Nottinghamshire County Council

Health Scrutiny Committee

Monday, 26 January 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 24 November 2014 at 2pm

Membership

Councillors

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

District Members

A	Trevor Locke	Ashfield District Council
A	Brian Lohan	Mansfield District Council
	David Staples	Newark and Sherwood District Council
A	Griff Wynne	Bassetlaw District Council

Officers

	Martin Gately	Nottinghamshire County Council
	Alison Fawley	Nottinghamshire County Council

Also in attendance

	Jacqui Tuffnell	Sherwood Forest Hospitals NHS Foundation Trust
	Phil Mettam	NHS Bassetlaw CCG
	Heather Woods	NHS Bassetlaw CCG
	Barbara Brady	Adult Social Care, Health & Public Protection
	Anne Pridgeon	Adult Social Care, Health & Public Protection

MINUTES

The minutes of the last meeting held on 29 September 2014, 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 Councillor J Williams (illness).

DECLARATIONS OF INTEREST

There were no declarations of interest.

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

Jacqui Tuffnell, Director of Operations, Sherwood Forest Hospitals NHS Foundation Trust presented a briefing that updated Members on the work of the group. During discussions the following points were made:

- The proposal to replace the existing CT scanner at Newark Hospital with a mobile unit had been amended after consultation with patients, staff and other stakeholders through a number of listening events. A new static scanner was planned for 2015/16 in the Hounsfield Suite at Newark Hospital. In response to questions from Members, Mrs Tuffnell said that lessons had been learned for future consultations.

- The strategic vision for Newark Hospital was outlined so that services at Newark were best utilised for both the Trust and Newark residents. Members welcomed this approach to local services for local people. Mrs Tuffnell explained how services at Kings Mill and Newark hospital would work together with GPs to provide a package of care which was best for the patient. A series of Market Stall events would be held during December in Newark to promote services.

- Mrs Tuffnell explained how patient safety was paramount and that sometimes it was necessary to provide treatment for an acute episode at Kings Mill Hospital and then repatriate the patient via the Discharge Nurse Service to their local area. Day case services were very well organised at Newark and this good practice had been shared with colleagues at Kings Mill.

- Members requested that Mrs Tuffnell bring a report to a future committee to provide more detail and data on the key outcomes.

NHS BASSETLAW CLINICAL COMMISSIONING GROUP – OVERVIEW

Phil Mettam, Chief Officer, NHS Basetlaw CCG presented a briefing on the work of Bassetlaw Clinical Commissioning Group (CCG) during its first year as a statutory body. During discussions the following points were made:

- The Telehealth Pilot had seen emergency admissions reduce by 50% in the small discrete test group of patients. Mr Mettam described how the service was provided by a team of specialist nurses who are familiar with the particular needs of each patient and who can be contacted on an as required basis.

- As part of the focus on developing clinical practice Mr Mettam described how the CCG had developed and implemented the Bassetlaw Quality Improvement Tool across all care homes to drive up standards.

- In response to members questions Mr Mettam asked for specific questions to be sent to him regarding mental health services. An external review of mental health services was listed as a priority in the

five year strategic plan. This would also cover the transition arrangements available for young adults.

- Community services had been reorganised in to 4 neighbourhood clusters so that they worked more closely with general practitioners.

- Bassetlaw CCG had recently introduced social prescribing which had been modelled on a successful initiative in Rotherham and had worked closely with voluntary sector organisations to complement GP services.

- Areas for improvement included ambulance services, diagnostic delays and inappropriate approaches to A&E.

- The CCG had formed collaborative partnerships with other CCGs in the Working Together programme.

- The chair agreed to arrange a visit for Members to Bassetlaw Hospital.

BASSETLAW – DIABETIC CARE FOR THE ELDERLY IN HOSPITAL

Heather Woods, Diabetic Nurse, discussed diabetic care in Bassetlaw, with particular reference to care for elderly patients. During discussions the following points were made:

- Care depended on the symptoms presented during the stay on the ward. Any concerns were referred to the Diabetes Team who would liaise with families and other agencies.

- Diabetic patients were encouraged to carry evidence of their medication with them to help with faster diagnosis. This could be as simple as carrying the repeat prescription information or the Insulin Passport for insulin users.

- A specific case was discussed and it was suggested that Members forwarded their concerns to the Chief Executive of Bassetlaw Hospital prior to the proposed visit.

NEW OBESITY SERVICES – CONSULTATION AND SERVICE DESIGN

Barbara Brady and Ann Pridgeon, Adult Social Care, Health & Public Protection, briefed Members on the consultation on obesity services and how it had influenced service design. During discussions the following points were made:

- Service design would be people centred and would look to address the needs of individuals. It was based on the best evidence available from NICE and the service would respond to this.

- Focus would be on what was needed at a local level and work would be done through central government concerning labelling, content of food and sizing.

- The service provider would be expected to offer responsibility for all 3 tiers as outlined in the report and would need to demonstrate positive outcomes which previously had been too fragmented. Public Health committee would have responsibility for monitoring the provider.

- Year 1 of the contract would be used to set baselines and outcome measures would be available to the Committee in Year 2.

- Members agreed to invite Ms Brady and Ms Pridgeon to report back to the Health Scrutiny Committee in 2016.

WORK PROGRAMME

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

- 23 March 2015 – Sherwood Forest Hospitals Foundation Trust (outcomes data)

- Public Health to attend Committee on a regular basis to update members on consultations/programmes of work.

- Hospital transport – this is a topic covered by Joint Health Scrutiny Committee. Martin Gately agreed to keep members informed.

The meeting closed at 4.25pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

26 January 2015

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

CARE QUALITY COMMISSION – HOSPITAL INSPECTIONS & GP SURGERIES

Purpose of the Report

1. To introduce a briefing from the Care Quality Commission (CQC) on hospital and GP surgery inspections in Nottinghamshire.

Information and Advice

2. The CQC makes sure hospitals, care homes, dental and GP surgeries and all other care services in England provide people with safe, effective, compassionate and high quality care, and encourage these services to make improvements.

3. The CQC does this by inspecting services and publishing the results on its website to help service users make better decisions about the care they receive.

4. The stated principles of the CQC are as follows:

    - puts people who use services at the heart of its work
    - has an open and accessible culture
    - is independent, rigorous, fair and consistent
    - works in partnership across the health and social care system
    - is committed to being a high-performing organisation
    - promotes equality, diversity and human rights

5. The CQC does its job by:

    - Setting national standards of quality and safety that people can expect whenever they receive care.
    - Registering care services that meet national standards.
    - Monitoring, inspecting and regulating care services to make sure they continue to meet the standards.
    - Protecting the rights of vulnerable people, including those whose rights are restricted under the Mental Health Act.
    - Listening to and acting on your experiences.
    - Involving people who use services.
    - Working in partnership with other organisations and local groups.
    - Challenging all providers, with the worst performers getting the most attention.

- Making fair and authoritative judgements supported by the best information and evidence.
- Taking appropriate action if care services are failing to meet the standards.
- Carrying out in-depth investigations to look at care across the system.
- Reporting on the quality of care services, publishing clear and comprehensive information, including performance ratings to help people choose care.

6. Ros Johnson, CQC Inspection Manager, Hospitals Directorate will attend the Health Scrutiny Committee to brief the committee on recent inspections in Nottinghamshire and answer questions.

7. A written briefing and presentation from Ms Johnson are attached as appendices to this report.

8. In addition, Linda Hirst, Inspection Manager, Primary Medical Services and Integrated Care Directorate will attend to brief Members on the CQC's new approach to inspecting GP practices.

9. Members may wish to consider how the information that comes to light during the routine operation of Health Scrutiny can best be conveyed to the CQC in order to inform future inspections.

10. Members may also wish to schedule further consideration of the results of CQC inspections in Nottinghamshire.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing and asks questions as necessary
2) Schedules further consideration of CQC inspections.

