Joint City / County Health Scrutiny Committee

Tuesday, 15 January 2013 at 10:15

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

AGENDA

1	minutes on the last meeting held on 11 December 2012	3 - 6
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	Minutes of the EMAS Change Programme Sub Committee held on 29 November 2012	7 - 14
5	Patient Transport Service	15 - 26
6	Quality Accounts	27 - 40
7	Eating Disorders Response	41 - 48
8	Work Programme	49 - 56

Notes

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

Customer Services Centre 0300 500 80 80

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

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Sara Allmond (Tel. 0115 977 3794) or a colleague in Democratic Services prior to the meeting.

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

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

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
11 December 2012 at 10.15am

Nottinghamshire County Councillors

Councillor M Shepherd (Chair)
Councillor G Clarke
Councillor V Dobson
Councillor Rev. T. Irvine
Councillor E Kerry
Councillor P Tsimbiridis
Councillor C Winterton
A Councillor B Wombwell

Nottingham City Councillors

Councillor G Klein (Vice- Chair)
A Councillor M Aslam
A Councillor E Campbell
Councillor A Choudhry
Councillor E Dewinton
Councillor C Jones
A Councillor T Molife
A Councillor T Spencer

Also In Attendance

District Councillor T Roberts – Member of EMAS Change Programme Sub Committee
County Councillor S Wallace – Member of EMAS Change Programme Sub Committee
Dr Peter Homa – Chief Executive, Nottingham University Hospitals NHS Trust
Laura Skaife – Nottingham University Hospitals NHS Trust
Tom Turner – Nottinghamshire County LINKs
Barbara Venes - Nottingham City LINks
Sara Allmond – Nottinghamshire County Council
Martin Gately - Nottinghamshire County Council
Noel McMenamin – Nottingham City Council

MINUTES

The minutes of the meeting held on 13 November 2012 were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors M Aslam (Medical/Illness), E Campbell and B Wombwell (other)

DECLARATIONS OF INTERESTS

None

DEVELOPMENT OF SERVICES AT LINGS BAR HOSPITAL - UPDATE

Following a review of care in community hospitals across the county which resulted in changes to service provision at Lings Bar Hospital, the Committee had received regular updates on the outcomes of the changes. The Joint Committee had requested a further progress report at this meeting.

Members were requested to agree a delay in receiving an update report pending the transfer to the new NHS structure when NHS Nottingham City and Nottinghamshire County would be in a better position to explain options going forward. It was proposed to receive a report at the March meeting.

The Joint Health Committee noted the latest service developments at Lings Bar Hospital and agreed that a further report be brought to the March meeting.

AGENDA ORDER

The Chairman agreed to take item 6 – East Midlands Ambulance Service Change Programme – Response as the next item to allow the two members of the EMAS Change Programme Sub Committee to leave following consideration of the item.

EAST MIDLANDS AMBULANCE SERVICE CHANGE PROGRAMME - RESPONSE

Councillor Shepherd introduced the report which provided Members with the East Midlands Ambulance Service (EMAS) Change Programme Sub-Committee's proposed response to the consultation.

Members of the Sub-Committee were thanked for their work along with the other organisations who attended including EMAS.

The Sub-Committee were content with the principle of the hub and spoke system but had some concerns about the impact it would have on some areas, rural areas in particular.

Five recommendations were proposed by the Sub-Committee. The Committee felt the five recommendations were appropriate, with an additional recommendation regarding the adequate supply of ambulances and crews to operate in rural areas. This was to ensure that there was appropriate and timely cover in all areas of the City and County.

Members had also raised concerns regarding a lack of information being provided to local members on consultation meetings, and a comment on this was included within the draft response letter to EMAS. Members also felt that it was important to ensure

good working relationships with neighbouring service providers were built into the model, to ensure that there were no service gaps and additional support could be provided and received when needed.

Members discussed the recommendation regarding fines levied against Ambulance Trusts and agreed that the recommendation should be included as it specifically referred to Trusts not commercial operations. It was also felt that Monitor should investigate any performance issues first, before any further sanctions were taken. This would be covered within the letter.

The Joint Health Committee:-

agreed the letter and recommendations as set out in the report, with an addition recommendation:-

"That an adequate supply of ambulances and crews be provided to operate in rural areas."

NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST – CANCELLATION OF NON-ELECTIVE OPERATIONS SINCE JANUARY 2012 – PROGRESS REPORT

Dr P Homa gave Members and update on cancellations of non-elective operations since January 2012. Actions were in place, including addition beds and an observation unit next Accident & Emergency (A&E). In November there had been a cancellation rate of 0.81% with fewer than 3% total cancellations. Nottingham University (NUH) Hospitals NHS Trust publish all cancellation performance figures. Since August there had consistently been cancellation rates of less than 3% and the Trust were continuing to work to reduce this figure further so there were as few cancellations as possible.

The Trust had a detailed Winter Plan including an extra ward of clinical beds. Over 130 nursing staff, other medical staff and support staff were currently being recruited for this ward, which was a permanent addition. It was planned to add a second additional ward. The situation would be assessed on a weekly basis to ensure that it was effectively managed over the winter period.

Dr Homa had a high level of confidence that the Trust would never again have the high level of cancellation rates seen earlier in 2012.

The increase in cancellations in July was due to an international shortage of a chemotherapy agent, which meant that patients had to be switched to alternative treatments so their original operation dates had to be cancelled.

The Trust focussed on re-admissions and outcomes for patients by procedure to assess their success rates. Any issues identified were given detailed scrutiny. The Trust was one of the finest in the Country for outcomes.

There had been no danger to life due to the cancelled operations.

The Trust performed strongly against its peers in relation to mortality rates. The hospitals had a significant range of specialisms with a wide breadth of experience, meaning the patients received the best care possible.

Members were assured that if an operation had been cancelled it would be rearranged as soon as possible at a time to suit the patient.

The external report commissioned by the Trust to investigate the cancellations earlier in 2012 had been published and gave constructive criticism from which the Trust had made changes. The Trust had been too focussed on the day of the operation, and had found that by examining cancellations the day before the operation this gave an earlier warning of any issues. The data was now forensically assessed on a daily basis and systems were being brought together to ensure better correlation of data across the hospitals.

The Joint Health Committee noted the presentation and additional information provided and that a further update would be provided at the March meeting, including how successful the Winter Plan had been.

WORK PROGRAMME

The Committee were advised that the East Midlands Stroke Review item had been deferred from the meeting to a future meeting (most likely March 2013).

The meeting closed at 11.10am.

Chairman

Nottinghamshire County Council

Nottingham City Council

MINUTES

EAST MIDLANDS AMBULANCE SERVICE (EMAS) CHANGE PROGRAMME SUB COMMITTEE
29 November 2012 at 10.00am

City Councillor G Klein (Chair)
County Councillor M Shepherd (Vice-Chair)
City Councillor C Jones
District Councillor T Roberts (Newark & Sherwood)
County Councillor S Wallace
County Councillor C Winterton
A County Councillor B Wombwell

Also In Attendance

County Councillor Alan Rhodes

Tracey Adams – Assistant Director – Operations, East Midlands Ambulance Service
Richard Henderson – Assistant Director – Operations (Notts), East Midlands Ambulance Service
Mark Ward – Unison
Anne Berry – GMB
David Seaton – Paramedic, East Midlands Ambulance Service
Carolyn White – Sherwood Forest Hospital Trust
Tom Turner – Nottinghamshire County LINKs
Barbara Venes - Nottingham City LINks
Martin Gately - Nottinghamshire County Council
Noel McMenamin – Nottingham City Council
Sara Allmond – Nottinghamshire County Council

APOLOGIES FOR ABSENCE

There were no apologies for absence

MEMBERSHIP OF SUB COMMITTEE

The Membership of the sub committee as listed above was noted.

CHAIR OF THE SUB COMMITTEE

It was agreed to appoint Councillor Klein as Chair of the Sub Committee

DECLARATIONS OF INTERESTS

None

EAST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST CONSULTATION – CHANGE PROGRAMME JOINT REVIEW

Tracey Adams informed Members that she was seconded to East Midlands Ambulance Service (EMAS) from West Midlands Ambulance Service (WMAS) who had started a similar change programme 18 months ago. WMAS would have 11 hubs and 131 ambulance posts. Five hubs were currently live and the remaining six would be live by the end of the financial year, meaning that WMAS were working to much shorter timescales than EMAS. The WMAS hubs would house the main fleet and was where most staff would report to. There were two types of ambulance posts – Reporting Posts where staff turned up for duty and collected the vehicle from there. These posts were at sites such as fire stations. The other type of ambulance posts were standby points with all required facilities. The location of the standby points were linked into local health delivery.

WMAS had a different operating model between rural and urban areas. In Herefordshire, staff would have had a 30 mile round trip to report on at a hub, so the reporting posts were developed to allow staff to report on locally. Crews were ring fenced to an area on a car basis. Initially there was resistance to the changes and concern that it would have a detrimental effect on the service, but this has completely turned around since April 2011 and WMAS has gone from being one of the worst performing rural services to the highest performing.

