NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY PANEL

Date: Wednesday, 30 July 2014

Time: 1.30 pm (pre-meeting for all Panel members at 1pm)

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Acting Corporate Director for Resources

Overview and Scrutiny Co-ordinator: Jane Garrard **Direct Dial:** 0115 8764315

AGENDA **Pages**

IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE OVERVIEW AND SCRUTINY CO-ORDINATOR SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

CITIZENS ATTENDING MEETINGS ARE ASKED TO ARRIVE AT LEAST 15 MINUTES BEFORE THE START OF THE MEETING TO BE ISSUED WITH VISITOR BADGES

NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 28 May 2014 from 13.30 - 15.35

Membership

Present	Absent
Councillor Thulani Molife (Vice Chair)	Councillor Ginny Klein (Chair)
Councillor Mohammad Aslam	Councillor Brian Parbutt
Councillor Azad Choudhry	Councillor Timothy Spencer
Councillor Eileen Morley	Councillor Emma Dewinton
Councillor Anne Peach	

Colleagues, partners and others in attendance:

Martin Gawith Ruth Rigby	)	Healthwatch Nottingham
Maria Principe Naomi Robinson Jo Williams	)	NHS Nottingham City Clinical Commissioning Group
Rosemary Galbraith	-	Nottingham CityCare Partnership
Jane Garrard	-	Overview and Scrutiny Coordinator
Angelika Kaufhold	-	Overview and Scrutiny Coordinator

1 APPOINTMENT OF VICE-CHAIR

Councillor Thulani Molife was appointed Vice-Chair for this municipal year.

2 APPOINTMENT OF LEAD HEALTH SCRUTINY COUNCILLOR

Councillor Ginny Klein is appointed as Lead Health Scrutiny Councillor

3 APOLOGIES FOR ABSENCE

Councillor Emma Dewinton - Personal
Councillor Ginny Klein – Annual Leave
Councillor Brian Parbutt
Councillor Tim Spencer

4 DECLARATIONS OF INTERESTS

None

5 MINUTES

The minutes of the last meeting held on 12 February 2014 were confirmed and signed by the Chair.

6 HEALTH SCRUTINY PANEL TERMS OF REFERENCE

The Committee considered a report of the Head of Democratic Services regarding the Health Scrutiny Panel Terms of Reference for the Panel and the implications for its operation during the coming year which had been approved at Full Council on 12 May 2014.

RESOLVED to note the Terms of Reference.

7 WALK IN CENTRES

The Panel considered a report updating the progress of the re-modelling of the Walk-in Centres (WIC) in Nottingham and development of a new enhanced Urgent Care Centre from a single site. A joint presentation was made by Maria Principe, Director of Primary Care Development and Service Integration and Naomi Robinson, Primary Care Development and Service Integration Manager. The key points of the presentation included:

(a) A reminder that the reason for this consultation is the contracts for both the Walk in Centre on London Road and the 8-8 Service on Upper Parliament Street are due to end in 2014/15. Due to the complexity of the issues surrounding the two locations and clinical governance issues, it was decided that an open and transparent procurement method was appropriate.

(b) Since February 2014 a period of consultation has taken place including the Clinical Congress, Clinical Council, Councillor Norris as part of his remit of the Chair of the Health and Wellbeing Board, the People's Council and the Health Scrutiny Panel on 26 March 2014. Other engagement activities with providers, patients and clinicians have been facilitated by the Patient Engagement and Communication teams to explore:

- What an Urgent Care Model should include?
- Define what is meant by good access and opening times
- What the new service could be called

(c) The Feedback received from clinicians, providers and the public through roadshow events. The online survey sent to all GP practices, 3rd Sector Organisations, patient groups and employers received almost 700 responses. The feedback from all the consultation included:

- It is important to assess and treat patients in one visit, reducing the need to refer to other services.
- The opening hours should be consistent.

- Having diagnostic facilities such as X-ray, a plaster room and eye casualty is essential to treat in a single visit and reduce the need to refer non-urgent cases elsewhere.
- The service should be open 7 days a week all year round from 7 or 8 am to 10 or 11 pm and the walk-in no appointment necessary philosophy is important. The idea of 24 hour care created resourcing issues in terms of costs etc.
- The location should be city centre, close to pharmacy provision with parking and public transport, as well as access for drop off/ambulance transfer being critical.
- A strong need for access to urgent dental appointments.
- Survey results showed that 33% of respondents had difficulty accessing primary care services which is why they chose to use the WIC.
- Over 50% of patients stated that assessment should be within 15 minutes to 1 hour, with treatment taking place within 2 hours. 27% recognised the importance of carrying out triage to assess the level of urgency.
- A strong mental health support was also identified by a patient group.

(d) The next steps are:

- To ensure publicity is clear, focused and clarifies the services provided by the new Urgent Care Centre and how this integrates with other healthcare provision services.

- Additional patient/public meetings (on request) for focused discussion and presentation of the urgent care model, especially for those who access emergency services frequently, regular users of walk-in centres and those who had difficulty accessing primary care (GP etc) services such as citizens who are not registered with a GP practice, homeless people and asylum seekers etc.

- The patient engagement report will be finalised and include feedback from surveys, road shows and patient engagement, and will be presented to the CCG governing body and published on the Clinical Commissioning Group website.

- A contract specification will be drafted including the clinical requirements, treatments and diagnostics required for the new service. In June 2014, a Procurement Delivery Group will be established with non-conflicted colleagues including Healthwatch and Patient Groups to review and finalise the specification, challenges and risks.

- The tendering process will start in June with shortlisting of potential providers taking place in July 2014. The procurement panel will include clinical and patient representatives.

- Patients will continue to be involved by:
  - The Procurement Delivery Group will include patient representatives;
  - Focused meetings to take place with patient groups as recommended by the Patient Engagement Report and through discussion with the CCG People's Council and Healthwatch.

- Engagement with help from Healthwatch, for patients not registered with GPs such as homeless, asylum seekers who currently represent 16 to 17% of WIC/8-8 attendees.
- Publicity planning to communicate the changes with a tailored approach to key patient groups. A 'readership panel' will help guide the development of publicity.

During discussion the following additional information was provided:

(e) The majority of the patients accessing the WIC are registered with a GP however, the consultation has showed that a walk in service is still needed for hard to reach groups such as homeless people and asylum seekers etc to access medical care. Further consultation is being carried out with hard to reach groups and Healthwatch are linking in with the CCG to continue consultation for the next two to three weeks;

(f) The option of locating the WIC with the Emergency Department at the hospital was considered but from the consultation it is clear that a city centre location is preferred for accessibility.

(g) The proposal to review the existing contracts and services provided and to locate the current WIC and 8-8 service into a single site is to release funding to expand the services available including diagnostics and X-ray facilities etc. It is not a cost-cutting exercise. All the diagnostic services will be developed over a period of time once the contract has been awarded and staffing is in place.

(h) The new site will be dependent on accommodation availability and it will be a challenge to find a place which is easily accessible for clients using cars and public transport.

RESOLVED to request that a further update on progress, including the service specification for the new contract be submitted to this Panel once available.

8 NOTTINGHAM CITYCARE PARTNERSHIP QUALITY ACCOUNT 2013/14

The Panel considered a report of the Head of Democratic Services relating to the Nottingham Citycare Partnership Quality Account 2013/14. Rosemary Galbraith introduced the Quality Account and confirmed that feedback is welcome. This Quality Account had to be submitted to the Board mid June for sign off before publication on the internet.

During discussion the following additional information was provided in response to questions:

(a) To increase the level of risk assessments and preventative action to reduce pressure sores, the National Pressure Sore Prevention Strategy is being implemented across all services. Care homes are also required to train staff to carry out risk assessments on residents for pressure sores.

(b) Not all the CQUIN targets have been met and some of these targets such as dementia care are considered to be very ambitious stretched targets. There can be many reasons why targets are missed which include competing priorities and the reasons for missing these will be explored as the year progresses. The CQUIN targets are agreed with commissioners and if missed the organisation will not receive the associated payment.

(c) In response to the Francis Report, the organisation has carried out whole workforce restructuring and provided training for front line staff to keep in line with national staffing guidance. The Board Assurance Framework and Risk Registers are uptodate and data on incident reporting is essential for training purposes, case conferences and serious case reviews.

(d) Part of the Francis Report recommendations is to encourage more open, transparent reporting of risks and incidents and the monitoring levels are low, severe and significant. There is an increase in the number of low level risks being reported and the learning from these is embedded into service development and staff training. One example is staff ensuring that insulin is given at the right time and that triggers are in place to ensure this happens. Serious Incident Reporting guides help staff through the grading and seriousness of events and how to report these.

(e) Complaints relating to waiting times for clinics need to be explored and could be the result of increased access choice, staff shortages or specialists. There has to be a flexible approach and appointments may need to be rearranged if patients arrive within ten minutes of a clinic closing.

(f) The review process to evaluate the CQUIN outcomes includes:

- Exploring action plans and early exception reports;
- Reflecting on what has worked well and sharing this information;
- Reviewing systems and data entry reports on performance and analysis;
- Holding regular meetings with service leads to review reports and progress on targets to ensure they are achievable;
- Share good practice at team and management events and training.

(g) Diet and nutrition are a large part of the Health and Wellbeing agenda and aids recovery when people are ill. Teams need to be vigilant to monitor eating and drinking by patients (including in the care home environment) and CityCare has a dedicated Dietician team to support this. Diet is included as part of patient assessment and has become more complex given the increasing number of allergies that patients present with. CityCare has embedded this into patient care programmes to ensure they receive the right care in terms of nutrition and fluid intake.

(h) Training on dementia care has started and is being rolled out to increase awareness amongst staff.

RESOLVED that Jane Garrard, Overview and Scrutiny Co-ordinator, draft a comment based on the issues identified for inclusion and circulate to the Panel by email for comment prior to final approval by the Chair.

9 ADULT INTEGRATED CARE PROGRAMME

The Panel considered a report of the Head of Democratic Services and joint presentation by Maria Principe, Director of Primary Care Development and Service Integration and Jo Williams, Adult Integrated Care Programme Manager relating to the progress of Adult Integrated Care Programme established in July 2012. In May 2013, the Panel heard that an integrated care model was being developed based around 8 Care Delivery Groups (CDGs) across the City comprising of GP Practices and multi-disciplinary neighbourhood teams of health and social care staff. This model took a new approach to assessment and re-ablement and use of assistive technology. The intention was for this model to be implemented by January 2014. This is a priority in the Joint Health and Wellbeing Strategy to 'improve the experience of and access to health and social care services for citizens who are elderly or who have long-term conditions'. Progress against this theme is due to be reported to the next meeting of the Health and Wellbeing Board in June 2014.

The structure for the integration of the Adult Care Programme is now in place and the next phase is to change the culture and practice. The developments in Phase 2 include:

- Review of specialist services;
- Joint assessment and care planning;
- Developing links with community and voluntary sector to support self care and on-going support.

The following additional information was provided in response to questions:

(a) As part of the project teams have visited other areas of the country to explore how other organisations are integrating these services as well as this project being part of the East of England Kings Fund Network which shares good practice. This project is quite advanced compared to other parts of the country and has involved developing a whole systems model including links and pathways to other services. The project team is receiving requests from other areas to come and see the model developed in Nottingham.

(b) Patients might see many different specialists or support workers at present providing a range of services. The proposal is to move away from having lots of 'specialists' carrying out very specific roles and move to having more 'generalists' who can be upskilled and provide core business such as carrying out assessments for falls when visiting clients. However, this project is in its very early stages and staff have to be engaged and encouraged to develop in this more 'generalist' holistic service delivery. The impact of asking staff to become more 'generalists' than specialists cannot be underestimated and will impact on culture and training. It is acknowledged that people will be proud of the specialisms they have built up and they will need to be supported in expanding their roles. Individuals have been trained as Change Champions

across Health and Social Care to support staff to adapt and this is proving to be a valuable resource.

(c) Feedback will be collected from focus groups of service users to evaluate their experiences of the new integrated service which will be available by the end of this year. An external evaluation of the project is also taking place.

(d) Evaluation of patients experience and satisfaction will be part on an ongoing monitoring process and included in contract management. An interim report by the evaluation team is expected in autumn 2014.

(e) A communication plan is in place with regular 'Connecting Care' newsletters informing stakeholders of developments and now plans are being made for an external communications campaign.

RESOLVED to request that findings of the initial evaluation of the Adult Integrated Care Programme be provided to the Panel when available.

10 NOTTINGHAM CITY HEALTH AND WELLBEING BOARD, HEALTHWATCH NOTTINGHAM AND HEALTH SCRUTINY WORKING AGREEMENT

The Panel considered a report of the Head of Democratic Services relating to a working agreement for the Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny.

RESOLVED

(1) to approve the Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny Working Agreement;

(2) that delegated authority is given to the Health Scrutiny Panel Chair to approve minor changes and updates to the Agreement.

11 GP PRACTICE CHANGE - THE PRACTICE, NIRMALA

The Panel considered a report of the Head of Democratic Services highlighting that NHS England Derbyshire and Nottinghamshire Team has advised of changes to a GP practice in Nottingham – The Practice Nirmala in Bulwell. A six month termination notice has been given to the Area Team by The Practice Nirmala stating they wish to terminate the contract. It had been decided to disperse the registered patient list to other practices when the contract expires following a full Stakeholder Engagement Plan to ensure all stakeholders are kept fully informed and patients supported in finding a new practice.

RESOLVED to

(1) note the information provided and that this information has been circulated to ward councillors in the areas affected; and

(2) inform the NHS England Derbyshire and Nottinghamshire Area Team of the correct names of the local MP and City Councillors.

12 GP PRACTICE CHANGE - MERGER OF BOULEVARD MEDICAL CENTRE AND BEECHDALE SURGERY

The Panel considered a report of the Head of Democratic Services highlighting that that NHS England Derbyshire and Nottinghamshire Area Team had advised of proposals for a merger between the Boulevard Medical Centre and Beechdale Surgery. The briefing provided by the Area Team included proposals for engaging with stakeholders about the proposed change.

RESOLVED to note the information provided and that the information had been circulated to ward councillors in the areas affected.

13 WORK PROGRAMME 2014/15

The Panel considered a report of the Head of Democratic Services relating to the work programme for the Health Scrutiny Panel for 2014/15.

RESOLVED to amend the work programme to include the following items:

- **Update on progress in developing an Urgent Care Centre including the service specification**
- **Findings of the initial evaluation of the Adult Integrated Care Programme**

14 FUTURE MEETING DATES

RESOLVED to meet on the following Wednesdays at 1.30 pm:

2014	**2015**
30 July	**28 January**
24 September	**25 March**
26 November	

HEALTH SCRUTINY PANEL
30 JULY 2014
INTEGRATION OF PUBLIC HEALTH WITHIN NOTTINGHAM CITY COUNCIL ONE YEAR ON
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To review how well the public health function has integrated into the Council since its transfer on 1 April 2013 and future work to maximise the potential of integration.

2. Action required

2.1 The Panel is asked to use the information provided to inform questioning and discussion about the integration of the public health function; and identify if any further scrutiny is required.

3. Background information

3.1 The Health and Social Care Act 2012 transferred public health responsibilities to local authorities. Throughout 2012/13 the Panel monitored the transition process, and responsibility for public health formally transferred on 1 April 2013. This represented a significant change both for local authorities and for the public health function, which had previously been located within primary care trusts.

3.2 The Council's public health responsibilities have now been in place for over 12 months and this provides an opportunity for councillors to consider how the function has integrated into the Council; allocation of the ring-fenced Public Health Grant; and current issues and future plans for public health in Nottingham.

3.3 The Director of Public Health has prepared a paper on the public health function in Nottingham which is attached to this report, and will be attending the meeting along with the Portfolio Holder for Adults, Commissioning and Health to discuss this with the Panel and answer questions.

4. List of attached information

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

Appendix 1 – Report of the Director of Public Health including:

1. Public Health Function within Nottingham City November 2012 – March 2014
2. Department of Health October 2013 'Directors of Public Health in Local Government: Roles, Responsibilities and Context'
3. Public Health England 'Nottingham Health Profile 2014'

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

None

6. Published documents referred to in compiling this report

Reports to and minutes of meetings of the Health Scrutiny Panel held on 23 May 2012, 25 July 2012, 29 November 2012, 29 January 2013 and 28 March 2013.

7. Wards affected

All

8. Contact information

Jane Garrard, Overview and Scrutiny Review Co-ordinator
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Email: jane.garrard@nottinghamcity.gov.uk

Report for the Health Scrutiny Committee
Nottingham City Council
30 July 2014

Public Health function within
Nottingham City
Nov 2012 – March 2014

1. Report Purpose

This report summarises the progress made by the new Public Health (PH) function within Nottingham City between November 2012 and March 2014.

2. Background

The current PH function in Nottingham City started on 1 November 2012, when the Director of Public Health (DPH) for Nottinghamshire County was asked to take on the DPH role for Nottingham City. Since then, the working arrangements between the city and county teams have much improved, with a much more efficient deployment of staff across important PH areas. This has coincided with a move to integrate the PH teams within the city council, and ensure the PH grant is used as effectively as possible

A summary of the main changes to the NHS and the incorporation of the PH function within local authorities can be found in Appendix A.

Also a summary of the role of the Director of Public Health can be found in Appendix B.

3. Key issues for the Public health function

a) ***Ensure a robust assessment of population health need.*** This is an ongoing process but a summary of the key health needs for Nottingham City is enclosed in Appendix C. The main points are:

I. Health in summary

II. The health of people in Nottingham is generally worse than the England average. Deprivation is higher than average and about 35.2% (19,100) children live in poverty.

III. Life expectancy for both men and women is lower than the England average.

IV. Living longer

V. Life expectancy is 9.2 years lower for men and 8.7 years lower for women in the most deprived areas of Nottingham than in the least deprived areas.

VI. Child health

VII. In Year 6, 21.7% (536) of children are classified as obese, worse than the average for England.

VIII. The rate of alcohol-specific hospital stays among those under18 was 32.1*, better than the average for England. This represents 20 stays per year.

IX. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

X. Adult health

XI. In 2012, 21.7% of adults are classified as obese.

XII. The rate of alcohol related harm hospital stays was 878*, worse than the average for England. This represents 2,205 stays per year.

XIII. The rate of self-harm hospital stays was 204.2*, worse than the average for England. This represents 703 stays per year.

XIV. The rate of smoking related deaths was 358*, worse than the average for England. This represents 422 deaths per year. Estimated levels of adult smoking are worse than the England average.

XV. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are worse than average.

*per 100,000 population

b) ***Transition of staff into the local authority***. This occurred on 1 April 2013. Further work is needed on developing the PH workforce. This is currently ongoing. A number of key elements of this process include:

I. **Reducing duplication wherever possible** in responsibilities between Consultants in the County and City

II. Ensuring the **senior PH teams** across both organisations act as strategic leaders for all the different PH areas

III. Ensuring that elected members receive timely and professional advice about use of the **PH ring fenced grant**, including developing plans to ensure the grant is spent in ways which maximise the opportunities for investment to promote the health and wellbeing of the population

c) Ensure continued understanding of the PH function by **elected members and officers** within the council; this would involve further briefings seminars etc. One of the issues to emphasise is the integration of the PH Consultants across the different directorates of the organisation to act as key link staff members as follows:

City	Development	Jo Copping
	Communities	Alison Challenger
	Resources	TBC
	Children and Adults	Lynne McNiven
		Jo Copping

d) Development and implementation of the **PH business plan** from April 2014 and integration of it into the council's strategic plans. This work is currently ongoing but an important part of the integration process. Part of this process will include developing more radical proposals in relation to Tobacco and Obesity, public health enemies numbers one and two. It is proposed that there is a **full council debate** on these two topics during 2014, both to raise the issues with elected members but also with the public. These could coincide the publication of the DPH Annual Report planned for Sept/Oct 2014.

e) Lead the process for identifying **efficiencies within the PH budget in 20015/16, 20016/17 and 20017/18**, and the **realignment** of this resource within the overall city council's expenditure plans (please see Appendix D for more details).

f) Continue to ensure a strong **PH function within the CCG** and review the Memorandum of Understanding (MOU) to continue from March 2014. This review has been done with any changes being implemented from now onwards.

g) Continue to support and develop the **Health and Wellbeing Board** to ensure they are robust and fit for purpose. Again this work is ongoing with a PH paper presented to each meeting whenever possible. A particular focus needs to be the translation of the strategic plans into action plans, as part of the routine council business.

h) Ensure the safe transfer of the **Commissioning responsibility for Health visiting and the Family Nurse partnership**, from NHS England to the local authority from October 2015. This will enable a greater degree of flexibility in the use of overall resources for children and young people, including resources for school nursing, health schools, children's centres etc

11 Summary

This report has summarised the progress made by the new Public Health (PH) function across Nottingham City in the first year of its operation between November 2012 and March 2014, and has made recommendations for further development and integration of the PH function in the future.