Councillor Colleen Harwood
Chairman of 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

Care Quality Commission

Inspecting hospitals to drive up standards in the NHS

December 2014


Care Quality Commission
The Mid Staffo
Foundation Tru
Independent Inquiry into care pro
Mid Staffordshire NHS Foundation
January 2005 – March 2009
Volume I
Chaired by Robert Francis QC
HC375-I
THE MID STAFFORD
NHS FOUNDATION
PUBLIC INQUIRY
Chaired by Robert Francis QC
Report of
the Mid Staffordsh
NHS Foundation Tr
Public Inquiry
Volume 1:
Analysis of eviden
lessons learned (
HC 898-I
A promise to learn
– a commitment to act
Improving the Safety of Patients
in England
National Advisory Group on the
Safety of Patients in England
August 2013

Our purpose and role

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

We will be a strong, independent, expert inspectorate that is always on the side of people who use services

The new CQC hospital inspection programme

Built on the **Keogh Reviews** process for hospitals with high mortality.

Brought together the **best of different approaches**.

Aim to be **robust, fair** and helpful.

Reports **do not apportion blame**.

Intend to promote transparency and honesty about standards in healthcare as a driver for **quality improvement**.

Our key questions

Our focus is on five key questions that ask whether a provider is:

- **Safe?** – people are protected from abuse and avoidable harm
- **Effective?** – people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
- **Caring?** – staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive?** – services are organised so that they meet people's needs
- **Well-led?** – the leadership, management and governance of the organisation assure the delivery of high-quality care, supports learning and innovation, and promotes an open and fair culture.

8 Core Services

- In acute hospitals the following 8 core services are always inspected:

  1. Urgent and emergency services
  2. Medical care (including older people's care)
  3. Surgery
  4. Critical care
  5. Maternity and gynaecology
  6. Services for children and young people
  7. End of life care
  8. Outpatients and diagnostic imaging

- We will also assess other services if there are concerns (e.g. from complaints or from focus groups)
- The inspection team splits into subgroups to review individual areas, but whole team corroboration sessions are vital

Inspection teams and visits

Visited:

- 4 inpatient wards at 4 hospitals
- Paediatric inpatient ward
- 3 minor injury units
- 4 Dental clinics
- 11 other community locations
- Home visits with 4 nurses & 5 children's therapists

Spoke with:

- 155 patients, relatives and carers
- 233 staff
- Senior managers and Board members
- 10 people at pre-inspection listening event
- Collected 94 comment cards

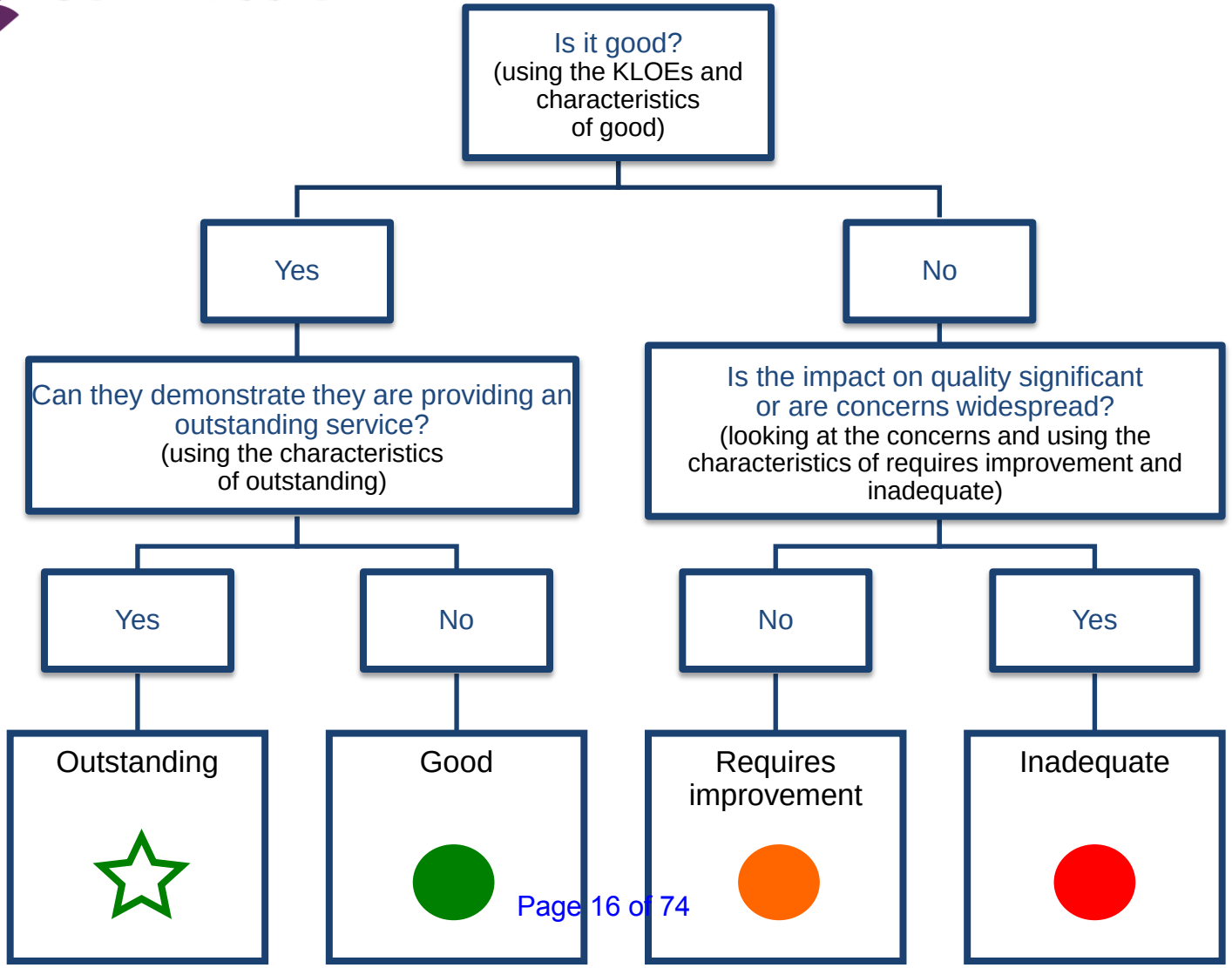
Inspection Team

Lead and Chair

9 CQC inspectors

13 specialist advisers

4 experts by experience


Is it good?
(using the KLOEs and characteristics of good)
Yes
No
Can they demonstrate they are providing an outstanding service?
(using the characteristics of outstanding)
Is the impact on quality significant or are concerns widespread?
(looking at the concerns and using the characteristics of requires improvement and inadequate)
Yes
No
No
Yes
Outstanding
Good
Requires improvement
Inadequate

How we rate

- Ratings take account of all sources of information:
  - Intelligent monitoring tool
  - Information provided by trust
  - Other data sources
  - Findings from site visits:
    - Direct observations
    - Staff focus groups
    - Patient and public listening events
    - Interviews with key people
- Bottom up approach: each of the 8 core services is rated on each of the five key questions (safe, effective, caring, responsive, well led).
- Where trusts provide services on different sites we rate these separately.
- We then rate the trust as a whole on the five key questions, with an overall assessment of well-led at trust level.
- We then derive a final overall rating.

Ratings example 1

	Safe	Effective	Caring	Responsive	Well-led		Overall
A&E	Good	Inspected but not rated	Good	Requires improvement	Good		Good
Medical care	Good	Good	Good	Requires improvement	Good		Good
Surgery	Good	Good	Good	Good	Requires improvement		Good
Critical care	Good	Good	Good	Good	Good		Good
Maternity & family planning	Requires improvement	Requires improvement	Good	Good	Good		Requires improvement
Children & young people	Good	Good	Good	Good	Good		Good
End of life care	Good	Good	Outstanding	Good	Good		Good
Outpatients	Good	Inspected but not rated	Good	Requires improvement	Good		Good
Overall	Good	Good	Good	Requires improvement	Good		Overall Good

Ratings example 4

	Safe	Effective	Caring	Responsive	Well-led		Overall
A&E	Inadequate	Inspected but not rated[1]	Requires improvement	Inadequate	Inadequate		Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement
Surgery	Inadequate	Requires improvement	Good	Inadequate	Requires improvement		Inadequate
Critical care	Requires improvement	Good	Good	Good	Good		Good
Maternity & family planning	Requires improvement	Requires improvement	Good	Good	Requires improvement		Requires improvement
Children & young people	Good	Good	Good	Good	Good		Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement
Outpatients	Good	Inspected but not rated[1]	Good	Requires improvement	Requires improvement		Requires improvement
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate		Overall Inadequate

