Joint City / County Health Scrutiny Committee

Tuesday, 14 June 2016 at 10:15

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

AGENDA

1	To note the appointment by the County Council on 12 May 2016 of Councillor Parry Tsimbiridis as Chair of the Committee and Councillor Anne Peach as Vice-Chair	
2	Minutes of the last meeting held on 10 May 2016	3 - 8
3	Apologies for Absence	
4	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
5	Terms of Reference and Joint Health Protocol	9 - 16
6	Update on Progression of Service Redesign Projects within the Adult Mental Health Directorate of Nottinghamshire Healthcare Trust	17 - 26
7	POhWER - Mental Health Advocacy	27 - 32
8	Nottinghamshire Sustainability and Transformation Plan - Presentation by Lucy Dadge, Programme Director for the Plan	
9	Work Programme	33 - 38

Notes

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

Customer Services Centre 0300 500 80 80

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

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

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

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

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

NOTTINGHAM CITY COUNCIL

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 10 May 2016 from 10.15 - 12.00

Membership

Present	Absent
Councillor Ginny Klein	Councillor Eunice Campbell
Councillor Carole-Ann Jones	Councillor John Handley
Councillor Parry Tsimbiridis	Councillor Brian Parbutt
Councillor Joyce Bosnjak	Councillor Colleen Harwood
Councillor Richard Butler	Councillor Corall Jenkins
Councillor John Clarke	
Councillor Jacky Williams	
Councillor Anne Peach (Vice Chair)	
Councillor Merlita Bryan	
Councillor Chris Tansley	
Councillor Mrs Kay Cutts MBE	

Colleagues, partners and others in attendance:

Simon Smith	Nottinghamshire Healthcare Trust
Gary Eves	Nottinghamshire Healthcare Trust
Dr Christine Johnson	Derbyshire Health United
Jan Dixon	Derbyshire Health United
Helen Jones	Nottingham City CCG
Pete McGavin	Healthwatch Nottingham
Martin Gately	Lead Officer for Health Scrutiny
Jane Garrard	Senior Governance Officer
Noel McMenamin	Governance Officer

72 APPOINTMENT OF VICE CHAIR

The Committee noted that Councillor Anne Peach has been appointed Vice-Chair of the Committee for 2016/17.

73 COMMITTEE MEMBERSHIP

The Committee noted the appointment of Councillor Joyce Bosnjak to the membership of the Committee for 2016/17.

74 APOLOGIES FOR ABSENCE

Councillor Merlita Bryan – Council business

Councillor Eunice Campbell – unwell
Councillor John Handley
Councillor Colleen Harwood
Councillor Corall Jenkins – Personal
Councillor Brian Parbutt – work commitments

75 DECLARATIONS OF INTEREST

None.

76 MINUTES

Subject to recording Councillor Cutts' attendance at the meeting, the minutes of the meeting held on 19 April 2016 agreed as a true record and they were signed by the Chair.

77 NOTTINGHAMSHIRE HEALTHCARE TRUST TRANSFORMATIONAL PLANS FOR CHILDREN AND YOUNG PEOPLE - CAMHS AND PERINATAL MENTAL HEALTH SERVICES

Nottingham Healthcare Trust representatives Simon Smith, Executive Director Local Services, and Gary Eves, Programme Development Manager, introduced a report and short film, updating the Committee on plans for a new facility to deliver both Child and Adolescent Mental Health Services (CAMHS) and Perinatal Mental Health Services in Nottingham.

Mr Smith and Mr Eves made the following points:

(a) proposals for establishing a modern, fit for purpose CAMHS and perinatal facility in Nottingham were drawn up in early 2015, and formal consultation took place throughout the summer of 2015, with 85% of respondents supporting the proposals;

(b) the Trust's Board of Directors approved the business case in September 2015, planning consent has been secured for the proposed site on Foster Drive, off Mansfield Road, and the contract to build the facility has been signed. Construction is scheduled to complete in February 2018, with services delivered on-site shortly after;

(c) the expected benefits include improved fit for purpose facilities offering therapeutic caring environments and increased bed capacity for those requiring specialist inpatient care, meaning fewer children and young people having to travel out of area to access services;

(d) Nottinghamshire Healthcare Trust is in discussions with Nottingham City Council about the provision of education within the perinatal mental health facility, as the site falls within the Nottingham City boundary.

