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Nottingham City Council
Health Scrutiny Committee

Date: Thursday, 17 June 2021

Time: 10.00 am

Place: The Ballroom - The Council House, Old Market Square, Nottingham, NG1 2DT

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

Director for Legal and Governance

Governance Officer: Kim Pocock **Direct Dial:** 0115 876 4321

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2	**Declarations of interest**	
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Nottingham City Council

Health Scrutiny Committee

Minutes of the meeting held at The Ballroom - The Council House, Old Market Square, Nottingham, NG1 2DT on 13 May 2021 from 10.00 am - 12.20 pm

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Phil Jackson
Councillor Cate Woodward (Vice Chair)	
Councillor Michael Edwards	
Councillor Samuel Gardiner	
Councillor Maria Joannou	
Councillor Kirsty Jones (left at 11.15am)	
Councillor Angela Kandola (left at 11.45am)	
Councillor Anne Peach	

Colleagues, partners and others in attendance:

Julie Attfield	-	Director of Mental Health and Learning Disabilities, Nottinghamshire Healthcare Foundation NHS Trust
John Brewin	-	Chief Executive, Nottinghamshire Healthcare Foundation NHS Trust
Lynette Daws	-	Head of Primary Care, Nottingham and Nottinghamshire Clinical Commissioning Group
Joe Lunn	-	Associate Director of Primary Care, Nottingham and Nottinghamshire Clinical Commissioning Group
Ajanta Biswas	-	Nottingham and Nottinghamshire Healthwatch
Kim Pocock	-	Scrutiny Officer

1 Apologies for absence

Councillor Phil Jackson (medical appointment)

2 Declarations of interest

Councillor Mike Edwards declared a personal interest in item 7: Platform One - Progress Towards Transition/ Dispersal Launch Date, as he is a patient currently registered with the Platform One practice. He took no part in the discussion on this item.

3 Appointment of Vice-Chair

Councillor Cate Woodward was elected as Vice Chair of the Health Scrutiny Committee 2021/22.

4 Minutes

The Committee agreed the minutes of the meeting held on 15 April 2021 as an accurate record and they were signed by the Chair.

The Committee noted that comments, made publicly at its meeting held on 15 April 2021, stating that partner organisations had not addressed recommendations made by the Committee when it previously discussed suicide prevention were inaccurate. No recommendations were made in relation to the suicide prevention item in January 2020 and all areas raised by the Committee in January were responded to by partners in the Committee's meeting held on 15 April 2021.

5 Health Scrutiny Committee Terms of Reference

The Committee noted its terms of reference, as agreed at Council on 26 April 2021.

6 Nottinghamshire Healthcare NHS Foundation Trust Strategy

John Brewin, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust and Julie Attfield, Director of Mental Health and Learning Disabilities, Nottinghamshire Healthcare NHS Foundation Trust, attended the meeting to present information on and discuss with the Committee the Trust's strategy, which is currently being reviewed. They highlighted the following information:

(a) Responding to the pandemic over the last 16 months has been challenging. Nottinghamshire Healthcare NHS Foundation Trust (the Trust) set up a command centre, through which all services have been co-ordinated. No service has been formally stood down (although the memory clinic did not operate for a period of time), but there have had to be adaptations to ensure Covid 19 compliance and that priority services continue to operate with the available workforce.

(b) A significant proportion of the workforce was redeployed to keep key services open, for example in crisis teams, on wards and in children's services. In addition, staff were absent due to shielding, isolating, family reasons and sickness absence. As regular lateral flow tests and vaccinations have been introduced, workforce capacity is improving. 90% of the workforce has now been vaccinated.

(c) Many services require face-to-face contact, but where it has been possible, remote consultations have been held and have largely been well-received by patients. The Trust is now operating a mixed model of service delivery.

(d) Significant funding will accompany the national long-term plan to transform mental health services provision, leading to broader access.

(e) Due to the pandemic, the Trust has seen loss of bed capacity and access to clinic space. As a consequence of this, and other changes which had to be implemented to manage the impact of the pandemic, the Trust is not seeing more patients but those that it is seeing are more acutely unwell.