Ratings example 5

	Safe	Effective	Caring	Responsive	Well-led		Overall
A&E	Outstanding	Inspected but not rated[1]	Good	Outstanding	Outstanding		Outstanding
Medical care	Good	Good	Outstanding	Outstanding	Outstanding		Outstanding
Surgery	Good	Good	Good	Outstanding	Outstanding		Outstanding
Critical care	Outstanding	Good	Outstanding	Good	Outstanding		Outstanding
Maternity & family planning	Good	Good	Good	Good	Good		Good
Children & young people	Requires improvement	Good	Outstanding	Good	Good		Good
End of life care	Good	Outstanding	Outstanding	Outstanding	Outstanding		Outstanding
Outpatients	Good	Inspected but not rated[1]	Good	Outstanding	Good		Good
Overall	Good	Good	Outstanding	Outstanding	Outstanding		Overall Outstanding


Care Quality Commission
How CQC regulates:
NHS acute hospitals
Provider handbook
September 2014
Care Quality Commission
How CQC regulates:
NHS acute hospitals
Appendices
to the provider handbook
September 2014

Initial findings from acute inspections

We inspected 68 acute trusts in the first year (42%).

There are many positives for staff and the public to be proud of:

- Compassionate care
- Critical care services were high quality
- Maternity services were good
- Many trusts were improving care for patients with dementia

Early lessons

- 13% of trusts were inadequate and 63% required improvement.
- Only 20% of hospitals were judged good for safety, none were outstanding.
- 60% of trusts needed to improve their leadership.
- Leadership at clinical team or directorate level was variable.
- Formal and informal leadership was often in denial.
- Services and hospitals that accepted their problems made swifter quality improvements.

A Local Flavour

- Complaint Handling- timescales, communication, early resolution
- Staff are caring and passionate
- Staffing levels
- Discharging patients- waiting times, unsafe discharges for vulnerable patients
- Discharging patients- some positive work to improve process
- Attitude of staff and communication
- ‘staff go the extra mile’ ‘excellent service’ ‘staff made me feel at ease’

Partnership Priorities

- To continue to develop relationships with partners and making use of intelligence
- To increase cross directorate working
- To strengthen how we involve and engage with the public
- To reflect and develop our approach to inspection and monitoring standards

CQC Inspection Update January 2015

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

New Approach to Hospitals Inspections

Background to changes

We recognise that the previous inspection approach had flaws – but it had good elements, in particular in relation to rigorous evidence gathering. We have built on the Keogh Reviews process for 14 acute hospitals with high mortality rates. We have brought together the best of different approaches. We aim to be robust, fair and helpful. Our reports do not seek to apportion blame. We intend to promote transparency and honesty about standards in healthcare as a driver for quality improvement.

What we are doing now

We use larger inspection teams including specialist inspectors, clinical experts, and experts by experience. We will use intelligent monitoring to decide when, where and what to inspect. Inspections focus on our five key questions about services or “domains.” We use key lines of enquiry (KLOEs) as the overall framework for a consistent and comprehensive approach. There is a strong focus on talking and listening to staff and patients.

We determine and publish ratings to help compare services and highlight where care is outstanding, good, requires improvement and inadequate. A quality summit is held with the provider and stakeholders to launch the quality improvement process.

Our focus is on five key questions that ask whether a provider is:

- **Safe?** – people are protected from abuse and avoidable harm
- **Effective?** – people’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

- **Caring?** – staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive?** – services are organised so that they meet people's needs
- **Well-led?** – the leadership, management and governance of the organisation assure the delivery of high-quality care, supports learning and innovation, and promotes an open and fair culture.

Core services

In acute hospitals the following 8 core services are always inspected:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging
- We will also assess other services if there are concerns (e.g. from complaints or from focus groups)

The inspection team splits into subgroups to review individual areas, but whole team corroboration sessions are vital

Inspection team

- ✓ Chair – Senior clinician or manager
- ✓ Team Leader
- ✓ Doctors (senior and junior)
- ✓ Nurses (senior and junior)
- ✓ AHPs/Managers
- ✓ Experts by experience (patients and carers)
- ✓ CQC Inspectors
- ✓ Analysts

Around 30 people for a medium sized hospital

High level characteristics of each rating level

Outstanding

Innovative, creative, constantly striving to improve, open and transparent

Good

Consistent level of service people have a right to expect, robust arrangements in place for when things do go wrong

Requires Improvement

May have elements of good practice but inconsistent, potential or actual risk, inconsistent responses when things go wrong

Inadequate

Significant harm has or is likely to occur, shortfalls in practice, ineffective or no action taken to put things right or improve

Ratings take account of all sources of information:

- Intelligent monitoring tool
- Information provided by trust
- Other data sources
- Findings from site visits:
    - ► Direct observations
    - ► Staff focus groups
    - ► Patient and public listening events
    - ► Interviews with key people
- Bottom up approach: each of the 8 core services is rated on each of the five key questions (safe, effective, caring, responsive, well led).
- Where trusts provide services on different sites we rate these separately.
- We then rate the trust as a whole on the five key questions, with an overall assessment of well-led at trust level.

- We then derive a final overall rating.

Early Findings

We inspected 68 acute trusts in the first year (42%).

There are many positives for staff and the public to be proud of:

- Compassionate care is alive and well
- Critical care services were delivering high quality, compassionate care
- Maternity services were generally providing good quality care, and were good at monitoring their effectiveness
- Many of the trusts were making a determined effort to improve care for patients with dementia
- We have been impressed by the willingness on front line staff to discuss their concerns.

But we also found marked variations in quality:

- Wide range of quality **between hospitals**
- In several hospitals, there were marked variations **between services**
- In some hospitals, there was variation **within a service**

General areas for concern:

- **A&E departments** are under the greatest strain
- **Staffing** is a major concern in many services
- Most services don't know whether they are **effective** or not
- Still unacceptable variation in the rigour of clinical risk management and **quality assurance**
- **Outpatient services** were badly managed in many cases

Early findings showed that:

- 13% of trusts were inadequate and 63% required improvement.
- Only 20% of hospitals were judged good for safety, none were outstanding.
- 60% of trusts needed to improve their leadership.

- Leadership at clinical team or directorate level was very variable and was often a critical factor in the quality and safety of a service.
- Formal and informal leadership was often in denial about the problems or blamed the system.
- Those services and hospitals that accepted their problems seemed to make more rapid quality improvements.

CQC's new approach to inspecting GP practices

Linda Hirst Inspection Manager
Primary Medical Services and Integrated Care Directorate.

PMS – What sits in our Directorate

- In hours GP practices
- Out of hours GP services including urgent care centres and 111 services
- Dental Services
- Prison Healthcare
- Children's Health and Safeguarding
- Integrated Care
- Thematic inspections

How we inspect

- We inspect practices by CCG area. We have worked out an inspection programme covering all of the CCGs which will enable us to rate every practice by September 2016.

- We aim to inspect approximately a quarter of practices in the CCG each time we visit. We will meet with Area Teams and CCGs before and after inspections of practices in the area and will also invite LMCs, Healthwatch and OSGs to make comments about the practices we are inspecting.

- We gather intelligence about each practice, the health information profile of the CCG and will look at intelligence from QOF data (if available), patient survey data, comments and ratings on NHS Choices, intelligence from NHS England. We will look at the practice website (if available). We will take account of direct concerns and complaints received from patients, information from whistleblowers, information from stakeholders and professional bodies (GMC, NMC, HPC). We will use information from listening events and from other directorates to identify any information of good practice or areas of concern. We will use this information to target and plan our inspections.

- We will announce our comprehensive inspections two weeks in advance. Our focussed visits (in response to concerns and to follow up requirements or enforcement action) will not be announced.

How we inspect and how we differ from other directorates

• Our inspections do not just cover and rate the domains, they also cover and rate how well each location is serving particular population groups. The practice receives an overall rating.

•Our population groups are: Older people (Over 75); People with long term conditions; Mothers, babies, children and young people; Working age population and those recently retired; People in vulnerable circumstances who may have poor access to primary care (including gypsies and travellers; sex workers, people with a learning disability, people with drug or alcohol dependency, homeless people) and People experiencing a mental health problem.

