quality Home Care Services
- Small secure hospice accommodation in Nottinghamshire and how they get a voice.
- First diagnosis of dementia – what happens next
- Transition for disabled teenagers into adult services

Healthwatch would ensure that they were not carrying out work already being done by other partners.

During discussion the following points were raised:

- There was a question regarding whether or not it was appropriate to be a member on the Health and Wellbeing Board and a member of a scrutiny committee. Further clarification would be sought.
- How Public Health Committee and Joint Health Scrutiny Committee fitted in was also raised.

RESOLVED: 2015/001

It was agreed that approval be given to the protocol between the Health and Wellbeing Board, Healthwatch Nottinghamshire and health scrutiny.

ARRANGEMENTS FOR SCRUTINY OF PUBLIC HEALTH SERVICES

Barbara Brady, Public Health Consultant introduced the report which set out proposals for public health to re-commission services this year. Six service areas were to be re-commissioned with some having already begun, as set out in tables 1 and 2 of the report.

During discussion the following points were raised:

- If there were concerns regarding delivery at any time these could be raised. Public Health Committee regularly received reports on the progress of contracts.
- The Consultation process would comply with local authority standards

- The soft market testing started before the consultation period to help shape the consultation.

- Progress reports would be provided quarterly or at whatever frequency the Committee felt was appropriate.

The Chair thanked Barbara Brady for her briefing.

RESOLVED: 2015/002

The arrangements to include Health Scrutiny in Public Health service redesign whilst progressing re-procurement projects in a timely manner was agreed.

WORK PROGRAMME

The work programme was discussed and the following items were noted:

- End of Life Care Review removed from the Programme

- Mental Health Issues in Bassetlaw to be changed to Adult Mental Health Issues

- Winter Pressures to be added to the Programme

The meeting closed at 4.55pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

20 July 2015

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

GENERAL PRACTIONER COMMISSIONING

Purpose of the Report

1. To consider current issues in relation to GP practices in the Mansfield and Ashfield and Newark and Sherwood CCGs.

Information and Advice

2. Members may be aware that the responsibility for commissioning GP services in some areas of England transferred from NHS England to Clinical Commissioning Groups (CCGs) in April 2015.

3. David Ainsworth, Director of Engagement and Service Redesign, NHS Mansfield and Ashfield CCG and Newark &.Sherwood CCG will attend the Health Scrutiny Committee to brief on this new role and its implications. A written briefing from Mr Ainsworth is attached as an appendix to this report.

4. Members may also wish to make Mr Ainsworth aware of how they would like to be kept informed of forthcoming GP practice, closures, mergers, relocations and the consultations in relation to them.

RECOMMENDATION

1) That the Health Scrutiny Committee considers and comments on the information provided.

2) That further consideration of these issues be scheduled, as necessary.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

