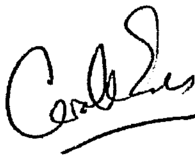
NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY PANEL

Date: Thursday 28 March 2013

Time: 11.00am

Place: Meeting Room LB 31 - 3rd Floor at Loxley House, Station Street

Councillors are requested to attend the above meeting on the date and at the time and place stated to transact the following business.



Deputy Chief Executive/Corporate Director for Resources

Overview and Scrutiny Review Co-ordinator: Jane Garrard 0115 8764315

AGENDA

1	**APOLOGIES FOR ABSENCE**	
2	**DECLARATIONS OF INTEREST**	
3	**MINUTES** Last meeting held on 29 January 2013 (for confirmation)	Attached
4	**NHS TRANSITION ARRANGEMENTS UPDATE** Report of Head of Democratic Services	Attached
5	**EX SERVICE PERSONNEL - MENTAL HEALTH ISSUES**	
(a)	**REPORT OF HEAD OF DEMOCRATIC SERVICES**	Attached
(b)	**APPENDIX 2 - NOTTINGHAMSHIRE EX-ARMED FORCES AND FAMILIES PARTNERSHIP: INFORMATION FOR ARMED FORCES LEAFLET**	Attached
6	**ISSUES FOR HEALTH SCRUTINY ARISING FROM THE FRANCIS INQUIRY** Report of Head of Democratic Services	Attached

7 **DRAFT WORK PROGRAMME 2013/14** Attached
Report of Head of Democratic Services

CITIZENS ATTENDING MEETINGS ARE ASKED TO ARRIVE AT LEAST FIFTEEN MINUTES BEFORE THE START OF THE MEETING TO BE ISSUED WITH VISITOR BADGES

IF YOU ARE UNSURE WHETHER OR NOT YOU SHOULD DECLARE AN INTEREST IN A PARTICULAR MATTER, PLEASE CONTACT THE OVERVIEW AND SCRUTINY CO-ORDINATOR SHOWN ON THIS AGENDA, IF POSSIBLE BEFORE THE DAY OF THE MEETING, WHO WILL PROVIDE ADVICE IN THE FIRST INSTANCE.

A PRE-MEETING FOR ALL PANEL MEMBERS WILL BE HELD AT 10:30AM IN LB31

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http://open.nottinghamcity.gov.uk/comm/default.asp

NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES

of the meeting held on **29 JANUARY 2013** at Loxley House from 11.02 am to 12.40 pm

Membership

✓	Councillor G Klein	(Chair)
✓	Councillor T Molife	(Vice Chair)
✓	Councillor M Aslam	
	Councillor M Bryan	
✓	Councillor E Campbell	
✓	Councillor A Choudhry	
	Councillor E Dewinton	
	Councillor B Ottewell	
✓	Councillor S Parton	
	Councillor T Spencer	

✓ indicates presence at meeting

Also in attendance

Councillor Nicola Heaton - Chair of Health and Wellbeing Board

Ms Rosemary Galbraith	- Assistant Director of Quality and Safety, and Deputy Director of Nursing	Nottingham CityCare Partnership
Ms Cath Ziane-Pryor	- Constitutional Services	Nottingham City Council
Ms Jane Garrard	- Overview and Scrutiny Co-ordinator	
Ms Dawn Smith	- Chief Operating Officer	NHS Nottingham City Clinical Commissioning Group
Mr Andrew Hall	- Acting Director of Health and Wellbeing Transition	NHS Nottingham City / Nottingham City Council

37 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Bryan and Molife, on other Council Business, and Councillors Dewinton and Spencer.

38 DECLARATIONS OF INTERESTS

No declarations of interests were made.

39 MINUTES

RESOLVED that the minutes of the last meeting held on 29 November 2012, copies of which had been circulated, be confirmed and signed by the Chair.

40 NHS TRANSITION ARRANGEMENTS

(a) Report of Head of Democratic Services

Consideration was given to the report of the Head of Democratic Services, copies of which had been circulated, briefly summarising the transition to date.

RESOLVED that the report be noted.

(b) Update from Acting Director of Health and Wellbeing Transition

In updating the Panel, Mr Andrew Hall, Acting Director of Health and Wellbeing Transition, made the following points:

With respect to the transfer of public health functions to the local authority:

- Plans for the transfer of public health functions to the local authority were on track;

- the 2 year financial settlement had now been received, with £27 million allocated for 2013, and £27.8 million for 2014. £23.4 million had been budgeted for each year, and although the settlement was higher than expected, it was to include additional areas of responsibility, including Community Infection Control, and some long term investment requirements;

- 'due diligence' had been paid with regard to the transfer of contracts, which were now in the final stages of transfer with completion predicted in the next couple of weeks;