•We always inspect with a GP, often with a practice nurse as well and sometimes with an expert by experience or a pharmacist inspector (if we are inspecting a dispensing practice)

•We hold a post inspection meeting with stakeholders after all reports have been finalised to enable all stakeholders to understand patterns of findings and target any action needed to improve GP services within their CCG area.

How we inspect

- The inspection team will always

- Speak to patients and observe interactions between practice staff and patients – this will NOT involve sitting in on patient consultations unless there is a very good reason for this and the patient agrees.

- Speak to a range of practice staff

- Inspect the practice in respect of; cleanliness and infection control, safety of premises, safety of equipment, confidentiality of patient records, safety of medicines and prescribing practices.

- We **may** look at patient records **if there is a specific need to do this** – this will usually be because we have highlighted a risk to patients. We will ask our GP advisor or an inspector will do this.

- We will meet/have a telephone discussion with members of the PPG.

- We may visit other branches depending on the information about risk from intelligence.

How we inspect

- We will speak to managers of care homes who have patients registered at the practice to get feedback about the GPs.

- We may organise and attend relevant listening events in the local area to gain feedback about how the practice serves and supports particular population groups.

- We have established links with some voluntary agencies who support groups whose circumstances may make them vulnerable to gain feedback about practices and barriers to access.

QA process for GP reports

- The report is drafted and sent to all members of the inspection team for checking

- The report is reviewed by another inspector who was not involved in the inspection

- The report is reviewed by the inspection manager to ensure it meets quality standards, that the evidence is corroborated and that the rating is right in all domains and population groups.

- At present all reports then proceed to the regional quality assurance panel

- There is clear criteria for reports to go to national panel

- The rating is ratified at panel and the report can proceed to factual accuracy.

- This process is leading to significant delays in reports being sent to providers at present and we are making them aware of this.

Initial Themes from rating in Q3 (Oct – Dec 2014)

- In our local area we have inspected three CCGs – none of these are in North Notts

- The majority of practices are being rated as good, we have some which may be rated outstanding. The lowest rating to be approved by panel locally so far is requires improvement.

- Reports are starting to be published. They are being published in batches with a national press release on each publication date. The reports will have been sent to the practice, the Area Team, the CCG, Healthwatch and the LMC before they are published. The practice will have been informed of the publication.

- We have no local practices currently in special measures.

Quarter 4 (January – March 2014)

•We will be inspecting several North Notts CCGs in this quarter. These are Newark and Sherwood, Mansfield and Ashfield and Nottingham North and East.

•The CCG/AT meetings for the early inspections have or are being scheduled in.

•Any intelligence any stakeholder wishes to share about practices is welcome. We constantly monitor intelligence and risk and use this to help prioritise our inspection scheduling activity.

Links to useful information

Our website

www.cqc.org.uk

About our inspections
http://www.cqc.org.uk/sites/default/files/20141008_gp_practices_and_ooh_provider_handbook_main_final.pdf
http://www.cqc.org.uk/sites/default/files/20141008_gp_practices_and_ooh_provider_handbook_appendices_final.pdf

Thank you for listening

Any questions?

CQC's new approach to inspecting GP practices

Linda Hirst Inspection Manager

Primary Medical Services and Integrated Care Directorate.

PMS WHAT SITS IN OUR DIRECTORATE?

- In hours GP practices
- Out of hours GP services including urgent care centres and 111 services
- Dental Services
- Prison Healthcare
- Children's Health and Safeguarding
- Integrated Care
- Thematic inspections

HOW WE INSPECT

- We inspect practices by CCG area. We have worked out an inspection programme covering all of the CCGs which will enable us to rate every practice by September 2016.
- We aim to inspect approximately a quarter of practices in the CCG each time we visit. We will meet with Area Teams and CCGs before and after inspections of practices in the area and will also invite LMCs, Healthwatch and OSGs to make comments about the practices we are inspecting.
- We gather intelligence about each practice, the health information profile of the CCG and will look at intelligence from QOF data (if available), patient survey data, comments and ratings on NHS Choices, intelligence from NHS England. We will look

at the practice website (if available). We will take account of direct concerns and complaints received from patients, information from whistleblowers, information from stakeholders and professional bodies (GMC, NMC, HPC). We will use information from listening events and from other directorates to identify any information of good practice or areas of concern. We will use this information to target and plan our inspections.

- We will announce our comprehensive inspections two weeks in advance. Our focussed visits (in response to concerns and to follow up requirements or enforcement action) will not be announced.
- The inspection team will always
- Speak to patients and observe interactions between practice staff and patients – this will NOT involve sitting in on patient consultations unless there is a very good reason for this and the patient agrees.
- Speak to a range of practice staff
- Inspect the practice in respect of; cleanliness and infection control, safety of premises, safety of equipment, confidentiality of patient records, safety of medicines and prescribing practices.
- We **may** look at patient records **if there is a specific need to do this** – this will usually be because we have highlighted a risk to patients. We will ask our GP advisor or an inspector will do this.
- We will meet/have a telephone discussion with members of the PPG.
- We may visit other branches depending on the information about risk from intelligence
- We will speak to managers of care homes who have patients registered at the practice to get feedback about the GPs.
- We may organise and attend relevant listening events in the local area to gain feedback about how the practice serves and supports particular population groups.
- We have established links with some voluntary agencies who support groups whose circumstances may make them vulnerable to gain feedback about practices and barriers to access.

HOW WE DIFFER FROM OTHER DIRECTORATES

- Our inspections do not just cover and rate the domains, they also cover and rate how well each location is serving particular population groups. The practice receives an overall rating.
- Our population groups are: Older people (Over 75); People with long term conditions; Mothers, babies, children and young people; Working age population and those recently retired; People in vulnerable circumstances who may have poor access to primary care (including gypsies and travellers; sex workers, people with a learning disability, people with drug or alcohol dependency, homeless people) and People experiencing a mental health problem.
- We always inspect with a GP, often with a practice nurse as well and sometimes with an expert by experience or a pharmacist inspector (if we are inspecting a dispensing practice)
- We hold a post inspection meeting with stakeholders after all reports have been finalised to enable all stakeholders to understand patterns of findings and target any action needed to improve GP services within their CCG area.

QA PROCESS FOR GP REPORTS

- The report is drafted and sent to all members of the inspection team for checking
- The report is reviewed by another inspector who was not involved in the inspection
- The report is reviewed by the inspection manager to ensure it meets quality standards, that the evidence is corroborated and that the rating is right in all domains and population groups.

- At present all reports then proceed to the regional quality assurance panel
- There is clear criteria for reports to go to national panel
- The rating is ratified at panel and the report can proceed to factual accuracy.
- This process is leading to significant delays in reports being sent to providers at present and we are making them aware of this.

Initial Themes from rating in Q3 (Oct – Dec 2014)

- In our local area we have inspected three CCGs – none of these are in North Notts
- The majority of practices are being rated as good, we have some which may be rated outstanding. The lowest rating to be approved by panel locally so far is requires improvement.
- Reports are starting to be published. They are being published in batches with a national press release on each publication date. The reports will have been sent to the practice, the Area Team, the CCG, Healthwatch and the LMC before they are published. The practice will have been informed of the publication.
- We have no local practices currently in special measures.

Quarter 4 (January – March 2014)

- We will be inspecting several North Notts CCGs in this quarter. These are Newark and Sherwood, Mansfield and Ashfield and Nottingham North and East.

- The CCG/AT meetings for the early inspections have or are being scheduled in.
- Any intelligence any stakeholder wishes to share about practices is welcome. We constantly monitor intelligence and risk and use this to help prioritise our inspection scheduling activity.

Links to useful information

Our website

www.cqc.org.uk

About our inspections

http://www.cqc.org.uk/sites/default/files/20141008_gp_practices_and_ooh_provider_handbook_main_final.pdf

http://www.cqc.org.uk/sites/default/files/20141008_gp_practices_and_ooh_provider_handbook_appendices_final.pdf

Any questions?