The Committee welcomed the significant progress made since it last considered the issue in July 2015, and was very positive about the design and site layout as

presented in the short film. The Committee requested a further update for May 2017, and following issues were raised in discussion:

(e) Mr Smith and Mr Eves confirmed that the new facility will be built to the highest sustainability specifications, and that the business case fully considered sustainability and maintenance issues;

(f) Mr Smith explained that the current Thorneywood site has 13 beds, while the new facility will have 30 beds, serving all Nottinghamshire and Derbyshire. He also agreed that having more effective lower-level intervention was key to preventing service users' conditions escalating to requiring inpatient services, and expressed the view that the new integrated CAMHS offer will help deliver this;

(g) Mr Eves explained that the Trust has a comprehensive Strategic Workforce Plan under which sat a Workforce Model, identifying the required skills mix to deliver the Trust's objectives. The Workforce Plan was also informed by the Trust's Organisational Development Plan and Recruitment and Retention Plan, which set out the organisation's mission, values, and education, training and personal development needs. Mr Eves offered to update the Committee on recruitment issues as part of the May 2017 update;

(h) Mr Smith confirmed that funding of the education element of the facility still needed clarifying, and that the Department for Education are being lobbied to press for pupil funding to be increased proportionately to the increase in bed capacity. An update will be included in the May 2017 progress report;

(i) the Committee requested a progress report on the updated integrated CAMHS model for consideration in July or September 2016, depending on other items of business on the work programme;

(j) Mr Smith and Mr Eves agreed that the Committee should have a tour of the new facility when it opens.

RESOLVED to

(1) thank Mr Smith and Mr Eves for the progress report and film, and to commend the progress made to date;

(2) to request a further progress report on CAMHS and Perinatal Mental Health Services to the Committee's May 2017, to incorporate updates on education and workforce recruitment;

(3) to request a progress report on the updated integrated CAMHS model for consideration in July or September 2016.

78 NHS 111 PERFORMANCE UPDATE

Dr Christine Johnson and Jan Dixon of Derbyshire Health United, and Helen Jones, Head of Urgent Care Nottingham City Clinical Commissioning Group introduced a report updating the Committee on the performance of the NHS 111 service, making the following points:

(a) the current service provider, Derbyshire Health United (DHU), had its contract initially extended until October 2016 so that the tendering process could be completed. The new NHS 111 service contract will be delivered by a consortium made up of DHU and EMAS;

(b) performance in respect of the number of calls answered within 60 seconds has improved, and is consistently higher than the national average, but has not met the target of 95%;

(c) the numbers of callers advised to attend an emergency department or been sent an emergency ambulance is broadly in line with national statistics;

(d) the numbers of nurse callbacks, and the time taken to call back remains a cause for concern. A priority identification process has been introduced to ensure resources are targeted at those most in need;

(e) patient experience feedback continues to be positive, with 35% of respondents indicating that they would have gone to Accident and Emergency (A&E) or dialled 999 if they had not contacted the NHS 111 service.

During discussion, the following points were made:

(f) it is difficult to recruit nurses to the NHS 111 service and, even if successful, there are substantial notice periods and training programmes to complete before recruits can be used;

(g) areas identified for improvement include smarter technological modelling to predict patient behaviours and peak periods, greater use of pharmacists within the system as 20% of calls are medication-related, and working harder to retain staff, primarily through internal development;

(h) under the new contract from October 2016 there will be an integrated urgent care approach to signpost patients appropriately;

(i) 7-10% of calls are dental related, and there will be more dental advisors available under the new contract. Healthwatch colleagues welcomed this development as it was currently difficult to access out-of-hours urgent dental care;

(j) there is a national conversation on the principle of ‘Call before you go’ so that patients get appropriately signposted to the relevant service and do not end up attending A&E as a default;

(k) the least favourable feedback from service users was about delays in providing callback advice, but recent performance has improved significantly.

RESOLVED to note the report and verbal update, and to request a further update in May 2017 to scrutinise performance under the new NHS 111 service contract.

79 JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2016/17

The Committee considered the report of the Head of Democratic Services about the Committee's workload in 2016/17. Jane Garrard, Senior Governance Officer, introduced the report, and the Committee suggested a number of amendments to and inclusions within the work programme during the discussion which followed:

(a) a CAMHS update in July or September 2016, with a review of on-site progress for the new CAMHS facility in May 2017;

(b) an update on the NHS 111 service in May 2017;

(c) Ms Garrard informed the Committee that the Care Quality Commission has just published its inspection report on the East Midlands Ambulance Service (EMAS). The report highlighted a number of shortcomings, including around staffing and handover times, though the latter was less of an issue in Nottingham City and County. The Committee acknowledged the challenges facing EMAS, and welcomed the suggestion of having an informal meeting of the region's Health Scrutiny chairs to discuss with EMAS how they intend addressing those challenges;

(d) the Committee requested that the Chief Executive of Nottingham University Hospitals Trust attend a Committee meeting in January or February 2017 to consider emergency pathway planning;

(e) in response to a comment from Healthwatch Nottingham, Ms Garrard advised that the City Council's Scrutiny Committee will consider City-specific GP issues at a forthcoming meeting.

RESOLVED to note the work programme and suggested updates.

80 DATES OF FUTURE MEETINGS

RESOLVED to meet on the following Tuesdays at 10.15am at County Hall, West Bridgford:

2016 – 14 June; 12 July; 13 September; 11 October; 8 November; 13 December.
2017 – 10 January;7 February; 14 March; 18 April.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

14 June 2016

Agenda Item: 5

REPORT OF THE CHIEF EXECUTIVE

TERMS OF REFERENCE AND JOINT PROTOCOL

Purpose of the Report

1. To note the Committee's terms of reference and Joint Protocol (protocol attached as Appendix 1).

Information and Advice

2. County Council on 12 May 2016 agreed the following terms of reference for the Joint City and County Health Scrutiny Committee:-

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE– TERMS OF REFERENCE

3. The exercise of the powers and functions set out below are delegated by the Full Council to the Joint City and County Health Scrutiny Committee:-

   3.1 To scrutinise health matters which impact both on the areas covered by Nottingham City Council and Nottinghamshire County Council.