NHS
Newark and Sherwood
Clinical Commissioning Group

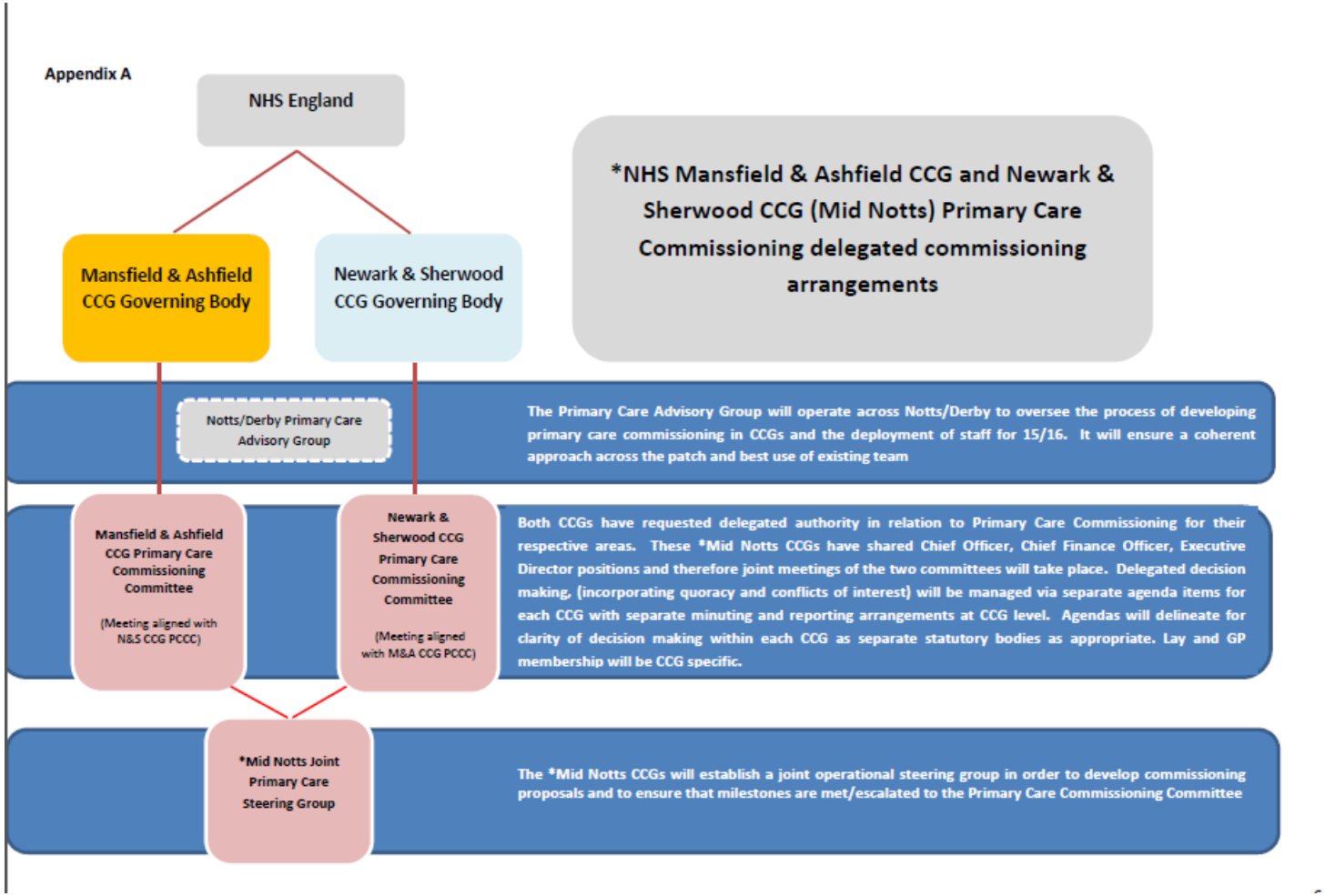
Paper Title	**Commissioning of Primary (Medical) Services**
Status	**Information**
Meeting	**Health Scrutiny Committee**
Date of Meeting	**20th July 2015**
Prepared by	**Robert Ferris-Rogers, Director of Engagement and Service Redesign, Newark and Sherwood CCG**
Presented by	**Elaine Moss, Chief Nurse, Newark and Sherwood and Mansfield and Ashfield CCGs** **David Ainsworth, Director of Engagement and Service Redesign, Mansfield and Ashfield CCG** **Jonathan Rycroft, Head of Primary Care, North Midlands, NHS England**

1	**Overview** Over the last year a number of policies and publications have been released which inform the overall direction of primary care and required CCGs to think through future plans. This included the policy of primary care co-commissioning to increase CCG leadership of primary care commissioning and collaboration between CCGs and NHS England. In addition the Newark and Sherwood and Mansfield and Ashfield CCGs have developed their strategies for Primary Care, which align with the mid-Nottinghamshire service transformation programme 'Better Together'. This report sets out the new context for primary care and updates the Committee on progress with co-commissioning.
2	**National and Local Context** In May 2014, Simon Stevens (CE of NHS England) invited CCGs to come forward to take on an increased role in the commissioning of primary care services. The intention is to empower and enable CCGs to improve primary care services locally, in part through co-commissioning, by enabling CCGs to commission right across the pathway of care. The overall aim of primary care co-commissioning is to harness the energy of CCGs to create a joined up, clinically led commissioning system which delivers seamless, integrated out-of-hospital services based around the needs of local populations. The CCG Governing Bodies considered the co-commissioning options available to them at the Extra Ordinary Joint Meeting of the Newark & Sherwood CCG and Mansfield & Ashfield CCG Governing Body meeting on Wednesday 7 January 2015. Approval was given for the CCG to apply for delegated primary care (medical) commissioning. NHS England subsequently approved the CCG to take formally take full delegated responsibility for primary care (medical) commissioning from 1st April 2015. There is a formal delegation agreement in place between the individual CCGs and NHS England. The two CCGs are supported in this by the primary care commissioning staff in NHS England. A Primary Care Commissioning Committee has been established and this meets in public every two months. It is chaired by and has a lay majority. The governance arrangements are outlined in Appendix A. All 6 CCGs in Nottinghamshire County and Nottingham City have full delegated responsibility for primary care (medical) commissioning. To facilitate a consistency of commissioning process a leads group has been developed between the CCGs and NHS England.