The model for WMAS was developed based on a model which had been successfully in use in Staffordshire since 1995. WMAS tried to implement this model into cities, but it did not work, so the city model was changed. The majority of staff within a city are able to report to a hub, so there are now mostly only standby posts.

In response to questions, Tracey Adams provided the following information:-

- Equipping the vehicles properly was part of the model. At the start of each shift each ambulance would be stocked with enough supplies to last for the whole shift. In WMAS, as cars were not able to hold as much stock, there were designated locations holding minimum stock to enable the cars to restock during the shift when required. Other options could be considered such as holding stock at hospitals or having drivers who deliver items out to smaller sites as required, but generally this would not be required as the vehicle would have enough supplies for the whole shift.
- In stocking a vehicle, WMAS used sealed packs which were packed and checked and only sealed once all equipment was included and had been checked and signed off by the crew. There was a governance process in place regarding the checking and signing off of equipment.
- Finding the right locations for the standby points was important as the vehicles needed to be able to access appropriate services. A hospital could be a good location for this. There was likely to be only 1 vehicle at a standby point at any one time meaning that they would not take up too much car parking from visitors.
- Some staff at WMAS did have to travel further to work than they used to, but they were given the opportunity to move to a nearer area if they wished to.
- WMAS had an aging estate with some surplus space. The facilities were not fit for purpose.

- Following each area being rolled out, a six month review was carried out to identify benefits and any issues. A further 12 month review would also be carried out. The review reports were presented to the Board. The report on Herefordshire implementation and a city implementation would be requested for the Sub Committee, including information on the number of vehicles in the areas before and after the change programme was implemented.
- There had been improvements in all areas where the changes had been implemented. For example Hereford performance on A8 was under the 75% target at between 70% and 72%, in the last three months, performance has been 79%, 80.1% and 81.9%.
- WMAS did not carry out a formal consultation on the whole programme, they consulted locally as the programme was rolled out. There was union resistance and staff disputes and it was difficult to get to an agreement. But the views of the staff had since turned around completely. There was flexibility on how the change programme was implemented locally and the programme was sold on the benefits it would have to patients.

Mark Ward, Unison spoke to Members of the concerns that Unison had regarding the proposals. Unsion were not against making improvements to the service, but there was concern regarding the number of hubs being proposed, including the fact that there was no hub north of Mansfield, only standby points. Usually it was only cars that could meet the attendance targets, but what about if an ambulance was needed? There was concern that a vehicle would be sent to a call which did not have the right equipment to deal with the incident to ensure attendance targets were met. There was also concern regarding equipping the vehicles as it would be the ambulance crew who would be accountable if they did not have the equipment they should have. In relation to travelling to a hub to report on and off, for the 12 hour shifts, which could end up running to 14 hours if the crew were dealing with an incident, the crew might have to travel 40 minutes to then get back to the hub at the end of the shift, and then travel home. The 11 hour working directive would also have an impact here.

Concern was also raised regarding the fines the ambulance service received if it did not hit targets, and that funding was not being provided to enable service improvements.

David Seaton informed Members that he had been a paramedic for 28 years and worked in the National Health Service (NHS) for 34 years. There had been many occasions where he had been assured that equipment was on the vehicle before starting a shift, only to find it missing. Morale was as low as it could be and things were very bad on the roads. Ambulance crews wanted to be asked their views on any proposals as they knew whether or not things would work. He felt hubs were a good idea, but there were not going to be enough of them. In reality, standby points were not currently used, as the vehicles went straight from one call to the next, meaning that they would be a waste of money if established. Currently he could start a shift and there would be no vehicle, meaning he would have to go to Alfreton, where fleet maintenance was carried out and spare vehicles kept, to pick a vehicle up before being able to start taking calls. The proposal of spare vehicles being kept and maintained at the hubs was positive as long as there were enough skill mechanics in each hub to carry out the work. He also had concerns regarding the number of incidents that ambulance crews were currently being sent to incorrectly as priority calls, which were coming via the 111 and NHS Direct services.

Richard Henderson – EMAS informed Members that the performance targets for all ambulance services were A8 – 75%, meaning 25% did not arrive within eight minutes. 95% must arrive within 19 minutes (A19), for life threatening calls. If these targets were not achieved than there was a financial penalty of approximately £2.6 million per missed target. This came at the same time as cost pressures with the service having to reduce its budget by £5m per year. There was a 5% increase in emergency calls each year with a 6.5% increase this year so far. 111 were passing through a higher number of calls than expected. There was a service level agreement of an 8% pass through rate, however this was currently higher.

EMAS had inefficiencies such as having vehicles in the wrong place and not making good use of paramedic's time. It was intended that the change programme would address these inefficiencies which would improve the service to patients. It was important to get the governance arrangements correct and in place first.

In relation to the 111 and NHS direct calls, an internationally recognised computer system was used which gave automated responses meaning operators could not go off script. All "red" calls (critical) were referred to the Clinical Assistance Unit made up of doctors and nurses who were able to ask further questions.

The proposals for rural areas would be scrutinised again after the consultation process had ended and EMAS would work with staff and the local community to get the best fit for both. EMAS did need to change how it worked, and it would listen to the feedback and adapt the plans taking into account of the consultation responses.

The hubs and standby points were worked out across the region, not just by county and the vehicles were not limited by the county boundaries. There were also reciprocal arrangements with other ambulance services such as South Yorkshire.

There was the possibility that a hybrid post could be create at Newark which was more than a standby point, but did not have as many facilities as a hub. All these proposals would be considered following the end of the consultation period.

The ambulance crews all did a fantastic job and there was no slack in the system. This was why changes to the system were needed to keep up with demand.

Anne Berry, GMB informed Members that she was a paramedic based in Lincolnshire and had been for eight years. As a GMB staff representative she represented staffing Nottinghamshire and Lincolnshire. GMB had been invited to meeting early in the process and had been advised that there would be 33 hubs. We saw the logic of the proposals and felt it was a reasonable business plan, although they were aware that some staff would be upset by the proposals. However, when the draft proposal came out the number of proposed hubs had dropped to 13, which raised concerns for GMB. GMB felt that this was too drastic a reduction and would not enable a safe service to be provided. When we asked how a safe service would be provided with this number of hubs, we were not given an answer. We asked for the evidence that the proposals were based on so we could assess whether it was an appropriate proposal and whilst we received some answers, we did not receive all the evidence we had asked for. Therefore GMB was forced to give a vote of no confidence as they did not have the evidence needed to be able to determine whether this was a good proposal. Claims were made by EMAS regarding the outcomes that would be achieved, such as reducing the carbon footprint, however, GMB did not think this would be the case and

that it could actually increase. The time of 30 minutes taken to check vehicles at the beginning and the end of each shift appears to have only been anecdotal evidence, rather than based on fact. There was also no evidence that rural areas would receive a good service and no evidence that EMAS would ring fence vehicles to specific areas within the consultation document. Some staff live 50 miles from the nearest hub. WMAS learnt that there was a need for local booking on in rural areas, why has EMAS not included this in the proposals? Staff who live and work in the same area, may have to travel a distance to get to the hub only to have to then drive back again to get home.

There was concern that there were not enough ambulances to cover all community ambulance posts and that if the vehicles are not ring fenced it could result in a postcode lottery for service.

A rota review had also been carried out as part of the change programme. Night time patient transport capability in Worsop, Retford and Newark had been reduced as a result and was not being increased during the day.

If significant changes are made to the proposals following the consultation, there is then no opportunity to comment on the changes which could result in a programme that staff and local communities did not want.

If option 1 was agreed, then GMB felt that more vehicles would be needed to offset against the longer travelling times. These was no evidence in the pack that additional vehicles would be provided.

If option 2 was agreed then more booking on points would be needed. The WMAS approach seemed a sensible approach, why was this not included in the proposals and why is this possibility only being mentioned now?

The main concern of GMB was to ensure that there was a fair and equitable service for the whole community. GMB felt that 13 hubs would create a postcode lottery. GMB were against the proposal of 13 hubs. The cost of the programme had also not been provided, other than headline figures.

Tracey Adams advised Members that the ring fencing of vehicles in WMAS worked on an elastic band principle, meaning that the vehicle was linked to its base and would be pulled back towards its base after completion of a call.

Richard Henderson advised Members that ring fencing worked well but had limitations, as when a vehicle was on a call all other vehicles not on a call were moved to offset the cover. Ring fencing did not work as well for ambulances as cars. Mr Henderson also gave an assurance that, in his view, the introduction of revised working arrangements in North Nottinghamshire would not lead to increased response times within the conurbation. EMAS were willing to work with GMB to develop a plan that could be agreed on. Some compromise may be needed and it was hoped that the staff would work with them.