Other Options Considered

4. None.

Reason/s for Recommendation/s

5. To inform the committee of its terms of reference.

Statutory and Policy Implications

6. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the report be noted.

Mick Burrows
Chief Executive

For any enquiries about this report please contact: Martin Gately, Democratic Services Officer – 0115 977 2826

Constitutional Comments

7. As the report is for noting only, no constitutional comments are required.

Financial Comments

8. There are no financial implications arising directly from this report.

Background Papers

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.

a) Report to County Council – 15th May 2014 (published).

Electoral Division(s) and Member(s) Affected

All

PROTOCOL FOR THE OPERATION OF A JOINT COMMITTEE ON THE OVERVIEW AND SCRUTINY OF HEALTH IN GREATER NOTTINGHAM

1. Nottinghamshire County Council and Nottingham City Council established a Joint Committee between the two Authorities in 2003 to scrutinise health matters which impact upon the Greater Nottingham area.

2. The role and operation of the Joint Committee will be kept under review, with a further complete review of its responsibilities and workings to be carried out on an annual basis from the adoption of this protocol.

Role

3. The role of the Joint Committee is

    - To scrutinise health matters which impact both on the areas covered by Nottingham City Council and Nottinghamshire County Council.

4. A list of stakeholders is attached to this protocol.

Responsibilities

5. The Joint Committee will scrutinise significant health developments that cover the Greater Nottingham area. This means that a decision will impact on both Nottingham City and Nottinghamshire County residents.

6. The main focus will be on issues relating to public health with particular regard to health inequalities and access to services.

7. The agenda will be determined by the Chair and Vice-Chair, and the lead officers for both councils.

Purposes of Joint Health Scrutiny

8. Issues for potential scrutiny include:

    - Major capital projects;
    - Proposals to close services such as hospital wards and GP surgeries;
    - Issues that impact on health inequalities;
    - Issues that affect access to services such as the ending of a service or its relocation to an alternative site, including the availability of appropriate public transport;
    - Performance issues – but only those not already monitored by other bodies;
    - Issues that impact widely on public health;

- Issues that impact significantly on the local economy.

Definition of Significant Variation/Development of Health Services

9. There is no national definition. Local authorities are requested to arrive at a local definition following consultation with bodies such as Healthwatch.

10. National guidance states that in considering whether a proposal is substantial, health service organisations, committees and stakeholders should consider generally the impact of the change upon patients, carers and the public who use or have the potential to use a service. More specifically they should take into account:

    - Changes in accessibility of services, for example both reductions and increases on a particular site or changes in opening times for a particular clinic. Communities attach considerable importance to the local provision of services, and local accessibility can be a key factor in improving population health, especially for disadvantaged and minority groups. At the same time, development in medical practice and in the effective organisation of health care services may call for reorganisation including relocation of services. Thus there should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location.

    - Impact of proposal on the wider community, and other services including economic impact, transport, regeneration;

    - Patients affected, changes may affect the whole population (such as changes to accident and emergency), or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial;

    - Methods of service delivery, altering the way a service is delivered may be a substantial change – for example moving a particular service into community settings rather than being entirely hospital-based. The views of patients and patient's forums will be essential in such cases.

Notification of Potential Scrutiny Items

11. In line with the Guidance on Overview and Scrutiny of Health, health bodies will need to notify the lead officer of the Joint Committee secretariat of relevant issues for potential scrutiny. Commissioners and providers should agree on potential joint health scrutiny items to notify to

the joint Committee, and they should also become a standing item on executive level management meetings. Similarly Healthwatch will need to inform the secretariat of any issues they wish to raise. The secretariat will inform the Chair and Vice-Chair of issues raised so that they can decide on the best way of responding.

Chair and Vice Chair

12. The Chair and Vice Chair from each Social Services authority will be appointed in alternate years from each council. The Vice Chair will always be appointed from the authority not holding the Chair.

Size of Committee

13. It is proposed that the Joint Committee will comprise 8 non-executive members of the City Council and 8 members of the County Council. The County Council should look to include members who represent electoral divisions in Broxtowe, Gedling, Hucknall and Rushcliffe areas.

14. Allocation of seats will be determined by the two Social Services authorities involved.

Co-opted Members

15. The power of health scrutiny lies with local authorities with responsibility for Social Services i.e. the City Council and County Council for Nottinghamshire. However non-executive district council members can be co-opted to Health Scrutiny Committees on an indefinite basis or for a time-limited period. Similarly Health Scrutiny Committees have the power to co-opt other people, regardless of background, as long as it is felt that they add value to the Committee. The Joint Committee can determine any co-options.