3	**Primary Care Commissioning Functions Relating to CCG's** The formal delegation agreement for primary (medical) services outlines roles, responsibilities and accountabilities from 1st April 2015. Appendix B outlines to full range of delegated functions and obligations for both CCGs and NHS England. Some of the key areas delegated to CCGs include: • Actively managing the Primary Medical Services Contract, including quality standards, incentives and the Quality Outcomes Framework. • Commissioning Enhanced Services • Design of Local Incentive Schemes • Planning the provider (primary medical services) landscape • Approving GP Practice Mergers and Closures Newark and Sherwood CCG and Mansfield and Ashfield CCG, will ensure that engagement that NHS England undertook previously with Health Overview and Scrutiny Committee is strengthened in line with previous discussions between NHS England and the Health Scrutiny Committee. It is worth noting that there are a small number of functions that have been retained by NHS England. These functions primarily relate to: • Management of the national performers list • Management of the revalidation and appraisal process • Functions relating to complaints management
5	**Newark and Sherwood CCG – Current Primary Care Work** Alongside broader primary care development, the following issues may be of interest to Health Scrutiny Committee: • Significant housing expansion is planned for the Newark and District Council area. The CCG, in line with the District Councils refresh of their Housing Strategy will be undertaking further review of the health and health care requirements for the local population. The CCG would welcome the involvement of the Health Scrutiny Committee in this work as it develops. • The CCG in collaboration with NHS England colleagues, are working together with practices in the Rainworth area to identify options for sustainable premises development. This work is in very early stages and is identifying what options at a high level may be feasible. • The Rainworth Surgery and Sherwood Medical Partnership have merged their partnership from 1st May 2015. The new partnership still holds two separate contracts and the for the delivery of General Medical Services. One covering Rainworth and the other covering Clipstone/Farnsfield. • The re-procurement of the Alternative Provider Medical Services (APMS) Contract covering Balderton Primary Care Centre is currently underway and will conclude during 2016.
6	**Mansfield and Ashfield CCG – Current Primary Care Work** Alongside broader primary care development, the following issue will be of interest to Health Scrutiny Committee: • Since 1st April Mansfield & Ashfield CCG, supported by NHS England (NHSE), have been planning the future of Kirkby Community Primary Care Centre contract. Central Nottingham

	Clinical Services (CNCS) expressed their desire to terminate the contract early due to difficulties in recruiting to key clinical posts. An immediate interim solution was put into place supported by local GPs and a process to appoint a caretaker solution is underway; with the expected contract award by 31st July 2015. Work to award a longer term contract has also commenced.
4	**Recommendation** The **Health Scrutiny Committee** are requested to: 1. Note the changes that have occurred in relation to the formal delegation agreement for primary (medical) services for Newark and Sherwood CCG and Mansfield and Ashfield CCG 2. Note the issues outlined in the paper relating to primary care in Newark and Sherwood CCG and Mansfield and Ashfield CCG

NHS
Newark and Sherwood
Clinical Commissioning Group



Appendix B

CCG Delegated Functions

The following content is taken from the Delegation Agreement in place from April 2015, a part of the standard agreement for delegated functions from NHS England.

Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 *(Delegated Functions)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;

2.1.4. comply with all current and future relevant national Guidance regarding PMS reviews and the management of practices receiving Minimum Practice Income Guarantee (MPIG) (including without limitation the *Framework for Personal Medical Services (PMS) Contracts Review* guidance published by NHS England in September 2014 (http://www.england.nhs.uk/wp-content/uploads/2014/09/pms-review-guidance-sept14.pdf));

2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

2.1.6.1. name of counter-party;
2.1.6.2. location of provision of services; and
2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause *(Financial Provisions and Liability)* or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:

2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;
2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;
2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the HSCIC IG Toolkit SIRI system);
2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;
2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and
2.4.7. complying with and implementing any relevant Guidance issued from time to time.