- staff consultation on transfer to the local authority had started, but clarity was awaited from Central Government as to the details and limitations of the transfer scheme, although it was predicted that TUPE principals would be followed. A training programme for staff had been put in place;

- a work programme for the transition of ICT had begun. This was one of the outstanding risk areas but mitigation plans were in place and the programme was on track. The practical transfer of data was to be a huge piece of work and would include consideration of information governance as access to NHS data was required;

- there were risks associated with the health protection work strand, but it had now been clarified that health protection issues would be considered through the Nottingham and Nottinghamshire Resilience Group;

With respect to the establishment of HealthWatch:

- the tender process was ongoing and due to close on 31 January 2013;

- the Health and Social Care Network was an existing consultative body for commissioning activity and would be available for the newly appointed HealthWatch to liaise with;

- the lessons learnt from issues regarding LINk had been reflected in processes applied to the establishment of HealthWatch. One of the potential issues was around the existence of a large number of consultation mechanisms and ensuring that consultation overload was avoided and that consultation activity was co-ordinated. It was intended that the existing Health and Social Care Network would provide a good base to support HealthWatch in getting established;;

- it was anticipated that HealthWatch would initially have an Interim Board for 2013/14 with a view to establishing a partly elected, partly appointed Board in due course.

(c) Update from Chief Operating Officer, NHS Nottingham City Clinical Commissioning Group

Ms Dawn Smith, Chief Operating Officer, NHS Nottingham City Clinical Commissioning Group (CCG), presented the following update:

- on 18 January 2013, the CCG received authorisation from the National Commissioning Board, but until the transition date of 1 April 2013, a formal agreement was in place that the CCG only had limited powers;

- work was nearing an end to finalise the Draft CCG Strategy which was to be submitted to the Health and Wellbeing Board in February 2013;

- the Nottingham City CCG were confident that the transition would take place, as planned, on 1 April 2013. One of the areas of potential liability which could not be planned for was that of complaints referring to issues which occurred prior to the transfer;

- there had not been any public consultation in regard to the constitution for the CCG, as the requirement was only for consultation with membership organisations. Some aspects of the constitution had been discussed in broader forums, for example patient engagement group, and the CCG was confident that the Constitution set out how the CCG would be open and transparent in making decisions and allowing the public to raise issues.

In response to a question from a member of the public regarding scrutiny of the CCG constitution by the Health Scrutiny Panel, the Panel had not found any issues which would merit further scrutiny at this stage.

41 HEALTH AND WELLBEING STRATEGY

(a) Report of the Head of Democratic Services

Consideration was given to the report of the Head of Democratic Services, copies of which had been circulated, outlining the background to the Health and Wellbeing Board and the development of its strategy.

RESOLVED that the report be noted.

(b) <u>Presentation by the Chair of the Health and Wellbeing Board</u>

Councillor Heaton, Chair of the Health and Wellbeing Board, delivered the presentation, a copy of which was submitted to the online agenda following the meeting.

The Health and Wellbeing Strategy was a requirement of the Health and Social Care Act and fed into, and complimented, the Nottingham Plan to 2020, and was to be developed to address the needs identified in the City's Joint Strategic Needs Assessment.

The four main priorities had been identified as follows:

- Prevention - Healthy Nottingham;
- Integration - Supporting Older People;
- Early Intervention - Mental Wellbeing;
- Whole Systems Change - Priority Families.

The Panel's questions and comments were responded to as follows:

- while some of the targets of the strategy may appear very ambitious, especially in the current financial context, it was always worth being ambitious;

- the strategy focus would be over 2 years, in 4 topic areas, where progress could be measured and tracked;

- all targets were measurable, with clear headline targets measured first within each group, and then the underlying targets. Some targets could be measured with existing data collection, such as that collected in the citizen survey, but further clarity was sought in regard to securing indicators to track the impact of work on a quarterly or six monthly basis. Currently some data was only available annually;

- benchmarking against data collected from other similar cities would also be considered, as some performance would be likely to be affected by national issues and not necessarily attributable to activity in Nottingham. One example was the decrease in Nottingham's smoking rate, which may have been atleast partly due to the nation-wide smoking ban;

- there were already existing targets and timescales in place for work with families, and also Supporting Older People;

- meeting the mental health priority targets within the timeframe was one of the most challenging areas as it was such a significant issue which linked into many other areas of health across the City;

- meeting the targets within the timescales would be challenging;

- consultation on development of the Strategy had been with, or would include, the Equalities and Fairness Commission, HealthWatch, and the Health and Wellbeing

Board Steering Group. In addition to larger public consultation events there would also be smaller, targeted events to engage with specific groups;

- o the Health and Wellbeing Board would need to work with HealthWatch and the Health Scrutiny Panel to ensure that the respective roles complement each other and resource available is maximised to achieve the best outcomes for citizens.