Nottinghamshire County Council

Report to Health Scrutiny Committee

Agenda Item: 5

NOTTINGHAMSHIRE CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) OVERVIEW AND PATHWAY REVIEW UPDATE

Purpose of the Report

1. To inform the Members of the Committee of:

   a. the challenges faced by CAMHS both nationally and within Nottinghamshire

   b. findings from the review of the Nottinghamshire CAMHS Pathway, the resulting recommendations and expected benefits of the proposed service model

   c. the next steps required for approval and implementation of the model

.

Information and Advice

2. In a report published in November 2014, the Health Select Committee concludes that "*there are serious and deeply ingrained problems with the commissioning and provision of children's and adolescent's mental health services*" through the whole system from prevention and early intervention through to inpatient services. The executive summary of the Health Select Committee report is attached as **Appendix 1** of this report. A National CAMHS Taskforce has been established to take forward the recommendations made within the report and this is expected to raise CAMHS as a priority and increase levels of scrutiny nationally.

3. Locally, in November 2013, the findings of the 2013 health needs assessment (HNA) of the mental health and emotional wellbeing of children and young people in Nottinghamshire was published. In February 2014, a Health and Wellbeing Workshop focusing on CAMHS was held, where concerns were raised in relation to the changing patterns of mental health problems in children and young people and the capacity of CAMHS in Nottinghamshire to meet these needs. In December 2014, the HWB received a report describing the findings of the Nottinghamshire CAMHS pathway review and proposals for future commissioning.

4. Community CAMHS are currently commissioned by Clinical Commissioning Groups (CCGs), with specialised Tier 4 (in-patient CAMHS) commissioned by NHS England. In Nottinghamshire, the Children, Families and Cultural Services Department (CFCS) in the County Council funds additional posts within the Tier 2 CAMHS and also joint-commission the CAMHS Looked After Children service.

5. This paper reports on the CAMHS Pathway Review undertaken in Nottinghamshire, the recommendations arising from the review and proposals for future commissioning of services across the County.

Background to the CAMHS Pathway Review

6. On behalf of Nottinghamshire Clinical Commissioning Groups (CCGs) and Nottinghamshire County Council (NCC), the Children's Integrated Commissioning Hub (ICH) carried out a review of the Nottinghamshire CAMHS Pathway between October 2013 and April 2014. The review was initiated in response to the findings of the 2013 health needs assessment (HNA) of the mental health and emotional wellbeing of children and young people in Nottinghamshire and the reported pressures faced by CAMHS locally. The aim was that the findings of the review would inform the development of a commissioning framework for services going forward, to ensure that children and young people in Nottinghamshire achieve the best possible emotional wellbeing and mental health.

7. The review process, overseen by a Pathway Review Group, involved bringing service commissioners, providers, clinicians, third sector organisations, children, young people and their families together to review the current service provision, undertake gap analyses and consider evidence-based models of future delivery.

8. It was anticipated that the programme of work would result in the following outputs:

- evidence review
- new operating model
- implementation strategy
- workforce development strategy
- performance management framework including a health needs assessment template for future use.

Key findings, proposed new service model and implementation plan

9. The review highlighted that staff are passionate, dedicated and are working hard to meet the needs of children, young people and their families. Areas of excellent practice were identified; however, significant challenges across the entire pathway, systems and processes were identified, reflecting the national concerns in relation to CAMHS. In summary:

- parts of the CAMHS pathway are at gridlock and there is evidence of cumbersome processes affecting flow through the pathway
- children and young people are falling through gaps between elements of the service
- there are artificial barriers for families to navigate
- in some localities children and young people are waiting a long time for a service
- services are becoming crisis driven and are having difficulty in responding to new crises. This has impacts earlier in the system
- primary care and universal services, including schools, do not receive sufficient support and advice to enable them to support children and young people.

10. Areas requiring further exploration included transition arrangements (between CAMHS and adult services) and the impact of parental risk factors – mental health, substance misuse and domestic abuse.

11. A new service model has been proposed in response to the findings of the pathway review and policy and evidence reviews. An overview of the model is attached as **Appendix 2**. The proposed model has been presented to all Nottinghamshire CCGs, the Children's Trust Board and HWB. The model has been widely supported with its ambition of improving the experience and outcomes for children, young people and their families through the provision of a responsive, flexible, service-user led model. The key components of the model aims to address the issues highlighted above:

Key components and benefits of new service model

Current issues	Proposed changes	Expected benefits
• Primary care, schools and universal services receive insufficient support	• Provide a primary mental health function that offers training, advice and consultation	• Build understanding and capacity in primary care, schools and universal services • Improve early identification of and support for emerging emotion and mental health needs • Improve quality, timeliness and appropriateness of referrals into CAMHS • Improve transition from specialist CAMHS to universal settings
• Artificial barriers to navigate • Children and young people falling through gaps between elements of the service	• Merge tier 2 and 3 CAMHS into 'One CAMHS'	• Remove artificial barriers between teams and tiers • Reduce waiting, duplication and waste
• Unclear referral criteria and processes • Limited interface with Early Help services	• Integrate or co-locate CAMHS Single Point of Access within NCC's Early Help Unit	• Single referral point for CAMHS and Early Help services with clinical oversight and telephone advice • Clearer referral criteria for professionals • Multiagency triage and care planning
• Parts of the system are at gridlock affecting flow of the pathway • Long referral to assessment / treatment waiting times • Limited national and local	• Implement Choice and Partnership Approach (CAPA)	• Evidenced-based model to manage capacity, demand and flow and reduce waiting times • Delivery of evidenced-based, standardised interventions (care

capacity and demand intelligence		bundles) • Enables measurement of capacity, demand and outcomes, to inform future commissioning
• No dedicated assertive outreach and rapid response provision for CAMHS • Increasing numbers of children and young people are presenting in crisis, including as section 136 detentions in police cells • Increased inpatient admissions and length of stay	• Dedicated assertive outreach and rapid response team • Crisis response team to be developed in partnership with adult service	• Increase support for children and young people to be treated in the right place, at the right time, by the right person • Reduce admissions to inpatient care, reduce length of stay • Children and young people receive care closer to home

12. It is envisaged that robust, appropriately resourced implementation of the new service model will address many concerns raised within the Health Select Committee report in relation to CAMHS.

Agreeing and implementing model

13. Agreement to the recommendations and investment plans will require approval from each CCG Governing Body, as the accountable organisations commissioning CAMHS. Therefore the final review report, recommendations, any identified non-recurrent investment requirements and proposed implementation plan will be presented to the six Nottinghamshire County CCG Governing Bodies for consideration during January and February 2015.

14. Current implementation timescales are estimated to be 18 months, starting in April 2015. This is dependent on agreement by the six CCGs across Nottinghamshire.

15. As highlighted in the Health Select Committee report, "*those planning and running CAMHS have been operating in the fog*" which reflects the challenge in identifying current and realistic investment requirements at CCG level. In Nottinghamshire, CCGs are working to quantify levels of non-recurrent investment, using available data relating to estimated prevalence levels, current expenditure, activity and waiting times. It is envisaged that during the implementation phase, robust data on need, demand and required service capacity will be collated, to inform future commissioning.

Other Options Considered

16. There is widespread acknowledgement that the mental health and emotional wellbeing needs of children and young people in Nottinghamshire are not being met by current services and structures. The option of maintaining the status quo and not endeavouring to develop a CAMHS model fit for the future was not considered acceptable.

RECOMMENDATION/S

That the Health Scrutiny Committee:

1) Considers and comments on the findings of the review of the Nottinghamshire CAMHS Pathway, the resulting recommendations and expected benefits of the proposed new CAMHS model

2) Schedule further consideration of CAMHS issues, as necessary.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Briefing compiled by:
Dr Kate Allen
Children's Commissioner and Consultant in Public Health

Gary Eves
Senior Public Health and Commissioning Manager

On behalf of Nottinghamshire Clinical Commissioning Groups

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Children's and young people's mental health and emotional wellbeing in Nottinghamshire – report to Health and Wellbeing Board on 6 November 2013

Nottinghamshire Children and Adolescent Mental Health Services (CAMHS) report to Health and Wellbeing Board on 3 December 2014

House of Commons Health Committee: Children's and adolescents' mental health and CAMHS, published on 5 November 2014

Appendix 1 – House of Commons Health Committee CAMHS Report Summary

There are serious and deeply ingrained problems with the commissioning and provision of Children's and adolescents' mental health services. These run through the whole system from prevention and early intervention through to inpatient services for the most vulnerable young people.