Frequency of Meetings

16. The Joint Committee will meet as and when required with a minimum of two meetings per year.

Organisation and Conduct of Meetings

17. Notice of meetings, circulation of papers, conduct of business at meetings and voting arrangements will follow the Standing Orders of the authority which holds the Chair, or such Standing Orders which may be approved by the parent authorities. Meetings will be open to members of the public.

Officer Support

18. The secretariat for the Joint Committee will alternate annually between the two authorities with the Chair. The costs of operating the Joint Committee will be met by the Council providing the secretariat services.

Reports from the Joint Committee

19. When the Joint Committee has completed a scrutiny review, it should produce one report on behalf of the committee. The report should reflect the views of both the City Council and County Council and so the aim should be for consensus whenever possible.

20. The health service organisation(s) receiving the report must respond in writing to any requests for responses to the report or recommendations, within 28 days of receipt of the request.

Joint Health Scrutiny Protocol

Adopted	May 2005
Reviewed	July 2006
	June 2007
	April 2008
	May 2010
	June 2011
	May 2012
Amended	July 2006
	April 2008
	May 2010
	May 2014

KEY STAKEHOLDERS IN GREATER NOTTINGHAM

Nottinghamshire Social Services Authorities (who comprise the Joint Health Committee)

Nottingham City Council (eight Members)
Nottinghamshire County Council (eight Members)

District Councils

Ashfield District Council (Hucknall area)
Broxtowe Borough Council
Gedling Borough Council
Rushcliffe Borough Council

NHS Trusts

Nottingham University Hospitals NHS Trust
East Midlands Ambulance NHS Trust
Nottinghamshire Healthcare NHS Trust

Clinical Commissioning Groups

Nottingham City Clinical Commissioning Group
Nottingham West Clinical Commissioning Group
Nottingham North and East Clinical Commissioning Group
Rushcliffe Clinical Commissioning Group

NHS England Local Area Team

Health and Wellbeing Boards

Nottingham Health and Wellbeing Board
Nottinghamshire Health and Wellbeing Board

Healthwatch

Healthwatch Nottingham
Healthwatch Nottinghamshire

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
14 JUNE 2016
UPDATE ON PROGRESSION OF SERVICE REDESIGN PROJECTS WITHIN THE ADULT MENTAL HEALTH DIRECTORATE OF NOTTINGHAMSHIRE HEALTHCARE TRUST
REPORT OF CORPORATE DIRECTOR FOR RESILIENCE (NOTTINGHAM CITY COUNCIL) **ITEM 6**

1 Purpose

1.1 To consider an update on the implementation of changes to the delivery of adult mental health services provided by Nottinghamshire Healthcare Trust, including the impact of changes that have already been implemented.

2 Action required

2.1 The Committee is asked to review the implementation of changes to the delivery of adult mental health services provided by Nottinghamshire Healthcare Trust, including the impact on service users; and identify if any further scrutiny is required.

3 Background information

3.1 Over the course of the last 18 months the Committee has been looking at the development of adult mental health services provided by Nottinghamshire Healthcare Trust, including: changes to rehabilitative care with a move from inpatient to community based provision; a reduction in inpatient acute beds; and development of Enhanced Crisis Resolution and Home Treatment Team.

3.2 In December 2015, the Committee heard about:

a) Non-crisis community services – following a review of the delivery of non-crisis community services, a locality based community model had been identified as the preferred model for community service delivery. It was anticipated that the changes would begin to take place from 1 April 2016.

b) Rehabilitation services – Work included expanding the community rehabilitation team serving the City and south Nottinghamshire; developing a community rehabilitation service for the population of Mansfield and Ashfield; and the closure of Broomhill House, Gedling and Heather Close, Mansfield on 31 October 2015. The Trust

advised that the impact of these changes would be monitored via regular audits at 6 months to evaluate.

c) Acute service transformation – these changes related to the closure of acute inpatient beds at Queens Medical Centre and the development of Enhanced Crisis Resolution and Home Treatment Team and a Crisis House. In December the Trust reported that there had recently been an increase in demand for acute beds that necessitated the use of out of area placements and private beds.

3.3 Representatives of Nottinghamshire Healthcare Trust will be attending the meeting to provide an update on changes that have taken place since December and on the findings of work to assess the impact of changes.

4 List of attached information

4.1 Nottinghamshire Healthcare Trust paper 'Local Services Division Adult Mental Health Directorate Review of Adult Mental Health Service Transformation'

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

5.1 None

6 Published documents referred to in compiling this report

6.1 Reports to and minutes of meetings of the Joint City and County Health Scrutiny Committee held on 7 October 2014, 16 June 2015, July 2015 and 15 December 2015.

7 Wards affected

7.1 All

8 Contact information

8.1 Jane Garrard, Senior Governance Officer
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

LOCAL SERVICES DIVISIONADULT MENTAL HEALTH DIRECTORATE

REVIEW OF ADULT MENTAL HEALTH SERVICE TRANSFORMATION

1 EXECUTIVE SUMMARY

This paper provides a review of the progression and impact of service transformation within the Adult Mental Health (AMH) Directorate in 2015/16. The paper will give feedback on service transformation undertaken across the city and county of Nottinghamshire and offer updates on new service improvements in development to support the ongoing success of the transformation.