RESOLVED

(1) that good communication between the Health and Wellbeing Board and the Panel was important and it would be useful to have regular updates from the Board, initially reporting back in 4 months time on development of the Strategy, prior to its final approval in June 2013;

(2) that the thanks of the Panel to Councillor Heaton for her presentation and attendance, be recorded.

42 QUALITY ACCOUNT 2012/13 -CITYCARE PARTNERSHIP

Ms Rosemary Galbraith, Assistant Director of Quality and Safety, and Deputy Director of Nursing at Nottingham CityCare Partnership, presented the proposed outline for Nottingham CityCare Partnership's Annual Quality Account for the year April 2012 to March 2013. Following further engagement with stakeholders, the final Account was to be presented to the Health Scrutiny Panel in May 2013.

The following points were made, or responses given to the questions of the Panel:

- o having considered the comments of staff, partners and patients, the priorities of patient safety, patient experience, and clinical effectiveness were to remain for 2013/14. Work had been done to address these priorities, but further focus was required to ensure that competencies were embedded;
- o the Medicines Management Team worked with front line staff and partners to ensure that patients understood their medication, including how to take it, and the possible side effects. Discharge planning was also to be the focus of further work and training of patients, GPs, staff and pharmacies, including medication being provided in a community setting, disposal and safety;
- o pressure ulcers were usually an existing issue for patients transferring from residential or their own homes, but CityCare had signed up to the national programme for prevention of pressure ulcers, including educating staff in care homes.

RESOLVED

(1) that any further comments or suggestions on the proposed outline of the Quality Account be forwarded to Ms Galbraith;

(2) that the Quality Account for 2012/13 be submitted to the Panel for consideration in May 2013;

(3) that the thanks of the Panel to Ms Galbraith for her report and attendance, be recorded.

43 WORK PROGRAMME 2012/13

Consideration was given to the report of the Head of Democratic Services, copies of which had been circulated.

RESOLVED

(1) that the work programme for the remainder of the current municipal year be approved;

(2) that the following topics be considered for scrutiny at future meetings:

- **services for those suffering from self harm;**
- **services available for blind and partially sighted citizens;**
- **Adult Social Care;**
- **Older Person's Pathway;**
- **Mental Health - with specific reference to the length of waiting lists for counselling for young people;**

(3) that when developing the Committee's future work programme consideration be given to the work plans of the Portfolio Holder for Health, Commissioning and Human Resources and the Health and Wellbeing Board.

HEALTH SCRUTINY PANEL
28 MARCH 2013
NHS TRANSITION ARRANGEMENTS UPDATE
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To fulfil the remit of the Health Scrutiny Panel to:
  a) scrutinise local arrangements for the commissioning and delivery of local health services to ensure reduced health inequalities, access to services and the best health outcomes for citizens; and
  b) monitor the Council Executive's statutory responsibility to ensure an effective LINk through commissioning a host organisation.

2. Action required

2.1 The Panel is asked to consider the updates provided by contributors and to discuss progress with them to ensure:
  a) that robust arrangements are in place for commissioning and delivery as we transfer to new arrangements under the Health and Social Care Act; and
  b) that effective arrangements are in place to support the transition to Local Healthwatch from April 2013.

3. Background information

3.1 The Health and Social Care Act requires significant changes to arrangements for the commissioning and delivery of local health services.

3.2 The Panel decided to scrutinise each key area of NHS transition at every meeting to ensure that arrangements for the commissioning and delivery of local health services are robust and in the best interests of local health services, patients and the public.

3.3 At its meeting in January 2013, councillors were advised that the Clinical Commissioning Group (CCG) had been authorised and work was underway to finalise its strategy; and that progress was on track in relation to the transfer of public health responsibilities to the Council. The Panel also received a presentation on the draft Health and Wellbeing Strategy, which is now being consulted on and is due to be approved by the Health and Wellbeing Board in June 2013. Since the meeting, Healthwatch Engagement and Liaison Partnership (HELP) has been appointed to run Healthwatch Nottingham.

3.4 At this meeting Andrew Hall, Acting Director of Health and Wellbeing Transition NHS Nottingham City / Nottingham City Council will advise on progress in respect of:
- Local Healthwatch
- Public health transition to local authority and
- Nottingham City Health and Wellbeing Board.

3.5 The Chair has agreed that, as the CCG has now been authorised and the Panel has been satisfied with progress towards its formal commencement Dawn Smith, Chief Operating Officer, NHS Nottingham City CCG can provide a written update to the Panel. This will be circulated when it becomes available.

3.6 It is the role of this Panel to
a) scrutinise local arrangements for the commissioning and delivery of local health services to ensure reduced health inequalities, access to services and the best health outcomes for citizens; and
b) monitor the Council Executive's statutory responsibility to ensure an effective LINk through commissioning a host organisation.