Chris Kenny
Director of Public Health
Nottinghamshire County and Nottingham City
July 2014

Appendix A – summary of key changes to the NHS and incorporation of the PH function within local authorities during 2013/14

1 Changes to the NHS

The Health and Social Care Act 2012 laid down the legal framework for a number of changes within the NHS:

- Abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs)
- Creation of Clinical Commissioning Groups (CCGs)
- Creation of NHS England (NHSE)
- Creation of Public Health England (PHE)
- Responsibility for health and wellbeing, including the public health function, moving to unitary and upper tier local authorities
- Creation of Health and Wellbeing Boards (HWBBs) to develop and oversee the local health and wellbeing agenda

2 Summary of the PH function

Locally the PH staff are currently leading the PH agenda under 3 headings:

- **Health improvement**, including a number of PH policy areas such as tobacco, obesity, substance misuse, sexual health, children's health age 5-19, oral health, mental health, workplace health, health inequalities
- **Health protection**, including community infection control, screening, vaccination and immunisation programmes, health emergency planning
- **Health services**, including giving PH advice and support to the CCG to ensure services are commissioned based on population need

3 PH ring fenced grant

In addition, Nottingham City Council has received a PH grant to commission services to help achieve outcomes within the new PH outcomes framework (see below). This expenditure includes:

- PH staff including pay and non pay
- Priority areas (PH support to local NHS commissioners, health emergency planning, health checks, child measurement programme, sexual health)
- Other areas (eg tobacco, obesity, drug or alcohol misuse, school nursing, oral health, cancer prevention, community safety)

For Nottingham City the figures are £27.1m in 2013/14 rising to £27.9m in 2014/15. There is no confirmation that the grant will remain ring fenced beyond 2015/16. The proportion of the grant spent on different items is as follows:

Drug and alcohol services	35%
Sexual Health	20%
School nursing	7%
Tobacco	7%
Obesity	7%
Health checks	2%
PH leadership / support for CCGs	10%
Other	12%

4 Public Health Outcomes Frameworks

The performance of the new health and wellbeing system will be measured through a new Public Health Outcomes Framework (PHOF). This is one of a suite of frameworks[1] through which the Government intends to ensure accountability and transparency.

[1] Public Health Outcomes Framework 2013-16, Adult Social Care Outcomes Framework 2013/14 and NHS Outcomes Framework 2013/14.

Councils and Health and Wellbeing Boards will be expected to improve their performance against the measures in the PHOF through addressing the health needs of their local population. These are set out in the Joint Strategic Needs Assessment (JSNA) then prioritised and tackled through their Health and Wellbeing Strategy. While local authorities are expected to drive improvements themselves, the Government intends to link performance on some elements of the PHOF and the Health Premium. Only limited information on the Health Premium has been released, so it is not exactly clear how this would work. The premium is not expected to begin until at least April 2015.

5 Key points regarding the local PH function

a) 2 PH Departments 1 Director of Public health

The 2 PH departments across Nottinghamshire County and Nottingham City are managed separately, but by the same joint DPH, and they now work much more closely together. In particular:

- There are now a number of managerial responsibilities which span the 2 departments (eg health emergency planning) and working arrangements are now much more efficient within the PH senior team.
- "Public Health Nottingham City" is now routine to describe the way in which the PH function is available locally, not only to the local authority but also to the CCG, and other local stakeholders.
- There have been 3 meetings of all the PH staff. December 2012, July 2013, and December 2013, all of which have focused on team development, integration within the local authority, and use of the PH grant.

b) Other key aspects include:

- **Communication** – both PH teams now have a single PH communications service hosted by Nottinghamshire County Council but jointly funded by the City and County PH grants; this allows both organisations to half their financial contribution to this issue but still have a very strong cohesive communications service
- **PH Information teams** – these are working together to ensure an efficient use of PH analyst time and expertise
- **Matrix working** has become the norm, with flexible line management arrangements to ensure efficient deployment of specialist skilled staff.
- Work has also taken place to harmonise titles of staff. All general PH staff on A4C Bands 5-7 are **Public Health Managers**, and most of those on Bands 8abc are **Senior Public Health Managers**. All staff directly accountable to the Director of Public Health (DPH) in the City are a Consultant in PH.

c) Integration within LA structures

This is progressing well. Key points include:

- Consultants have been allocated to different corporate directorates to try and ensure PH skills are used to best effect within the council as a whole.
- PH outcomes are slowly being incorporated into the council's strategic plans
- Support functions such as finance Information Technology (IT) and Human Resources (HR) have been very helpful in the integration process
- The interface with procurement is crucial and progressing well generally; more joint working between procurement teams across county and city is needed to really see the benefits of joint PH working
- PH teams are integral to developing plans for the council to achieve financial balance over the next 3 years

- Engagement with elected members is improving all the time; in the City portfolio holder briefings are working well.

d) Nottingham City specific developments:

- Commissioning staff – now fully integrated with the Early Intervention (EI) teams within Nottingham City Council; however, there are still commissioning staff within the Crime and Disorder Partnership (CDP) who procure drug and alcohol services on behalf of the DPH, who would be better sited within the EI team too, to ensure maximum efficiency in the use of the PH Grant
- Business support – secretarial staff are now fully embedded within the business support infrastructure of the council
- Health promotion team – this is no longer a separate team and staff are integrated within the main PH teams
- Knowledge and Resources team – options are currently being actively pursued as to how to integrate this function into the mainstream city council knowledge management services

e) Resources

The whole of both PH teams across the county and city are committed to becoming as efficient as possible, and to contributing to the corporate financial needs of both organisations. Key points include:

- In the city, efficiencies within the staff budget will yield about £300k savings in 2014/15; in addition staff are working towards achieving savings of £8m over the 4 years 2013/14 – 2016/17 as part of the councils financial recovery plans
- Although PH staff will work in a flexible way for the benefit of both organisations, the PH grant will remain separate and different allocations to PH services will be made reflecting the separate statutory status of each organisation
- A significant part of the PH grant is being realigned against a variety of council priority areas; please see Appendix D for details

6 Health and Wellbeing Board

This has now been in existence for a couple of years although only in a statutory form since April 2013. It is extensively supported by the PH team, and will continue to do so, to ensure a well functioning Board into the future.

7 Memorandum of Understanding (MOU) with NHS Nottingham City Clinical Commissioning Groups (CCG)

Support for local NHS commissioners is a mandatory PH function to be provided by the local authority. This has been in place since April 2013, and is working well. The process was reviewed in March 2014, with some minor revisions coming into effect from April 2014.

8 Business Plan

The PH business plan is used to guide the work of the department. It is being integrated into the mainstream LA business plan as part of the overall integration process.

9 Director of Public Health (DPH) role

The latest guidance on the roles and responsibilities for Directors of Public Health has recently been issued by the Department of Health (DH) and is included as Appendix B. Locally the DPH has been appointed as a Chief Officer within Nottinghamshire County Council, and there is a contract with Nottingham City Council to provide a DPH role there. In the City although not a member of staff, the DPH has been given equivalent powers and responsibilities of a corporate director. He is currently attending both county and city corporate leadership teams (CLTs) on

a Tuesday morning. As far as possible, he is trying to ensure the various policy groups that he chairs are either joint ones (eg Health Protection, Local Health Resilience Partnership, sexual health steering group) or ones that are about to become joint. He is providing a DPH service to both authorities for 5 days per week ie there is no artificial 2/3 day split.

Appendix B – Department of Health Guidance on the role of the Director of Public Health October 2013

Please see separate Department of Health Document

Appendix D
PH Grant realignment 2014/15

Introduction
From April 2013 the statutory duties of upper tier local authorities have included improving the health of their populations as defined within the Health and Social Care Act 2012. Upper tier local authorities have been allocated an annual public health grant to help discharge these duties. The mandatory areas of public health spend are sexual health: contraception/STI testing and treatment, NHS Health Check Programme, Health Protection, National Child Measurement Programme and Public Health Advice.

Local Authorities have discretion to spend their public health grant on other activities to improve the health and wellbeing, reducing health inequalities and restoring or protecting health of their population. This should be informed by the priorities set out in the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and other local strategies. This can include action to tackle the wider determinants of health as set out in the Public Health Outcomes Framework.

Nottingham City Public Health Grant Expenditure
The Public Health Grant for Nottingham City Council is £27.1m in 2013/14 and £27.8m in 2014/15. The City Council has undertaken a strategic review of the inherited public health expenditure in 2013/14. This has reviewed the distribution of the inherited expenditure, the contribution of City Council services and functions to the Public Health Outcomes Framework; and where public health grant expenditure should be invested in city council services for the greatest health impact.

From 2014/15 the City Council aims to have reinvested £5.3M of the public health grant into existing council funded services. This will release £5.3M from the city council's services to contribute to the council's corporate savings programme. An additional, £1.59m additional reinvestment is planned by 2016/17.

The budgeted expenditure for 2014/15 is outlined below. Further detail of the planned reinvestment is in appendix 2.

Planned Public Health Expenditure 2014/15

PUBLIC HEALTH	**2014/15 £m**
Staff & Non Pay Costs	2.564
Nutrition, Physical Activity and obesity	2.674
Prevention & Early Intervention	3.329
Tobacco Control & Stop Smoking	1.342
Sexual Health	4.625
Drugs & Alcohol	9.628
Children 5-19/School Health	3.548
TOTAL	**27.71**

Appendix 1 – Proposed Saving by Public Health Priority

Public Health Priority	2014/15 £m	Where and how proposed saving are being made
Savings brought forward from 2013/14	(1.722)	
Staffing Efficiencies	(0.200)	Disestablished Posts.
Nutrition & Physical Activity	(0.444)	Efficiencies in Public Health Nutrition contract Efficiencies in men's weight management contract Decommissioning of child weight management to reinvestment proportion in new school health model Efficiencies in Breastfeeding Peer Support contract Decommissioning adult cycle training and funding through non-recurrent monies Decommissioning of Active Families Programme Efficiencies in adult physical activity referral contract
Prevention, Early Intervention and Infection control	(0.677)	Efficiencies in dental health contract Efficiencies in NHS Healthcheck IT software Efficiencies in Domestic Violence Nurse Specialist Decommissioning of Third Sector Health and Wellbeing Forum support Efficiencies in infection control
Tobacco Control & Stop Smoking Services	(0.287)	Efficiencies in stop smoking contract Decommissioning of smoke free homes Decommissioning of Young Peoples Peer mentoring Decommissioning of stop smoking enhanced service in pharmacies
Sexual Health Services	(0.787)	Decommissioning sexual health health promotion Efficiencies in CASH and Chlamydia screening office contract Ending TSC: CQUIN
Drugs & Alcohol	(1.140)	
Children 5-19/School Health	(0.043)	Efficiencies in School Health contract
TOTAL	**(5.300)**	

Appendix 2 – Proposed reinvestment into council services

Process

- Council services that contribute to the Public Health Outcomes Framework Indicators and are funded by the council recurrently were identified.
- These services were assessed against a public health prioritisation framework.
- Funding has been proposed towards services assessed as having the greatest potential public health contribution.
- The proposals have had extensive discussion with council Directors.
- Agreements are in place between Public Health and council Directorates to ensure that the funding enables a greater emphasis on health improvement and health inequalities within the council.

Service Proposed for a contribution from the Public Health grant

Service Name	Service Description	Public Health Service Categorisation	PHOF indicator service contributes to	Local Strategy
Befriending Service – Family Befriending	Provides parenting information, engagement and support to families with additional needs in relation to their parenting.	Children 5-19	1.4 First time entrants to youth justice system 2.23 Self reported well-being	Health and Wellbeing Strategy-Priority Families Nottingham Plan - antisocial behaviour
Education Link Workers	Education Link Workers within Compass Young People's Drug Service who to follow up drug incidents in schools and providing support to the young people.	Substance misuse (Youth Services)	2.15 Successful completion of drug treatment	Children's Plan
Teenage Pregnancy and Early Intervention Specialist	Coordination of the Teenage Pregnancy and Aspirations strategy and action plan.	Sexual Health (advice prevention and promotion) Children 5-19	2.4 Under 18 conceptions 3.4 Chlamydia diagnosis	Nottingham Plan-teenage conceptions
Healthy Schools: SRE post	Provides Sexual Health and relationship support to schools as part of the local Healthy Schools Programmes	Sexual Health (advice prevention and promotion) Children 5-19	2.4 Under 18 conceptions 3.4 Chlamydia diagnosis	Nottingham Plan-teenage conceptions

Drug Aware Healthy Schools Team	Drug awareness work in schools	Substance misuse (Drug Misuse)	2.15 Successful completion of drug treatment	Children's Plan
18 Children's Centres	Health improvement and wellbeing support and intervention to children and families.	Children 5-19	2.1 Low birth weight of term babies 2.2 Breastfeeding 2.3 Smoking status at time of delivery 2.5 Child development at 2-2.5 years	Nottingham Plan - Early years Child development
Youth and Play Services	Provision of play services to children and youth engagement	Children 5-19	1.4 First Time Entrants to the Youth Justice System	Nottingham Plan - child obesity antisocial behaviour
Independent Living Support Service	To provide housing related support to vulnerable people at risk of homelessness - this includes those just exiting homelessness	Miscellaneous (Social Exclusion)	1.15 Statutory homelessness	Vulnerable Adults Plan
Physical Activity, Sport and PE Strategy Manager	Coordination of a programme of school physical activity across the city	Physical Activity	2.4 Excess weight in 4-5 & 10-11 year olds	Nottingham Plan - child obesity
Outdoor and Adventurous Activities	Provision of outdoor and adventurous activities to children and young people	Physical Activity	2.4 Excess weight in 4-5 & 10-11 year olds	Nottingham Plan - child obesity
Health and Wellbeing Team	Health & Wellbeing Manager	Public Health Structure Costs		
Asylum Seeker Officer	Work with families in relation to finding funding and relevant support.	Miscellaneous (Social Exclusion)	1.18 social isolation	Vulnerable Adults Plan

Trading Standards Tobacco and Alcohol enforcement	Work to tackle the provision of illicit and counterfeit alcohol & tobacco and underage sales .	TobaccoSubstance misuse (alcohol)	2.9. Smoking prevalence – 15 year olds 2.14 Smoking prevalence – adults (over 18s)2.18 Alcohol-related admissions to hospital	Nottingham Plan Tobacco and Alcohol
Sports Development Team	Work to increase participation in sport and active recreation with different groups	Obesity Physical Activity	2.6 Excess weight in 4-5 year olds 2.12 Excess weight in adults 2.13 Proportion of physically active and inactive adults	Nottingham Plan Child obesity, Adult obesity, Physical Activity
Books on Prescription	Scheme delivered with the NHS and is aimed at people with anxiety and depression and builds on best practice - combining expert endorsed self-help reading and health information alongside mood-boosting creative material recommended by readers.	Miscellaneous (Public mental health)	2.23 Self Reporting Wellbeing	Nottingham Plan - mental wellbeing
Bookstart coordination and resources	Bookstart is run in partnership with Health Visitors. Health Visitors use book packs to teach interaction with very young children.	Miscellaneous (Public mental health)	1.2 school readiness	Nottingham Plan - Early years Child development
Leisure Centres	Provision of facilities and programmed activities at 10 Centres.	Physical Activity	2.6 Excess weight in 4-5 year olds 2.12 Excess weight in adults 2.13 Proportion of physically active and	Nottingham Plan Child obesity, Adult obesity, Physical Activity

			inactive adults	
Park Ranger Team	Outdoor activities such as health walks and orienteering programme. Proactive site based community engagement, events and activities.	Physical Activity	2.6 Excess weight in 4-5 year olds 2.13 Proportion of physically active and inactive adults 2.23 Self reported wellbeing	Nottingham Plan Child obesity, Adult obesity, Physical Activity
Prevention Adaptations Schemes (PADS)	Falls and injuries in the over 65s. Installation of minor preventative adaptations	Miscellaneous (Accident Prevention)	2.24 Injuries due to falls in older People	Vulnerable adults Plan
Nottingham Futures	Funded by the City and County councils identifies and supports NEETs and pre 16 who are identified as being at risk of NEET.	Miscellaneous (other Public Health)	1.5 16-18 year olds not in education, employment or training	Nottingham Plan - increase the city's employment rate
GIS Team, Data and Information Team	GIS Team, Data and Information Team			
Nottm & Notts Refugee Forum	Provides welfare rights to refugees	Miscellaneous (Public Mental Health/Social Exclusion)	2.23 Self-reported well-being1.18 social isolation	Vulnerable Adults PlanCouncil Plan -lessen impact of economic recession
Nottm & District Citizen Advice Bureau	Provides broad range of welfare rights services	Miscellaneous (Public Mental Health)	2.23 Self-reported well-being	Council Plan -lessen impact of economic recession
Internal welfare rights service	Provision of benefit and debt advice with a view to maximising incomes and reducing debt to 5049 per annum.	Miscellaneous (Public Mental Health)	1,17 Fuel Poverty	Council Plan -lessen impact of economic recession

Notts Deaf Society	Provides welfare rights to Deaf citizens	Miscellaneous (Public Mental Health/Social Exclusion)	2.23 Self-reported well-being 1.18 social isolation	Vulnerable Adults Plan Council Plan -lessen impact of economic recession

Department of Health

Directors of Public Health in Local Government

Roles, Responsibilities and Context

October 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Directors of Public Health in Local Government

Roles, Responsibilities and Context

Prepared by the Public Health Policy and Strategy Unit, Department of Health

This guidance is published under section 73A(7) of the NHS Act 2006 as guidance that local authorities must have regard to.

Contents

1. Introduction

1.1 Public health practice made huge strides during the 20th century, transforming the living standards of millions and saving countless lives in the process. Yet real threats still linger and new ones emerge. Dealing with the avoidable mortality caused by, say, smoking or obesity as conclusively as cholera and typhoid were dealt with requires different ways of thinking and acting.

1.2 The 2010 White Paper *Healthy Lives, Healthy People* set out an ambitious vision for the public's health in the 21st century, based on an innovative and dynamic approach to protecting and improving the health of everyone in England. The test that the White Paper sets is clear – we will have succeeded only when we as a nation are living longer, healthier lives and have narrowed the persistent inequalities in health between rich and poor.

1.3 As the White Paper proposed, and after a gap of almost 40 years, the Health and Social Care Act 2012 returned a leading public health role to local government. With it comes a sizeable proportion of the responsibility for rising to these challenges. In April 2013 unitary and upper tier authorities took over a raft of vital public health activity, ranging from cancer prevention and tackling obesity to drug misuse and sexual health services. Just as significantly, the reformed public health system gives local authorities an unprecedented opportunity to take a far more strategic role. They can now promote the public's health through the full range of their business and become an influential source of trusted advice for their populations, the local NHS and everyone whose activity might affect, or be affected by, the health of the people in their area.