2 INTRODUCTION

The Adult Mental Health Directorate has undergone a period of significant transition over recent years which has aspired to refocus care to a community setting wherever possible, allowing people who would have been historically cared for in a hospital environment to receive care in their own homes. This transformation has allowed the Directorate to achieve a corresponding reduction in inpatient beds in both the acute and rehabilitation setting.

Acute Inpatient Services has achieved a reduction of 25% in available beds during 2014/2015 and Rehabilitation Inpatient Services has achieved a reduction of 62.5% in available beds.

Preliminary impact assessment has shown:

1 A total of 42 AMH acute beds were closed.

- 6 beds reduced through reduction in bed days lost to DTOC.
- 32 beds reduced through reduction in LoS.
- 5 beds reduced through reduction in emergency readmissions.

2 DTOC has reduced in terms of delayed bed days per available bed days (based on 85% occupancy as clinically agreed safe occupancy model for acute wards).

3 Length of Stay has reduced

4 Private bed use is continued despite the above evidencing that 43 beds could have been closed. This doesn't factor in the evidential increases in population and demand

for secondary care services which has shown to be ***six times greater*** than the rate of population growth.

5 Demand for AMH services as a whole ***is*** increasing and this is evidential beyond population growth estimates.

6 The transformation programme reinvested in ECRHT services, yet these services have seen an increase in demand beyond levels of re-investment.

3 SERVICE DEVELOPMENTS TO SUPPORT TRANSFORMATION

3.1 BED MANAGEMENT TEAM

The Local services division has funded the development of a 24 hour a day and 7 day per week bed management team which will be centrally based at Millbrook but will be visible on all inpatient sites. This service will provide:

- One single point of bed management for all admissions 24 hours a day and 7 days a week.
- In reach to all inpatient wards every day to support and facilitate leave and discharge arrangements.
- Support with identification, recording and escalation of DTOC's.
- Support the implementation and monitoring of the 50 day LoS Peer Case Review, ensuring that all service users experiencing an inpatient length of stay of longer than 50 days are subject to a clinical second opinion.
- Support the repatriation of service users from private provision to local beds.
- A dedicated post to support service users with housing and benefits advice to ensure timely discharge can occur

The new team Manager, service Manager and operational Manager will work to support the development of:

- Consistent guidelines for the use of leave and facilitation of discharge.
- The development of information for service users with regard to the purpose of acute admission and the expectations they can have of the inpatient team.
- Safe delegation of responsibility for decisions with regard to admission stay and discharge.
- Implementation of the new electronic bed and patient management systems which is being jointly developed by AMH and applied informatics.

3.2 BED MANAGEMENT PROTOCOL

- The purpose of this protocol is to provide a clear framework for staff when dealing with bed management issues across inpatient wards.
- This protocol has been developed to ensure the optimal use and effective management of all of the Directorates inpatient acute beds, in order that service users receive prompt, effective and appropriate inpatient treatment. This protocol provides guidance to staff and service users regarding the procedures and practices relating to arranging inpatient admissions, and the responsibility of the Adult mental health Directorate with regard to the same. The protocol offers clear direction especially with regard to situations where there is a shortage of available acute beds within local services.

  The policy incorporates procedures to support:

  - Location and authorisation of private provision in the absence of local beds.
  - Management of beds across the division in cases of emergency and governance guidelines for the same.
  - Management and escalation processes relating to patients requiring admission from the emergency department.
  - Guidance on Use of PICU (psychiatric intensive care unit) beds.
  - Guidance on Use of Health Based Place of Safety beds.

3.3 USE OF PRIVATE BEDS AND GOVERNANCE OF THE SAME

During 2015/2016, 94% of all admissions were facilitated in local trust beds. While only a small number of admissions were to private or out of area providers AMH recognise the significant impact an out of area admission can have on services users and carers and are engaging in a number of strategy's to minimise and mange this impact, as out lined below.

Guidance for staff has been developed with regard to monitoring and assurance relating to service users admitted to private providers as follows:

- Repatriation of service users to local AMH beds is a daily priority for the bed management team and decisions relating on prioritization of patients should be based on:

  - Length of stay in private provision
  - Complexity of needs and care package required
  - Distance from home and carers/loved ones
  - Concerns or complaints raised by service users/carers

- Contact should be maintained with both the service user and agreed/involved carer throughout the admission at a frequency no less than weekly by the involved clinician or a designated representative. This contact should discuss:

    - Progress
    - Care planning
    - Leave/discharge arrangements
    - Complaints or concerns

- Contact should be maintained with the clinical team within the inpatient area at a frequency no less than weekly by the involved clinician or a designated representative, the purpose of this contact should be.
    - To develop an appropriate care plan and identify purpose for admission and goals for recovery and to allow discharge.
    - To share information relevant to clinical presentation including details relating to risk, presentation, safeguarding and vulnerability.
    - To assure that admission remains relevant, appropriate and proportionate to meet the needs of the service user.
    - Any concerns regarding care provision decisions regarding admission stay or discharge or repatriation must be raised and escalated appropriately.