3.8 In order to fulfil this role, councillors will need to engage in focused discussion and questioning in order to be reassured that robust arrangements are in place.

3.9 With the new arrangements for the commissioning and delivery of local health services commencing from April 2013 this is the final in the series of progress updates. The Panel will want to consider if there are any issues that it wishes to pick up in its work programme for 2013/14.

4. List of attached information

None

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

None

6. Published documents referred to in compiling this report

Health and Social Care Act 2012
Minutes of meeting of the Health Scrutiny Panel 29 January 2013

7. Wards affected

All

8. Contact information

Jane Garrard
Overview and Scrutiny Co-ordinator
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0115 8764315

5a

HEALTH SCRUTINY PANEL
28 MARCH 2013
EX-SERVICE PERSONNEL - MENTAL HEALTH ISSUES
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 A representative of Nottinghamshire Healthcare NHS Trust will be attending the meeting to provide information, and answer questions about the Nottingham Veterans Partnership to inform scrutiny of mental health issues affecting ex-service personnel.

2. Action required

2.1 The Panel is asked to consider the information provided at the meeting and decide whether to:

a) make any recommendations relating to the information provided: and
b) carry out any further scrutiny of mental health issues affecting ex-service personnel and if so, the scope for that piece of work.

3. Background information

3.1 In November 2012 the Panel decided to include consideration of mental health issues affecting ex-service personnel in its work programme.

3.2 It is difficult to establish the size of the ex-service community. There are over 20 active armed forces units based in the East Midlands and it is estimated that 2500 former soldiers settle in the region every year. The Ministry of Defence does not keep central records of where personnel are recruited, where they go on leaving the services or where they subsequently move to. Some are members of veterans' organisations but not all. However, it is recognised that Nottingham has a significant ex-service community and it is anticipated that this will increase as levels of discharge from the armed forces increase in response to the Strategic Defence Review 2010.

3.3 Most people leave the armed forces healthy and make a successful transition to civilian life. However there is evidence of a prevalence and pattern of particular factors that disproportionately affect ex-service personnel, one of these being mental health issues. A briefing note on ex-service personnel and mental health issues is attached at Appendix 1.

3.4 As would be expected from the lack of data on the size of the ex-service population, it is difficult to identify the level of mental health need amongst ex-service personnel nationally and locally. Ex-service

personnel are not identified within the adult mental health strand of the Joint Strategic Needs Assessment, but may fall disproportionately within certain mental health risk categories given parallel issues with housing and employment for example.

3.5 The Nottingham Veterans Partnership was established in December 2011. The Partnership links over 20 organisations including health service providers, housing and social support services, local authorities and the voluntary sector to provide a single point of contact for veterans to access the relevant type of support. Individuals only have to contact one of the partner organisations and they will then be assessed and provided with tailored support, bringing together all the necessary services required to meet their needs. The following mental health partners are involved: Rethink; Combat Stress, Nottinghamshire Healthcare NHS Trust, MIND and Joint Service Alliance. Other partners include Framework, Royal British Legion, Nottingham University Hospitals NHS Trust, CVS, Portland College. A representative of Nottinghamshire Healthcare NHS Trust will be attending the meeting to provide information, and answer questions about the work of the Partnership.

3.6 The Panel needs to decide whether to carry out further scrutiny of mental health issues affecting ex-service personnel and if so, the scope for that piece of work. This should include the focus and timescales for work.

3.7 One Nottingham is considering exploring the impact of changes in the armed forces on the provision and use of services in Nottingham and the wider conurbation. The scope of this work is still being developed but may include mental health issues. The Panel will want to consider if/ how it links to this work.

4. List of attached information

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

Appendix 1 – Ex-service personnel and mental health: briefing note

Appendix 2 - *Nottinghamshire Ex-Armed Forces and Families Partnership: Information for Armed Forces* leaflet

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

None

6. Published documents referred to in compiling this report

Minutes of meeting of the Health Scrutiny Panel held on 29 November 2012

Nottingham City Joint Strategic Needs Assessment Adult Mental Health 2011

7. Wards affected

All

8. Contact information

Jane Garrard
Overview and Scrutiny Co-ordinator
jane_garrard@nottinghamcity.gov.uk
0115 8764315

Ex-service personnel and mental health: briefing note

Approximately 22,000 Armed Forces personnel leave Service and return to civilian life each year and there are an estimated 5 million veterans in the UK. Both the previous Government and the current Government have recognised that physical injuries and mental health issues can create additional healthcare needs for some veterans.[1]

A report published by the Royal British Legion in 2010[2] highlighted that:

- Prevalence of mental health disorders in serving personnel and veterans is broadly similar to that of the normal population.
- A 2009 survey of serving and ex-serving personnel found the weighted prevalence of common mental disorders such as depression and anxiety was 27.2% with Post Traumatic Stress Disorder (PTSD) syndrome at 4.8%. Common diagnoses were alcohol abuse (18%) and neurotic disorders (13.5).
- Reservists were at a far greater risk of developing psychiatric problems than Regular Service personnel.
- A 2009 study found that the overall suicide rate was not greater compared to the general population but suicide risk was associated with being a younger age at discharge, male gender, Army service, lower rank, being single and having a length of service of 4 years or less.
- Prevalence of hazardous drinking was higher for serving and ex-serving personnel than the general population.