Carolyn White, Sherwood Forest Hospital Trust advised Members that there were pressures on the health service as a whole at the moment with an ever increasing demand. The Trust's concern as a receiving centre was to get the patients as quickly as possible, which meant that vehicles needed to be used as efficiently as possible.

Newark area was of concern for the Trust. The Commission had invested additional support for transport between Mansfield and Newark, which had helped and the Trust would be closely watching the changes to ensure that they did not have a detrimental impact.

Tight governance arrangements regarding the stocking of vehicles would be essential and was something hospitals already used.

Richard Henderson advised Members that EMAS had to make savings and were also undertaking a management review. EMAS would reduce the number of managers by £2m allowing this money to be reinvested into frontline services.

Members were offered assurance that the views expressed during the consultation would be taken into account and changes to the proposals would be made.

The Chairman reminded Members that a letter from NUH had also be received for their consideration.

Members were generally in support of the principle of the hub-and-spoke system being introduced by EMAS and during discussions felt that the following recommendations should be put forward:-

- There should be another hub in the north of the County – to cover the Bassetlaw and Newark areas
- There should be proper provision of maintenance resources (I.e. mechanics) once the changes have been implemented across all areas
- EMAS should carefully review all existing arrangements and protocols for cross-boundary working to ensure that the greatest possible benefits are secured for the people in the North of Nottinghamshire
- All issues relating to ambulance stocking governance and accountability should be carefully reviewed – practitioners picking up vehicles should not be held accountable for equipment and medication that is missing
- The facility to transport patients should be available all through the night
- The fines levied against Ambulance Trusts for not meeting targets are unfair and counter to the interests of local people and health service – Members recommend that EMAS campaigns hard to have the regime of fines lifted. In addition, the Chairman of the Joint Health Scrutiny Committee will write to the Secretary of State for Health regarding this issue.

The Sub Committee:-

RESOLVED 2012/001:-

that the following recommendations be put forward to the Joint Health Scrutiny Committee for consideration and approval:-

- **There should be another hub in the north of the County – to cover the Bassetlaw and Newark areas**
- **There should be proper provision of maintenance resources (I.e. mechanics) once the changes have been implemented across all areas**

- **EMAS should carefully review all existing arrangements and protocols for cross-boundary working to ensure that the greatest possible benefits are secured for the people in the North of Nottinghamshire**
- **All issues relating to ambulance stocking governance and accountability should be carefully reviewed – practitioners picking up vehicles should not be held accountable for equipment and medication that is missing**
- **The facility to transport patients should be available all through the night**
- **The fines levied against Ambulance Trusts for not meeting targets are unfair and counter to the interests of local people and health service – Members recommend that EMAS campaigns hard to have the regime of fines lifted. In addition, the Chairman of the Joint Health Scrutiny Committee will write to the Secretary of State for Health regarding this issue.**

The meeting closed at 12.14pm.

Chairman

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

15 January 2013

Agenda Item: 5

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

PATIENT TRANSPORT SERVICE

Purpose of the Report

1. To allow Members the opportunity to consider the performance of Nottinghamshire Patient Transport Service.

Information and Advice

2. On 13 March 2012, representatives of NHS Nottinghamshire County and Ambuline (sub-contractor of Arriva) attended the Joint Health Committee to provide a briefing on the competitive tender process that had been carried out prior to awarding the contract for patient transport service to Arriva.

3. At that time, the contract was still in a transition phase with ongoing work still taking place between the existing provider (East Midlands Ambulance Service), the new provider and hospitals in order to ensure the smooth transition of service from 1 July 2012.

4. Further to receiving this briefing, the Joint Health Committee resolved to request that Ambuline returned in January 2013 to report back on progress of transition arrangements, incorporating performance against the key performance indicators within the contract.

5. Representatives of Ambuline, NHS Nottinghamshire County and NHS Nottingham City will be in attendance to provide a briefing and answer questions. A written briefing is attached as an appendix to this report.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:-

1) receive the briefing and ask questions as necessary

2) determine when further performance information is required

.

Councillor Mel Shepherd
Chairman of Joint City and County Health Scrutiny Committee

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

Background Papers

Nil.

Electoral Division(s) and Member(s) Affected

All

Nottingham City and
Nottinghamshire County

Contract Performance Review Report

Nottinghamshire Patient Transport Services

12/1/2012

Introduction

Following a part A OJEU procurement process, the contract for Nottinghamshire Patient Transport Services (PTS) was awarded to Arriva Transport in March 2012 with ago live date of 1st July 2012. During the period leading up to July, a transition group chaired by EMPACT attended by commissioners, renal network, Arriva, and the incumbent provider EMAS, oversaw the transition of the East Midlands wide PTS service incorporating the TUPE of nearly 600 employees to the new service providers.

The first few weeks of operation across Nottinghamshire were challenging, predominantly due to an underestimate of call volumes booking the PTS service along with internal recruitment drives by EMAS which reduced the anticipated resource levels transferring across to Arriva. Remedial plans were promptly agreed with Arriva to increase resources in call centres, increase the volume of on-line bookings to reduce booking call volumes and increase the resources of transport staff.

The last six months of the contract have been challenging and all parties have and are continuing to work in partnership to improve the performance.

The following information illustrates the trends for the KPIs against the contract, and the measures being put in place to improve service, to a satisfactory level and in accordance with the contract.

Key Highlights

KPIs generally show improvement in November over October and an improving trend since the start of the contract

Further improvement needed to reach all timeliness KPI targets

Revised complaints handling system being implemented, going live in December 2012

Stakeholder engagement continues, e.g., attending bed meetings. This gives secondary care the opportunity to work collaboratively on developing service improvement plans

Road and tram-works on A52 and Clifton Boulevard are causing significant challenges on service provision and delivery. In order to address the issues meetings are being held with the relevant hospital to identify and implement solutions.

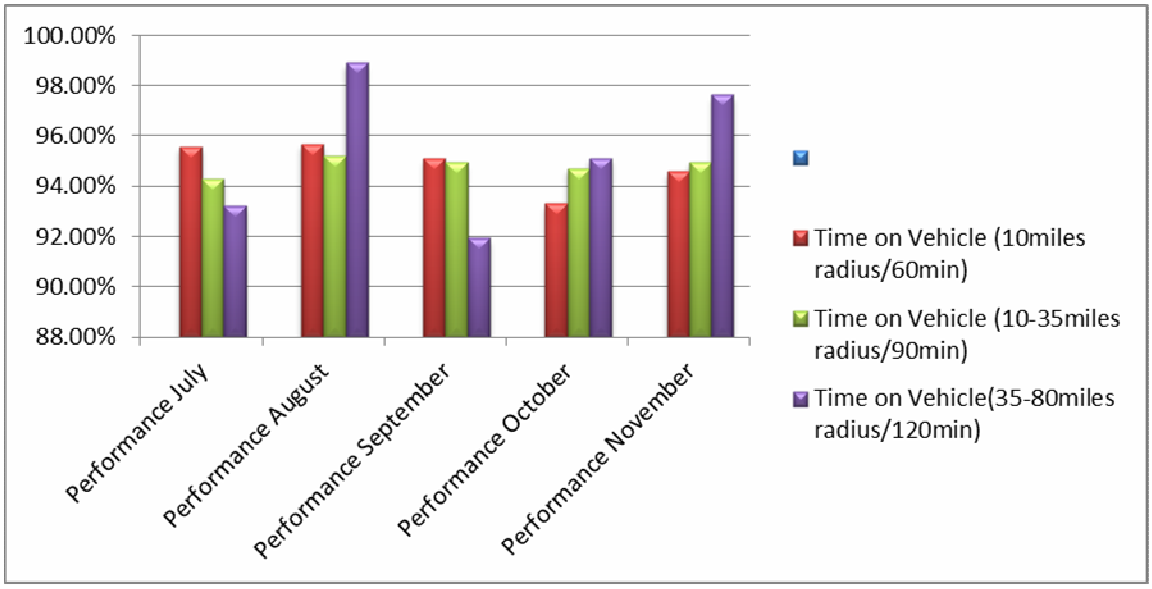
Overall additional resources being provided e.g. new call centres set up to address customer service and operational issues

KPI Performance

Waiting Time on Vehicle

Target: 90% for all three KPIs

	Performance July	Performance August	Performance September	Performance October	Performance November
Time on Vehicle (10miles radius/60min)	95.59%	95.69%	95.13%	93.31%	94.58%
Time on Vehicle (10-35miles radius/90min)	94.32%	95.22%	94.95%	94.71%	94.98%
Time on Vehicle(35-80miles radius/120min)	93.22%	98.92%	91.93%	95.13%	97.63%