The Committee draws conclusions and makes recommendations for action in the following areas:

Information

- The lack of reliable and up to date information about children's and adolescents' mental health and CAMHS means that those planning and running CAMHS services have been operating in a "fog".

- Ensuring that commissioners, providers and policy makers have up-to-date information about children's and adolescents mental health must be a priority for the Department of Health/NHS England taskforce.

Early intervention

- Compelling arguments have been made to this inquiry that the focus of investment in CAMHS should be on early intervention–providing timely support to children and young people before mental health problems become entrenched and increase in severity, and preventing, wherever possible, the need for admission to inpatient services. However in many areas these are suffering from insecure or short term funding, or being cut altogether.

- Health and Wellbeing Boards, and the transfer of public health budgets to local authorities, both represent significant opportunities for health issues to receive higher priority within local authorities. We have been told of some areas where these opportunities are beginning to be exploited, but this is patchy and progress remains slow. We have also heard that in times of financial constraint, some local authorities do not consider CAMHS early intervention services as "core business".

- We recommend that, given the importance of early intervention, the DH/NHS England task force should have an explicit remit to audit commissioning of early intervention services in local authorities, and to report on how best to improve incentives in this area. They should also look at the best mechanisms to provide stable, long term funding for early intervention services.

Outpatient specialist CAMHS services (Tier 3)

- Providers have reported increased waiting times for CAMHS services and increased referral thresholds, coupled with, in some cases, challenges in maintaining service quality. In the view of many providers, this is the result of rising demand in the context of reductions in funding. Not all services reported difficulties–some state that they have managed to maintain standards of access and quality–but overall there is unacceptable variation.

- Young people and their parents have described “battles” to get access to CAMHS services, with only the most severely affected young people getting appointments; they also described the devastating impact that long waits for treatment can have. Even amongst those providers implementing quality and efficiency improvement programmes there was concern that improvements were being stalled or even reversed because of increasing demand and reduced funding.

- While demand for mental health services for children and adolescents appears to be rising, many CCGs report having frozen or cut their budgets. CCGs have the power to determine their own local priorities, but we are concerned that insufficient priority is being given to children and young people’s mental health. We recommend that NHS England and the Department of Health should monitor and increase spending levels on CAMHS until we can be assured that CAMHS services in all areas are meeting an acceptable standard, and for NHS England to give CAMHS further monitoring and support to address the variations in investment and standards that submissions to this inquiry have described. Service specifications for Tier 2 and 3 services should set out what reasonable services should be expected to provide, and NHS England and the Department of Health should carry out a full audit to ensure all services are meeting these. We welcome recent funding announcements for mental health services, but we remain concerned and recommend that our successor Committee reviews progress in this area.

- In addition to the universal concerns expressed about CAMHS services, written submissions highlighted problems with CAMHS for children and young people suffering from particular conditions, or from especially vulnerable groups of society. We recommend that the DH/NHS England taskforce takes full account of the submissions we have received detailing these problems.

- Transition from CAMHS to adult mental health services has been described by NHS England as a “cliff edge”, and the stories we heard from young people bear this out. We plan to review progress in this area early in 2015.

- As well as the transition to adulthood, a crucially important time for promoting good mental health is the perinatal and infant period, but there is unacceptable variation in the provision of perinatal mental health services, and we recommend that this is addressed urgently.

Tier 4 inpatient services

- There are major problems with access to Tier 4 inpatient services, with children and young people’s safety being compromised while they wait, suffering from severe mental health problems, for an inpatient bed to become available. In some cases they will need to wait at home, in other cases in a general paediatric ward, or even in some instances in an adult psychiatric ward or a police cell. Often when beds are found they may be in distant parts of the country, making contact with family and friends difficult, and leading to longer stays.

- The Committee is particularly concerned about the wholly unacceptable practice of taking children and young people detained under s136 of the Mental Health

Act to police cells, which still persists, with very few mental health trusts providing a dedicated place of safety for children and young people. In responding to this report we expect the Department of Health to be explicit in setting out how this practice will be eradicated.

- Alongside problems with access, we also heard from young people and their parents, as well as those who work with them, of quality concerns in some inpatient services; NHS England reported that over the past year some inpatient services have in fact been closed owing to quality concerns.
- Concerns have also been raised about the quality of education children and young people receive when they are being treated in inpatient units. It is essential that clear standards are set for the quality of education provision in inpatient units, and that there is clear accountability and ownership for ensuring that these standards are upheld. As a first step towards this, we recommend that OFSTED, DFE and NHS England conduct a full audit of educational provision within inpatient units as a matter of urgency.

- Despite the move to national commissioning over a year ago, we have been told that NHS England has yet to 'take control' of the inpatient commissioning process, with poor planning, lack of co-ordination, and inadequate communication with local providers and commissioners. NHS England is now recruiting more case managers. However, while many of the difficulties NHS England is now seeking to address may be a legacy from previous arrangements, we are disappointed that during its first year as a commissioner of inpatient services, many of the perceived benefits of national planning have not been realised, and we intend to review NHS England's progress addressing these problems early in 2015. In particular, we recommend that NHS England should introduce a centralised inquiry system for referrers and patients, of the type that is already in operation for paediatric intensive care services.

- NHS England has announced 50 extra inpatient CAMHS beds, but by its own admission, it is not clear how many beds are needed to provide sufficient Tier 4 capacity. It is essential that the extra beds are commissioned in the areas which need them most, and are supported by an improved system of case management.

Bridging the gap between inpatient and community services

- Out-of-hours crisis services, paediatric liaison teams within acute hospitals, and Tier 3.5 assertive outreach teams can have a positive impact, including reducing both risk and length of inpatient admission; however availability of such services is extremely variable. The experience of care reported by those young people suffering a mental health crisis remains extremely negative.

- Perverse incentives in the commissioning and funding arrangements for CAMHS need to be eliminated to ensure that commissioners invest in Tier 3.5 services which may have significant value in minimising the need for inpatient admission and in reducing length of stay. The Department of Health and NHS England must act urgently to ensure that by the end of this year all areas have clear mechanisms to access funding to develop such services in their local area, where this is appropriate. A key responsibility for the newly set up task force will be to determine a way in which commissioning can be sufficiently integrated to allow

rational and effective use of resources in this area, which incentivises early intervention. The Government has recently announced extra funding for early intervention in psychosis services and crisis care; we recommend that the Government ensures that a substantial proportion of this new funding is directed towards services for under-18s.

Education and digital culture

- We heard from young people that while some teachers and schools provide excellent support, others seem less knowledgeable or well trained, and can even seem 'scared' of discussing mental health issues. The launch of MindEd, together with new guidance for schools on mental health, are both welcome steps towards addressing this. However, with both of these, the onus is on individual schools and teachers to find time to prioritise this, and within a sea of competing priorities, it may be difficult to ensure that all schools and teachers use these tools.

- We recommend the Department for Education looks to including a mandatory module on mental health in initial teacher training, and should include mental health modules as part of ongoing professional development in schools for both teaching and support staff. We also recommend that the Department for Education conducts an audit of mental health provision and support within schools, looking at how well the guidance issued to schools year has been implemented, what further support may be needed, and highlighting examples of best practice. OFSTED should also make routine assessments of mental health provision in schools.

- It is clear that education about mental health could and should contribute to prevention and support for young people. We recommend that the Department for Education consult with young people, including those with experience of mental health issues, to ensure mental health within the curriculum is developed in a way that best meets their needs.

- For today's children and young people, digital culture and social media are an integral part of life; whilst this has the potential to significantly increase stress, and to amplify the effects of bullying, the internet can also be a valuable source of support for children and young people with mental health problems. We have not investigated the issue of internet regulation in depth. However, in our view sufficient concern has been raised to warrant a more detailed consideration of the impact of the internet on children's and young people's mental health, and in particular the use of social media and the impact of pro-anorexia, self-harm and other inappropriate websites, and we recommend that the Department of Health/NHS England taskforce should take this forward in conjunction with other relevant bodies, including the UK Council for Child Internet Safety.