From this, the Royal British Legion notes:

- There is a common misconception that the majority of Service personnel and veterans experience PTSD and that any mental health disorder is necessarily caused by a traumatic experience during Service.
- The crux of mental health problems experienced by service personnel and veterans are common mental health disorders such as depression and anxiety and therefore mental health services need to reflect these needs.
- Despite the minority of individuals that do suffer from PTSD, the disorder has a weighty affect on the quality of life for an individual, and therefore, needs early identification, intervention and specialised treatment.
- The causes of mental health issues can be a mixture of pre-Service vulnerabilities, during Service experience and transition/post Service experiences.
- Alcohol misuse/abuse is a growing factor related to mental health illnesses for Service personnel and veterans
- Research has evidenced vulnerable groups to be Reservists and early Service leavers.

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[1] House of Commons Library (2011) *Healthcare for Veterans*
[2] Royal British Legion (2010) *Armed Forces and Veterans Mental Health*

Transition from military to NHS services

When staff leave HM Forces their healthcare transfers from the military to the NHS and they draw upon the same services as the rest of the population, alongside a number of groups that focus specifically on the ex-service community.

The Royal British Legion comment that the transition from military culture and health services to civilian life and NHS services can be a difficult process for some. Problems can range from alcohol misuse, housing and employment to those of health and social care. Early service leavers (those leaving before 4 years service) are particularly vulnerable to mental health risks. Support during the transition is often filled by charities.[3]

Priority access to NHS services

War pensioners have been entitled to priority access to treatment for conditions relating to their service since 1953 and since 2008 this has been extended to all veterans whose medical conditions or injuries were due to military service. Clinicians determine the allocation of priority based on clinical need. The Department of Health considered that the extension of priority to all veterans was likely to have a particular impact on mental health, audiology and orthopaedic services[4].

Mental healthcare services

The NHS Choices website outlines the mental health services currently available to veterans.[5]

For those who leave the Forces with a medical discharge on mental health grounds, a military social worker works with them for up to 12 months to help them access the right NHS services.

Combat Stress and Rethink provide a helpline for veterans with mental health concerns. Combat Stress is the leading UK charity specialising in the care of veterans' mental health.[6] It gives practical support, such as on housing and employment matters and a clinical assessment of mental health needs if necessary. It also has short stay residential facilities offering rest and treatment and community psychiatric nurses who can provide care at home.

Veterans, including reservists, who feel that they have mental health problems relating to their Service can access the Ministry of Defence's national Veterans and Reserves Mental Health Programme which is based in Chilwell. This service is available on GP referral or self-referrals are accepted. The

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[3] Royal British Legion (2010) *Armed Forces and Veterans Mental Health*
[4] House of Commons Library (2011) *Healthcare for Veterans*
[5] NHS Choices website (accessed 18/03/2013) http://www.nhs.uk/Livewell/Militarymedicine/Pages/Veteransmentalhealth.aspx
[6] See Combat Stress (accessed 18/03/2013) www.combatstress.org.uk

Programme provides veterans with a full mental health assessment by a consultant psychiatrist and the results of this assessment along with advice on further treatment and care is passed to the GP and other local health professionals. If the individual is diagnosed with a combat-relate mental health condition outpatient treatment is offered at one of the Ministry of Defence's Departments of Community Mental Health. If acute care is needed there will be liaison to provide access to NHS inpatient treatment. The NHS Choices website reports that approx 100 veterans a year access the Programme.[7]

Combat Stress reports that there is some evidence that veterans are reluctant to seek help from civilian health professionals due to perceptions that they will have a lack of understanding of military life or the context of their injuries. Consequent delays in seeking treatment can make successful treatment more difficult.[8] This is supported by anecdotal evidence received by the Royal British Legion from veterans and military charities that some veterans do not believe that GPs or mental health services can relate to their military culture, language and experiences. In its 2010 report the Royal British Legion conclude that "mental health services need to be structured in such a way as to encourage veteran engagement and equity of access...The integration of care pathways is the only way for a whole person's mental health needs to be truly address."[9] During 2008-11 the Ministry of Defence funded six pilots within the NHS to test out ways of delivering longer term mental healthcare to veterans.[10] More successful features of pilot services included:

- Self-referrals being an option for accessing a service
- Availability of staff who were themselves veterans
- Staff with training and experience of working with veterans
- Availability of group work with other veterans
- Provision of multi-agency 'clinics' with advice on pensions, employment, housing, physical health etc
- Teams/ buildings 'badged' as being for veterans
- Services offering assessment and treatment together with no wait in between
- Joint work and information sharing with other agencies to support one another and prevent duplication
- Routinely accessing Forces' service records of new referrals

Less successful features included:

- Assessment only services leading to treatment in generic NHS settings
- Pathways involving onward referral with a further waiting list at each stage
- Staff who had little or no experience of working with veterans
- Sole practitioner services where this led to discontinuity of service through having nobody in post at times

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[7] NHS Choices website (accessed 18/03/2013) http://www.nhs.uk/Livewell/Militarymedicine/Pages/Veteransmentalhealth.aspx

[8] Combat Stress (accessed 18/03/2013) www.combatstress.org.uk

[9] Royal British Legion (2010) *Armed Forces and Veterans Mental health*

[10] University of Sheffield (2010) *Evaluation of Six Community Mental Health Pilots for Veterans of the Armed Forces*

- Services requiring veterans always to travel long distances for assessment of treatment.

The current Government's mental health strategy, *No Health Without Mental Health,* includes a specific section on mental health services for veterans[11].

Armed Forces Covenant

In May 2011 the Government published the Armed Forces Covenant, which sets out a framework for how the armed forces community can expect to be treated. It includes the following guidance relating to the healthcare of veterans:

> Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in Service, whether physically or mentally, should be cared for in a way which reflects the Nation's moral obligation to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture. [12]

The Government also published an outline of measures it intended to put in place to support that Covenant. This includes proposed measures to improve veterans' access to healthcare services and mental health services in particular.

[11] HM Government (2011) *No Health Without Mental Health*
[12] Ministry of Defence (2011) *Armed Forces Covenant*

COMBAT STRESS

They fight our wars. We fight their battles.

We can help with any of the following issues:

- Feeling down or depressed
- Feeling anxious or stressed out
- Drug and alcohol therapy and support
- On site mental health nurse
- Assistance with the Criminal Justice System
- Priority and emergency housing
- Families / Relationship difficulties
- Debt / Benefits advice
- Advocacy support / Training
- Resettlement advice and support
- Apprenticeships and Employment

For support please contact:

Wayne Kirkham,
Project Manager
Nottinghamshire Ex-Armed Forces & Families Partnership
Nottinghamshire Healthcare NHS Trust
Westminster House
598 The Wells Road
Nottingham
NG3 3AA
Tel: 0115 9560815 / Mobile: 07785 950272
Email: wayne.kirkham@nottshc.nhs.uk

ROYAL NAVY

NH

October 2012

positive

Nottinghamshire Healthcare
NHS Trust

Positive about integrated healthcare

NOTTINGHAMSHIRE EX-ARMED FORCES & FAMILIES PARTNERSHIP

Information for Ex-Armed Forces

Providing a wide range of services for Ex-Armed Forces & their families

5b

Attention Ex-Armed Forces & Families

If you have served in HM Armed Forces, Merchant Navy (including National Servicemen, Regulars or Reserves) this service could be for you.

Some people find the transition from military to civilian life hard, we're here to help you.

To support the Military Covenant, the Department of Health has directed the NHS to prioritise veterans' treatment for service related conditions.

The Veterans and Families Partnership is a collaboration of many key service providers working together to support and assist veterans and their families in a variety of ways.

Individuals may be suffering from any of the following:

- Resettlement into civilian life
- Sleepless Nights
- Low Tolerance / Anger
- Isolation / Depression
- Mental Health and Post Traumatic Stress Disorder (PTSD)
- Increased alcohol use / Drug misuse
- Encounters with the criminal justice system
- Housing / Homelessness issues
- Self harm

The service provides rapid assessment of health and social care needs, priority treatment for service related conditions and works in partnership with other charity organisations that support veterans and their families.

Being a veteran opens the door to a range of help and support from the Ministry of Defence, other government departments and ex-service voluntary and charity groups.

It can take years for a veteran to seek help after becoming unwell, either because of stigma or because they believe that nothing can be done.

Leaving the armed forces brings unique challenges. These can be practical things, like understanding how to manage bills or finding a job. They can also be emotional like dealing with post-traumatic stress or addiction.

If they aren't addressed, these issues can lead to long-term physical and mental health problems.

All of these services are ready to SUPPORT YOU & YOUR FAMILY

Nottinghamshire County Council

SSAFA Forces Help

Rethink Mental Illness.