1.4 Local government is ready, willing and able to take this on. To support it, every local authority with public health responsibilities must employ a specialist Director of Public Health (DPH) – appointed jointly with the Secretary of State for Health – who is accountable for the delivery of their authority's duties. The post is an important and senior one. The DPH is a statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health - health improvement, health protection and healthcare public health.

1.5 Local authorities must take the action that they decide is appropriate to improve the health of the people in their areas – it is not the job of central government to look over their shoulders and offer unnecessary advice. Nevertheless, the statutory basis of the DPH role, its transfer to local government and the involvement of the Secretary of State mean that there is value in clear, informative guidance that establishes a shared understanding of how this vital component of the reformed system should work. This statutory guidance is issued in that spirit.

1.6 It describes both the statutory and non-statutory elements of the DPH function and sets out principles critical to their appointment, to delivery of an effective public health strategy and to other aspects of their relationship with their employer and the Secretary of State.

2. The role of the director of public health

2.1 The most fundamental duties of a DPH are set out in law and are described in the next section. How those statutory functions translate into everyday practice depends on a range of factors that are shaped by local needs and priorities from area to area and over time.

2.2 Nevertheless, there are some aspects of the role that define it in a more complete way than the legislation can, and that should be shared across the entire DPH community. All DsPH should:

- be the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues, from outbreaks of disease and emergency preparedness through to improving local people's health and access to health services;
- know how to improve the population's health by understanding the factors that determine health and ill health, how to change behaviour and promote both health and wellbeing in ways that also reduce inequalities in health;
- provide the public with expert, objective advice on health matters;
- be able to promote action across the life course, working together with local authority colleagues such as the director of children's services and the director of adult social services, and with NHS colleagues;
- work through Local Resilience Fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to its health;
- work with local criminal justice partners and Police and Crime Commissioners to promote safer communities; and
- work with wider civil society to engage local partners in fostering improved health and wellbeing.

2.3 Within their local authority, DsPH also need to be able to:

- be an active member of the health and wellbeing board, advising on and contributing to the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, and commission appropriate services accordingly;
- take responsibility for the management of their authority's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money;
- play a full part in their authority's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children Board; and

- contribute to and influence the work of NHS commissioners, helping to lead a whole system approach across the public sector.

3. Statutory functions of the director of public health

3.1 A number of the DPH's specific responsibilities and duties arise directly from Acts of Parliament - mainly the NHS Act 2006 and the Health and Social Care Act 2012 - and related regulations. Some of these duties are closely defined but most allow for local discretion in how they are delivered. This section summarises and explains the main legal provisions in effect from April 2013.

3.2 In general the statutory responsibilities of the DPH are designed to match exactly the corporate public health duties of their local authority. The exception is the annual report on the health of the local population – the DPH has a duty to write a report, whereas the authority's duty is to publish it (section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act). The content and structure of the report is something to be decided locally.

3.3 Otherwise section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, gives the DPH responsibility for:

- all of their local authority's duties to take steps to improve the health of the people in its area;
- any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations – these include services mandated by regulations made under section 6C of the 2006 Act, inserted by section 18 of the 2012 Act;
- exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to the public's health;
- their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders; and
- such other public health functions as the Secretary of State specifies in regulations (more on this below).

3.4 As well as those core functions, the Acts and regulations give DsPH some more specific responsibilities from April 2013:

- through regulations made under section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, the Department has confirmed that DsPH are responsible for their local authority's public health response as a responsible authority under the Licensing Act 2003, such as making representations about licensing applications (a function given to local authorities by sections 5(3), 13(4), 69(4) and 172B(4) of the Licensing Act, as amended by Schedule 5 of the 2012 Act);

- if the local authority provides or commissions a maternity or child health clinic, then regulations made under section 73A(1) also give the DPH responsibility for providing Healthy Start vitamins (a function conferred on local authorities by the Healthy Start and Welfare Food Regulations 2005 as amended); and
- DsPH must have a place on their local health and wellbeing board (section 194(2)(d) of the 2012 Act).

4. Other relevant statutory provisions

4.1 The 2012 Act makes a number of other provisions that are directly relevant to DsPH. DsPH are made statutory chief officers of their local authority, and therefore holders of politically restricted posts, by section 2(6)(zb) of the Local Government and Housing Act 1989, inserted by Schedule 5 of the 2012 Act.

4.2 Under section 73A of the 2006 Act, inserted by section 30 of the 2012 Act:

- DsPH must be appointed jointly by their local authority and the Secretary of State (in practice Public Health England), although their subsequent employment relationship is with the local authority exclusively. There is more detail below on how the joint appointment process should work, and further information on best practice is published by Public Health England;

- if the Secretary of State believes that a DPH is not properly carrying out any Secretary of State function that has been delegated to the local authority s/he can direct the authority to review the DPH's performance, to consider taking particular steps, and to report back. This power does not extend to the DPH's performance of the local authority's own health improvement duties; and

- a local authority must consult the Secretary of State before dismissing its DPH. The authority may still suspend its DPH from duty (following its standard rules and procedures) and the Secretary of State cannot veto its final decision on dismissal. An authority proposing dismissal for any reason should contact Public Health England for advice on how to proceed with the consultation. PHE will normally provide the Secretary of State's formal response within a maximum of 28 days.

5. Corporate and professional accountability

Corporate accountability

5.1 The DPH is a chief officer of their local authority and shares the same kind of corporate duties and responsibilities as other senior staff. To discharge their responsibility to their authority and deliver real improvements in the public's health the DPH needs both an overview of the authority's activity and the necessary degree of influence over it.

5.2 This may or may not mean that the DPH is a standing member of their local authority's most senior corporate management team. That should be determined locally, not least because the scope of the DPH role can also vary locally – for instance, where it is agreed that a DPH's role will extend beyond its core statutory responsibilities.

5.3 However, it does mean that there should be direct accountability between the DPH and the local authority chief executive (or other head of paid service) for the exercise of the local authority's public health responsibilities, and direct access to elected members.

5.4 DsPH should also have full access to the papers and other information that they need to inform and support their activity, and day to day responsibility for their authority's public health budget - although formal accountability will rest with the authority's accounting officer (usually the chief executive).

Professional accountability

Regulation and registration

5.5 Medical and dental public health consultants are registered with - and regulated by - the General Medical Council or the General Dental Council. They, and other public health consultants, can also register with the voluntary UK Public Health Register. PHE will not regard an applicant for a DPH post as suitable unless s/he has the appropriate registration with the GMC, the GDC or the UKPHR.

5.6 To assure themselves of the continuing competence of their DPH, local authorities should ensure that s/he:

- undertakes a continuing professional development (CPD) programme that meets the requirements of the Faculty of Public Health or other equivalent professional body;
- maintains a programme of personal professional development to ensure competence in professional delivery. This programme should include all training and development needs identified by both management and professional appraisal processes; and
- undertakes appropriate annual professional appraisal in order to ensure revalidation and fitness to practise.

5.7 The Government has announced its intention to extend statutory regulation to public health consultants with backgrounds other than medical or dental through the Health and Care Professions Council and expects this to be in place in 2015. The HCPC will consult on the standards and criteria it will use for the new statutory register. Prior to the

establishment of the new register, public health specialists with backgrounds other than medical or dental are expected to adhere to the standards set by the UKPHR.

Revalidation

5.8 Medical revalidation is the process by which all licensed doctors, including DsPH with medical qualifications, are required to demonstrate to the General Medical Council (GMC) that their skills are up to date and that they are fit to practise in order to retain their license to practise. The GMC publishes guidance on the revalidation process.

5.9 PHE acts as the designated body for revalidation, where appropriate, for all doctors for whom it is the employing organisation and for those holding honorary contracts with PHE. PHE also acts as the designated body for doctors employed by local government organisations. Equivalent arrangements for revalidation are likely to be agreed for all public health consultants with backgrounds other than in medicine, including dental public health consultants.

The role of responsible officers

5.10 Responsible officers help to evaluate doctors' fitness and monitor their conduct and performance in the context of fitness to practise. The role of the responsible officer is to support doctors in maintaining and improving the quality of service they deliver, and to protect patients and citizens in those cases where doctors fall below the high standards set for them. Responsible officers are licensed doctors themselves, and as such must have their own responsible officer.

5.11 The Responsible Officer Regulations came into force on 1 January 2011 and apply to medically qualified DsPH. The regulations designate those bodies that are required to nominate or appoint a responsible officer for the purposes of medical revalidation – this includes local authorities that employ medically qualified staff. PHE provides the responsible officer for all doctors in local government.

5.12 The responsible officer:

- makes recommendations to the GMC about the fitness to practise of doctors;
- assures the quality of professional appraisers;
- ensures that recommendations are informed by clinical governance information provided by the employing organisation, and other key stakeholders, where appropriate; and
- provides support and advice to employers and appraisers where performance concerns have been identified, in liaison with GMC, GDC and UKPHR when appropriate.

Professional appraisal and continuing professional development

5.13 Local authorities should reassure themselves that all public health professionals are in a position to participate in professional appraisal and that those with suitable experience and training are enabled to appraise others in the public health system.

5.14 CPD is an essential feature of the revalidation process for public health consultants and specialists. The overall aim of CPD is to ensure that those who work in the field develop and maintain the necessary knowledge, skills and attributes to practise effectively and work towards improving and protecting the health of the population. Local authorities should consider how to support their DPH to meet these aims

5.15 CPD is a professional obligation for all public health professionals and protected time for CPD is a contractual entitlement for directors transferring into local government on medical and dental contracts. In order to comply with the Faculty of Public Health's minimum standards for CPD all Faculty members must either submit a satisfactory CPD return annually or have been formally exempted by the Faculty from this requirement.

5.16 The UK Public Health Register expects all its registrants to participate in CPD, preferably as part of a formal scheme operated by a professional body.

5.17 Personal development plans should include recommendations made as a result of both management and professional appraisal. This ensures that CPD activities are suitably aligned to the needs of the employing body, and the professional development requirements of the individual.

6. Appointing directors of public health

6.1 The Secretary of State for Health (and therefore Public Health England, which acts on the Secretary of State's behalf) has two general duties that apply to the joint appointment process:

- to promote the comprehensive health service (section 1 of the NHS Act 2006, as amended by section 1 of the 2012 Act); and

- to promote local autonomy so far as that is compatible with the interests of the comprehensive health service (section 1D of the 2006 Act, inserted by section 5 of the 2012 Act).

6.2 Local authorities undertaking public health duties conferred on them by the 2012 Act are part of the comprehensive health service. This means that the Secretary of State may not normally intervene in decisions about matters such as the role or position within local authorities of DsPH, but must intervene - and ultimately may refuse to agree a joint appointment - if s/he has reason to believe that anything about an authority's proposals for the appointment of a DPH would be detrimental to the interests of the local health service.

Requirements for directors of public health appointments

6.3 Local authorities recruiting a DPH should:

- design a job description that includes specialist public health leadership and an appropriate span of responsibility for improving and protecting health, advising on health services and ensuring that the impact on health is considered in the development and implementation of all policies;

- make every effort to agree the job description with the Faculty of Public Health and the PHE regional director, ensuring in particular that it covers all the necessary areas of professional and technical competence; and

- manage the recruitment and selection process and set up an advisory appointments committee to make recommendations on the appointment to the leader of the local authority.

6.4 The advisory appointments committee should be chaired by a lay member, such as an elected member of the local authority (the cabinet member of the health and wellbeing board, for example). It should also normally include:

- an external professional assessor, appointed after consultation with the Faculty of Public Health;

- the chief executive or other head of paid service of the appointing local authority (or their nominated deputy);

- senior local NHS representation;

- the PHE regional director, or another senior professionally qualified member of PHE acting on his or her behalf; and

- in the case of appointments to posts which have teaching or research commitments, a professional member nominated after consultation with the relevant university.

The role of the Secretary of State and Public Health England

6.5 The relationship of the Secretary of State and the local authority in the joint appointment process is one of equals. The role of the Secretary of State is to provide additional assurance of the DPH's competency. This means that PHE, acting on behalf of the Secretary of State, should be involved in all stages of the process. PHE will advise the Secretary of State on whether:

- the recruitment and selection processes were robust; and

- the local authority's preferred candidate has the necessary technical, professional and strategic leadership skills and experience to perform the role - proven by their specialist competence, qualifications and professional registration.

6.6 In order to provide this assurance for the Secretary of State, PHE will:

- agree with the local authority and the Faculty of Public Health a job description that fits with the responsibilities of the DPH and sets out the necessary technical and professional skills required;

- offer advice in relation to the recruitment and selection process, including the appointment of Faculty of Public Health assessors;

- participate in the local advisory appointment committee;

- confirm to the local authority the Secretary of State's agreement to the appointment.

6.7 PHE regional directors will work with local authorities in any area where there is a DPH vacancy to ensure a robust and transparent appointment process is established and a timescale for recruitment and appointment agreed. This should be completed within three months of a post becoming vacant.

6.8 If the regional director has concerns about the process or their involvement in it, s/he will seek to resolve these through negotiation with the local authority. They will be able to draw upon advice and dispute resolution support if it is required. It is important that the interaction between the regional director and the local authority is based on dialogue, collaboration and agreement.

6.9 The local authority has the primary role in recruiting people who will be under contract to it. However, there are clear joint considerations in processes for appointing a DPH. If, at the end of this procedure, the Secretary of State is not satisfied that an appropriate recruitment process has taken place and that the local authority preferred candidate has the necessary skills for the role, s/he will write to the lead member and chief executive of the council setting out in full the reasons for not agreeing the appointment and proposing steps to resolve the situation.

Public Health England

Nottingham

Unitary Authority

This profile was produced on 8 July 2014

Health Profile 2014

Health in summary
The health of people in Nottingham is generally worse than the England average. Deprivation is higher than average and about 35.2% (19,100) children live in poverty. Life expectancy for both men and women is lower than the England average.

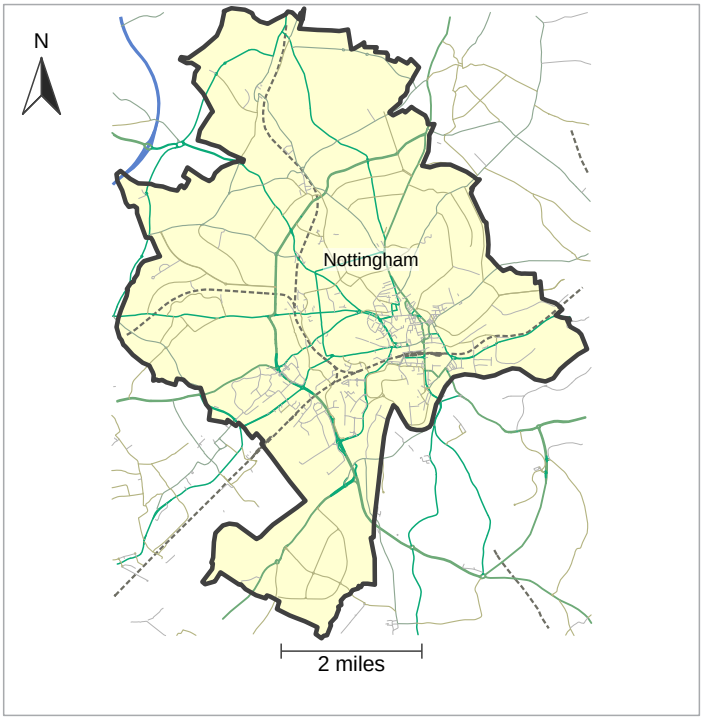
Living longer
Life expectancy is 9.2 years lower for men and 8.7 years lower for women in the most deprived areas of Nottingham than in the least deprived areas.

Child health
In Year 6, 21.7% (536) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 32.1*, better than the average for England. This represents 20 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

Adult health
In 2012, 21.7% of adults are classified as obese. The rate of alcohol related harm hospital stays was 878*, worse than the average for England. This represents 2,205 stays per year. The rate of self-harm hospital stays was 204.2*, worse than the average for England. This represents 703 stays per year. The rate of smoking related deaths was 358*, worse than the average for England. This represents 422 deaths per year. Estimated levels of adult smoking are worse than the England average. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are worse than average.

Local priorities
For more information, including locally agreed priorities see www.nottinghamcity.gov.uk

* rate per 100,000 population



Population: 309,000
Mid-2012 population estimate. Source: Office for National Statistics.

This profile gives a picture of people's health in Nottingham. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info
or scan this Quick Response code: for more profiles, more information and interactive maps and tools.

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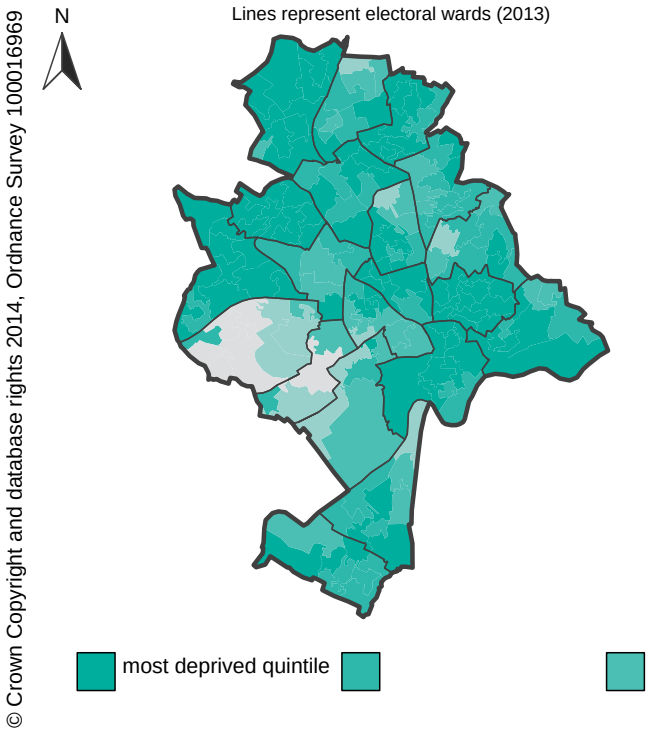
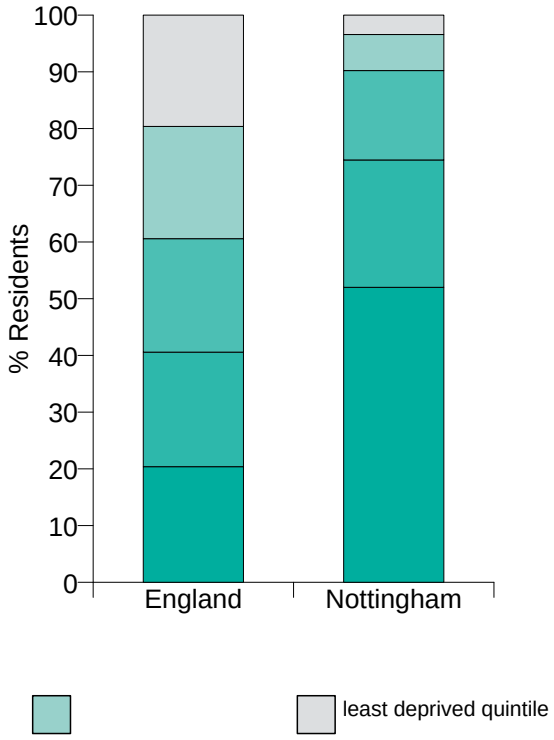
Deprivation: a national view

The map shows differences in deprivation levels in this area based on national quintiles (fifths) of the Index of Multiple Deprivation 2010 by Lower Super Output Area. The darkest coloured areas are some of the most deprived areas in England.