- Children and young people also need to know how to keep themselves safe online. It is encouraging that e-safety will now be taught at all four key stages of school education. We recommend that as part of its review of mental health education in schools, the Department for Education should ensure that links between online safety, cyberbullying, and maintaining and protecting emotional wellbeing and mental health are fully articulated. We recommend clear pathways

are identified for young people to report that they have been sent indecent images of other children or young people, and that support is provided for those who have been victims of image sharing. Pathways should also be established for children and young people who have experienced bullying, harassment and threats of violence.

- CAMHS providers may also need further support–both in helping the children and young people they treat to cope with the challenges of online culture and manage the impact it might have on their mental health - and so that they themselves are better able to use online means of communication for reaching out to young people. We recommend that the Department of Health/NHS England taskforce should also investigate and report on the most effective ways of supporting CAMHS providers to do this.

GPs

- We have heard that many GPs currently feel ill-equipped and lacking in confidence in dealing with mental health issues in children and young people, and that their current training does not prepare them adequately for this. We therefore ask HEE together with the GMC and relevant Royal Colleges to provide us with a full update on their plans to enhance GP training in children's and adolescents' mental health.

National priority and scrutiny

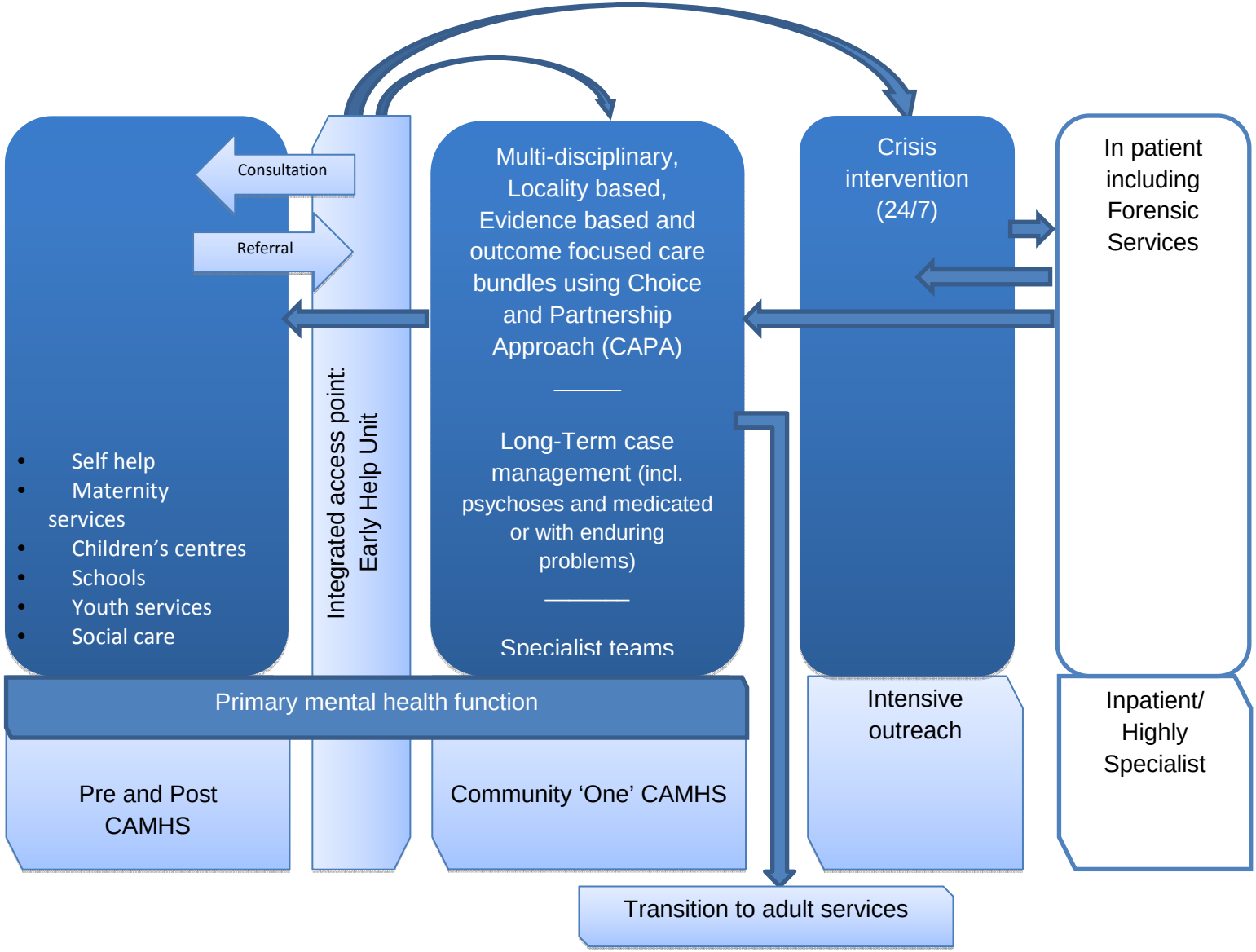
- It is clear that there are currently insufficient levers in place at national level to drive essential improvements to CAMHS services. These have received insufficient scrutiny from CQC and we look to review progress in this area following their new inspection regime. The Minister has argued that waiting time targets will improve CAMHS services but we recommend a broader approach that also focuses on improving outcomes for specific conditions in children's and adolescents' mental health.

- We therefore recommend the development, implementation and monitoring of national minimum service specifications, together with an audit of spending on CAMHS. We recommend that the Department of Health/NHS England taskforce look to remove the perverse incentives that act as a barrier to Tier 3.5 service development and ensure investment in early intervention services. There must be a clear national policy directive for CAMHS, underpinned by adequate funding.

Full report available at:

http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf

Appendix 2 - Proposed Nottinghamshire Child and Adolescent Mental Health Service Model



Nottinghamshire County Council

Report to Health Scrutiny Committee

26 January 2015

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

STROKE PATHWAY DEVELOPMENTS

Purpose of the Report

1. To introduce a briefing on developments in the stroke pathway.

Information and Advice

2. In May 2012, Sherwood Forest Hospitals NHS Foundation Trust announced that more patients would be able to receive gold standard stroke treatment closer to home due to the launch of thrombolysis (clot-busting) treatment at Kings Mill Hospital. The service operated from 8:00 a.m. to 5:00 p.m., Monday to Friday (including public holidays). Weekend and out of hours services continued to be provided at Nottingham University Hospital's City Hospital campus.

3. In July 2013, Sherwood Forest Hospitals NHS Foundation Trust indicated that the thrombolysis treatment service for hyper-acute stroke patients at Kings Mill Hospital had been extended to cover Mondays, Tuesdays, Wednesdays and Thursdays overnight, offering a 24 hour provision (with emphasis that the service also covers patients from Newark). The Trust also indicated that on Fridays, Saturdays and Sundays patients would continue to be treated in Nottingham. At this time, Philip Bolton, Head of Nursing, stated that "We are delighted to have extended the availability of our thrombolysis service, meaning patients won't need to travel to Nottingham to receive the treatment. Thrombolysis can spare patients from permanent disability and a prolonged length of stay in hospital."

4. On Friday 6 December 2013, stroke patient Mr John Mallalieu experienced lengthy delays in treatment due to breakdowns in communication between the East Midlands Ambulance Service and Kings Mill Hospital. The communication breakdown was based around confusion over the time when the stroke unit closed. Very sadly, Mr Mallalieu died in hospital on 22 December.

5. In August 2014, further to a review of stroke services, the Trust announced that thrombolysis would be available 24 hours a day. There should therefore be no requirement for stroke patients to travel to City Hospital in Nottingham.

6. Elaine Moss, Director of Quality and Governance at Sherwood Forest Hospitals NHS Foundation Trust will attend the Health Scrutiny Committee to brief Members on developments in stroke services and answer questions as necessary.

7. Members may wish to schedule further consideration of these issues.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing and asks questions as necessary
2) Schedules further consideration of stroke service development issues.

Councillor Colleen Harwood
Chairman of 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

NOTTINGHAMSHIRE COUNTY COUNCIL

HEALTH SCRUTINY COMMITTEE 26th January 2015

Briefing on the Provision of Hyper-Acute Stroke Services within Nottinghamshire

1. Overview and Background

A broad definition of a stroke is the sudden death of brain cells due to an inadequate blood flow in the brain. A stroke can cause paralysis, speech impairment, loss of memory and reasoning ability, coma, or death. There are a number of causes of strokes with the vast majority caused by either bleeding in the brain or a clot that obstructs the flow of blood. Strokes caused by a clot have a time crucial treatment called thrombolysis.