ABF The Soldiers' Charity

Forces for Their FUTURE

Joint Forces Alliance JFA co-ordinating local services for veterans

framework opening doors to homeless and vulnerable people

Service Personnel & Veterans Agency

Nottingham City Council

Cartwright King Solicitors

mind

East Midlands Reserve Forces and Cadets Association

6

HEALTH SCRUTINY PANEL
28 MARCH 2013
ISSUES FOR HEALTH SCRUTINY ARISING FROM THE FRANCIS INQUIRY
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider issues and implications for health scrutiny arising from the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Inquiry) into care at Stafford Hospital between 2005 and 2008.

2. Action required

2.1 The Panel is asked to consider the findings of the Francis Inquiry insofar as they relate to health scrutiny and determine if any changes to the operation or approach to health scrutiny in Nottingham are required to ensure that it operates as effectively as possible.

3. Background information

3.1 The Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Inquiry) examined the appalling care and serious failings at Stafford Hospital between 2005 and 2008. The number of excess deaths between 2005 and 2008 was estimated at 492 people. Examples of poor care included patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'. The Inquiry looked at the hospital and the roles of the main organisations with an oversight role including the Department of Health, the strategic health authority, the PCT, national regulators, other national organisations, local patient and public involvement and health scrutiny. It made 290 detailed recommendations.

3.2 The report attributes accountability for the appalling care at Stafford Hospital to the Trust Board, but also points to a systemic failure by a range of national and local organisations to respond to concerns. This includes the two local authorities who have both publicly acknowledged that they could have done more.

3.3 The primary means for local authorities to do this is through the use of the health scrutiny powers available to them. Given that the Council

holds these powers there would be a reasonable expectation that if similar problems identified in Stafford were happening in Nottingham (and the report indicates that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS) the Council would be aware and take strong early action. Consequently, the Council needs to ensure that its health scrutiny function operates as effectively as possible and to this end there is potential to learn lessons from the comments and recommendations relating to health scrutiny made in the Francis Inquiry report.

3.4 Chapter 6 of the Francis Inquiry report relates to Patient and Public Involvement and Scrutiny. The inquiry took evidence from councillors and senior officers with responsibility for health scrutiny in Staffordshire and the report goes into some detail in its observations and comments concluding that "the local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust".

3.5 Comments relating to health scrutiny
In its commentary on the role and operation of health scrutiny in Staffordshire the report identifies a number of issues:

3.5.1 Lack of detail in notes of some scrutiny meetings – the report commented "...it is unfair to councillors and obstructive to public involvement and engagement for there to be no record of the contributions made by the committee's members whether by way of observations or questions, and of responses given."

3.5.2 Over-dependency on information from the provider rather than other sources, particularly patients and the public, and the need to be more proactive in seeking information – Councillor Edgeller of Stafford Borough Council's Health Scrutiny Committee accepted the committee "...did not get underneath what the representatives from the hospital were telling it...Chief Executives usually talk up an organisation and put on a positive gloss. If the same happened again, then I would look deeper and ask questions to the people below...e.g. nurses, doctors and consultants."

3.5.3 Questions about expertise of some health scrutiny members – for example the report commented that neither the committee nor the council had the expertise to mount an effective challenge to the Trust's cost cutting proposals, and that there are occasions when lay people need expert assistance in interpreting information. Similarly, scrutiny of the Trust's Foundation Trust application was unchallenging, with Councillor Edgeller accepting that the process was meaningless.

3.5.4 Scrutiny can be better conducted at arms-length rather than as a 'critical friend' – the report suggests that there is a tendency to be deferential towards local trusts and this can make challenging the quality of local health services more difficult.

3.5.5 Lack of resources, particularly in small borough committees

3.5.6 Need for clarity about the role of district and county health scrutiny committees

3.6 Recommendations relating to health scrutiny
The report makes the following recommendations relating directly to overview and scrutiny:

3.6.1 The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'. (Rec 47)

3.6.2 Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality. (Rec 119)

3.6.3 Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees. (Rec 147)

3.6.4 Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks. (Rec 149)

3.6.5 Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action. (Rec 150)

3.6.7 Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch. (Rec 246)

3.7 The government is due to respond to the report and recommendations by the end of March 2013.

3.8 While some of the recommendations would require legislative changes (such as giving scrutiny inspection powers), other issues highlighted in

the report can inform and improve the way in health scrutiny operates in Nottingham immediately.

3.9 The report is also critical of the local Patient and Public Involvement Forum and its successor LINk, and raises concerns about Local Healthwatch in the future. Given that the Council is responsible for appointing and funding a host for Local Healthwatch, the Panel may wish to consider its role in ensuring Local Healthwatch is effective in voicing the concerns of local people.

4. List of attached information

None

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

None

6. Published documents referred to in compiling this report

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013 http://www.midstaffspublicinquiry.com/report

7. Wards affected

Citywide

8. Contact information

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HEALTH SCRUTINY PANEL
28 MARCH 2013
DRAFT WORK PROGRAMME 2013/14
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To give initial consideration to the work programme for 2013/14 to ensure that available resources are used to their full potential to make a positive impact on improving the wellbeing of local communities and people who live and/or work in Nottingham.