The Bed Management Team Leader has gathered information from all private providers on

- Ligature safety of their inpatient environments.
- Admission and referral criteria and any exclusion to the same.
- Gender split and mixed and single sex bed numbers.
- Willingness to accept transgender service users or any other exclusion criteria relative to equality and diversity particularly disability access.
- What information they require to make a timely decision on a referral.

3.4 TRANSITIONAL SERVICE

AMH recognise that for some of our service users the step from inpatient to community care can be a big one and often because of this their length of admission can be unnecessarily protracted. I order to combat this and improve access to the right care at the right time for all of our services users, AMH have, in conjunction with Turning point agreed to develop a transitional service offering a short term step between in patient acute care and discharge. This service will provide a recovery orientated step down pathway from

acute care in Nottinghamshire and the care provision will be led by Turning point with support from Nottinghamshire healthcare staff. The service will provide 24 hour care and support, and will provide a solution focused, person centred approach, enabling choice, control and hope for the individuals coming to the service. Staff will have a positive view of each person's potential to achieve independence and will provide 'just enough support', working with each individual to do as much for themselves as possible to build their skills and confidence to allow a successful return to community living.

3.5 DAILY DEMAND MEETING

This meeting has now been embedded as routine practice in the Directorate. The teleconference meeting takes place each morning at 9.30 – 10.00am, chaired by the AMH Operational Managers, the meeting covers staffing, bed management, serious incidents, , and any other urgent issues to address. Actions are identified and followed up through the day. Actions are then checked the next day to assure action and outcomes have taken place. This meeting has improved communication, escalation and scrutiny of any issues within the directorate in a timely way

3.6 . DAILY CONSULTANT REVIEWS

Daily reviews with medical representation take place on all acute wards with more formal MDT's taking place weekly. With the support of the newly developed bed management team acute managers will be:

- Auditing the robustness of these processes.
- Assessing the utilisation and impact of the red, amber, green rating system Implemented on acute wards.
- Implementing the system of 50 day peer case review as described above.
- Supporting the implementation of the electronic bed management and patient information systems.
- Supporting the development of guidance for delegated responsibility relating to admission stay and discharge

4 ONGOING REVIEW AND EVALUATION

The Division continues to monitor and manage a range of Key performance indicators in relation to the closure of inpatient beds.

The AMH Directorate is undertaking a project within the Theory of Constraints methodology to improve inpatient flow throughout the Directorate. There has been good engagement with the wards and consultant medical staff in the inception and roll out of this project. Terms of reference have been agreed and the Directorate is working with an organisation called QFI in the delivery of this project.

Some of the expected outcomes of this work include:

- To identify a lean process for admission through to discharge
- To identify at the start of admission the discharge date
- The process will have tasks identified throughout the patient's admission what is required to meet the discharge date or before. This will ensure that any delays will be managed daily to prevent DTOC.
- To reduce occupied bed day
- To reduce length of stay
- To improve patient experience
- To improve staff experience
- To prevent AHMP's sitting with patient's for long periods waiting for abed to be identified
- To reduce out of area beds
- To reduce financial impact on the Directorate
- To achieve 85% occupancy
- To improve safety for patient's
- To reduce the stress and pressure for on call managers and bed managers leading to long hours of work
- To reduce the ED delays

A more comprehensive evaluation of AMH ward closures has been commissioned from the School of Social Sciences at Nottingham Trent University. This will be led by Dr Di Bailey, Professor of Mental Health with draft terms of reference being a review of local and national data and what this tells us about the AMH transformation and a qualitative understanding of the patient and staff experience of the service re-designs. Commissioner colleagues have been invited to a meeting with AMH leads and NTU on 01/06/16 to contribute to and agree the terms of reference.

5 CONCLUSION

AMH have successfully achieved wide ranging service transformation and the directorate continues to focus on the delivery of recovery focused service user centered care and continues to develop services to support the continued success of the transformations already achieved. The directorate will closely monitor and evaluate the impact of service

transformation ensuring the maintenance of excellent clinical quality and striving as always to ensure excellent service user experience in all of our care environments

Adult Mental Health Directorate June 2016.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

14 June 2016

Agenda Item: 7

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

POHWER – MENTAL HEALTH ADVOCACY

Purpose of the Report

1. To introduce the work of POhWER, an organisation engaged in mental health and other advocacy.

Information and Advice

2. Over the last twenty years, from 1996 to 2016, POhWER has expanded to cover various parts of the country providing advocacy services to the following people:

    - People who feel they have been let down by the NHS and want to make a complaint
    - Older people
    - People with mental health issues
    - People with sensory impairment
    - People with physical disabilities
    - People with learning disabilities
    - Children and young people
    - People with autism
    - People who have experienced discrimination or exclusion
    - Children's Advocacy Services
    - Direct Payments and Brokerage
    - Information, advice and signposting (helpline services)
    - Independent Mental Health Capacity Advocate/Independent Mental Health Advocacy
    - Specialist Secure Services and complex advocacy
    - Community Engagement Services

3. An Independent Mental Capacity Advocate (IMCA) becomes involved When someone is assessed by a doctor or social worker as lacking mental capacity to make key decisions in their lives - perhaps because of mental illness, dementia, learning difficulties, a stroke or brain injury - they can have the help of a specialist Independent Mental Capacity Advocate (IMCA). This is a legal right for people over 16 who lack mental capacity and who do not have an appropriate family member or friend to represent their views.