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services, including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;
2.7.2. support Data Controllers in providing 'fair processing' information as required by the DPA;
2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;
2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;
2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;
2.7.6. obtain the appropriate read codes, to be maintained by the HSCIC;
2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and
2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:

2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG's assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 *(Procurement and New Contracts)* and Schedule 2, Part 1, paragraph 2.3:

3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 *(Financial Provisions and Decision Making Limits)* deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice's registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 *(Procurement and New Contracts)*, where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 *(Information Sharing with NHS England)* is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

5.1.3. any other data/data sets as required by NHS England; and

5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.

5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.

6. Making Decisions in relation to Management of Poorly Performing GP Practices

6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

6.2.2. ensure that any risks identified are managed and escalated where necessary;

6.2.3. respond to CQC assessments of GP practices where improvement is required;

6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

7.2.2. revisions to existing payments being made under the Premises Costs Directions.

7.3. The CCG must comply with any decision-making limits set out in Schedule 5 *(Financial Provisions and Decision Making Limits)* when taking decisions in relation to the Premises Costs Directions Functions.

7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

Delegated Functions: General Obligations

1. Introduction

1.1. This Part 2 of Schedule 2 *(Delegated Functions)* sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;

2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and

2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

3.2. In discharging its responsibilities set out in clause **Error! Reference source not found.** *(Performance of the Delegated Functions)* of this Agreement and paragraph 1 of this Schedule 2 *(Delegated Functions)*, the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor's guidance *Substantive guidance on the Procurement, Patient Choice and Competition Regulations* (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf).

3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:

3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions).

Reserved Functions (NHS England)

1. Introduction

1.1. This Schedule 3 *(Reserved Functions)* sets out further provision regarding the carrying out of the Reserved Functions.

1.2. The CCG will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1. NHS England will continue to perform its primary medical care functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2. NHS England's functions in relation to the management of the national performers list include:

2.2.1. considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.2.2. identifying, managing and supporting primary care performers where concerns arise; and

2.2.3. managing suspension, imposition of conditions and removal from the national performers list.

2.3. NHS England may hold local Performance Advisory Group (**"PAG"**) meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.4. NHS England may notify the CCG of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the CCG to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.5. The CCG must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The CCG will comply with any Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1. NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2. All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1. the funding of GP appraisers;
3.2.2. quality assurance of the GP appraisal process; and
3.2.3. the responsible officer network.

3.3. Funding to support the GP appraisal is incorporated within the global sum payment to GP practices.

3.4. The CCG must not remove or restrict the payments made to GP practices in respect of GP appraisal.

4. Administration of payments and related performers list management activities

4.1. NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2. NHS England may continue to pay GPs who are suspended from the national performers list under the Secretary of State's Determination: Payments to Medical Practitioners Suspended from the Medical Performers List (1 April 2013).

4.3. For the avoidance of doubt, the CCG is responsible for any ad hoc or discretionary payments to GP practices (including those under section 96 of the NHS Act) in accordance with clause and Schedule 2 *(Delegated Functions)* Part 1 paragraphs 2.13 and 2.14 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A Functions

5.1. In accordance with clauses. NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2. In accordance with clauses, the CCG will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

6. Capital Expenditure Functions

6.1. In accordance with clauses NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

7. Functions in relation to complaints management

7.1. NHS England retains its functions in relation to complaints management and will be responsible for taking decisions in relation to the management of complaints. Such complaints include (but are not limited to):

7.1.1. complaints about GP practices and individual named performers;
7.1.2. controlled drugs; and
7.1.3. whistleblowing in relation to a GP practice or individual performer.

7.2. The CCG must immediately notify the Local NHS England Team of all complaints received by or notified to the CCG and must send to the Local NHS England Team copies of any relevant correspondence.

7.3. The CCG must co-operate fully with NHS England in relation to any complaint and any response to such complaint.

7.4. In accordance with clauses, NHS England may ask the CCG to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the CCG) in relation to the handling and consideration of complaints.

8. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

8.1. NHS England will carry out such other ancillary activities that are necessary in order for NHS England to exercise the Reserved Functions.

8.2. NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.3. The CCG must assist NHS England's controlled drug accountable officer (**"CDAO"**) to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.4. The CCG must nominate a relevant senior individual within the CCG (the **"CCG CD Lead"**) to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.5. The CCG CD Lead must, in relation to the Delegated Functions:

8.5.1. on request provide NHS England's CDAO with all reasonable assistance in any investigation involving primary medical care services;

8.5.2. report all complaints involving controlled drugs to NHS England's CDAO;

8.5.3. report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

8.5.4. analyse the controlled drug prescribing data available; and

On request supply (or ensure organisations from whom the CCG commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's

Nottinghamshire County Council

Report to Health Scrutiny Committee

20 July 2015

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

SHERWOOD FOREST HOSPITALS TRUST – WINTER PRESSURES

Purpose of the Report

1. To allow Members to consider Sherwood Forest Hospitals NHS Foundation Trust's planning for winter pressures.

Information and Advice

2. Members will be aware that severe winter conditions can result in Emergency Department closures, cancelled operations, bed pressures and ambulance delays. This is because cold weather can affect the health of the elderly, the very young and the chronically ill – greatly increasing the number of hospital attendances and admissions

3. Winter pressures are unpredictable and therefore present acute trusts with considerable difficulty when it comes to putting in place effective planning.

4. Sue Barnett, Interim Chief Operating Officer at Sherwood Forest Hospitals NHS Foundation Trust will attend the Health Scrutiny Committee to brief Members and answer questions as necessary. In addition, a written briefing from the Interim Divisional Manager for Emergency Care and Medicine is attached as an appendix to this report.

RECOMMENDATION

1) That the Health Scrutiny Committee considers and comments on the information provided.

2) That further consideration of these issues be scheduled, as necessary.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Improving Emergency Flow across the health and social care community

SUE BARNETT
CHIEF OPERATING OFFICER
SHERWOOD FOREST HOSPITALS NHS FT

2013 – 2014 Performance

Sherwood Forest Hospitals NHS
NHS Foundation Trust

4 hour Access target (95% standard)

- Achieved for the year but failed Q4

Key contributory factors

- Insufficient in-patient bed capacity
- ED delays in decision making by a senior clinician
- Case mix change – increase in majors (adults and children) and decrease in minors

Sherwood Forest Hospitals NHS
NHS Foundation Trust

2014 -2015 Performance

4 hour access target

- Failed 9 months of the year
- 5 Consecutive quarters failed

ECIST review May 2014

- 101 patients in delay either by the Trust,
  social care, other healthcare, patient choice

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Summary of changing demand

	12/13	13/14	14/15
Total attendances	119,286	133,969	143,450
No's Admitted	26,362	25,928	27,428
No's > 65 yrs admitted	12,707	12,780	13,728
% > 65 Admitted	48.20%	49.29%	50.05%

2014 – 2015 Recovery Plans

Sherwood Forest Hospitals NHS
NHS Foundation Trust

SFHFT Emergency Flow Transformation Plan

5 project streams

- Front end Decision making
- Ambulatory care
- Ward based discharge
- Discharge pathway
- Capacity plan

Aligned to: Better Together Transformation Board

Urgent Care and Crisis Response workstream

2 workstreams

- Partnership working
- Single front door

Sherwood Forest Hospitals NHS
NHS Foundation Trust

2015 – 2016 Performance

4 hour access target (95% standard)

- April and May achieved, Q1 achieved

Key changes - Q1

- Senior decision makers in ED
- Board/ward rounds across all specialties
- 7 day Integrated discharge team
- Standardised bed management and escalation processes
- Increased 7 day consultant presence
- Transfer to Assess

2015 – 2016 Performance cont'd

Q2 key areas of focus

- Implementation of Ambulatory Care pathways
- Increased short stay capacity
- Single Front Door in ED
- Care Navigation System
- Point of Prevalence Profile/Bed modeling across acute and community

2015 – 2016 Performance cont'd

Average Length of Stay

- 13/14 – 5.89 days
- 14/15 – 6.07 days
- 15/16 so far – 5.85 days

Reduced occupied bed- days (Cohort of patients whose LoS >14 days)

- 25th June 2014 cohort of 235 patients occupied 8,573 bed days
- 25th June 2015 cohort of 225 patients occupied 7,579 bed days

Impact: Closure of beds without compromising flow through the system

Thank you

Questions?