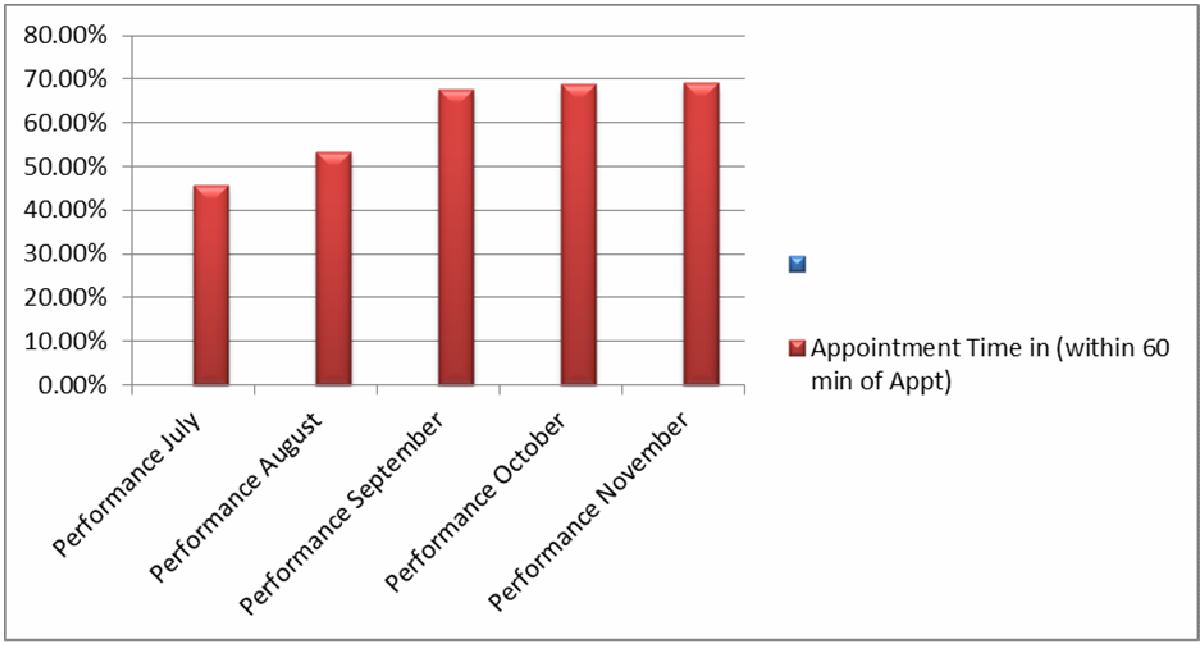


Performance is being met throughout the duration of the contract with performance for time on vehicle for 120mins+ achieving a very commendable 97.63%

Appointment time within 60 minutes

KPI Target: 95%

Indicator	Performance July	Performance August	Performance September	Performance October	Performance November
Appointment Time in (within 60 min of Appt)	45.78%	53.48%	67.52%	68.84%	69.15%



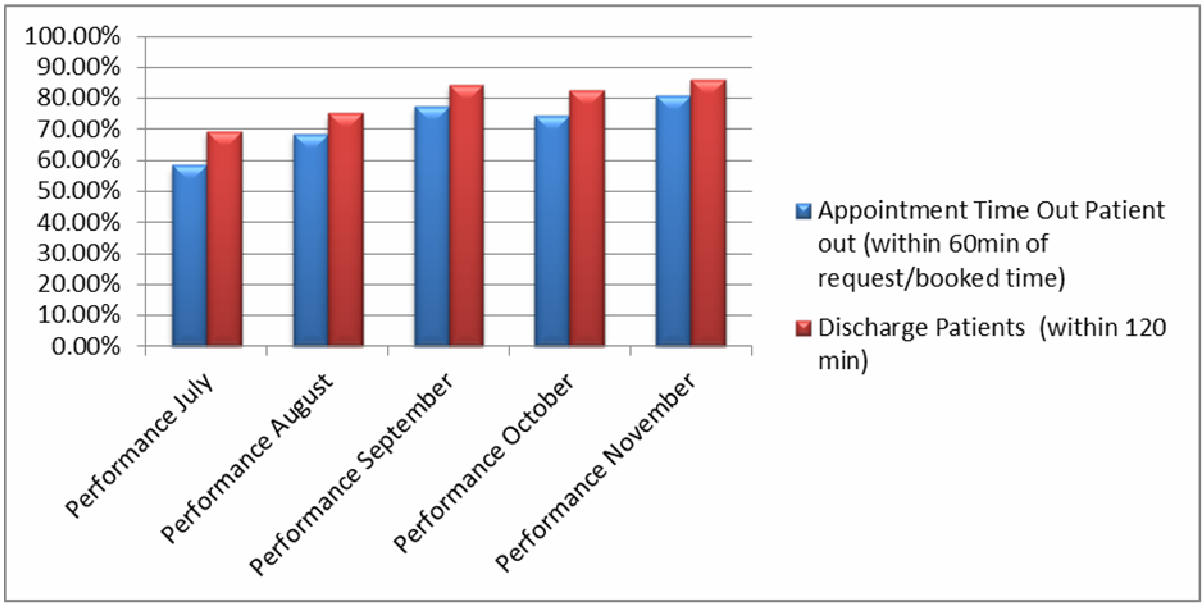
Performance is improving over time, although significantly still below KPI target. In the last 5 months performance has improved from 23.37% to 69.15%. Arriva are bringing in additional resource and training with the expectation of significant will be achieved in the next quarter.

Appointment time out (within 60 mins of booked ready)

KPI target 90%

	Performance July	Performance August	Performance September	Performance October	Performance November
Appointment Time Out Patient out (within 60min of request/booked time)	58.37%	68.31%	77.36%	74.36%	80.77%
Discharge Patients (within 120 min)	69.29%	75.06%	84.32%	82.57%	86.12%

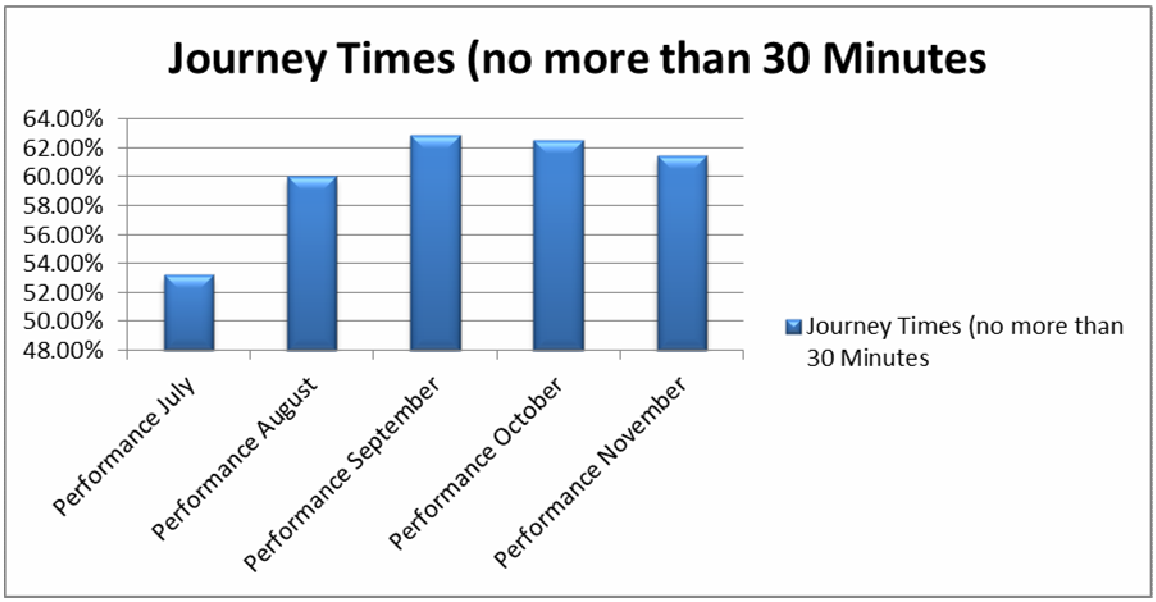
Appointment time out (within 60 mins of booked ready)



It is expected that performance in this KPI will improve significantly by next quarter; performance has improved and is now almost achieving the 90% target level. Subject to any adverse winter pressures

KPI Renal dialysis journey time

	Performance July	Performance August	Performance September	Performance October	Performance November
Journey Times (no more than 30 Minutes	53.22%	60.04%	62.86%	62.57%	61.45%



Renal performance has been recognised as being poor by Arriva since the start of the contract and to date has only seen an improvement of 8%, which is well below the required standard of 90%.