2. Action required

2.1 The Panel is asked to give consideration to:

a) the Panel's draft work programme for 2013/14 prior to approval in May; and
b) agree the items for consideration at the Panel's meeting in May.

3. Background information

3.1 The Health Scrutiny Panel has four key roles, to:

(a) undertake the Council's statutory role in scrutinising health services for the City;
(b) engage with and respond to formal and informal NHS consultations;
(c) monitor the Council Executive's statutory responsibility to ensure an effective LINk through commissioning a host organisation (for 2013/14 this will be amended to reflect the cessation of LINk and establishment of Local Healthwatch);
(d) scrutinise local arrangements for the commissioning and delivery of local health services to ensure reduced health inequalities, access to services and the best health outcomes for citizens.

3.2 In setting a programme for scrutiny activity, the Panel should aim for an outcome-focused work programme that has clear priorities and a clear link to its terms of reference as listed in paragraph 3.1 above.

3.3 As it is the responsibility of this Panel to carry out the statutory health scrutiny role (see (a) and (b) in paragraph 3.1 above), the work programme will need to incorporate NHS consultations as they arise. It is important, therefore, that there is the flexibility to incorporate unplanned scrutiny work requested in-year. However, it is acknowledged that, to date, NHS consultations have been primarily considered at the

Joint City and County Health Scrutiny Committee, given its responsibility for scrutinising health services across the conurbation.

3.4 Councillors are reminded of their statutory responsibilities as follows:

While a 'substantial variation or development' of health services is not defined in Regulations, a key feature is that there is a major change to services experienced by patients and future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area.

This Panel has statutory responsibilities in relation to substantial variations and developments in health services. These are to consider the following matters in relation to any substantial variations or developments that impact upon those in receipt of services:

(a) Whether, as a statutory body, the relevant Overview and Scrutiny Committee has been properly consulted within the consultation process;
(b) Whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation;
(c) Whether a proposal for changes is in the interests of the local health service.

Councillors should bear these matters in mind when considering proposals.

3.5 Overview and scrutiny committees are invited to provide information to the Care Quality Commission (CQC) to help the CQC judge how well NHS and Adult Social Care commissioners and providers meet essential standards. Information can be provided at any time throughout the year to be used as part of ongoing checks on services.

3.6 At Appendix 1 is a draft schedule of work and a list of potential topics previously identified by the Panel. The Panel needs to ensure that its work programme has a clear purpose and is focused on improving the wellbeing of local communities and people who live and/ or work in Nottingham. This work programme will be finalised at the first meeting of the municipal year in May.

4. List of attached information

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

Appendix 1 – Health Scrutiny Panel 2013/14 Draft Schedule of Work

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

None

6. **Published documents referred to in compiling this report**

None

7. **Wards affected**

Citywide

8. **Contact information**

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Health Scrutiny Panel 2013/14 – Draft Schedule of Work

May 2013	July 2013	Sept 2013	Nov 2013	Jan 2014	March 2014
CityCare Quality Account Healthwatch Nottingham Integration of health and adult social care Any Qualified Provider (tba)				CityCare Quality Account	

Possible topics for inclusion in the work programme:
Below is listed possible topics previously identified by the Panel. They do not necessarily have to be scheduled in the 2013/14 work programme – the Panel may wish to add, amend or delete from this list. Additional topics may be identified from, for example discussions with Healthwatch Nottingham; issues raised by ward councillors. All topics should have a clear purpose and potential to make a positive impact on improving the wellbeing of local communities and people who live and/or work in Nottingham.

Additional issues for possible inclusion on the work programme are currently being identified and will be reported to the first meeting of the municipal year when the Panel will agree its 2013/14 work programme.

i	Nottingham CityCare Partnership Quality Account 2012/13 (May) To consider the draft Quality Account and whether to make a statement for inclusion
ii	Nottingham CityCare Partnership Quality Account 2013/14 (suggest January and May 2014) To consider the draft Quality Account and whether to make a statement for inclusion
iii	Healthwatch Nottingham (suggest May 2013) To: a) discuss how health scrutiny and Healthwatch Nottingham can work together effectively b) identify issues for inclusion on the scrutiny work programme
iv	Integration of health and adult social care (suggest May 2013) To hear about the progress of the Integrated Care Programme for adults
v	Any Qualified Provider *In November requested an update in May 2013 – the Panel needs to identify a focus for this*
vi	Access to counselling services for young people

vii	Services for those suffering from self harm
viii	Services for blind and partially sighted citizens

Consultations on substantial developments or variations in health services will be scheduled as required.

The Panel will also want to consider its ongoing engagement with:

- Health and Wellbeing Board
- Healthwatch Nottingham