Nottinghamshire County Council

Report to Health Scrutiny Committee

20 July 2015

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

MENTAL HEALTH ISSUES IN NOTTINGHAMSHIRE

Purpose of the Report

1. To allow Members to consider issues raised by Healthwatch Nottinghamshire regarding mental health.

Information and Advice

2. Members will recall that Joe Pidgeon, Chairman of Healthwatch Nottinghamshire, indicated that he would bring to the committee concerns regarding mental health in Nottinghamshire. Mr Pidgeon will attend the Health Scrutiny Committee to brief Members and has provided a short briefing which is attached to this covering report as an appendix.

3. Members will be aware that the scrutiny of Nottinghamshire Healthcare Trust – provider of mental health services across Nottinghamshire falls under the remit of the Joint Health Scrutiny Committee. However, the experiences of service users and carers of Nottinghamshire GPs dealing with mental health matters does fall under the remit of the Health Scrutiny Committee.

4. Members may wish to schedule further consideration, or evidence gathering with regard to these issues, as necessary (or refer issues to the Joint Health Committee if necessary).

RECOMMENDATION

1) That the Health Scrutiny Committee considers and comments on the information provided.

2) That further consideration of these issues be scheduled, as necessary.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Insight brief: Experiences of mental health services in Nottinghamshire

Introduction:

Some people told us that they have had a poor experience of local mental health services. We wanted to understand more about people's experiences of these services so we launched 'Mental health month' in October 2014 and extended this through to early 2015. We gathered views and experiences from local people, through surveys, interviews and focus groups at locations across the county. In total we spoke to over 120 people, this included:

- 72 people who indicated they had experienced mental health illness themselves
- 40 people who have cared for a family member who had a mental health illness

This report identifies the key findings from a preliminary analysis of their experiences of mental health services in Nottinghamshire, to help us to identify where further in depth insight and action is required.

Main findings:

Experiences of getting help for mental health issues were mixed, some people had very positive experiences and some people had very poor experiences. This was evidenced through the range of scores provided when asked to use a five star rating, where one is the worst and five is the best, and the written comments to explain their scores.

Carers' overall experience of NHS mental health services in Nottinghamshire were generally poorer than service users themselves. This was the only significant difference across the scores.

Average rating provided by service users (Base = 25)

Average rating provided by carers (Base = 13)

43% v 15

Service users Carers

Agree or strongly agree that their experiences have been positive

As well as asking about mental health services overall we also asked about the different types of services. The same split in experiences were reported for GPs, community mental health teams and inpatient services, roughly equal numbers of people reported either a good or a poor experience. For example:

"My husband had [an] exceptional response from his GP."
Carer

"The GP didn't understand - didn't read my notes."
Service user

How service users and carers were treated on a personal level emerged as one of the strongest factors determining their experience of services.

Poor experiences were often spoken of in terms of people not being listened to or having their opinions ignored,

"GPs need to listen to their patients. I felt unimportant and felt that I was taking up too much of their time."
Service user

"Will often speak of the patient to the carer as if the patient was not there."
Carer

Good experiences mentioned professionals who understood and considered the views and feelings of patients and carers,

"Got to talk. Support staff at <service name> *listened to me."*
Service user

"…better trained in showing sympathy, in displaying a reassuring or helpful attitude on the phone."
Carer

Being able to see the same professional over a period of time so that a good relationship could be formed was one of the main things people identified when talking about improving experiences of mental health services and describing poor experiences.

The greatest issue around accessibility emerged in relation to crisis services. Both carers and service users reported difficulties in getting help from this service.

Overall experiences were rated poorly, and over half (59%) of all the 34 written comments about these services were negative.

Most frequent rating of crisis services provided by service users
(Base = 8)

Most frequent rating of crisis services provided by carers
(Base = 7)

When calling the crisis helplines, a number of people talked about being placed on hold for long periods of time and messages receiving no response:

"On one occasion, I was kept on hold for 30 minutes…I eventually gave up trying."
Service user

"If you left a message they didn't always phone back."
Carer

"I can't get through on the phone -it just keeps ringing."
Carer

Another group of comments were from people who mentioned not knowing where to get help in a crisis situation. Accessing this service overnight was identified as particularly problematic.