This chart shows the percentage of the population in England and this area who live in each of these quintiles.

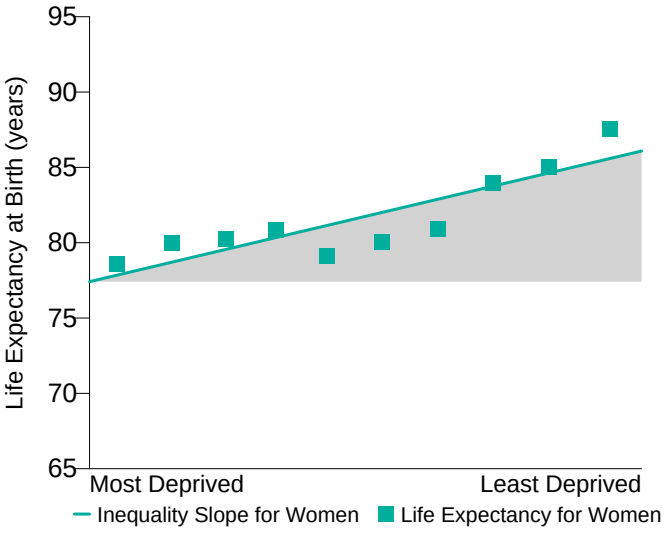


Life Expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2010-2012. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life Expectancy Gap for Men: 9.2 years

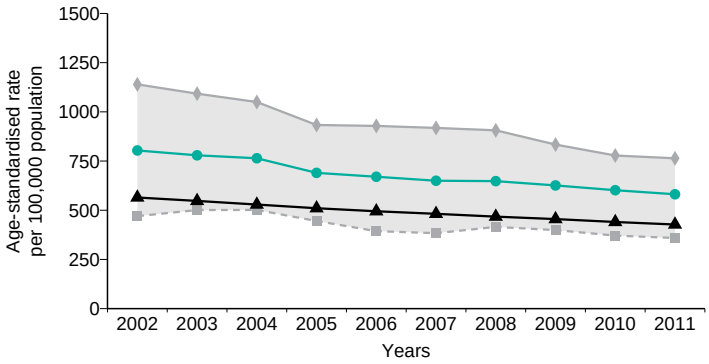
Life Expectancy Gap for Women: 8.7 years



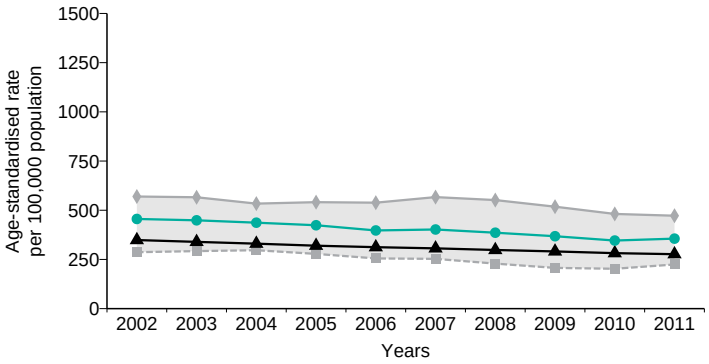
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

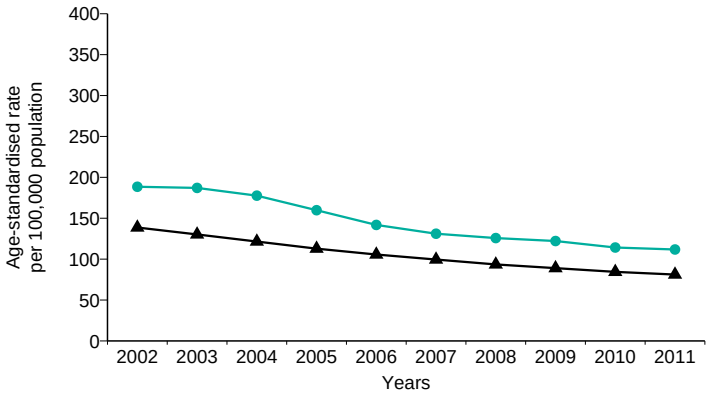
Early deaths from all causes: MEN



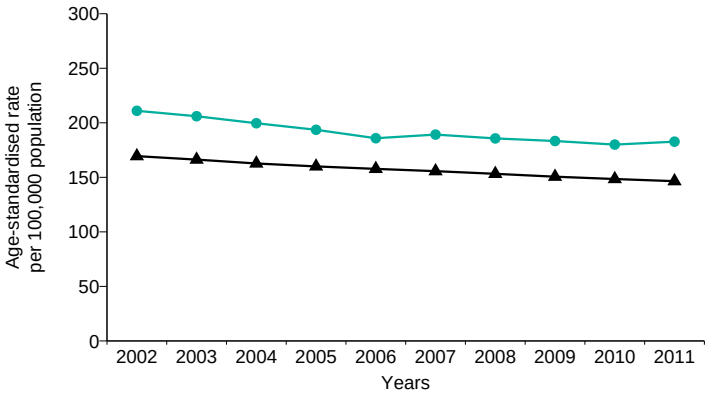
Early deaths from all causes: WOMEN



Early deaths from heart disease and stroke



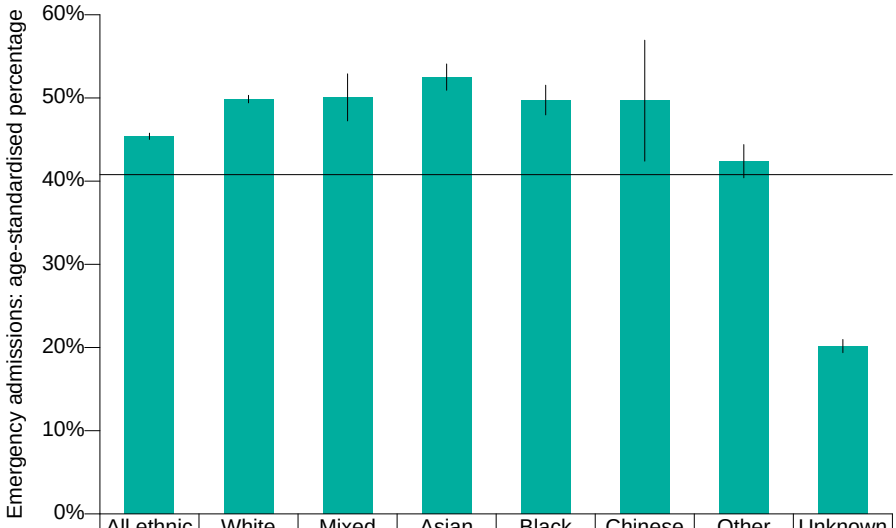
Early deaths from cancer



England average | Local average | Local least deprived | Local most deprived | Local inequality

Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group



This chart shows the percentage of hospital admissions in 2012/13 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Nottingham

England average (all ethnic groups)

95% confidence interval

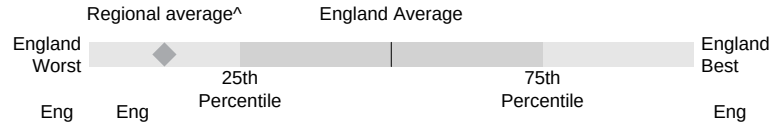
Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
30,384	22,986	720	2,041	1,523	91	1,055	1,968	Local number of emergency admissions
45.4	49.9	50.1	52.5	49.7	49.7	42.4	20.2	Local value
40.8	41.3	40.8	45.4	45.0	37.0	46.5	30.3	England value

Health Summary for Nottingham

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation	160,553	52.0	20.4	83.8		0.0
	2	Children in poverty (under 16s)	19,120	35.2	20.6	43.6		6.4
	3	Statutory homelessness	78	0.6	2.4	33.2		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1,191	49.8	60.8	38.1		81.9
	5	Violent crime (violence offences)	5,820	19.2	10.6	27.1		3.3
	6	Long term unemployment	4,515	20.9	9.9	32.6		1.3
Children's and young people's health	7	Smoking status at time of delivery	823	17.9	12.7	30.8		2.3
	8	Breastfeeding initiation	3,176	68.9	73.9	40.8		94.7
	9	Obese children (Year 6)	536	21.7	18.9	27.3		10.1
	10	Alcohol-specific hospital stays (under 18)	20	32.1	44.9	126.7		11.9
	11	Under 18 conceptions	181	37.7	27.7	52.0		8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	24.4	19.5	30.1		8.4
	13	Percentage of physically active adults	n/a	51.9	56.0	43.8		68.5
	14	Obese adults	n/a	21.7	23.0	35.2		11.2
	15	Excess weight in adults	453	60.7	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma	25	9.4	14.8	31.8		3.6
	17	Hospital stays for self-harm	703	204.2	188.0	596.0		50.4
	18	Hospital stays for alcohol related harm	2,205	878	637	1,121		365
	19	Drug misuse	2,706	12.7	8.6	26.3		0.8
	20	Recorded diabetes	14,501	5.2	6.0	8.7		3.5
	21	Incidence of TB	22	21.3	15.1	112.3		0.0
	22	Acute sexually transmitted infections	4,247	1,398	804	3,210		162
	23	Hip fractures in people aged 65 and over	220	541	568	828		403
Life expectancy and causes of death	24	Excess winter deaths (three year)	110	15.1	16.5	32.1		-3.0
	25	Life expectancy at birth (Male)	n/a	76.9	79.2	74.0		82.9
	26	Life expectancy at birth (Female)	n/a	81.5	83.0	79.5		86.6
	27	Infant mortality	21	4.7	4.1	7.5		0.7
	28	Smoking related deaths	422	358	292	480		172
	29	Suicide rate	21	7.6	8.5			
	30	Under 75 mortality rate: cardiovascular	196	111.8	81.1	144.7		37.4
	31	Under 75 mortality rate: cancer	316	183	146	213		106
	32	Killed and seriously injured on roads	142	46.6	40.5	116.3		11.3

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

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HEALTH SCRUTINY PANEL
30 JULY 2014
DISCUSSION WITH PORTFOLIO HOLDER FOR ADULTS, COMMISSIONING AND HEALTH
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To hear from the Portfolio Holder for Adults, Commissioning and Health about progress in delivery of objectives relating to health and adult social care; current areas of work and priorities for the year ahead; and future challenges and plans for addressing them.

2. Action required

2.1 The Panel is asked to use the information received at the meeting from the Portfolio Holder for Adults, Commissioning and Health to inform questioning as part of scrutiny's role in holding the Executive to account and to identify where scrutiny can most usefully support the achievement of Council priorities relating to health and adult social care.

3. Background information

3.1 As part of scrutiny's role in holding the Executive to account, every year the Panel invites the Portfolio Holder with responsibility for health and adult social care issues to attend a meeting to discuss:

a) progress of delivery of objectives relating to health and adult social care over the last year;
b) current areas of work and priorities for the year ahead; and
c) future challenges and plans for addressing them.

3.2 Councillor Alex Norris has been appointed Portfolio Holder for Adults, Commissioning and Health for 2014/15 and will be attending the meeting.

3.3 The remit of this Portfolio has expanded since 2013/14 with the addition of commissioning responsibilities.

3.4 When the Panel spoke to Councillor Norris in July 2013 he identified the following areas as those in which he believed he could add particular value as Portfolio Holder:

Health

i) driving delivery on the priorities of the Joint Health and Wellbeing Strategy
ii) continuing, and completing the transition of public health into the City Council
iii) creating a sense of stability during a period of significant change in the NHS

Adults

iv) supporting the continued existence of the Council as a direct provider of care, helping to drive up standards in the sector
v) ensuring personalisation is appropriately applied and supported.

3.5 The Portfolio Holder for Adults, Commissioning and Health is also the Chair of the Health and Wellbeing Board. The Board has been in operation for over one year now and 12 month progress against the Joint Health and Wellbeing Strategy was recently reported to the Board. The Panel may wish to explore the Portfolio Holder's assessment of the development and progress of the Board and its Strategy.

3.6 The Panel may wish to take this opportunity to discuss with the Portfolio Holder how scrutiny can support achievement of the Council's priorities relating to health and adult social care and/ or address the challenges that it faces. This can be used to inform the Panel's work programme.

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

Minutes of the meeting of the Health Scrutiny Panel held on 24 July 2013.

7. Wards affected

All

8. Contact information

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HEALTH SCRUTINY PANEL
30 JULY 2014
IMPLICATIONS OF THE CARE ACT 2014 FOR NOTTINGHAM CITY COUNCIL
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider how the Council is responding to ensure that it meets the requirements of the Care Act 2014.

2. Action required

2.1 The Panel is asked to use the information provided to inform questioning and discussion about the implications of the Care Act 2014 and how the Council is responding to these implications; and identify if any further scrutiny is required.

3. Background information

3.1 The Care Act passed into law in May 2014. The Act makes major changes to the legal framework for adult social care, the funding system, the rights of those needing social care and the duties on local authorities. Therefore it will have a significant impact on the Council. Implementation of the Act is phased - some aspects need to be implemented by April 2015 and others need to be implemented by April 2016.

3.2 Information on aspects of the Act relevant to local authorities, identified impacts for the Council, implications and next steps is attached. The Council's Chief Social Worker and Policy Officer will be attending the meeting to provide further information and answer questions about the implications for the Council and work taking place to address these.

4. List of attached information

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

Appendix 1 – Implications of the Care Act 2014

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

None

6. Published documents referred to in compiling this report

Care Act 2014

7. Wards affected

All

8. Contact information

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Health Scrutiny Panel
Wednesday 30 July 2014

Implications of the Care Act 2014

Submitted by: Helen Jones, Director of Adult Social care

Report author and contact details:
Linda Sellars, Chief Social Worker, Linda.sellars@nottinghamcity.gov.uk / 0115 8764150
Laura Catchpole, Policy Officer, laura.catchpole@nottinghamcity.gov.uk / 0115 8764964

Context

- The Act passed into law in May 2014.
- Draft regulations and statutory guidance published in June for consultation (closing 15 August). Final regulations and statutory guidance (part one) to be published in October 2014.
- Care Act Programme Board in place, with programme leads in key areas.
- Corporate risks related to how the Act affects the wider adult social care system are being developed.

Summary
The Care Act sets out general responsibilities of local authorities, describing their broader care and support role towards integration with health provision and the local community. It emphasises a preventive approach including providing information to those needing care and duties to consider physical, mental and emotional wellbeing. The Care Act is being phased in, in two parts: part one duties need to be implemented by April 2015 and part two (funding reform) to be implemented by April 2016.

Part one - key areas and impacts include:

1. <u>General Duties and Universal Provision</u>

Timeline: from April 2015

- **Wellbeing:** Local authorities (LAs) must promote wellbeing and actively seek improvements when carrying out any of their care and support functions in respect of a person – this includes from provision of information and advice to reviewing a care and support plan.

  Impact: *The Act requires that wellbeing is embedded into all aspects of the Council's adult social systems, however due to the complex nature of the Act and the broad definition of 'wellbeing', there is an implication that wellbeing will need to be at the heart of all Council services.*

- **Prevention:** The Act requires local authorities to ensure the provision or arrangement of services, facilities or resources to help prevent, delay or reduce the development of

needs for care and support. This can include 'universal' services such as promoting healthier lifestyles.

Impact: *This reflects the Council's commitment towards effective prevention and early intervention, but enshrines it as a duty throughout all aspects of care and support.*

- **Information and Advice:** There is a duty on LAs to provide a comprehensive information and advice service, so that people know what type and range of care and support is available, how to access that care and support, where they can find independent financial advice about care and support and how they can raise concerns about the safety or wellbeing of someone who has care and support needs.

  Impact: *The 'Choose My Support' directory might go some way to deliver the information and advice requirement, however there is significant further development work to ensure citizens receive information about signposting services including independent financial advice and universal services.*

- **Marketing shaping and provider failure:** LAs' responsibilities around market provision have been strengthened and is a driver for establishing a wide range of sustainable high-quality care and support services that is available in local communities.

- There will also be new responsibilities in place if care providers should fail where LAs will have temporary responsibility to ensure both residential and domiciliary care continues, regardless of who pays for the care.

  Impact: *Generally this expands current the Council's Market role, although a better understanding of the relationship between Care Quality Commission and LAs is required.*

2. <u>First Contact and Identifying Needs</u>

Timeline: from April 2015

- **Assessment**: All individuals are entitled to receive an assessment of eligibility for care and support and, if relevant, a care plan based on needs. Individuals can ask the LA to arrange care irrelevant of whether or not the individual or the LA is responsible for funding care. Assessments must be outcome focused, strength based and holistic. There is an increased requirement to ensure independent advocacy is provided.

- Eligibility for care must be identified using the new national framework.

  Impact: *We are confident with some adjustment current assessments will meet legal requirements but further understanding of the guidance is needed. The increase for advocacy services will need to be scoped.*

- **Carers:** LA will now not only have to complete Carers Assessments but also be under a duty to meet carers' eligible needs. Carers can be eligible for support in two

ways firstly to help them continue with their caring role and secondly their caring role is having a significant impact on their wellbeing and is having an adverse effect on their life.

Impact: *Currently we meet the needs of carers who are caring for citizens who are eligible. Some modelling work is taking place to estimate the number of assessments required, of which there is likely to be an increase.*

3. Charging and Financial Assessment

Timeline: April 2015

- **Deferred payments:** People will not have to sell their home to pay for residential care whilst they are still alive. However, LAs will be able to charge interest to cover their costs.

  Impact: *Deferred payments are not new for the Council, however it has not been general practice. Therefore there is potential for a greater administrative and financial burden in keeping track of the value of the property.*

Timeline: April 2016

- **Cap on care costs:** The cap sets a limit how much people pay towards their care costs, with the local authority (LA) paying the full cost thereafter
- Individuals in residential care will be expected to contribute £12k annually to daily living costs (not part of cap)
- The cap will be set depending on the age of the person when they are assessed as having eligible needs e.g. £72k for state pension age, £0 for those aged 18
- Contributions to the cap will be tracked through a 'care account' managed by the LA
- The Act provides people with a legal entitlement to a personal budget and it consolidates the existing legislation on direct payments – whereby LAs must provide direct payments to with people with capacity

Impact:

- *More people will want a care assessment in order to start contributing towards the cap (self-funders) and more people are likely to qualify for support. At present numbers and costs unknown – modelling work is underway to estimate this.*
- *It is not yet known how the cap will be applied to citizens with eligible needs of 'working age'.*
- *Care accounts will be a new administrative burden for LAs and require the development and investment in IT systems.*
- *Nationally £470m Government funding has been allocated for 2015/16 to help implementation. There is no additional funding beyond this, although if funding was insufficient the Government has indicated guidance and regulations may be revised.*
- *As implementation for this part of the Act is post General Election 2015, there is potential for change. In the last stages of the Care Bill, the Labour Party withdrew its support, citing that that it did not address the under-funding of adult social care or protect individuals from large care costs, including living costs.*

4. Person Centred Care and Support Planning

Timeline: from April 2015

- **Care and support planning/personal budgets:** The Act places a duty on LAs to provide a care and support plan. The individual must be involved in the development of their plan and it must be periodically reviewed. Citizens and carers can have a joint care and support plan.

- **Direct payments:** Using the information from the personal budget, the person has a legal entitlement to request a direct payment. The local authority must provide a direct payment to someone who meets the conditions in the Act and regulations.

  Impact: *Previously only direct payments have had a place in law. Care and support planning and personal budgets, have only been set out in guidance. The Council currently provides care and support plans and direct payments. The Direct Payment policy will be refreshed.*

5. Integration and Partnership Working

Timeline: April 2015

- The Act requires greater integration and co-operation between the NHS, care and support, and the wider determinants of health such as housing. This relates to the principles of wellbeing and prevention. LAs must promote integration between care and support provision, health and health related services, with the aim of joining up services. LAs and their partners must also cooperate where this is needed in the case of specific individuals who have care and support needs.