4. An IMCA can be instructed where there is a decision to be made regarding one of two specific issues:

- Serious medical treatment
- A change of accommodation.

5. Serious medical treatment applies where an NHS body proposes to provide, withdraw or withhold treatment. Change of accommodation applies where an NHS body or Local Authority proposes a move for the person to hospital for more than 28 days or to alternative accommodation for more than 8 weeks.

6. In addition, there is a duty to consider whether it would be of benefit for an IMCA to be instructed for the following issues:

    - Safeguarding Adults from Abuse
    - Care Reviews

7. Safeguarding Adults from Abuse applies where the NHS body or Local Authority have commenced Safeguarding procedures and the person lacks capacity regarding any of the protective measure being proposed. This is the only issue that the person can have family or friends appropriate and practical to consult and still have IMCA support.

8. Care Reviews applies where the NHS body or Local Authority have can instruct an IMCA to support and represent a person who lacks capacity when they have arranged accommodation for that person or they aim to review the arrangements as part of a care plan or otherwise

9. POhWER's IMCAs seek to ascertain the views and beliefs of the person referred to them and gather and evaluate all relevant information about that person. The advocate then writes a report to help decision-makers, like doctors, reach decisions which are in the best interests of the person concerned. Sometimes the advocate will look at courses of action other than those suggested by the professionals and sometimes seek a second medical opinion. An advocate has the right to challenge any decision made, informally if possible but otherwise through the relevant complaints procedure. In this way an advocate can enable the individual to participate to some extent in decision-making.

10. Ultimately the issue, if it is particularly serious, may go to the Court of Protection, which is a specialist court for all issues relating to people who lack capacity to make specific decisions. The court makes decisions and appoints deputies to act on behalf of people who are unable to make decisions about their personal health, finance or welfare.

11. POhWER’s strategy for 2016-19 is to reconnect and grow their membership while developing the POhWER local identity through existing services and capacity building in community inclusion projects.

12. The organisation will undertake a restructure of its charity governance and senior management while developing better support and delivery structures. POhWER will also develop unrestricted income streams to provide more value added and community-based services.

13. POhWER also plans to develop evidence-based research and metrics for advocacy and engagement services with leading UK academic institutions, as well as developing their existing advice helpline to be a 24 hour service.

14. Locally, POhWER plans to develop a distinct Nottingham and Nottinghamshire POhWER branded service, and, in addition, to widen the range of advocacy services in line with Human Rights and Equality issues.

15. Senior representatives of POhWER will attend the Joint Health Scrutiny Committee to brief Members on the work of the organisation and answer questions. [A written briefing from POhWER is attached as an appendix to this report.]

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee consider and comment on the information provided.

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

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

POhWER
advocacy, making your voice heard

POhWER is a charity and membership organisation. We provide information, advice, support and advocacy to people who experience disability, vulnerability, distress and social exclusion. Our services are designed by service users for service users. Last year we provided direct advocacy to over 25,000 people and handled 153,000 contacts for information and advice. Over 70,000 self help materials were downloaded from our website. POhWER is one of the largest providers of advocacy services in the UK and England's largest provider of NHS Complaints Advocacy. In Nottingham City and Nottinghamshire, POhWER currently delivers the ***Your Voice Your Choice*** *service, comprising information, advice and statutory and non-statutory advocacy services delivered across City and County We have opened 1696 new cases alone in Nottingham and Nottinghamshire in the past financial year.**

*The Your Voice Your Choice service includes:

A dedicated telephone ***Access to Advocacy Service*** delivering information, advice and supported signposting, as well as access to our full range of advocacy services:

Care Act Advocacy: a free, confidential and independent statutory advocacy service (part of the Care Act 2014) supporting and representing people experiencing substantial difficulty being involved in a needs assessment; carer's assessment; safeguarding enquiry/review; or the preparation or review of a care or support plan under the Care Act, and who have no one else to support their involvement.

NHS Complaints Advocacy: a free, confidential and independent service supporting those who need support to make a complaint about NHS treatment or care, including complaints about their GP, dentist, local hospital, ambulance service or pharmacy or supporting those making a complaint on someone else's behalf, including if someone has died.

Independent Mental Health Advocacy (IMHA): a free, confidential and independent statutory advocacy service now part of the Mental Health Act 1983, providing information, support and representation to 'qualifying patients' impacted by the Mental Health Act, namely those detained or subject to a Community Treatment Order (CTO) or Guardianship Order under the Act.