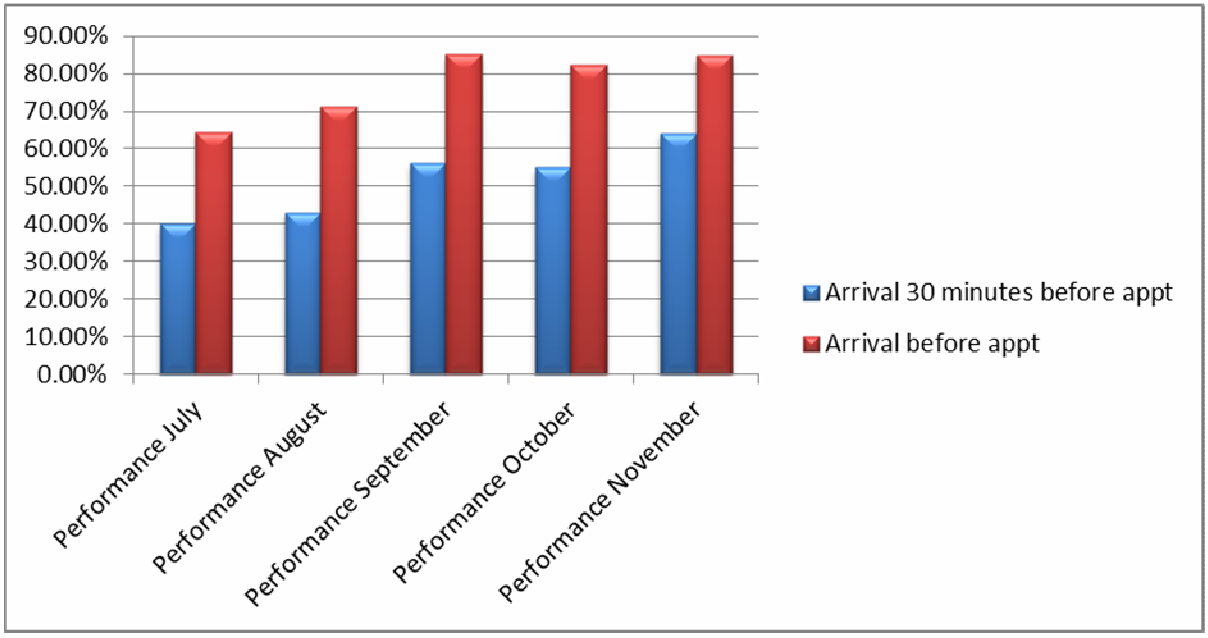
Arriva has implemented a renal action plan to tackle poor performance and the early signs are that it is working. Performance in week 23(ending Dec 8th) has shown a marked improvement.

The dedicated resource in Ilkeston, Kings Mill & Lings Bar is now in place with Nottingham City going live in February.

Renal dialysis inward journeys

KPI targets 95% and 100% respectively

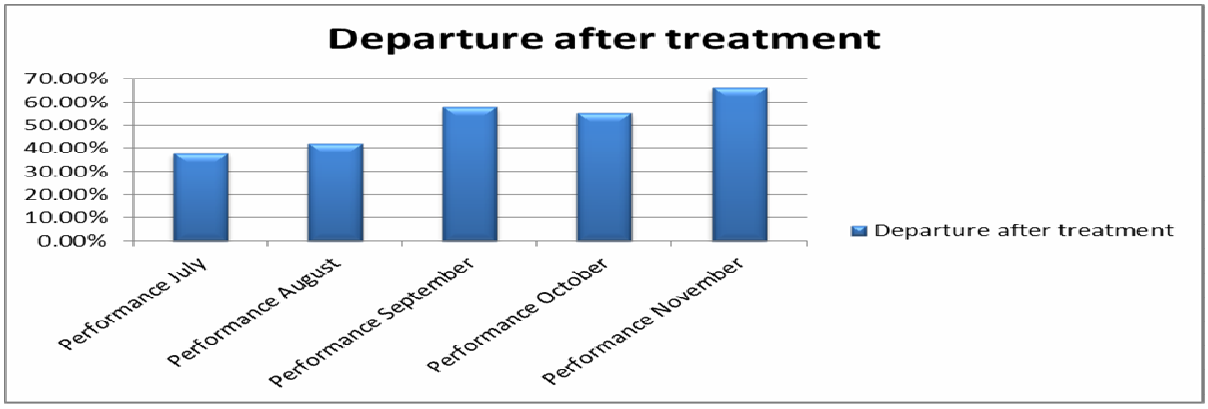
	Performance July	Performance August	Performance September	Performance October	Performance November
Arrival 30 minutes before appt	40.05%	43.08%	56.26%	55.01%	64.08%
Arrival before appt	64.29%	71.08%	85.08%	82.18%	84.73%



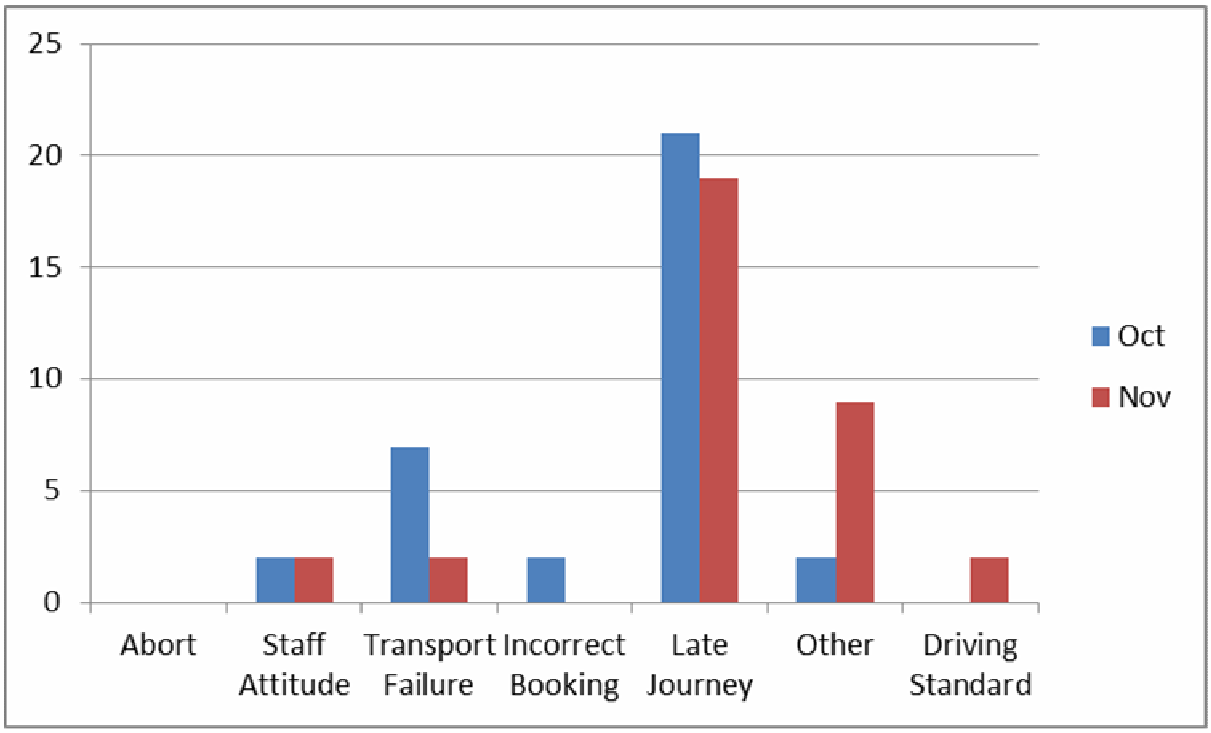
Performance has steadily improved over time, although still just below KPI target

KPI Renal dialysis outward time

	Performance July	Performance August	Performance September	Performance October	Performance November
Departure after treatment	37.80%	42.04%	57.63%	55.39%	66.35%



Complaints



93% of complaints handled within KPIs during November 2012

Complaints have been a major concern over the life of the contract and Arriva have just implemented a new complaints procedure and expect to see significant improvements February 2013 onwards.

The complaints procedure has been circulated to Commissioners. Arriva state there is now three ways to make a complaint – telephone, email & freepost address. Acknowledgement of complaint would be within 3 days and a full response within 23 days. The complaints process is monitored by Response software.

EMPACT have asked for an improved complaints report for monitoring purposes

Improved Complaints Handing Process

- New complaints handling system being put in place
- Discussed with Nottinghamshire Commissioners
- Phone Option 5 will initially go to Leicester or Nottingham control room
- Complaints will then be forwarded to dedicated team in Luton

- Complaint details taken and logged onto Respond System
- Improved monitoring of response times and improved reporting ability
- Acknowledgement sent to complainant
- Complaint sent to appropriate manager in Leicestershire and Nottinghamshire
- Response sent to complainant
- Target date for new system: December 2012
- February will see improvements in complaints monitoring and response

Other KPIs performance

These also require improvements and the following initiatives are being implemented to bring performance up to the standard required.

- Mandatory training - scheduled for all staff from January 2013
- Risk Register established - regularly updated
- Information Governance Training – all staff signposted to IG Website Toolkit as part of their individual training
- NICE Guidance – EM Training Manager responsible for reviewing NICE publications on a weekly basis and cascading where appropriate
- Infection Control Update – all vehicles are being deep-cleaned on six week rota, “observed practices” audits now being undertaken by managers
- Staff survey – has now been undertaken, results due January 2013
- Patient survey to be undertaken in January 2013 with results due in February 2013
- Untoward incidents – no incidents during November

Conclusion

Arriva have and are keen to continue to work in partnership with commissioners. There is a positive approach to improving performance, strong working relationships and have been making steady, consistent progress across all KPIs.