  Impact: *The Council is already on this journey through the work of the Health and Wellbeing Board and the partnership work Nottingham City Clinical Commissioning Group. However the Act places additional legal requirements on internal and external cooperation and partnership working.*

- **Transition**: The Act says that if a child, young carer or an adult caring for a child (a "child's carer") is likely to have needs when they, or the child they care for, turns 18, the local authority must assess them if it considers there is "significant benefit" to the individual in doing so. This is regardless of whether the child or individual currently receives any services. The Act gives local authorities a legal responsibility to cooperate, and to ensure that all the correct people work together to get the transition right.

  Impact: *Current practice and operational processes are being checked for compliance. Much work has already taken place as part of the implementation of the Children and Families Act 2014.*

6. Adult Safeguarding

- The Act creates a legal framework requiring LAs to establish Safeguarding Adults Boards with local partners, with public plans, annual reporting and clear processes for investigating suspected abuse or neglect.

  Impact: *Current practice and operational processes, including for the Board, are being checked against the guidance to ensure compliance.*

7. Moving between areas: inter local authority and cross-border issues

- The Act outlines a process to be followed so that local authorities know when someone wants to move areas, and what must happen to make sure that their needs are met when they arrive in the new area and that care remains continuous.
- There are changes to ordinary residence. Responsibilities of the placing authority widen to include supported living and shared lives schemes.

  Impact: *Current practice and operational processes are being considered against the guidance to ensure compliance. A clear policy will need to be developed and possible changes to IT systems may be required to allow easier transfer of information to other LAs.*

Overall implications and next steps

- Duties under the Care Act will increase the council's costs significantly, with potentially high levels of set up cost in terms of IT, undertaking an increased number of assessments and increased administrative burdens going forward. The detailed financial modelling that is currently taking place will be essential to enable us to understand the financial risks going forward.

- The Corporate Risk Specialist has drawn up initial risks to be included in the corporate risk register, as below. The next steps are to establish actions and mitigations to these risks, with input from programme leads to ensure all risks are considered and managed.

  - *The government fails to set aside adequate funds to meet the council's additional costs arising from implementation of, and compliance with, the Care Act impacting the financial sustainability of the service and the MTFP*

  - *That the implementation of the Care Act significantly increases the service workload processing cases to determine eligibility during the window for self funders to register with the LA in 2015/16 impacting the timeliness of assessments, the quality of service provision and increasing processing costs*

  - *Changes in the Act relating to deferred payments raises the risk that there will be a rise in requests with substantial upfront care costs which cannot be recovered in the short to medium term against assets that are not control by the Council*

- *Existing software is not adequate to meet the requirements of the Care Act with the risk that there is insufficient time to procure a replacement or develop existing software/processes prior to the Act coming into effect in 2015/16 the impact of which could be a failure to comply with statutory requirements, increased procurement/ development costs, compromised ICT implementation and service quality*

- Many provisions in the Act reinforce or formalise a number of current initiatives and ways of working and the Programme Board have examined the non-financial impact of the Care Act and are currently reviewing the draft regulations and guidance to ensure compliance. The next steps are to formalise plans for implementation to meet the duties.

- The Programme Board has a lead representative for each of the key areas above (including transition from childhood and how this links to the Children and Families Act 2014), as well cross-cutting themes of finance, legal, IT, workforce, communications and equalities.

- ADASS, the LGA and Department of Health are working together to support LAs and a regional Programme Lead has been appointed to coordinate the regional support network.

HEALTH SCRUTINY PANEL
30 JULY 2014
HEALTHWATCH NOTTINGHAM ANNUAL REPORT 2013/14
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the Healthwatch Nottingham Annual Report 2013/14.

2. Action required

2.1 The Panel is asked to give consideration to the Healthwatch Nottingham Annual Report 2013/14 and scrutinise whether the Council's arrangements for Local Healthwatch are operating effectively.

3. Background information

3.1 Healthwatch is a consumer champion for health and social care, gathering and representing the views of the public. It has a role at both national and local level to make sure that views of the public and service users are taken into account in decision making.

3.2 Healthwatch was created by the Health and Social Care Act 2012 and since 1 April 2013 every local authority with social services responsibilities has been required to establish arrangements for a Local Healthwatch organisation. In Nottingham this is Healthwatch Nottingham.

3.3 Healthwatch Nottingham is an independent organisation but the Council holds the contract for local Healthwatch arrangements and is responsible for ensuring that the arrangements operate effectively. There is currently a 3 year contract in place, which is due to end in March 2016.

3.4 In the working agreement between health scrutiny, Healthwatch Nottingham and the Health and Wellbeing Board, Healthwatch Nottingham agreed to provide a copy of its annual report to the Health Scrutiny Panel for consideration. The Annual Report 2013/14 is attached.

3.5 The Annual Report outlines how Healthwatch Nottingham has developed over the last year, examples of activity that has taken place, information on how it has spent its money during 2013/14 and plans for the future.

3.6 A representative of Healthwatch Nottingham will be attending the meeting to present the annual report and answer questions from the Panel about its content.

4. List of attached information

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

Appendix 1 – Healthwatch Nottingham Annual Report 2013/14

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

All

8. Contact information

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healthwatch
Nottingham

Annual Report 2013/14

Foreword

Developing a strong voice for Nottingham citizens in shaping health and social care.

This is our first annual report, covering a year that has seen a huge amount of change in local health structures, the establishment of the city's Health and Well-being Board and our own development as the new voice for patients, services users, carers and the wider public committed to ensuring that the health and social care system that is as good as it possibly can be for our diverse population.
So, how have we done in our first year? This report sets out how we have made a difference. To do this, we have put new structures in place:

- We have a five-strong Board directing our work and setting our priorities;
- We have a small team engaging with the public and other networks, compiling the information we receive and ensuring is is fed into the development of local services and systems;
- We have developed relationships with a broad range of other bodies that will help us garner the views of Nottingham citizens, including:
  - the Partnership that hosts us, comprising AWAAZ, HLG, Independent Voices for Engagement (IVE) and Self Help Nottingham
  - HWB3, the voice of the third sector around health and wellbeing
  - Nottingham City Voices, the CCG's online consultation community that we link into

  There are many other networks that help us to hear the voices of those seldom heard.
- We have attracted a number of volunteers to help us reach into Nottingham communities and champion our role and the voice we offer

Also, we have developed relationships with:

- Our key commissioning stakekholders – the Nottingham City Clinical Commissioning Group (CCG), the City Council in relation to Public Health, Adult Social Care and Children and Young People's Services, NHS England.
- Our major providers, including Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Trust, Nottingham CityCare Partnership and a range of other smaller organisations providing health and care services in the city.
- The organisations that regulate and monitor our health and care services – the Care Quality Commission (CQC), Monitor, the Trust Development Authority.

We know that these orgnaisations need to trust us to act independently of the health and social care system, champion the views of local people and act as critical friend to them. They also need to trust that we understand the challenges they face, the constraints placed on them as they plan for major change which will see reduced funding whilst both people's expectations of the system and the needs of the local population increase.

Who's missing from this?
Our most important relationship is that between ourselves and Nottingham citizens:

- We have developed a membership of 800 Nottingham residents keen to be involved and hear more about our work. We know we need to work more closely with them.
- We have developed our relationships with local media so they understand our role.

But we need to do more. We want everyone in Nottingham to tell us about every experience they have of a health or social care service that they think must or could be improved. Alongside that, we want to know about every experience that exceeded their expections so that we can identify good practice.

Over the forthcoming year, we will put the development of our relationship with all Nottingham's citizens as our top priority as we want the whole of the city to Talk to Us to improve health and social care in Nottingham.

Martin Gawith,
Chair of the Board

Making a difference through statutory activities

Government legislation gives us some powers and requires us to undertake particular activities. This section details our actions over the last year and how we're starting to work for our local people.

Promoting and supporting the involvement of local people in in the commissioning, provision and scrutiny of local services

As well involving local people in our work we have worked with service providers and commissioners to promote and support the involvement of local people in the design and delivery of local services. Two thirds of the commissioners who responded to our annual survey told us we are making a difference to their work. When asked how, one respondents said this…

> *Raising awareness of the service user/patient perspective; being an active voice and participant.*
>
> Service commissioner

Here are some examples to illustrate our work in this area…

Urgent care public consultation…

We worked with the Clinical Commissioning Group (CCG), who were also acting on behalf of NHS England, on their plans for involving all local people in the consultation on the planned changes to walk-in centre provision and primary care access. We are supporting their consultation through targeted work with seldom heard groups.

Equality and diversity engagement network…

This is a commissioner and provider forum to share engagement findings and ensure that this activity represents the diversity of our local community. We have contributed to a shared work programme to promote best practice and partnership working.

South Nottingham Transformation Board…

We're participating observers on the board which is overseeing the transformation of local services to deliver improved outcomes for patients. Through our role in attendance at the Citizen Advisory Group of this board we have fed our views into proposals for how they will involve and engage local people. We raised the need for specific methods of engagement to ensure the voice of seldom heard groups is heard.

As well as promoting the involvement of local people in other organisations we're doing this too!

We're strongly committed to involving the diverse communities of Nottingham in our organisation so we've developed and promoted our volunteering strategy and our first wave of volunteering roles, which include:

Champion volunteers… will help us reach the diverse groups and communities in the city, collecting local people's views on and experiences of services.

Administration volunteers… will provide administrative support to our staff team, including responding to calls on our information line.

Event volunteers… will help promote Healthwatch Nottingham at community events.

We're also adopting the Older Citizens Charter. We have supported the city council work to involve a group of older citizens to develop a charter of pledges around how they should be involved in the design and delivery of local services. We've adopted their charter to inform our own development and engagement activities.

Enabling local people to monitor the standard of care

We felt we needed to fully understand the work already being undertaken by commissioners and regulators to monitor the standard of care, before we put our volunteers into these complex situations to undertake Enter and View visits. We wanted to make our work in this area complementary to other regulatory activities. Over the next year we will design and develop our Enter and View visits across all health and social care services to ensure that this activity fills gaps in existing regulatory activities.

Here are some examples of our other work in monitoring standards of care...

Dignity in Care Board...

This board oversees a series of pilots to develop community-based 'governing bodies' in local care homes. We're key participants of the board, and are supporting the development of the project to help fill the intelligence gap between the experience of residents and their family and friends, and the assessment of the regulators and contractors. Healthwatch Nottingham volunteers will join these boards, gathering information to monitor how the home works. This evidence will feed into quality improvement work undertaken by commissioners and providers, will act as an alternative to Enter and View visits and inform our future work with this sector.

Care Homes...

We acknowledged the view expressed by the Care Quality Commission (CQC) that the quality and standard of care in our care homes in our community is below average. We recognised that there has been some good multi-agency work to establish early warning systems, and so decided not to conduct Enter and View visits so as not to conflict with, or replicate, other regulatory activities.

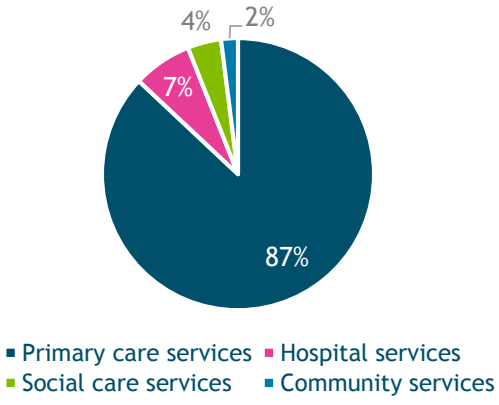
Providing advice and guidance

Our Information Line provides information and signposting services on issues relating to health and social care services in the city. The line is open 9am to 5pm. The Information Line number is:

0115 859 9511.

During 2013/14 we took enquiries from people in all 22 wards of the city, across a range of ethnic groups and age bands. The majority of our enquiries were about primary care services; over three quarters (77%) were related to accessing these services.

Figure 1 Subject of information line enquiries (base: 129 enquiries)



47%

Wanted information related to the administration and management of these services. Just under one in ten callers (9%) wanted advice and guidance on making a complaint. We signposted the latter to the appropriate advocacy and complaints services.

Wanted information and details for GP surgeries or health centres. We provided this where requested, and signposted people to appropriate services where required.

38%

I know I can rely on the staff to do all they can to help. If it's a problem they're not familiar with, they will pass it over to someone who is. I feel that the service is vital to the people of Nottingham.

Information line user

We're involving local people in our information line too!

We're recruiting volunteers to respond to incoming calls, provide information about local services, record local people's experiences of services, and where relevant, signpost callers to advocacy and complaints services.

Informal resolution...

We contributed to the development of the NHS England local area Team's Informal Resolution pilot, aimed at resolving people's concerns about primary care services. This has helped to ensure that people receive advice and guidance to get a swift resolution to concerns that can be resolved through liaison and improved communication between service providers.

Obtaining the views and experiences of local people

The views and experiences of local people have been gathered through our Information Line telephone service, through a 'Talk to Us' form on our website and attending a range of community events where we spoke with people face to face. We've also developed a relationship with Nottingham City Voices, the CCG's membership panel of local people, which is shared with the city council. When we're undertaking specific consultations we will be using this panel to gather the needs and experiences of local health and social care services.

Reaching out to priority groups

To engage people from disadvantaged and seldom heard communities we have used a variety of methods to raise awareness of Healthwatch and gather their needs and experiences.

Refugees and Asylum Seekers...

We've worked with the Nottingham Refugee Forum to gather the needs and experiences of their service users. We've incorporated their most significant concerns into our responses to public consultations on the provision of urgent care and access to primary health care services.

Carers...

We were a partner organisation for the delivery of the 2013 Carers Workshops, delivered in seven venues across the city in May and June 2013. We had a stand to raise awareness of Healthwatch and gather needs and experiences from the 450 people who attended.

Seldom heard groups...

We sit on the steering group of the Nottingham Third Sector Health and Well-being Board (HWB3). This has helped to ensure other member organisations promote Healthwatch Nottingham and support the collection of needs and experiences amongst the groups they support, including the seldom heard.

Young people...

We participated in events which involved a panel of young people from black and minority ethnic communities asking specific questions about local health services. Through this we identified a number of young people interested in working with us as Champion volunteers, supporting the collection of needs and experiences from other young people.

We have also worked with the specialist Children and Young People Worker from Healthwatch Nottinghamshire. This has enabled us to share practice and identify opportunities to work together in gathering the needs and experiences of children and young people in the city.

Black and minority ethnicities...

We held a stand at the Nottingham Caribbean Carnival to promote awareness of Healthwatch Nottingham.

We've supported the Asian Mental Health Resource Unit's Macmillan Coffee morning and mental health awareness event to raise awareness of Healthwatch and talk to local people about their needs and experiences. The unit provides advocacy, support and therapy to the Asian community suffering from any form of mental health difficulties.

Our chair has also featured on the Radio Dawn Health Show and Kemet FM radio station Health and Well-being show. The radio stations targets the Asian and Arabic, and Afro Caribbean communities.

Formulating views on the standard of provision

We take all the needs and experiences we've gathered from local people to identify trends and concerns in provision. These were the three most frequently identified concerns and what people told us about them…

48%

Identified concerns with their treatment and care. Continued and increased levels of pain were the most frequently reported concern. These were all linked to either unsuccessful treatments or low standards of care.

27%

Talked about referrals. Waiting times for the original service to undertake the referral and the amount of time between referral and appointment were the main concern.

18%

Referenced access to services. The time it takes to access services, often in an emergency or crisis situation was the main concern reported to us.

These trends indicated that improvements could be made across a range of services. Here are some examples of how we have looked into these trends to identify potential improvements…

Care homes…

We identified the standard of provision in care homes as an area we needed to further understand. This followed the CQC assessment that the quality of our local care homes was below the standard found in other areas across the country. We're now working through a programme of activity designed to understand service users' needs so that we can identify if and how improvements can be achieved through existing improvement activities.

The frail and older persons journey…

We participated in an event to walk the older person's journey through the acute care setting. This was insightful in both understanding and analysing the current provision and considering improvements that could be made. This has helped us to understand how and why the system needs to change, findings which we have fed into our work on the South Nottingham Transformation Board.

Making reports and recommendations

We've used the needs and experiences gathered to work with service providers and commissioners to improve our local services. Reports have been produced, and where appropriate we've taken our work to groups scrutinising relevant services. Our evidence suggests that we are starting to make a difference to their work. Over two thirds (68% of 16) who responded to our annual survey agreed with this statements. When asked how, they said…

> *The patient feedback that is received via Healthwatch Nottingham helps to inform areas where we need to do better and well, complementing the feedback we receive from a wide range of other sources.*
>
> Service provider

> *By being involved, visible and making a contribution to future planning and current issues…working with Healthwatch has been useful and mutually beneficial. We appreciate their independence and input.*
>
> Service commissioner

70% of providers responding to our annual survey, agreed that we're starting to make a difference for local people. When asked how, they said:

"By providing a systematic way to engage and influence both at a strategic and high operational level."

"By informing local practice and policy."

Here are some examples of how we've produced reports for service improvement...

Care homes...

We were involved in a lessons learnt event following the closure of one of the city's care homes. Following this event, Nottingham City Council and the CCG made ammendments to their operational procedure regarding the unplanned closure of a care home. Continuing to work with Healthwatch Nottingham is referenced in their actions. We took this issue to the Quality Surveillance Group (QSG) for the city, a group wich work to safeguard the quality of care that people receive. They commended this work as a good peice of collaborative working.

Ophthalmology...

We worked with Healthwatch Nottinghamshire to compile a report on concerns that were raised to us both about the Ophthalmology department at the Queens Medical Centre. The report was forwarded to Nottingham University Hospitals who deliver this service. They then produced an action plan which acknowledged the issues raised.

Care homes...

We participated in a strategic review of local care homes to assess if they met the needs of local people now and in the future. Out of this review came some recommendations to commissioners about quality improvements, gaps in the market and messages to the care home sector. We contributed to the development of these, challenging them as a critical friend.

Working with Healthwatch England

We have also worked with colleagues in our neighbouring local Healthwatch and supported Healthwatch England. For example...

Communications working group...

We sit on the Healthwatch England Communications Working Group, working with them to help develop their communications arrangements with local Healthwatch. We have used these to develop our approach to our communications activities.

Joint work with our neighbours...

We work closely with Healthwatch Nottinghamshire, particularly around communication – to ensure local people receive a clear message about what Healthwatch does irrespective of where they live – and we look to aggregate the information we hold about shared providers to enable us to spot trends and to help the provider make best sense of the information we have.

Rights and responsibilities charter...

We arranged and conducted a consultation with an Asian women's groups for Healthwatch England's rights and responsibilities charter.

Care homes...

We have met with the CQC and Healthwatch England to discuss provision in our local care homes. We alerted them to our work around one of the city's care home and sought, with CQC, to provide clear information to the public regarding the outcome of an inspection of a primary care setting that received negative media coverage.

Being active on the Health and Well-being Board

Local Healthwatch have a seat on their local Health and Well-being Board, leaders from local services who work together to improve the health and well-being of local people. This section illustrates how we've been an active member of the Nottingham board.

We have been an active member of the Health and Well-being Board since we started. We report back to them quarterly and provide an update for them on the issues being reported to us through our contact with the public. We've also presented back to them on the following...

Scrutiny...

We have presented to the Health and Well-being Board to improve their understanding of our role in scrutinising services and being the voice for local people. We have now developed a working protocol for how we work with them and the Health Scrutiny Committees.

Roles and responsibilities...