Independent Mental Capacity Advocacy (IMCA): a free, confidential and independent statutory advocacy service that is part of the Mental Capacity Act 2005. Where Health or Social Care professionals have to make a relevant decision about a person who lacks the mental capacity to make the decision themselves and where there is no one else appropriate to consult, the professional making the decision must instruct an IMCA to ensure the person is represented and safeguarded where decisions may not be in the person's best interests.

Paid Relevant Person's Representatives: For those who are subject to the Deprivation of Liberty Safeguards (DoLS) (part of the Mental Capacity Act 2005), and have no one appropriate to take on the role of representative, Paid Representatives maintain contact with the relevant person and represent and support them in all matters relating to the deprivation of liberty safeguards, including, if appropriate, triggering a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection.

Specialist Community Advocacy services: delivering a one-to-one issue based advocacy service to people with mental health issues, learning disabilities, physical disabilities, older people and people with dementia who need advocacy help to express their views about the services they receive and empowering them to achieve the outcomes they want.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

14 June 2016

Agenda Item: 9

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

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

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

3. The work programme for 2016-17 is attached as an appendix for information.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the work programme for 2016-17 and dates for future meetings.

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

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Joint Health Scrutiny Committee 2016/17 Work Programme

14 June 2016	• **Update on progression of service redesign projects within the Adult Mental Health Directorate in 2015/16** To review implementation of service redesign projects Nottinghamshire Healthcare Trust) • **POhWER – Mental Health Advocacy** • **Sustainability and Transformation Plan (tbc)** Update on the Nottinghamshire Plan • **Work Programme** To consider the 2016/17 Work Programme
12 July 2016	• **Transforming care for people with learning disabilities and/or autism spectrum disorders in Nottingham and Nottinghamshire – outcomes of consultation and progress against key deliverables** To consider the consultation process and findings and if/how proposals are changing to reflect those findings; and progress against the key deliverables to be completed by June 2016 (Nottingham City CCG lead) • **CAMHS services in the community (tbc)** To review the provision of CAMHS services in the community, including their effectiveness in reducing demand for inpatient CAMHS services (Nottinghamshire Healthcare Trust) • **Work Programme** To consider the 2016/17 Work Programme

13 September 2016	• **Environment, waste and cleanliness at Nottingham University Hospitals** To review progress in improving the environment, waste management and cleanliness at Nottingham University Hospitals sites (Nottingham University Hospitals) • **Work Programme** To consider the 2016/17 Work Programme
11 October 2016	• **East Midlands Clinical Senate and Strategic Clinical Networks** To receive the EMCSSCN Annual Report and updates on other recent developments (EMCSSCN) • **Work Programme** To consider the 2016/17 Work Programme
8 November 2016	• **Work Programme** To consider the 2016/17 Work Programme
13 December 2016	• **Work Programme** To consider the 2016/17 Work Programme
10 January 2017	• **Uptake of child immunisation programmes** To consider the latest performance in uptake and how uptake rates are being improved (NHS England/ Local Authority Public Health) • **Work Programme**

	To consider the 2016/17 Work Programme
7 February 2017	• **Work Programme** To consider the 2016/17 Work Programme
14 March 2017	• **Work Programme** To consider the 2016/17 Work Programme
18 April 2017	• **Urgent Care Resilience** To review progress in developing resilience within the urgent care system, including the delivery of services during winter 2016/17 and how effectively winter pressures were dealt with. (Nottingham City CCG/ NUH) • **Work Programme** To consider the 2016/17 Work Programme

To schedule:

- Rampton Secure Hospital Variations of Service – commissioners/ prison environment
- Daybrook Dental Service - findings and lessons learnt (NHS England)/ future dental regulation – awaiting outcome of General Dental Council case (contact: Dr Ken Deacon)
- Progress against JHSC recommendation that "that the City and County Councils work with their partners, for example Marketing Nottingham and Nottinghamshire to support Health Education East Midlands to promote the East Midlands as a place for health professionals and students to train and work"
- Integrated Community Children and Young People's Healthcare Programme – review of outcomes of service changes
- Procurement of Patient Transport Service, including development of service specification - awaiting confirmation of procurement timings

- Progress in establishing long term partnership between Nottingham University Hospitals and Sherwood Forest Hospitals
- Scrutiny implications of long term partnership between Nottingham University Hospitals and Sherwood Forest Hospitals
- POhWER advocacy services
- Evaluation of Urgent and Emergency Care Vanguard (primary care at the 'front door')
- Integrated Urgent Care
- Evaluation of GP Access pilots

Study Groups:

- Quality Accounts

Visits:

- Nottingham University Hospitals sites

Other meetings:

- NUH (Peter Homa)
- NHCT (Ruth Hawkins)
- EMAS (Greg Cox) (informal meeting with East Midlands Health Scrutiny Chairs to consider EMAS response to CQC inspection)

Items for 2017/18 Work Programme:

<u>May/ June</u>

- Nottinghamshire Healthcare Trust Transformational Plans for Children and Young People – CAMHS and Perinatal Mental Health Services update (to include workforce issues, development of Education Centre and financial position)

NHS 111 (align with publication of NHS 111 Annual Report)

Visit to new CAMHS and Perinatal Services Site (spring 2018)