Although not all contractual KPI’s are being achieved, over the first six months of operation there has been a positive steady increase in improved performance by Arriva with defined action and improvement plans in place which are being monitored through PTS contract management group on a monthly basis

Arriva have the developed the experience, skills and resources and most importantly the determination to make the service a high performing and successful one for both Arriva and Commissioners.

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

15 JANUARY 2013

REPORT OF THE HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

NHS SERVICE PROVIDERS – QUALITY ACCOUNTS

1 SUMMARY

This report introduces the Committee to Quality accounts and to the role of the Joint Health Scrutiny Committee to ensure quality services and public accountability. Representatives of a number of healthcare service providers will attend today's meeting to inform the Committee of proposals for their Quality Accounts 2012/13 and their plans for public engagement for developing these: Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Trust, East Midlands Ambulance Service NHS Trust and Nottinghamshire Hospice.

2 MATTERS FOR CONSIDERATION

The Committee is asked to consider and comment on the information presented at the meeting, focusing on how each healthcare service provider will determine its priorities for its Quality Account and how it will involve its stakeholders in doing so.

3 BACKGROUND AND SUPPORTING INFORMATION

3.1 A Quality Account is an annual report to the public from providers of NHS healthcare services about the quality of their services. It aims to enhance accountability to the public and engage the organisation in its quality improvement agenda, reflecting the three domains of quality: patient safety, clinical effectiveness and patient experience.

3.2 Since April 2010, all providers of acute, mental health, learning disability and ambulance services have been required to produce an annual Quality Account. Community providers were asked to develop Quality Accounts from 2011 and it is intended that primary care providers will need to provide Quality Accounts in the future.

3.3 A Quality Account should:

- improve organisational accountability to the public and engage boards (or their equivalents) in the quality improvement agenda for the organisation;
- enable the provider to review its services, show where it is doing well, but also where improvement is required;
- demonstrate what improvements are planned;
- provide information on the quality of services to patients and the public;

- demonstrate how the organisation involves, and responds to feedback from, patients and the public, as well as other stakeholders.

3.4 Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining what is being done well and where improvement is needed. But, they also look forward, explaining what has been identified as priorities for improvement.

3.5 Guidance from the Department of Health requires that a Quality Account should include:

- **priorities for improvement** – clearly showing plans for quality improvement within the organisation and why those priorities for improvement have been chosen and demonstrating how the organisation is developing quality improvement capacity and capability to deliver these priorities;

- **review of quality performance** – reporting on the previous year's quality performance offering the reader the opportunity to understand the quality of services in areas specific to the organisation;

- **an explanation of who has been involved** and engaged with to determine the content and priorities contained in the Quality Account; and

- **any statements provided from commissioning Primary Care Trust, Local Involvement Networks (LINks) or Overview and Scrutiny Committees** including an explanation of any changes made to the final version of the Quality Account after receiving these statements.

3.6 Quality Accounts are public documents, and while their audience is wide ranging (clinicians, staff, commissioners, patients and their carers, academics, regulators etc), Quality Accounts should present information in a way that is accessible for all. For example, data presentation should be simple and in a consistent format; information should provide a balance between positive information and acknowledgement of areas that need improvement. Use of both qualitative and quantitative data will help to present a rounded picture and the use of data, information or case studies relevant to the local community will help make the Quality Account meaningful to its reader.

3.7 As a first step towards ensuring that the information contained in Quality Accounts is accurate (the data used is of a high standard), fair (the interpretation of the information provided is reasonable) and gives a representative and balanced overview, providers have to share their Quality Accounts prior to publication with:

- their commissioning Primary Care Trust (PCT)
- the appropriate LINk (Local Involvement Network)
- the appropriate local authority Overview and Scrutiny Committee

3.8 The commissioning PCT has a legal obligation to review and comment on a provider's Quality Account, while LINks and Overview and Scrutiny Committees are offered the opportunity to comment on a voluntary basis. Any statement provided should indicate whether the Committee believes, based on the knowledge they have of the provider, that the report is a fair reflection of the

healthcare services provided. The organisation then has to include these comments in the published Quality Account.

3.9 The Committee has requested that organisations attend this meeting to discuss their early thoughts on priorities for their Quality Account and on how they would engage the public in the process. They will be invited to return to the Committee's 16 April meeting to present their Quality Accounts in their most up-to-date form, at which point the Committee can decide to put forward any comments for inclusion.

4 LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING EXEMPT OR CONFIDENTIAL INFORMATION

None.

5 PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

Quality Accounts : Department of Health
http://www.dh.gov.uk/en/Healthcare/Qualityaccounts/index.htm

CONTACT DETAILS

Debra La Mola
Head of Democratic Services
Nottingham City Council

Contact Officer: Noel McMenamin
Telephone number: 0115 8764304
Email address: noel.mcmenamin@nottinghamcity.gov.uk

5 January 2013

Appendix 1

Quality Accounts: a guide for Overview and Scrutiny Committees

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	15794
Title	Quality Accounts: a guide for Overview and Scrutiny commitees
Author	DH
Publication Date	16 Mar 2011
Target Audience	Local Authority CEs
Circulation List	Local Authority CEs
Description	Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.
Cross Ref	Quality Accounts Toolkit 2010/11
Superseded Docs	
Action Required	N/A
Timing	
Contact Details	Richard Owen NHS Medical Directorate Skipton House 80 London Road London SE1 6LH
For Recipient's Use	

Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs).

Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.

This gives OSCs the opportunity to review the information contained in the report and provide a statement on their view of what is reported.

Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account.

Providers must send their Quality Account to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

This mini-guide has been produced specifically for OSCs and draws on relevant information already published in the Quality Accounts toolkit :

http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/Makingqualityhappen/qualityaccounts/index.htm

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. This publication mirrors providers' publication of their financial accounts.

In the second year of Quality Accounts, providers will report on activities in the financial year 2010/11 and publish their Quality Account by the end of June 2011.

Who has to provide one?

All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations must publish an annual Quality

Account. For the first year of Quality Accounts, providers were exempt from reporting on any primary care or community healthcare services. This year the community healthcare service exemption has been removed.

What is the purpose of a Quality Account?

The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality accounts therefore go above and beyond regulatory requirements, which focus on essential standards.

If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

How will they be used?

Quality Accounts will be published on the NHS Choices website and providers will also have a duty to:

- display a notice at their premises with information on how to obtain the latest Quality Account; and

- provide hard copies of the latest Quality Account to those who request one.

The public, patients and others with an interest in their local provider will use a Quality Account to understand:

- where an organisation is doing well and where improvements in service quality are required;

- what an organisation's priorities for improvement are for the coming year; and

- how an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.

Commissioners and healthcare regulators, such as the Care Quality Commission, will use quality accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.

Quality Accounts will be public-facing documents, published on NHS Choices

How will the process of producing a Quality Account benefit the provider?

The process of producing a Quality Accounts is an opportunity for organisations and clinicians to collect, review and analyse information relating to quality, so that they can decide where improvement is needed in such a way that it becomes part of the core business of the organisation.

It can also help with benchmarking against other organisations.

The process of producing a Quality Account also provides an opportunity for providers to engage their stakeholders, including PCTs, LINKs and the public, in the review of information relating to quality and decisions about priorities for improvement.

This sort of quality monitoring and improvement activity can have many purposes for the provider. For example it will help them to assess their risks and monitor the effectiveness of the services they provide; the information could also inform their internal monitoring of compliance with CQC registration requirements.

Why are OSCs being asked to get involved with Quality Accounts?

The Department of Health engaged widely with healthcare providers, commissioners, patient groups and third sector organisations in the development of Quality Accounts.

A key message from our stakeholder engagement activity was that confidence in the accuracy of data and conclusions drawn on the quality of healthcare provided from these figures is key to maximising confidence in those reading Quality Accounts. Without some form of scrutiny, service users and members of the public may have no trust in what they are reading.

OSCs, along with LINks and commissioning PCTs , have been given the opportunity to comment on a provider's Quality Account before it is published as it is recognised that they have an existing role in the scrutiny of local health services, including the ongoing operation of and planning of services.

The powers of overview and scrutiny of the NHS enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities, or on any proposal to make any substantial variation in the provision of such service(s).

How can OSCs get involved in the development of Quality Accounts?

OSCs are ideally placed to ensure that a provider's Quality Account reflects the local priorities and concerns voiced by their constituents.

If an important local healthcare issue is missing from a provider's Quality Account then the OSC can use the opportunity in the form of a statement to be included in a provider's Quality Account to highlight this omission. Some of these issues might not directly relate to healthcare quality, so their omission by the provider might be unavoidable (given their legal obligation to report on healthcare only) and your commentary should acknowledge that.

Quality Accounts aim to encourage local quality improvements, OSCs can add to the process and provide further assurance by providing comments on the issues they are involved in locally.