We have contributed to and presented at Health and Well-being Board development sessions, designed to ensure the effective operation of the Board through a clear understanding of members' roles and responsibilities.

Nottingham has a third sector provider forum - HWB3 - representing those third sector organisations with a direct interest in health and well-being. The forum meets once a year but they also have a steering group which meets bi-monthly to allow the two HWB3 representatives on the Health and Well-being Board to appropriately liaise with third sector organisations and to identify opportunities for third sector involvement and influencing. Healthwatch Nottingham sits on the HWB3 steering group as a co-opted member. Our work on the group has resulted in a clearer link between the work plan of Healthwatch Nottingham and HWB3, allowing us to gather and utilise information from local third sector organisations and feed this through into our own information gathering to support our work to identify the views of seldom heard groups.

Making decisions at Healthwatch Nottingham

Local Healthwatch are required to have a procedure to make decisions and involve local people in making decisions. This is how we do it at Healthwatch Nottingham.

The Healthwatch Nottingham Board

The Healthwatch Nottingham Interim Board was selected following a widely advertised application process. Collectively, the Board brings a wealth of experience across health, social care and housing as well as the statutory and voluntary sector. Each member also brings knowledge, enthusiasm and experience of engaging with Nottingham citizens as well as a strong commitment to ensure the diversity of our local population is represented, and its views our reflected in our work. The board meets every two months and makes decisions about how we plan and deliver our activities and how much money we spend on these activities. For example...

Care homes...

Following the emergency closure of a care home in the city, and feedback from relatives of residents, the Board have prioritised care homes as an area of interest. They have initiated a work programme that seeks to maximise people's opportunities to tell us about their experiences of care homes.

You can find out more about our board members here:
http://www.healthwatchnottingham.co.uk/content/meet-board

During 2014/15, the Board will be further expanded, via election, to broaden our reach further into Nottingham's communities

Prioritising our work

To help the Board to make decisions about the services and other areas our activities should focus on, we undertake a three stage process:

- Identifying priority areas based on concerns or issues raised through engagement activities and other information received from local people.
- Looking at the work programmes of partner organisations, and gathering the views of local people to support these activities, e.g. the work of Health Scrutiny.
- Identifying other areas of interest, such as work with specific seldom heard groups whose views may be underrepresented in decision making regarding health and social care services.

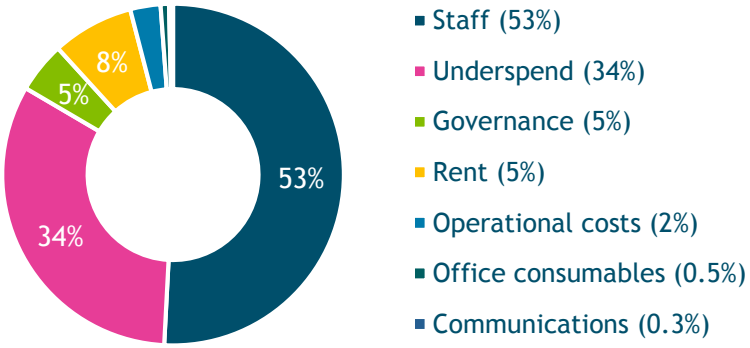
We will be reviewing arrangements during 2014/15 to increase the involvement of local people in setting our priorities.

Financial report

Healthwatch Nottingham receives just under £160,000 per year from Nottingham City Council to fund its service. In addition, a further £20,000 was been provided to assist with set up costs.

Figure 2 illustrates how we have spent our core grant money, with over half (53%) going on staffing costs. This cost in 2013/14 was significantly reduced as the permanent staff team was not fully in place until March 2014. Over the next two years, this underspend will be used to cover staffing costs, which will form the vast majority of our spending.

Figure 2 Healthwatch Nottingham expenditure 2013/14 *Note: this does not include the £20,000 set up costs*



Around three quarters of our set up funds has been spent on IT systems to allow us to store, manage, analyse and report the on the information we receive through our engagement and other work. Additional expenditure has been on establishing the Board, through advertising the recruitment process, and on other promotional materials.

Using the Healthwatch Trademarks

We use the Healthwatch England Brand Guidelines in all our communication material to ensure that the Healthwatch brand is distinctive and meaningful to everyone irrespective of where they live.
The Healthwatch logo is a registered trademark and is protected by law. If an external party uses it without permission, this constitutes infringement of the trademark. The use of the logo is controlled by Healthwatch England www.healthwatch.co.uk

Healthwatch Nottingham is licensed to use the Healthwatch trademark (including the logo and the Healthwatch brand) as per our license agreement with Healthwatch England and the Care Quality Commission.

The year ahead

At the end of the first year of our three year contract we've developed a business plan for delivering our core activities and achieving a longer-term, sustainable future for Healthwatch Nottingham. The two key outcomes we've identified are:

The design and delivery of health and social care services is informed by the views of local people.

Healthwatch Nottingham is a sustainable organisation.

In order to achieve these outcomes we've identified a series of activities we will need to undertake. The development of these activities has been informed by the results of our first annual survey. For example,

You told us...
We need to make more Nottingham citizens aware of Healthwatch Nottingham and the work that we do.
We know we need to prioritise this, so we're working on the following to help us do it:

- **Our Engagement Plan for 2014/15:** This will outline how we ensure everyone in Nottingham has a chance to talk to us about their experiences of health and social care. We will build on existing networks that reach across the whole geography of the city, into communities of interest and where possible we'll use existing relationships to hear from those who are seldom heard.
- **Our Volunteering Strategy:** This identifies the key volunteer roles within Healthwatch Nottingham. It sets out the timetable for recruitment for these roles, training plans to up skill our volunteers, and looks at how we will support them to work with us.
- **Plans to roll out a series of 'Talk to Us' points that will appear across the city during 2014/15:** These will provide a single point for people to both give us information about local services and find out about access to services, complaints processes as part of our signposting work. Initially we will be piloting a couple of these points, but plans are in place to roll out them out across the city once we've found the best way to set them up.
- **Publicising our information and signposting service:** We are moving this service from being staff run to being led by volunteers during the first half of the year. Once we have done this, the increased service capacity will allow us to promote the service more widely and will allow us to provide more detailed information and support in some areas, if needed.

We've developed a work plan that identifies some key themes of our work for 2014/15, which includes the following:

April – June 2014	**Electronic Prescriptions Scheme** - An information campaign for the public, in conjunction with Healthwatch Nottinghamshire, giving clear information about the pros and cons of the scheme, following concerns about links between the scheme and some online pharmacies. **Urgent Care Centre** - Broadening consultation undertaken by the CCG to focus on the needs of seldom heard groups following the plan to move away from the current Walk In Centre model.
July – September 2014	**Dignity in Care Project in Care Homes** - work with social care to look at increasing community involvement in care homes with a view to increasing awareness of any challenges homes may be facing. **Diaries Project** - looking at innovative ways of gathering information about health and social care through diaries, recording anything the diarist may hear.

	PPG survey analysis – To identify trends in the issues identified by PPGs across the city, with a view to monitoring these over time
October – December 2014	**Seldom heard group** – Working with the transgendered community to increase awareness across health and social care staff
January-March 2015	**GP Access/Primary Care Strategy** – Looking at progress in relation to the delivery of this strategy and the linked Integrated Care Programme, and the impact on access to services

We'll keep this work plan under review; our priority at all times will be to ensure the views of Nottingham citizens are represented.

We will also seek to develop those activities that we believe may assist in ensuring Healthwatch Nottingham is sustainable beyond 2015/16. This will primarily be in relation to:

Engagement: Working in conjunction with our voluntary section partners to gather and understand the needs and experiences of seldom heard groups.

Research and Information management: Developing our internal systems to provide robust analysis and innovative reporting of local peoples experiences to maximise its impact on decision making, and ensuring that we can measure and monitor the impact of our work and continue to add value to our partners.

About us

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Staff team

Ruth Rigby – Managing Director
Karen Emery – Information and Administration Worker
Courtney Nangle – Community and Partnerships Worker
Haleema Aslam – Volunteer Co-ordinator
Donna Clarke – Evidence and Insight Manager

HEALTH SCRUTINY PANEL
30 JULY 2014
WALK IN CENTRES/ URGENT CARE CENTRE
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider information from NHS Nottingham City Clinical Commissioning Group updating on progress in the development of an Urgent Care Centre in Nottingham; and the procurement process for the new service, including the service specification.

2. Action required

2.1 The Panel is asked to use the information provided to inform scrutiny of the development of the Urgent Care Centre; and decide if further scrutiny is required.

3. Background information

3.1 In March 2014, the Panel heard from NHS Nottingham City Clinical Commissioning Group (CCG) about proposals to remodel the current Walk In Centre provision in the City and develop an Urgent Care Centre when the current Walk In Centre contracts come to a natural end in April 2015. At that meeting it was agreed that this change constituted a 'substantial development' in service and as such the Panel had a statutory responsibility to consider:

- Whether, as a statutory body, the Panel has been properly consulted within the consultation process;
- Whether, in developing the proposals for service change, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and
- Whether the proposal for change is in the interests of the local health service.

3.2 In May 2014 the Panel received information on the outcomes of consultation that had taken place and plans for further consultation with specific groups and communities for example people not registered with a GP.

3.3 Attached is a paper from Nottingham City CCG updating on the remodelling of Walk In Centre provision/ development of an Urgent Care Centre including consultation and engagement that has taken place since the last meeting and how this has influenced development of the

service specification. The paper outlines the process for procurement of the new service. Also attached is the specification for the service, which has now been publicly released. The Director of Primary Care Development and Service Integration, Nottingham City CCG will be attending the meeting to provide the latest information on this and answer questions from the Panel.

3.4 Nottinghamshire County Council health scrutiny function has been advised that this item is being considered at this meeting so that councillors representing wards where residents might be affected by the changes can be made aware and able to attend this meeting if they wish to do so.

4. List of attached information

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

Appendix 1 – 'Remodelling of Walk In Centres' paper from Nottingham City Clinical Commissioning Group

Appendix 2 – Urgent Care Centre specification

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 to and minutes of meeting of the Health Scrutiny Panel on 26 March and 28 May 2014

7. Wards affected

All

8. Contact information

Jane Garrard, Overview and Scrutiny Review Co-ordinator
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

APPENDIX 1

Re-modelling of Walk-in Centres

SUMMARY

This report updates on the progress ofWalk-in centre re-modelling and the plans to pool resources from the current 'Walk-in Centre' and '8-8 Health Centre contracts to fund an enhanced Urgent Care Centre from a single city-centre location. The new service will continue to offer 'walk-in' provision for minor illness and injury and introduce enhancedsupport to treat immediate or urgent but non-life threatening conditions.The paper also reports on the progress of procurement plans, the development of the service specification and how clinical and patient views have helped shape the new service.

The report aims to offer assurance that the project is being developed to meet the needs of the local population and that links are being made with the appropriate panels and committees.

REPORT

BACKGROUND

In 2013, Sir Bruce Keogh published his report 'Transforming Urgent and Emergency Care Services in England'[1], which suggests the need to reduce the level of duplication and confusion caused by the range of current services (e.g. walk-in centres, minor injury units and minor illness services), all of which have differing configurations. The report sets out the vision that patients with urgent but non-life threatening needs are able to access effective services outside of hospital and as close to home as possible and supports the co-location of community-based urgent care services in coordinated Urgent Care Centres.

Nottingham has two 'walk-in centre' services, the 'Walk-in Centre' on London Road (including the satellite clinic; Clifton Nurse Access Point) and the '8-8 Health Centre' on Upper Parliament Street, both contracts are due to end on 31st March 2015.

Reason for the work/ programme

Both centres offer walk-in provision of face-to-face consultation for minor illness and injury and provide self-care advice, information and signposting services that are highly rated by patients. In 2011/12, ahead of the contract end dates we surveyed patients and engaged with clinicians to review the current services. A GP clinical engagement event was held in December 2011, where concerns were raised about duplication in resources between the 'Walk-in Centre', GP Practices and '8-8 Health Centre' and it was highlighted that the two walk-in centre contracts differ in both opening times and clinical provision; the 'Walk-in Centre' is nurse led, whilst the '8-8 Health Centre' offers GP assessment and some pre-bookable appointments. Whilst both services are highly rated by patients and perform well, clinicians and patients stated that two services running differently has led to confusion. A similar concern was raised through patient engagement in relation to the re-procurement of the Out of Hours service; the engagement report highlighted that future provision needs to support a clear, consistent approach, with simple information to allow for an informed choice[2]. The 2011 clinical engagement event looked at an options appraisal in relation to the two walk-in centre contracts and considered the following options:

[1] http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

[2]Nottingham City and Nottinghamshire County South Clinical Commissioning Groups.'Out of Hours Patient & Public Engagement Report, Phase 2: Focus Groups'. November 2012 – January 2013.

- Re-commission the same services
- Merge/ re-commission something different
- De-commission services

Clinicians were in favour of re-commissioning something different and agreed to committing the same level of funding and continuing to provide the 'walk-in' element of the service but remodelling provision to treat an extended range of urgent, non-life threatening health needs.

In line with this approach NHS Nottingham City CCG's Clinical Council supported the concept of pooling walk-in centre resources in order to develop a central Urgent Care Centre with extended clinical provision and diagnostics and closer links to the hospital emergency department. The concept was developed through previous patient feedback andin line with national and local clinical views but it has been crucial to carry out robust and wide engagement on the detail of the specification. The views of providers, patients and clinicians has shaped the development of the new Urgent Care Centre service model and close working with the CCG Patient Engagement and Communication teams will continue as we move into the procurement and implementation stages. We have ensured that our engagement activities adhere to the recommendations set out by Monitor in their publication 'Walk-in Centre review: final report and recommendations'[3].

Phase 1 Clinical & Public Engagement

During the last 7 months we have undertaken robust and wide ranging engagement activities to ensure that that the project is clinically led and that the voice of the local patient community is heard. A Clinical and Provider Engagement Event took place on 23rd April 2014 with representation from NUH, GPs, existing providers and County CCG commissioners. A Supply2Health notice ensured that any interested providers had the opportunity to attend. The event encouraged discussion around the future service, highlighted issues and generated solutions with an interactive focus on three main questions:

- What should an Urgent Care Centre model include?
- Define good access- location
- Define good access- opening times
- What should the service be called?

Clinical/ provider feedback:

- Important to assess and treat patients in one visit, reducing the need to refer on to other services.
- Important to keep opening hours consistent to avoid confusion.
- Diagnostics were key, in particular X-ray
- No requirement for repeat prescriptions and limited need for health advice (public health) or signposting.
- A general consensus that the service should open 7 days a week, 365 days a year and open at 7/

[3] Monitor. Walk-in Centre Review Final Report and Recommendations. Feb 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283778/WalkInCentreFinalReportFeb14.pdf

8am and close at 10pm/11pm (some said overnight but noted concern around resource).

- In terms of location, it was suggested that the service is located in the city centre, near a pharmacy with parking and public transport. It was highlighted that access for drop off and ambulance transfer is crucial.

Public Engagement has taken place in planned phases;with the support of the CCG Patient Engagement Teamand Healthwatch Nottingham we have aimed to ensure that we engage broadly, meaningfully and purposefully with the public and ensure that the views of all patient groups are heard.

The broad engagement of phase 1 began with a patient survey, whichwas disseminated on websites, via email and post to over 100 third sector organisations, patient groups and City and County GP Practices. The survey was also publicised at patient engagement road shows, held at each of the four Joint Service Centres, Hyson Green, Bulwell, Clifton and St Ann's; the meetings encouraged completion of the survey but also offered the opportunity for focused discussion with small groups of patients. We have had over 600 responses to the survey, allowing the public to comment about what services should be dealt with at an Urgent Care Centre and what is important in terms of location and opening time.

A Patient Engagement Event took place on 30th April 2014, one week later to the Clinical Engagement event and mirrored the content and interactive sessions. The emphasis was on the public opportunity to 'have their say'; the final say on the proposed model to ensure that the model discussed with the public remains recognisable as the final service that is implemented. Feedback from the clinical event was outlined and there were similarities in support for an enhanced service, that assessment and treatment can take place in one visit and strong support for the continuation of walk in appointments. Patients agreed with suggestion of diagnosis for suspected breaks, treatment of eye conditions and the emphasis on accessibility to public transport. Both meetings raised concerns about public understanding of the term 'urgent' and patients expressed nervousness about taking the responsibility to choose the appropriate place for their treatment, with some noting the existing confusion and duplication within the system.

A report on phase 1 patient engagement highlighted the following key themes, many of which mirror the feedback received from our local clinicians:

- Important to assess and treat patients in one visit, reducing the need to refer on to other services.
- Important to keep opening hours consistent to avoid confusion.
- Diagnostics and minor injuries were key, to include x-ray.
- Patients identified the need for strong mental health support
- Patients were keen to keep links with other services, including urgent dental services
- A general consensus that the service should open 7 days a week, 365 days a year, ideally 24 hours, but recognising financial impact, therefore open at 7/ 8am and close at 10pm/
- In terms of location, it was suggested that the service is located in the city centre, the group strongly emphasised access via public transport, disability drop off and some parking.

In order to ensure adherence to robust governance and accountability requirements, the results of initial clinical and public engagement and the proposal to commission an Urgent Care Centre were presented to key health and local authority committeesincluding the NHS Nottingham City CCG Clinical Council and People's Council, Clinical Congress and the Overview and Scrutiny Committee. All meetings were supportive of the approach taken to engagement and the proposal to re-commission a single enhanced Urgent Care Centre following the end of the current Walk-in Centre contracts.

On 28th May 2014, the NHS Nottingham City CCG Governing Body approved the Urgent Care Centreprocurement plan and the approach to engagement. It was agreed that GEM Commissioning Support Unit would be contracted to lead and advise the commissioners on the procurement process and that a Procurement Delivery Group (PDG) would be formed to agree the specification, set fair and robust evaluation criteria, address specific challenges and mitigate risk, particularly in relation to conflict of interest. Membership of the PDG includes representatives from quality, governance, clinicians and commissioners from all stakeholder CCGs. Patients will continue to be involved throughout the procurement by the creation of a Patient Procurement Panel and theirviews will by fed into the PDG meetings for discussion.

Phase 2 Focussed Engagement and Specification Development

Following our broad engagement activities, the phase 1 patient engagement report highlighted the need for focussed patient engagement, particularly within 'seldom heard' patient groups. The success of Walk-in centres in removing barriers to healthcare and improving access to healthcare for the most vulnerable people in society is highlighted in both Sir Bruce Keogh's report and the Monitor recommendations[4]; it is important thatparticular attention is paid to patients from protected characteristics and vulnerable patients who are frequent attenders of walk- in centre services.Discussion with the CCG Patient Engagement Team and Healthwatch Nottingham has helped us to plan to engage with as many communities as possible. During June and July, the Patient Engagement Team and commissioners have attended meetingswith over twenty minority patient groups, which has enabled focused discussion about their views and allowed an opportunity for them to be open about any concerns. Responses from Phase 1 & 2 engagement have been collated and considered in the development of the draft specification and will be discussed in detail by the Patient Procurement Panel. Engagement activities have had the added benefit of raising some cross-cutting concerns in relation to other services, includingaccess to GP Practices and some specialist services, this feedback will be shared with commissioners to be pursued via separate work-streams.