"I find it impossible to understand why there is no available crisis support between 9pm and about 9am as my own experience and that of others is that THAT is the time when specialist support would be most welcome"
Service user

"The person on the other end of the line kept my (well) friend talking for about 30 minutes, cross-examining her about her own health rather than the friend we were concerned about, then said that it was too late to send anyone out to see her as it was after 8.30 on a Friday night."
Carer

"They won't come out after a certain time at night."
Carer

Subsequently, one of the most common suggested improvements for mental health services was the introduction of 24-hour crisis provision.

"Need to be able to access crisis teams 24/7."
Carer

"Very difficult to know who to ring in a crisis. Crisis out of hour's number not answering. Ended up calling police because of personal safety issues. We need to know who to contact in a crisis and that person or number being accessible 24/7."
Carer

For those who did manage to get through and access these services, whilst there were a minority of comments stating this experience as positive, there were more comments from people who indicated that they felt the quality of the advice and care provided was poor:

"I was told by the crisis team when I rang to say I was suicidal 'what do you want us to do it's a Bank Holiday'."
Service user

"Husband had Psychosis crisis at a weekend and when called the crisis team they asked if he was taking meds and eating and drinking, he was and was told to call back if he stopped."
Carer

Nottinghamshire County Council

Report to Health Scrutiny Committee

18 May 2015

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information and Advice

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations and reviewing other issues which impact on services provided by trusts which are accessed by County residents.

3. The work programme is attached at Appendix 1 for the Committee to consider, amend if necessary and agree.

4. The work programme of the Committee continues to be developed. Emerging health service changes (such as substantial variations and developments of service) will be included as they arise.

5. Members may also wish to suggest and consider subjects which might be appropriate for scrutiny review by way of a study group or for inclusion on the agenda of the committee.

RECOMMENDATION

1) That the Health Scrutiny Committee considers and agrees the content of the draft work programme.

2) That the Health Scrutiny Committee suggests and considers possible subjects for review.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2015/16

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
20 July 2015				
GP Commissioning	Scrutiny of the new arrangements for commissioning GP Services by CCGs.	Scrutiny	Martin Gately	Mansfield and Ashfield and Newark and Sherwood CCG
Sherwood Forest Hospitals Trust – Winter Pressures	Examination of winter pressures and planning issues at Sherwood Forest Hospitals	Scrutiny	Martin Gately	Sue Barnett, Interim Chief Operating Officer, SFH
Mental Health Issues in Bassetlaw	Examination of information from Healthwatch	Scrutiny	Martin Gately	Joe Pidgeon, Chairman, Healthwatch Nottinghamshire
21 September 2015				
Bassetlaw Working Together Programme	Briefing on the establishment and operation of a collaborative partnership between NHS commissioners to lead a transformational change programme	Briefing	Martin Gately	Phil Mettam
CNCS/Kirkby Community Primary Care Centre	Consideration of provision of service from CNCS	Scrutiny	Martin Gately	Dr Sarah Hull, Medical Director, CNCS
Healthwatch Annual Report 2014/15	Presentation of Healthwatch Nottinghamshire annual report	Scrutiny	Martin Gately	Joe Pidgeon, Chairman, Healthwatch Nottinghamshire
GP Commissioning (Rushcliffe CCG)	Scrutiny of GP Commissioning arrangements in the rural south of the County	Scrutiny	Martin Gately	Vicky Bailey, Chief Officer, Rushcliffe

				CCG
23 November 2015				
CQC GP Inspection reports (TBC)	Presentation by the CQC on results of the inspection of GP practices earlier in the year.	Briefing	Martin Gately	Linda Hirst
18 January 2016				
Consideration of Quality Account Priorities TBC	Doncaster & Bassetlaw Hospitals NHS Foundation Trust and Sherwood Forest Hospitals NHS Foundation Trust	Scrutiny	Martin Gately	DBH and SFHFT
14 March 2016				
9 May 2016				
11 July 2016				

Potential Topics for Scrutiny:
Never Events
Health Inequalities
Substance Misuse