OSCs may also wish to comment on how well providers have engaged patients and the public, and how well they have promoted the Quality Account.

OSCs should not feel that they have to comment on areas of the Quality Account where they do not have relevant knowledge. However, conversations between providers and OSCs should start at the beginning of the planning process for the production of a Quality Account so both the provider and the OSC are aware each others expectations in the process.

OSCs could therefore comment on the following:

- does a providers priorities match those of the public;
- whether the provider has omitted any major issues; and
- has the provider demonstrated they have involved patients and the public in the production of the Quality Account;
- any comment on issues the OSC is involved in locally

What must providers do to give OSCs the opportunity to comment on their Quality Account?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located.

They must send it to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

The OSC then has the opportunity to provide a statement of no more than 1000 words indicating whether they believe, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided.

The OSC should return the statement to the provider within 30 days of receipt of the Quality Account to allow time for the provider to prepare the report, which will include the statement, for publication.

If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

How does the review of Quality Accounts in April fit in with the other activities carried out by OSCs?

Quality Accounts do not replace any of the information sent to CQC by OSCs as part of CQC's regulatory activities.

Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

It is recommended that discussions around the proposed content of a Quality Account and review of early drafts of the report is conducted during the reporting year in question so that by April each year OSCs will already have a good idea of what they expect to see in a provider's Quality Account and may have commented on earlier versions.

Where local elections are being held in April and OSCs will not have the opportunity to review Quality Accounts for 2009/10, it is advised that where possible, OSCs discuss plans and suggest content for 2010/11 Quality Accounts with providers when they reconvene in the summer.

Stakeholder engagement in the development of a Quality Account should be a year-long process – ideally starting at the beginning of the reporting year.

Which OSC should a provider send its Quality Account to?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located. This may be different from the geographical area of the lead commissioner. In these cases, liaison and co-operation will be the key to achieving a rounded view on the organisation for whose Quality Account you are providing feedback.

Does an OSC have to supply a statement for every Quality Account it is sent?

No. The role of OSCs in providing assurance over a provider's Quality Account is a voluntary one. Depending on the capacity and health scrutiny interests of the OSC, the committee may decide to prioritise and comment on those

providers where members and the constituents they represent have a particular interest.

It would be helpful to let the provider know that you do not intend to supply a statement so that this does not hold up their publication.

Does the statement have to be 1000 words longs?

No, this is a maximum set in the Regulations. We have increased the maximum limit for situations where LINks and OSC wish to produce joint comments.

Working with commissioning PCTs, LINks and other stakeholders

Existing DH guidance recommends that scrutiny of services provided, commissioned or planned by a single NHS body covering more than one local authority area, is undertaken by a joint committee.

Joint committees may therefore wish to work together when considering Quality Accounts for organisations that provide services across multiple authority areas such as ambulance trusts. For instance, joint arrangements may already be in place for providing third party comments on providers to the CQC (for instance, to provide comments to CQC about a provider's compliance with registration requirements) and it would be appropriate to use these existing arrangements to discuss provider's Quality Accounts.

It should be noted however that the legal requirement is for a provider to send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located and to publish within their final Quality Account any statement that they have provided. It is important therefore that when OSCs jointly consider a provider's Quality Account that it is the OSCs residing in the local authority area that sends the statement back to the provider. If the statement has been jointly written, it would be appropriate to state who has contributed to it.

How OSCs and other stakeholders work together is left for local discretion as there is variation across authority areas.

When OSCs jointly consider a provider's Quality Account, the OSC residing in the local authority area for the provider should send the statement back to the provider.

What should OSCs do if they receive a Quality Account from a provider with a national presence?

Some OSCs may receive Quality Accounts from multi-site providers. We do not expect an OSC to assure the quality of a national provider. Instead, we ask that the provider demonstrates how they nationally engage stakeholders day-to-day and in the production of the Quality Account.

How does Quality Accounts fit with the wider quality improvement agenda?

The objectives for Quality Accounts remain the same as last year, to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement, holding them accountable to stakeholders.

We will explore how Quality Accounts align with an NHS described in '*Equity and excellence: Liberating the NHS*'.

How do Quality Accounts relate to the work of regulators such as CQC and Monitor?

Quality Accounts do not replace any of the information sent to CQC as part of their regulatory activities. Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

When providing comments on a Quality Accounts, LINks should consider whether their reflections on the quality of healthcare provided should also be submitted to CQC.

Monitor's annual reporting guidance requires NHS foundation trusts to include a report on the quality of care they provide within their annual report. NHS foundation trusts also have to publish a separate Quality Account each year, as required by the NHS Act 2009, and in the terms set out in the Regulations. This Quality Account will then be uploaded onto NHS Choices.

Monitor's annual reporting guidance for the Quality Report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations, as well as additional reporting requirements set by Monitor. This is available from Monitor's website.

Quality Accounts for OSCs - Getting started

Before you receive a draft Quality Account:

- Identify which providers will be sending their Quality Account to you and start discussions on proposed content early on in the reporting year.
- Providers have been encouraged in guidance to share early drafts of their Quality Account and useful background information on the content with stakeholders .
- Discuss the provider's proposed content of their Quality Account at an early stage to ensure that it includes areas that have been identified as being local priorities.

Once you have received a draft Quality Account (between 1 – 30 April):

- Before providing a statement on a provider's Quality Account, OCSs may wish to consult with other OSCs where substantial activity (for instance specialised services) is provided to patients outside their area.
- Write a statement (no more that 1000 words in length) for publication in a provider's Quality Account on whether or not they consider, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided. The statement could include comment on for instance, whether it is a representative account of the full range of services provided.

Sending the written statement back to the provider:

- Send the statement back to the provider within 30 days of the draft Quality Account being received. Your statement will be published in the provider's Quality Account.
- If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

15 January 2013

Agenda Item: 7

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

EATING DISORDERS RESPONSE

Purpose of the Report

1. To allow Members the opportunity to consider the response to the Health Messages and Eating Disorders review.

Information and Advice

2. The Joint City and County Health Scrutiny Committee undertook a review of issues associated with health messages and eating disorders.

3. The recommendations produced by this review were passed to the Department of Health and the Department of Education for comment. The responses provided these departments are attached as Appendices 1 & 2.

4. An update in relation to the current position locally regarding the recommendations has been provided by Dr Kate Allen and is set out below. Dr Allen is a Consultant in Public Health at NHS Nottinghamshire County and provided information to the original study group which examined these issues.

Recommendations and Current Position

- Schools should seek early professional advice whenever they suspect that a child may be suffering from an eating disorder.

There is a Child and Adolescent Mental Health services (CAMHS) Training programme in Nottinghamshire County that provides training to multi agency universal staff (school nurses, teachers, etc) on a range of current mental health issues including Eating Disorders, OCD and anxiety. Thus staff understand how eating disorders can present and are trained to consider the possibility of eating disorders in children.

Staff in schools are able to seek early professional advice by accessing the consultation and advice service available through each District Emotional Health and Wellbeing Team.
It would be helpful to develop a clear approach to eating disorders key messages and work within Academies and schools. There are early proposals to include this in the No Health Without Mental Health life course strategy when this is written. In addition, through new

commissioning arrangements for school nursing, we can ensure the issue of identification and appropriate support/referral for children with eating disorders is included

- Academies should seek proper advice on their food and healthy eating policy from a suitably qualified source

The Healthy Schools Team works with all schools including academies, to develop healthy eating policies amongst other areas of health promotion and policy development All schools that have achieved Healthy Schools Status have a quality assured policy.
The Community Nutrition Team also offer support to schools, including direct educational activities with pupils, school events, advice and training to staff.
Both teams have advertised their role and offers of support in the forthcoming services for schools brochure (to be published soon).

- Healthy eating should be promoted via the Health and Wellbeing Board

A report on obesity was presented to the Nottinghamshire Health and Wellbeing Board in July 2012. The focus was on tackling obesity and promotion of healthy eating is a key element of the local approach.

- The focus of all healthy eating messages, especially those aimed at schools, should be on eating a balanced diet rather than on banning particular foods.

The Community Nutrition Team offers educational support packages focusing on the 'eat well plate'. They do not focus on banning food but on ensuring that children and young people understand the need for a balanced diet.

- An educational package for use by schools and academies should be developed to enable special sessions on body image to take place which could serve to counteract the unrealistic body image portrayals that are prevalent in the media.

There are a number of packages available and we have found a 1 hr lesson plan for use with CYP aged 11-12 available at http://www.mediasmart.org.uk/resources/bodyimage?file=%2Fdocs%2Fbodyimage%2FBody_Image_Powerpoint.ppt. It is produced by reputable professionals, but we will need to assess quality before promoting it to schools.

5. Dr Kate Allen has been invited to attend the meeting (with appropriate colleagues) and answer questions, as necessary.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee consider and comment on the response.