The Procurement Delivery Group has now formally agreed the draft specification, which outlines the minimum clinical, governance and quality standards. The specification fulfils the key themes highlighted by clinical and patient engagement activities; table 1 outlines the feedback received and how this has influenced the specification development:

Table 1 Specification Development

Clinical/ Patient Feedback	Specification/ ITT inclusion
Consistency of opening times	The Urgent Care Centre (UCC) will be open 7 days a week, 365 days a year at the same times each day
Opening hours outside of GP Practice provision	UCC will open from 7am until 9 pm

[4] Monitor. Walk-in Centre Review Final Report and Recommendations. Feb 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283778/WalkInCentreFinalReportFeb14.pdf. NHS England. Transforming urgent and emergency care services in England.http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf. Nov 2013

Initial assessment should be within 15-20 minutes of arrival	The provider will assess patients within 15-30 minutes (within 15 minutes for paediatric patients)
Extended diagnostic and clinical provision	UCC will have X-ray facilities as a minimum An objective of the service will be to provide a tier of care between primary and emergency services.
Patients will be seen and treated in the same visit	This will be a core objective of the new service
Mental Health Support	The specification requires the UCC to have an integrated response to patients who present from vulnerable groups and protocols in place for patients who present with mental health, alcohol and substance misuse issues.
An accessible, city centre location (particularly in terms of public transport and parking)	The UCC will be provided from a City Centre location and providers will be required to demonstrate accessibility of the location.
Patients were keen to see the continuation of 'walk-in appointments'	The UCC will continue this approach
Patients are unsure about the name Urgent Care Centre	The service will need to be called Urgent Care Centre in line with national requirements but we will consider the inclusion of a strap line of 'Walk-in Centre or service'. The Patient Procurement Group will continue to be involved in the publicity of the new service during the implementation phase.

The Urgent Care Centre will be accessible with no appointment needed and offer patients access to a range of health professionals in order to respond to the varied needs of patients across all ages and disabilities. The emphasis will be to assess and treat patients with immediate or urgent health conditions within one visit and will avoid duplication with existing Primary Care services and support access to community and third sector organisations. We will be asking as part of the procurement process that providers identify a system wide approach to delivering the Urgent Care Centre, working with Nottingham University Hospital NHS Trust to relieve pressures across the urgent and emergency care network.

Phase 3 Engagement& Next Steps

Following release of the PQQ documentation and draft specification to potential providers,we are now able to continue engagement activities with clinicians and patients around the specifics of the new service (appendix A. contains the draft specification).The draft service specification will also be shared with the following groups for discussion, feedback and to update on progress:

Chief Operating Officers

Urgent Care Board

CCG Clinical Council

Cluster Boards

Local Area Team

Clinical Congress

People's Council

Other Patient Groups upon request

The Invitation to Tender (ITT) stage of procurement will allow continued scope for clinicians, subject experts (e.g. Medicines Management) and patients to influence the final Urgent Care Centre service by having direct input into the Tender questions and the scoring/weighting of responses. The Procurement Delivery Group and Patient Procurement Panel will meet in August to discuss the responses to the draft specification and agree the questions and scoring for potential providers.

Timeline*(timeline for guidance only, official timescales for procurement will be released by GEM Commissioning Support Unit):*

July/August 2014- Local clinicians and public will continue to shape the final service with engagement on the draft service specification and input into the ITT documents

September 2014- Approval of ITT documents

October- December- ITT stage and scoring

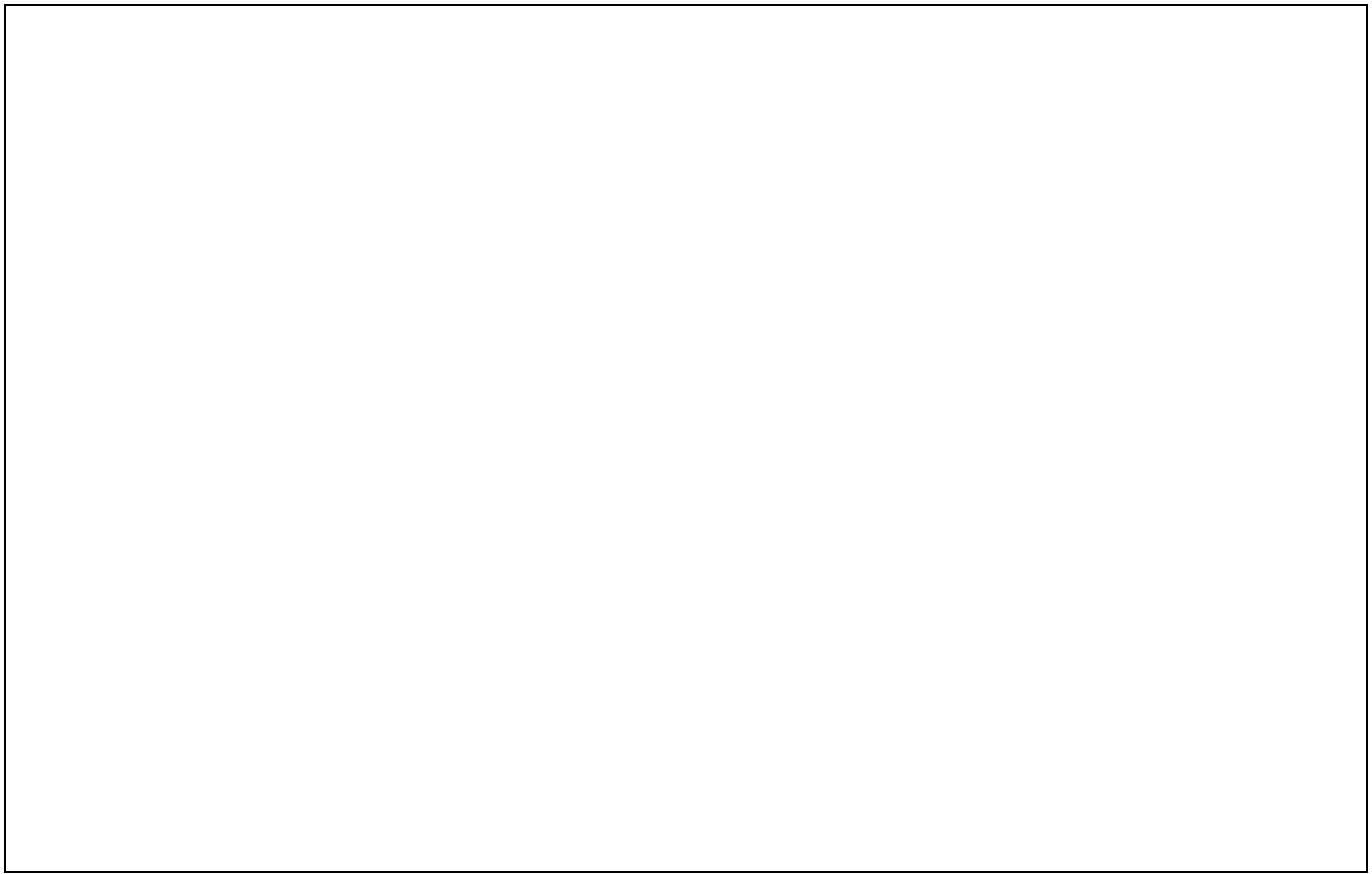
January- March 2015- Publicity about new service

February- April 2015- Implementation phase

April 2015- New Urgent Care Centre is launched.

EXPECTED OUTCOME
***** *what are the expected changes, when will this happen and how will it be evidenced*

- Provide a tier of provision between Primary Care and ED, for patients that have urgent but non-life threating health problems.
- Provision of high quality assessment, diagnosis and treatment of urgent health conditions within a single, enhanced service.
- Reduction in patient uncertainty around what service to access of urgent health needs
- Patients are informed and supported to access the right service for their health needs



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SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Urgent CareCentre (Walk-in Centre)
Commissioner Lead	Naomi Robinson
Provider Lead	
Period	1st April 2015 – 31st March 2018
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

The National Medical Director of NHS England proposes a fundamental shift in provision of urgent care, with more extensive services outside hospital and patients with more serious or life threatening conditions receiving treatment in centres with the best clinical teams, expertise and equipment.
The above is an extraction from:**http://www.england.nhs.uk/2013/11/13/keogh-urgent-emergency/**

In his 'Review of Urgent and Emergency Care', Professor Sir Bruce Keogh sets out the vision that, 'Firstly for those people with urgent but non-life threatening needs we must provide highly responsive and personalised services outside of hospital."

The report also highlights that nationally, "40% of patients attending ED are discharged requiring no treatment at all: there were 1 million avoidable emergency hospital admissions last year".Locally, data has shown that figure is nearer to 50%, with the inclusion of patients who are provided advice only and a further 25% require diagnostic x-ray.

The Urgent Care Centre will improve access to medical attention for patients with immediate but non-life threatening illness or injury outside of the hospital setting.Engagement with local clinicians and patients indicates that they are in support of a walk-in service that provides assessment and treatment in the city centre, while providing extended diagnostics such as x-ray and access to a wide range of health professionals.

The key policy documents related to this service include:

- Everyone Counts Planning For Patients 2014/15- 2018/19 http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-

wa.pdf

- Transforming Urgent and Emergency Cares Services in England. Urgent and Emergency Care Review. End of Phase 1 report. http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

Information about the Nottinghamshire patient demographic and current services relevant to the procurement are included in appendix A.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

2.2 Local defined outcomes

- To reduce the number of attendances to EDby providing a service for patients with urgent but non life-threating needs
- To see and treat the majority of patients within a single visit within the agreed timeframe andto avoid re-presentation by patients for unplanned care to this service or ED.
- Work with commissioners and patient groups to ensure understanding of the purpose and appropriate use of the new Urgent Care & Walk-in Centre
- Work in collaboration with other local health care providers to ensure appropriate signposting and provide seamless care for patients
- Provide an integrated and whole system approach to relieve pressures within both primary care and secondary care services.
- Work with Nottingham University Hospitals NHS Trust either contractually or through close collaborative working to integrate the Urgent Care Centre with the wider urgent care system to ensure streaming and transfer of care as appropriate and to develop protocols in order to provide an alternative destination for ambulance services

3. Scope

3.1 Aims and objectives of service

Aim

The aim of Urgent Care Centre is to assess and treat immediate but non-life threatening health conditions outside of the hospital, in a citycentre location. The service will be accessible with no appointment needed and offer patients access to a range of health professionals in order to respond to the varied needs of patients and across all ages and disabilities. The service will aim to assess and treat patients during one visit and decrease the number of attendances at the Emergency Department for non-emergency conditions

Objectives

- Improved access to health services for immediate health concerns outside of the hospital and within Nottingham city centre.
- Provide a tier of provision between Primary Care and ED, for patients that have urgent but non-life threating health problems.
- Avoid duplication with primary care services and promote the appropriate use local health services
- Provide assessment and treatment to the majority of patients within the same visit
- Provide access to a range of health professionals (including GP assessment as appropriate)
- Provide improved access to diagnosticsfor immediate health problems in the community (including X-ray)
- Provide improved access to assessment forimmediate minor eye conditions
- Complete assessment and treatment as soon as possible following patient presentingand within a maximum of 2 hours for tier 1 patients (no diagnostics required) and 4 hours for tier 2 patients (diagnostics required).
- Reduce health inequalities by improving health outcomes for non-registered patients and for vulnerable patient groups
- Have a system wide approach to service delivery, ensuring cohesive working between services within the Urgent Care Network and Primary Care services.
- The provider will work with commissioners to develop CQUIN and QIPP schemes to reduce unnecessary ED attendances over the duration of the contract.
- The service will offer family and child-friendly waiting and assessment areas.

3.2 Service description/care pathway

Assessment- minimum

- The service will offer a ‘see and treat’ approach as opposed to a triage service and treat model.
- The service will be able to identify all immediate life threatening conditions and to ensure an emergency response if required
- The service will offerface to face clinical assessment within 15-30 minutes of patient presentation by a trained and competent Nurse Practioner (within 15 minutes for paediatric presentations).
- Patients will be offered diagnostics or advanced clinical assessment if required.
- The process will be explained to the patient, who will be given an indication

of their likely waiting time and the contractual waiting times for comparison.
- The service will stream and signpost patients to other health services in primary, secondary or social care within agreed protocols
- Signpost patients to/for advice and information about self-care for minor health conditions as appropriate.

Diagnostics- Must state X-ray and plaster room as a minimum

- The service will provide core diagnostic provision for immediate minor illness
- Direct access to X-Ray located in the same building including
    - Performing and reporting the X-Ray
    - Reviewing X-Ray reports
    - Sharing X-ray reporting with the patient's GP
    - Provision of plaster facilities

Treatment–All the below are the minimum

- Minor illness
- Self-care advice, including brief intervention and signposting to pharmacy services
- Minor injury services (including but not limited to the following):
    - Management of lacerations, including closure of simple non-complex lacerations
    - Management of partial thickness of thermal burns or scalds including broken skin
    - Treatment of wounds including dressings (protocol will be in place to advise patients about appropriate to access to on-going wound care)
    - Bruising
    - Bites
    - Risk of tetanus via assessment
- Minor eye conditions (conjunctivitis, dry eye, inflammation, watery eye, flashes/ floaters, in-growing eyelashes, foreign bodies)
- Removal of foreign bodies (including from eyes, ears and nose)
- Emergency contraception, advice and signposting to specialist sexual health services

Medicines Management- minimum

The provider will:

- Supply medicines via FP10 prescription unless clinical need dictates urgent supply and there is no avenue for the medicine to be issued by a community pharmacy. On these occasions medicines will be supplied from stockthrough mechanisms to be agreed locally.
- The Service Provider must adhere to the Nottinghamshire Area Prescribing Committee prescribing guidance and clinical guidelines, such as Traffic Light List, Antimicrobial Guideline. Prescribe medicines compliant with the Nottinghamshire Joint Formulary, local formulary and clinical guidelines
- Prescribe medicinescompliant with the Nottinghamshire Joint Formulary, and with national and localclinical guidelines
- Ensure that an exemption clause is signed by the patient, if exempt from charges
-
- Ensure that medicines stocked at the base/carried by clinicians comply with

the agreed formulary and are in-date, stored, labelled and handled appropriately

- Implement systems to ensure all patients will be able to access medicines in a safe and timely manner
- Source information on and signpost patients to appropriate medicines facilities, services and pharmacies
- The Provider will be able to demonstrate that robust, auditable systems are in place to cover reconciliation, record keeping and disposal requirements for the drugs for which it is responsible.
- The provider will be able to demonstrate use of appropriate written procedures covering patient safety incidents and near misses, undertake regular audits, and will report incidents and near missesin accordance with local and national requirements.
- The Provider will have appropriate mechanisms for prescribing drugsincluding via FP10s, 'in-house stock or PGDs. In line with the remit of the Urgent Care Centre medicines should only be supplied/prescribed for a single episode of care.
- Providers will not provide repeat prescriptions unless deemed clinically necessary / urgent and only for a maximum of 7 days. The provider will undertake audit / monitoring of persistent requesters for repeat prescriptions.
- A patient will be discharged with a 48 hour provision and/or a prescription if needed

Patient Information & Navigation point

- Provide advice and guidance for non-registered patients about GP Practices and Dental services and their entitlements.
- Provide patients with information leaflets specific to their condition as appropriate
- Provide signposting to Pharmacy services and other services
- Offer advice about available self-referral and self-help services

Focused support for vulnerable patient groups

- Provide an integrated response to patients who present from migrant populations (students, economic migrants, asylum seekers, undocumented migrants, displaced persons, homeless and traveller communities). Service staff will be knowledgeable about their health needs and local services to meet their needs.
- Protocols will be in place for patients presenting with mental health, alcohol and substance misuse problems in order to quickly and safely refer patients to appropriate services

Opening Hours

- The service will be open 365 days a year
- The service will open (accept the first patient) at 7am and close (accept the last patient) at9pm

Workforce

- Staff will have the necessary skills and capability to deliver clinical services in adherence with all aspects of the service specificationand in line with national guidance
- Staff will be available within the specified opening hours to provide a

consistent level of service, including the provision of x-ray and staff with paediatric qualifications

3.3 Population covered

The service will be provided to any member of the general public regardless of residency. A re-charge arrangement will be in place with CCGs outside of the Nottinghamshire area. Charges will apply to patients from countries that do not have a reciprocal arrangement with the UK in line with guidance from NHS England.

The service will provide non-English speakingpatients with access to professional translationservices and have arrangements in place tosupport people with particular needs or disabilities.

3.4 Any acceptance and exclusion criteria and thresholds

The service will be provided to any member of the general public regardless of residency. The service will operate an open access model with no appointments needed.

The service will provide assessment and treatment for non-life threatening conditions (see section 3.5).

3.5 Interdependence with other services/providers

The service is expected to work closely with other healthcare professionals, including:

- Primary care (GPs and Practice Nurses)
- Secondary care
- Community healthcare
- Third sector organisations and services
- Mental Health Teams
- Optometrist
- Pharmacists
- EMAS
- Out of Hours Services
- 111
- Dentists

Streaming and transfer of care

The provider will have in place a detailed streaming process for primary and secondary care. Demonstrate close working with the wider urgent care network of services, including pharmacists, IntegratedDental Unit, GP Out of Hours, East Midlands Ambulance Service (EMAS) and NUH Emergency Department (ED).

The provider will work with ED and EMAS to agree protocols to receive transfer patients from and on to emergency services. Protocols will include clinical governance, information sharing and patient care arrangements.

A written summary of the episode of care will be communicated to the patient's GP with 24 hours and provide a patient copy. The written summary will be in a consistent format using a proforma that is agreed between commissioner and provider.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- The service must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with any relevant clinical standards including adherence to the NICE guidelines.
- Staff delivering the service should be appropriatelyqualified, trained and supervised as required to meet the objectives of the service.
- The provider will be registered with the Care Quality Commission and maintain compliance with the essential standards of the safety and quality
- The NHS Outcomes Framework 2014-15

Infection control & hygiene
The provider will demonstrate infection control and hygiene practice in accordance with The Health and Social Care Act: The Hygiene Code (2008), including:

- Management arrangements to include access to accredited microbiology services.
- Clinical leadership to include access to an infection control team.
- Evidence of application of evidence based policies through annual audit and observational audit for Infection Prevention and Control and Practice.
- Design and maintenance of the environment and medical devices.
- Education, information and communication, ensuring that all staffhave attended infection control training and prevention in particular hand hygiene, and this is documented.

Data & Information Sharing

The successful bidder will provide assurance and evidence of this annually by providing the CCGs in Nottingham City and Nottinghamshire County with an independent audit report of the IG Toolkit declarations (further information: https://www.igt.hscic.gov.uk/)
Through this mechanism the provider will demonstrate compliance with relevant legal and regulatory standards, including:

- NHS Code of Confidentiality (2003)
- Data Protection Act (1998)
- Access to Health Records Act (1990)
- Freedom of Information Act (2000)
- Environmental Information Regulations (2000)
- Computer Misuse Act (1990)
- NHS Code of Practice for Records Management (2009)
- Human Rights Act (1998)
- Caldicott Guardian Manual (2010)

The Provider must have a named individual with responsibility for Information Governance in adherence with the NHS IG Toolkit declarations (further information: https://www.igt.hscic.gov.uk/).

The provider will have IT that is compliant with national NHS standards, including access to the NHS network (N3) Summary Care Records, pathology systems to share and store reports and an electronic clinical system (compliant with local systems).

Medicines Management

Ensure that that there are policies and procedures in place for obtaining supplies of medicines, receipt, recording, storage (including controlled drugs and refrigerated items), handling, administration and disposal of medicines in accordance with:

- The Medicines Act 1968
- The Misuse of Drugs Act 2001 (amended)
- Health and Safety Regulations
- Essential standards for quality and safety (Care Quality Commission)
- Relevant professional codes of practice in relation to medicines e.g. Health Professionals Council (HPC),General Medical Council guidance on good medical practice and Nursing: Nursing and Midwifery Council (NMC) Standards for medicines management (2008)

Safety Alerts

The service must ensure that they are aware of any safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA)http://www.mhra.gov.uk/#page=DynamicListMedicines and the NHS Central Alerting System (CAS) https://www.cas.dh.gov.uk/Home.aspx that apply to any equipment or patient safety concerns associated with this service and that these are acted upon. Details of action taken must be reported back to NHS Nottingham City CCG within the designated timescale.