The National Stroke Strategy (2007) sets out a significant number of Quality Markers aimed at ensuring consistent, safe and effective care for people who suffer a stroke. Quality Marker 7 requires that "all patients with suspected acute stroke are immediately transferred by ambulance to a receiving hospital providing hyper-acute stroke services…"

The strategy and National Institute for Clinical Excellence (NICE) guidance also sets out that a patient requiring thrombolysis (clot busting treatment) should be given the drug within 4 hours of onset.

A patient that arrives at a Hyper-Acute Stroke Unit (HASU) within four hours of experiencing stroke-like symptoms, will be assessed immediately by stroke experts to see whether they have had a stroke. If a stroke is thought likely they will be immediately taken to a CT scanner to find out whether their stroke has been caused by a clot (an 'ischaemic stroke') or a bleed (a 'haemorrhagic stroke'). If a blocked artery is the cause thrombolysis treatment is then infused intravenously.

Patients get more benefit from stroke thrombolysis the earlier they are treated. We record the exact time that every patient arrives (this is called the 'door' time), and other essential steps along the way up to the point where the drug injection starts (the 'needle' time) this is called the door-to-needle time and is the crucial time (4 hours) for safe and effective thrombolysis treatment.

2. Nottinghamshire Hyper-Acute Stroke Unit (HASU)

In the County there is a two-site partnership model for hyper-acute stroke services. This was set up to ensure the provision of relevant clinical expertise and equipment across Nottinghamshire. The two sites are Kings Mill Hospital (part of Sherwood Forest Hospitals Foundation Trust) and Nottingham City Hospital (part of Nottingham University Hospitals). In 2008/9 the Strategic Health Authority approved Sherwood Forest Hospitals Kings Mill site and Nottingham University Hospitals City Hospital site, with a shared medical rota and governance as a Hyper-Acute Stroke Unit (HASU). This working arrangement is called the Nottinghamshire Stroke Partnership.

The Nottinghamshire Stroke Partnership service was set up to deliver:

- Improved clinical outcomes
- Improved quality of life outcomes e.g. reduced level of disability following a stroke
- An excellent patient and carer experience e.g. experience across the whole pathway and including improved access
- Evidence based standards 24/7 for all patients

Up to 2013 both sites ran a 24/7 service but due to a reduction of consultant staff (a consultant moved to work elsewhere in the NHS) at Kings Mill Hospital, an amended working arrangement was agreed. Nottingham City Hospital provided a 24 hour 7 day a week hyper-acute service and Kings Mill Hospital operated 09:00 Monday to 17:00 Friday, inclusive. Recruitment to additional consultant posts at the Kings Mill site was sought with the aim of then returning to the two sites providing 24/7 services.

The amended local pathway was that any patient identified as potentially needing thrombolysis treatment from 17:00 Friday to 09:00 Monday would be taken to Nottingham City Hospital. The stroke consultant rota at Kings Mill Hospital finished at 18:00 on Friday. This was to ensure time to deliver thrombolysis treatment, patients arriving by ambulance were accepted up to 17:00 after which patients were taken to Nottingham City Hospital.

This process had worked successfully until December 2013 when a patient experienced a journey to Kings Mill Hospital and was then diverted when only minutes from the Kings Mill site.

3. Current provision of Hyper-Acute Stroke in Nottinghamshire

Following a Nottinghamshire wide serious incident investigation and learning review, changes have been made to ensure such a diversion and associated poor patient and family experience could not occur again.

Acute thrombolysis service on both sites (24 hours, 7 days a week) was recommenced on 4th August 2014. This is again being delivered through a shared governance process and shared rota. The teams use Telemedicine to ensure that timely and effective consultant management of suspected strokes is delivered. This therefore means the patient can be taken to the nearest of the two sites and thrombolysis is not dependent upon a consultant being on that specific site. The partnership will monitor the outcomes through the partnership governance arrangements.

4. Conclusion

The two site 24/7 model is delivering safe services for the population of Nottinghamshire. Commissioners have joined the Nottinghamshire Stroke Partnership Board to ensure standards are assessed and challenged.

Elaine Moss

Chief Nurse and Director of Quality

Mid Nottinghamshire Clinical Commissioning Groups

Nottinghamshire County Council

Report to Health Scrutiny Committee

26 January 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. The Quality Account priorities for Doncaster & Bassetlaw NHS Foundation Trust and Sherwood Forest NHS Foundation Trust were due to be considered at this meeting. However, the priorities are still at an early stage of development and so this item has been rescheduled for the March meeting of the Health Scrutiny Committee.

6. 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 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2014/15

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
23 June 2014				
Proposed Merger of Clipstone Health Centre and Farnsfield Surgery	Consideration of GP surgery merger	Scrutiny	Martin Gately	Matt Doig, Dr Smith & Partners and Keith Mann NHS England
Mid-Nottinghamshire Better + Together Integrated Care Transformation	Consideration of transformation programme	Scrutiny	Martin Gately	Dr Amanda Sullivan, Newark and Sherwood CCG
Healthwatch Information Sharing	A new regular item focussing on the work of Healthwatch	Briefing	Martin Gately	Joe Pidgeon of Healthwatch
29 September 2014				
NG25 Mortality Rates Group – Final Report	A verbal update from Councillor Bruce Laughton on the work of this group	Briefing	Martin Gately	Councillor Bruce Laughton
Healthwatch Nottinghamshire – Annual report	To examine the Annual Report of Healthwatch Nottinghamshire	Scrutiny	Martin Gately	Joe Pidgeon, Chairman of Healthwatch
24 November 2014				
Sherwood Forest Hospitals Foundation Trust	Update on the work of the Sherwood Forest Hospitals Foundation Trust TBC	Briefing	Martin Gately	Paul O'Connor, Chief Executive [or other relevant senior officer] TBC

Bassetlaw Health Services	An update on the work of Bassetlaw Clinical Commissioning Group from the Chief Operating officer, Mr Phil Mettam. TBC	Briefing	Martin Gately	Mr Phil Mettam Bassetlaw CCG
Care of Diabetic Elderly People in Hospital (Bassetlaw)	An initial briefing on diabetic care of the elderly in hospital	Briefing	Martin Gately	Heather Woods Bassetlaw CCG
Obesity Service	An initial briefing on the service design for new obesity services, with a focus on how the service design was consulted on	Briefing	Martin Gately	Anne Pridgeon, Barbara Brady Public Health
26 January 2015				
CQC Hospital Inspections & GP Surgeries	Briefing on outcomes from recent inspections	Briefing	Martin Gately	Ros Johnson, CQC Inspection Manager, Hospitals Directorate and Linda Hirst Inspection Manager Primary Medical Services and Integrated Care Directorate
Child and Adolescent Mental Health Services (CAMHS) contracts operating with the County	Initial briefing on the operation of Child and Adolescent Mental	Briefing	Martin Gately	Dr Kate Allen Children's Commissioner and Consultant in Public Health, Gary Eves Senior Public Health and Commissioning Manager and CCG colleagues
Stroke Pathway Briefing TBC	Update on the current position with stroke services	Briefing	Martin Gately	Elaine Moss, Director of Quality and Governance,

				Newark and Sherwood CCG
23 March 2015				
End of Life Care	Initial briefing with a view to undertaking a review	Briefing	Martin Gately	TBC
Misdiagnosis	Further briefing with a view to undertaking a review	Briefing	Martin Gately	Dr Amanda Sullivan, Newark and Sherwood CCG
Kings Mill Hospital Car Parking Charges	An initial briefing with a view to undertaking a review	Briefing	Martin Gately	Sherwood Forest Hospitals Foundation Trust
18 May 2015				
Quality Accounts	Consideration of draft Quality Accounts (Sherwood Forest and Doncaster & Bassetlaw Trusts)	Scrutiny	Martin Gately	TBC
20 July 2015				

Potential Topics for Scrutiny:
Never Events
Health Inequalities
Substance Misuse