Councillor Mel Shepherd
Chairman of Joint City and County Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Department for Education

Castle View House
East Lane
Runcorn
Cheshire
WA7 2GJ

Tel: 0370 000 2288
www.education.gov.uk/contactus

Councillor Mel Shepherd
Nottinghamshire County Council, County Hall
Loughborough Road
West Bridgford
NOTTINGHAM
NG2 7QP

Our ref: 2012/0063891
12 October 2012

Dear Councillor Shepherd

Thank you for your letter of 20 September, addressed to the Secretary of State, enclosing a draft final report of the review of health messages and eating disorders. I am sure you will appreciate that the Secretary of State receives a vast amount of correspondence and is unable to answer them all personally. It is for this reason I have been asked to reply.

Ministers appreciate it when organisations make the Department aware of work they are doing on issues relating to education. The draft final report was forwarded to the relevant policy team for their consideration and they have provided the following feedback:

In response to the recommendation about an educational pack for schools to enable special sessions on body image; as you may know, body image and self-esteem are covered within the personal, social, health and economic (PSHE) education non-statutory programmes of study for Key Stages 3 and 4. This includes how the media portrays young people, body image and health issues. However, the Department does not prescribe to schools how they should teach PSHE.

We are committed to giving teachers more freedom to decide how to teach their pupils. Schools are free to use external resources or engage expert organisations to improve teaching practice. You may be interested to know that we are reviewing PSHE education, which also includes diet and healthy lifestyles, to determine how we can support schools to improve the quality of PSHE teaching. We will publish the outcome of the review in due course.

I note that your report has a number of recommendations targeted at Ofsted. Ofsted school inspections focus on teaching quality, pupils' achievement, the quality of leadership and pupils' behaviour and safety. Inspectors are not required to assess, specifically, a school's adherence to the school food standards during their routine visits. If however, inspectors become aware of concerns, these can be taken into account as part of the inspection. It is the responsibility of the school governing body to ensure that the school meets its statutory obligations, including those related to school food.

Thank you again for taking the time to make the Department aware of your work.

Yours sincerely

Pamela Kearns
Public Communications Unit

Department of Health

Our ref: TO00000728226

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Councillor Mel Shepherd
Chairman of the Joint Health Scrutiny Committee
Nottinghamshire County Council
County Hall
West Bridgford
Nottingham NG2 7QP

15 OCT 2012

Dear Councillor Shepherd,

Thank you for your letter of 21 September to Jeremy Hunt about health messages and eating disorders. I have been asked to reply on Mr Hunt's behalf.

The Government recommends a healthy balanced diet, as shown in the UK's national food guide 'the eatwell plate'. As you will be aware, the eatwell plate defines the Government's recommendations on a healthy diet. It makes healthy eating easier to understand by giving a visual representation of the types and proportions of foods needed for a healthy balanced diet.

The eatwell plate shows that, for a healthy balanced diet, people should try to eat a variety of foods from the four main food groups, including plenty of starchy foods, fruit and vegetables, some milk, dairy, meat, fish and other non-dairy sources of protein and only small amounts of food and drinks high in fat or sugar.

I also note your concerns about long-term research into the effect of messages on obesity. As you may be aware, the Government published a *Call to action on obesity in England* in October 2011. This set out how obesity will be tackled in the new public health and NHS systems, and the role of key partners. The call to action presents a clear vision of what action needs to be taken to tackle obesity across four main areas including improving the evidence base.

The Department has also continued investment in data collection, improving the evidence base, and dissemination through the National Obesity Observatory and Obesity Learning Centre. Information about these bodies is available online at www.noo.org.uk and www.obesitylearningcentre-nhf.org.uk respectively.

Finally, I would suggest that you raise your concerns about healthy eating in schools with the Department for Education directly. The contact details are:

Department for Education
Castle View House
East Lane
Runcorn WA7 2GJ

Tel: 0370 000 2288
Website: www.education.gov.uk

I hope this reply is helpful.

Yours sincerely,

Chris Hall
Ministerial Correspondence and Public Enquiries

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

15 January 2013

Agenda Item: 8

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

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents – specifically, those located within the City and in the Southern part of the County.

3. Changes to the work programme include bringing forward the consideration of Quality Accounts to the April meeting and also the inclusion of Psychological Therapies on the April agenda.

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

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee agree the content of the draft work programme.

Councillor Mel Shepherd
Chairman of Joint City and County Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

15 May 2012	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 (new)** To consider the reasons for the recent spate of cancelled operations, to find out what actions are being taken to address the situation, and to agree any follow-up action by the Committee (Nottingham University Hospitals Trust) • **Quality Accounts** To consider Trust's Quality Accounts 2010/11 and whether to make a statement for inclusion (Nottinghamshire Healthcare Trust / Nottingham University Hospitals Trust / East Midlands Ambulance Service/NHS Treatment Centre/Nottinghamshire Hospice - new) • **East Midlands Ambulance Service (EMAS) NHS Foundation Trust consultation (new)** To consider review of EMAS Service Delivery Model and Operating Strategy as part of formal consultation. (EMAS)	
12 June 2012 (revert to County)	• **Review of Specialist Palliative Care Services across Nottinghamshire - update** To consider proposals and the consultation process for changes to improve access to day care for people with life limiting diagnoses (NHS Nottingham City / Nottingham University Hospitals Trust) • **Integrated Health and Social Care Discharge Project - update** To consider how to partners are working together to deliver more efficient services on discharge from hospital (Nottingham University Hospitals Trust and partners – to be identified)	
10 July 2012	• **Out of Hours Services** To consider an update on the procurement exercise being planned for Out of Hours Services in Nottinghamshire (NHS Nottingham City / NHS Nottinghamshire County) • **Mental Health Utilisation Review** To receive the findings of the review undertaken by NHS Nottingham City CCG and NHS Nottinghamshire County CCG in conjunction with the local authorities	

	(NHS Nottingham City/NHS Nottinghamshire County)	
11 September 2012	• **Psychological Therapies Service Changes – update** To consider how the changes to the Service have been delivered, and their impact on service users (Nottinghamshire Healthcare NHS Trust) • **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 - update** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust)	
9 October 2012	• ***Care Quality Commission (CQC)*** *To consider the work of the CQC in the City and County and the implications for scrutiny (CQC)* • **Contraceptive and Sexual Health Services** (from June 2012) To consider findings informing the new service model (NHS Nottingham City / NHS Nottinghamshire County / Nottingham University Hospitals Trust)	
13 November 2012	• **East Midlands Ambulance Service (EMAS) NHS Foundation Trust consultation – Change Programme (new)** To consider the EMAS Change Programme as part of formal consultation ▪ **Royal College of Nursing – Presentation** To consider an introductory presentation on the work of the RCN ▪ **Healthcare Trust Foundation Status** To consider the Healthcare Trust's application for Foundation Status	

11 December 2012	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 – progress report** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust) ▪ **East Midlands Ambulance Service Change Response**	
15 January 2013	• **Patient Transport Service (PTS)** Update on performance of Arriva Group following takeover of PTS contract from EMAS (NHS Nottinghamshire County / NHS Nottingham City) • **Quality Accounts** Preliminary consideration of priorities for Trusts' Quality Accounts 2012/13 (Nottinghamshire Healthcare Trust/Nottingham University Hospitals Trust/NHS Nottingham Treatment Centre/Nottinghamshire Hospice) ▪ **Eating Disorders – feedback on review recommendations** To consider responses to the study group recommendations (Department for Education , Department of Health, others to be confirmed) TBC	
12 February 2013	• **Dementia Care (ongoing Scrutiny)** Annual update on dementia issues, including national audit on dementia (Nottingham University Hospitals Trust) • **Out of Hours Services (ongoing Scrutiny)** To consider an update on the procurement exercise being planned for Out of Hours Services in Nottinghamshire (NHS Nottingham City / NHS Nottinghamshire County) • **Mental Health Utilisation Review (ongoing Scrutiny)** To receive an implementation update undertaken by NHS Nottingham City CCG and NHS Nottinghamshire County CCG in conjunction with the local authorities ▪ **EMAS Change Programme – response to recommendations** (East Midlands Ambulance Service)	

12 March 2013	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 – progress report** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust) ▪ **Lings Bar Update** (NHS Nottinghamshire City/Nottinghamshire County**)** ▪ **East Midlands Regional Stroke Pathway Proposals** (NHS Midlands and East)	
16 April 2013	▪ **Consideration of Quality Accounts** ▪ **Psychological Therapies Service Changes (ongoing Scrutiny)** To consider how the changes to the Service have been delivered, and their impact on service users (Nottinghamshire Healthcare NHS Trust)	
May 2013		

To schedule:

Review of Specialist Palliative Care Services across Nottinghamshire – further update (June 2013)
Integrated Health and Social Care Discharge Project – further update (June 2013)
Children's Cardiac Services
Psychological therapies update
Care Quality Commission (postponed from October 2012)

EMAS control centre visit

Date in May 2013 –as part of consideration of dates in June 2012