The provider will meet the requirements of the Medicines Act and the Care Quality Commission.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

See section 4

4.3 Applicable local standards

The service willhave in place a Safeguarding policy for children and vulnerable adults, which ensures that the interests and safeguarding of childrenand vulnerable adults is paramount at all times. This must be in accordance with the standards set out in the Department of Health's publications, Working Together to Safeguard Children (2013) and No Secret: guidance on protecting vulnerable adults in care (2000) and adhere to local protocols within Nottingham City and Nottinghamshire County.

The Provider must provide Safeguarding training to all staff and submit an annual return to commissioners in order to demonstrate compliance.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

Providers are required to have a robust incident reporting and investigation procedure in place for all clinical and non-clinical incidents. All serious incidents (SI's) should be recorded and reported to the NHS Nottingham City CCG as the contract lead within the timeframes stated in the NHS England's 'Serious Incident Framework March 2013'.


sif-guide.pdf

See Schedule 4 & 6 of the NH Standard contract for further quality and information requirements.

Patient, staff and clinical feedback will be monitored and captured via satisfaction surveys, comments and complaints. The Provider will work closely with patient groups to ensure continued engagement, monitoring and evaluation of the service.

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

To be jointly agreed between provider and commissioners

6. Location of Provider Premises

Patients will present to a single reception point and the service will be delivered from a city-central location

- The service must have adequate mechanisms and facilities including premises and equipment to enable ambulance and emergency drop off/ pick up.
- The service will be provided in a location that is accessible to patients

The Provider's Premises are located

8. Baseline Performance Targets – Quality, Performance & Productivity				
Performance Indicator	*Threshold*	*Method of Measurement*	*Consequence of Beach*	*Frequency of Monitoring*
Quality				
Reporting of all mandatory Quality and Safety information *(see Schedule 16 Part 1)*	100% (and exception reporting for non-compliance)	Monitoring	Failure to report will be escalated via procedures in Clause 32.	Monthly
'See and treat' Tier 1 patients within 2 hours of presenting	100%	Monitoring	Raised as a performance issue in Quarterly or 6-month review	
'See and treat' Tier 2 patients within 4 hours of presenting	95%	Monitoring	Raised as a performance issue in Quarterly or 6-month review	
Number of patients 'seen and treated' within 1 hour Number of patients 'seen and treated' within 2 hours Number of patients 'seen and treated' within 3 hours Number of patients 'seen and treated' within 4 hours	Actual	Monitoring	Raised as a performance issue in Quarterly or 6-month review	Monthly

From service users' initial contact with service and the time/date of consultation				
No. (and %) of service users who waited to be seen for an assessment 0 – 15 hours 15 – 30 minutes • 30 – 45 minutes 45 - 1 hour • over 1 hour	Actual figures	*(as above)*		
% of patients who leave before receiving definitive treatment		Monitoring	Raised as a performance issue in Quarterly or 6-month review	
No. of responses received from patient, staff and other health professionals surveys, and % who rated their satisfaction with service as 'Good' or better (including breakdown by protected characteristic)	85% rate service good or better *All service users must be invited to feedback on or before discharge.*	Patient Satisfaction Survey	Raised as a performance issue in Quarterly or 6 month review	Quarterly
Plan re-attendance as a % of patients seen		monitoring	Raised as a performance issue in Quarterly or 6-	

			month review	
Performance & Productivity				
Additional Measures for Block Contracts:-				
Staff turnover rates				
Sickness levels				
Agency and bank spend				
Contacts per FTE				

9. Activity

9.1 Activity (Information Requirements) – All to be split by CCG

Activity Performance Indicators	*Threshold*	*Consequence of breach*	*Frequency of Monitoring*
Total number of service users who received an: • Assessment • Minor Eye Intervention • X-Ray • Other diagnostics • Other Minor Intervention • Information Only	Actual figures	*Breach of Information Agreement (action required in DQIP)*	*Monthly*

Attendances by service user Final Disposition: • Treated & no follow-up required • Referred to ED • Referred to GP <6 hours • Referred to Acute • Referred to Community Service (name of service) • Service user left before being seen • Sign posted to GP • Sign posted to Patient Support Group (name of organisation • F/up at Urgent Care Centre	Actual figures	*(as above)*	*Monthly*
No of Ambulance transfers received	Actual figures	*(as above)*	*Monthly*
No of attendances by • Postcode (resident) • GP practice • CCG • Nine Protected Characteristics	Actual figures	*(as above)*	*Monthly*
No of attendances by age group: • Under 1 year 1 to 5 years 6 to 14 years • 15 to 20 years 21 to 31 years	Actual figures	*(as above)*	*Monthly*

32 to 44 years • 45 to 64 years • 65 to 75 years • 75-85 years • 85+			
No. (and %) of service users who waited to be seen for an assessment (split by tier 1 and tier 2 patients) 0 – 15 hours 15 – 30 minutes • 30 – 45 minutes 45 - 1 hour • over 1 hour	Actual figures	*(as above)*	*Monthly*
Top ten Presenting Conditions and to ten treatments provided by: Adults and Children (separately)	Actual figures	*(as above)*	*Monthly*

HEALTH SCRUTINY PANEL
30 JULY 2014
GP PRACTICE CHANGES – MERGER OF MEADOWS HEALTH CENTRE (DR RAO AND PARTNER) AND WILFORD GROVE SURGERY
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To provide information on GP practice changes – merger between Meadows Health Centre (Dr Nao and Partner) and Wilford Grove Surgery.

2. Action required

2.1 The Committee is asked to consider the information provided.

3. Background information

3.1 NHS England Derbyshire and Nottinghamshire Area Team has advised of changes to two GP practices in Nottingham – merger of Meadows Health Centre (Dr Nao and Partner) and Wilford Grove Surgery. A report outlining the changes and plans for future arrangements is attached.

3.2 It is not intended that a representative of the NHS England Area Team will attend the meeting to discuss the changes outlined in the report. If a Panel member has a particular issue that they wish to raise in relation to this change they should contact Jane Garrard, Overview and Scrutiny Co-ordinator as soon as possible in advance of the meeting.

4. List of attached information

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

Appendix 1 – Proposed merger – Update 19 June 2014 from NHS England Derbyshire and Nottinghamshire Area Team

Appendix 2 – Letter to patients (same letter to patients of both practices)

Appendix 3 – Patient engagement details

Appendix 4 – Other stakeholder engagement details

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

All

8. Contact information

Jane Garrard, Overview and Scrutiny Review Co-ordinator
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

Appendix 1

Derbyshire & Nottinghamshire Area Team

Meadows Health Centre (Dr Rao) and Wilford Grove Surgery

Introduction:

Derbyshire & Nottinghamshire Area Team has received an application proposing the merger two practices Dr Rao, Meadows Health Centre (1 Bridgeway Centre, The Meadows, Nottingham, NG2 2JG) and Wilford Grove Surgery (55 Wilford Grove, The Meadows, Nottingham, NG2 2DR). Both of these practices are constituents of Nottingham City Clinical Commissioning Group.

Dr Rao's practice operates from a health centre shared with another practice (Drs Larner & Jadoon). The second practice, provided by Dr Larner & Jadoon, is not included as a party to the proposed merger.

Dr Rao's practice, in the Meadows Health Centre, and Wilford Grove Surgery are located approximately 200 yards apart in The Meadows, a large estate with high deprivation, which is situated half a mile from the city centre of Nottingham. The Meadows Health Centre also accommodates Nottingham City Care services and is close to a parade of shops

Dr Rao's practice has approximately 2,800 patients. Dr RSC Rao is senior partner of the practice following the retirement of Dr Shankar in March 2014; the practice has two doctors in total which provide 1.4 Whole Time Equivalent (WTE).

Wilford Grove Surgery has approximately 2,200 patients with one doctor. Dr Anandappa joined the practice in November 2013 and is the only doctor following the subsequent retirement of the previous doctor, Dr Hazarika.

Both practices have seen a decline in the size of their patient list size over the last few years. Within approximately half a mile of both practices is the APMS practice at Platform One run by NEMS, which opened in 2012. This has attracted many new patients and it is thought that many have been drawn from the Meadows catchment area.

The premises currently utilised by Wilford Grove Surgery is an Edwardian converted house that is not expected to meet the full standards of the Care Quality Commission standards for the provision of primary medical services in the future.

Proposal

The practices have jointly approached the NHS England Area Team to seek permission to merge the practices. The proposal requests the continuation of the on consolidated practice within the Meadows Health Centre and the closure of the Wilford Grove premise.

The practices involved are currently considering any adjustments (if any) are required to the Meadows Health Centre to accommodate the patients and staff of Wilford Grove Surgery.

In making the application for merger, the practices have outlined plans extended the services available in the Meadows Health Centre.

In considering this application, Derbyshire & Nottinghamshire Area Team have sought the view of Nottingham City Clinical Commissioning Group. Nottingham City Clinical Commissioning Group is in development for the Primary Care Strategy within the area. The Clinical Commissioning Group has indicated that this merger change would fit with the Primary Care Strategy as planned.

Impact/benefits for local population

The main benefit to patients will include a wider-range of clinicians (including a female GP for Wilford Grove patients) available at the new merged practices. Increasing the overall numbers enables greater flexibility for the practices to provide appointments across a greater part of the day and to have arrangements in-house where unplanned cover is required.

The practices propose to offer a greater range of services to all patients of the new practice. These include phlebotomy, minor surgery, spirometry and nebulisation. In addition the patients of Wilford Grove Surgery will benefit from improved facilities in the health centre as well as access to designated parking (not currently available at Wilford Grove Surgery).

The Meadows Health Centre is situated on the ground floor only which improves access for all patients particularly patients with disabilities or mobility difficulties.

Under the terms of the application, NHS England has asked the new practice to put in place increased opening on a Thursday afternoon when both practices are currently closed.

The larger practice will also offer online booking of appointments, online repeat prescriptions ordering and the Electronic Prescribing Service which will benefit patients interested in access through technology.

Wilford Grove Surgery recognises there may be an element of anxiety in some patients regarding the relocation of services. Both practices will endeavour to listen to concerns and provide assurance to patients including providing information on the benefits of the merger.

Derbyshire & Nottinghamshire Area Team Area Team consideration:

The Area Team considered this application at the Primary Care Panel on 19 June 2014. The Area Team has given its support to this application subject to the following conditions:

- Both practices are expected to complete a period of engagement with patients and stakeholders on the future arrangements for patient services to ensure full awareness of the changes.

- The practices have secured capital funding arrangements for the premises alterations within the Meadows Health Centre to accommodate the additional patients.

Appendix 2

Dear Patient

Joining together Wilford Grove Surgery(Dr Kiran Anandappa) and Meadows Health Centre(Dr Rao Rudrashetty & Dr MalathiKiran)

We are writing to you as a patient registered with Meadows Health Centre to tell you about our plans to join together **Wilford Grove Surgery** and **Meadows Health Centre**.

We are proposing to join these two practices together to form a new merged practice from 1 October 2014. We want to share with you the reasons why we think these changes will benefit patients from both practices and are also keen to hear your views on this.

The new practice believes in high quality primary care delivered by a team you can know and trust. General practice has changed so much in recent years and we hope this opportunity will allow us to give our patients and staff a bright and secured future. The practices regard this as a positive move and look forward to work together.

The merged practice will be based at Meadows Health Centre, 1 Bridge way Centre, Meadows, Nottingham, and NG22JG. We are hoping that the same staff at both the practices will continue to work in the merged practice.

As part of this process, we believe patients will benefit from…

a. Improved access
b. Increased appointments
c. Facility for car parking
d. Choice of seeing female doctor/nurse/HCA
e. Improved services

We will be ensuring that all patients affected by the proposed changes have the chance to keep up to date with the latest news and have the opportunity to raise questions to share views with members of the practice teams. We will use the feedback we receive to consider how the new practice will work in the future. We believe it's important that everybody's views are considered, so please do take the time to let your practice team know your views.

We will be holding open sessions where you can come along and speak to members of both practices. These will take place on the following days:

- Event 1 (Wilford Grove Surgery- 20/08/14)
- Event 1 (Meadows Health Centre- 20/08/14)

To ensure we have adequate accommodation for you to attend, please confirm you are attending by contacting our practice manager- Kashmira Patel – 01159861128.

If you have any specific access requirement for these events please inform earlier so that necessary arrangements can be made. We would like to bring to your attention that we have easy access for the disabled people.

Information about the proposal will be on display in the practice waiting room and the practice team will also be able to help you with any queries.

You can have your say in a number of ways:

- Write to the doctors at Meadows Health centre, 1 Bridge way centre, Meadows, Nottingham, NG22JG

- Attend the open events: we are holding these events on the same day for your convenience.

    - Event 1
    - Event 2

Yours sincerely

Dr Rao Rudrashetty
Dr MalathiKiran

Appendix 3

Patient Engagement details:

1. Wilford Grove Surgery currently already has a practice website and are planning to inform the details regarding the merger on it: 01/08/14

2. Meadows Health Centre already has electronic notice board in the waiting area and we are planning display the information regarding the merger on it: 01/08/14

3. Both the surgeries are planning to add the information regarding merger on the repeat prescription slips: starting from 01/08/14

4. We are planning to write to the councillors/MP`s, other local practices, Health & Wellbeing board, Healthwatch, local pharmacies as soon as we get the permission for merger to go ahead from the NHS England: 28/07/14

5. We are planning to write to all the patients in the both the surgeries informing them personally regarding the merger: 01/08/14

6. We are planning to have meeting with Patient Participation Group in both the practices to inform regarding the merger. Dr Kiran Anandappa at Wiford Grove Surgery is planning to have meeting with their PPG on the 23/07/14. Dr Rao Rudrashetty and Dr MalathiKiran at Meadows Health Centre are planning to have meeting with their PPG on the 21/07/14.

7. Both the practices are planning to have open day meeting with their patients to address any questions regarding merger on 20/08/14

Appendix 4

Other Stakeholders engagement:

1. We are planning to write to the following people and make arrangements to meet: 01/08/14
   a. Local Member of Parliament
   b. Local Councillor
   c. Health & Well Being Board
   d. Neighbouring practices
   e. Health watch
   f. Local community pharmacies
   g. Any other local health providers as necessary

2. We are planning to write to the post office to inform them of the merger so that the mails from Wilford Grove Surgery will be re-directed to Meadows Health Centre in the future. Date planned: 01/08/14

3. Dr Kiran Anandappa from Wilford Grove Surgery will be informing his Landlord regarding closing down of the practice. Date planned: 24/07/14

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HEALTH SCRUTINY PANEL
30 JULY 2014
WORK PROGRAMME 2014/15
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the Panel's work programme for 2014/15, based on areas of work identified by the Panel at previous meetings and any further suggestions raised at this meeting.

2. Action required

2.1 The Panel is asked to note the work that is currently planned for municipal year 2014/15 and make amendments to this programme if considered appropriate.

3. Background information

3.1 The Health Scrutiny Panel is responsible for carrying out the overview and scrutiny role and responsibilities for health and social care matters and for exercising the Council's statutory role in scrutinising health services for the City.

3.2 The Panel is responsible for determining its own work programme to fulfil its terms of reference. The work programme is attached at Appendix 1.

3.3 The work programme is intended to be flexible so that issues which arise as the year progresses can be considered appropriately. This is likely to include consultations from health service providers about substantial variations and developments in health services that the Panel has statutory responsibilities in relation to.

3.4 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Panel.

3.5 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 set out in legislation and associated regulations and guidance. 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.

3.6 Nottingham City and Nottinghamshire County Councils have established a Joint Health Scrutiny Committee which is responsible for scrutinising decisions made by NHS organisations, together with reviewing other health issues that impact on services accessed by both City and County residents.

4. List of attached information

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

Appendix 1 – Health Scrutiny Panel 2014/15 Work Programme

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

All

8. Contact information

Jane Garrard, Overview and Scrutiny Review Co-ordinator
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

APPENDIX 1

Health Scrutiny Panel 2014/15 Work Programme

28 May 2014	• **Nottingham CityCare Partnership Quality Account 2013/14** To consider the draft Quality Account 2013/14 and decide if the Panel wishes to submit a comment for inclusion in the Account (Nottingham CityCare Partnership) • **Adult Integrated Care** To review progress in the Adult Integrated Care Programme (lead – Nottingham City CCG) • **Health Scrutiny, Healthwatch and Health and Wellbeing Board Working Agreement** To agree a protocol guiding the relationship between health scrutiny, Healthwatch Nottingham and Nottingham City Health and Wellbeing Board • **Walk In Centres** To consider the outcomes of consultation and engagement carried out in relation to remodelling Walk-in Centres/ development of an Urgent Care Centre and next steps in development of the proposals (Nottingham City CCG) • **GP Practice Change - The Practice Nirmala** To consider proposals to close The Practice Nirmala (NHS England Derbyshire and Nottinghamshire Area Team) • **GP Practice Change - Merger of Boulevard Medical Centre and Beechdale Surgery** To consider proposals to merge Boulevard Practice and Beechdale Practice (NHS England Derbyshire and Nottinghamshire Area Team)
30 July 2014	• **Discussion with Portfolio Holder for Adults and Health/ Chair of the Health and Wellbeing Board** To consider the Portfolio Holder for Adults and Health's work over the last year and progress in delivery of

	objectives relating to health and adult social care; current areas of work; and priorities and plans for 2014/15. (Nottingham City Council) • **Healthwatch Nottingham Annual Report** To receive, and give consideration to the Annual Report of Healthwatch Nottingham (Healthwatch Nottingham) • **Integration of Public Health within Nottingham City Council** One year on, to review the integration of public health within the Council, including how the Public Health Grant is used to address wider determinants of health. (Nottingham City Council) • **Urgent Care Centre Specification** To receive information about the draft specification for a new Urgent Care Centre (Nottingham City CCG) • **Implications of Care Act for Nottingham City Council** To consider the implications of the Care Act for Nottingham City Council and how the Council is responding (Nottingham City Council) • **GP Practice Change – Merger between Meadows Health Centre, Bridgeway Centre and Wilford Grove Surgery, 55 Wilford Grove** To consider proposals to merge Meadows Health Centre and Wiford Grove Surgery (NHS England Derbyshire and Nottinghamshire Area Team)
24 September 2014	• **NHS Health Check Programme** To review performance of the NHS Health Check Programme and progress in access for individuals not registered with a GP (Nottingham City Council)

26 November 2014	• **Bowel cancer screening uptake** To receive information on the uptake on bowel cancer screening in the City and to scrutinise activity to improve uptake (NHS England Derbyshire and Nottinghamshire Area Team/ Nottingham City CCG)
28 January 2015	• **Nottingham CityCare Partnership Quality Account 2014/15** To consider performance against priorities for 2014/15 and development of priorities for 2015/16 (Nottingham CityCare Partnership)
25 March 2015	

To schedule

- Implications of the Cavendish Review (review of healthcare assistants and support workers in NHS and social care) for Nottingham
- Transition between CAMHS and adult mental health services
- School nurse service
- The strategic response to health inequalities/ to what extent is the JHWS supporting a reduction in health equalities?
- How is public health contributing to progress with carbon emission reductions, energy savings and sustainable development?
- Sex and Relationships Education in schools
- Transfer of public health services for children aged 0-5 years
- Adult Integrated Care – evaluation of programme to date (autumn/ winter 2014)
- Overview of the work of OSCAR Nottingham

Scrutiny Review Panel

- Service user experience of care at home services (autumn 2014)

Items to be scheduled for 2015/16

May 2015

CityCare Partnership Quality Account 2014/15

Implementation of Strategy to Reduce Avoidable Injuries in Children and Young People

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