(f) The Trust has seen the following changes in relation to Adult Mental Health referrals and access:

(i) During the first lockdown, referrals to Adult Mental Health services dropped significantly as people did not contact their GPs. This is the only pathway not fully restored – all others are seeing restoration/ an increase to pre-pandemic rates.
(ii) Crisis referrals have increased. There have been 150 crisis calls per month since August 2020.
(iii) Intellectual Development Disability (IDD) referrals have increased since September 2020. This is believed to be due to the impact of isolation on carers.
(iv) Face to face contact is increasing week by week in most services.

(g) Child and Adolescent Mental Health Services (CAMHS) have continued throughout the pandemic, using a mix of face to face and virtual contact, including group work.

(h) Key services to note in terms of access to services and waiting times are as follows:

(i) Waiting times have improved for Improving Access to Psychological Therapies (IAPT), with 9 out of 10 people now seen within 6 weeks, and less than 1% of patients waiting over 18 weeks.
(ii) Early Intervention in Psychosis (EIP) teams are delivering treatment to over 85% of patients within two weeks, significantly ahead of the national target of 60%.
(iii) Waits for Memory Assessment Services have reduced significantly, to under 14 weeks currently, having been above 20 weeks for several months in 2020/21.
(iv) The goal of 95% for routine and urgent treatment of young people with eating disorders has not been achieved, with 80% of patients treated within 4 weeks (routine) and 56% of patients treated in one week (urgent), over the course of 20/21.
(v) Step 4 Psychotherapy and Psychological Therapies have been particularly disrupted by COVID, as certain therapies cannot be delivered virtually; this has led to patients commonly waiting in excess of 6 months for treatment.
(vi) Average waiting time for treatment at a Local Mental Health Team (LMHT) is currently around 7 to 8 weeks, an improvement on waiting times for the same period last year.
(vii) Despite COVID, access rates into Children and Adolescents Mental Health Services (CAMHS) in the community have improved by 6% year on year. The length of time a patient waits for assessment from CAMHS community services is currently around 11 - 12 weeks.
(viii) The Trust's Mental Health Support Teams in Schools service was the first to go live nationally and supports 112 schools across Nottinghamshire.
(ix) Monthly performance against the 72 Hour Follow Up target has remained above target throughout 2020/2021.
(x) The overall level of physical health checks continues to increase, driven by improved levels within Community Services, (now running at double the rate of last year).

(i) Inappropriate out of area mental health placements have halved from an average of 464 bed days per month in 2019/20 to 177 for 2020/21 as a result of changes to crisis pathways and sub-contracting arrangements with service providers. There are currently seven patients placed out of area. The Trust aims to have no out of area placements by October 2021.

(j) The Trust has higher referral acceptance rates across all services than national average rates. This is a positive challenge to the previous Trust reputation for not taking enough patient referrals.

(k) During the pandemic the Care Quality Commission (CQC) has focused on Covid risk and safety inspections of specific services, rather than full inspections. As a consequence, there has been no change to the Trust's overall rating of 'Requires Improvement'. This legacy rating will not change until there is further inspection.

(l) Since March 2020 the CQC has carried out focused inspections at Rampton Secure Hospital, Adult Mental Health in-patient wards, Infection Prevention and Control arrangements and Wells Road Low Secure Hospital. Work is ongoing to address the need for improvements in some core services at Rampton and Wells Road Low Secure Service (which received a CQC warning notice) and to continue improvements on Adult Mental Health wards. This work is monitored by Improvement Boards.

(m) There has been reduced patient experience feedback during the pandemic period. In lockdown #2 feedback was more critical than complimentary which does not reflect the previous trend of around equal critical/ complimentary feedback. Themes arising from critical feedback include, access and waiting times, not feeling heard, adult mental health crisis care, communication, rules and restrictions on wards. Complimentary feedback themes include, helpful/ caring/ friendly staff, support and advice, listening.

(n) The Trust has responded to critical feedback with improvements, including changes to carers' visiting processes on inpatient wards, change of hours for activity co-ordinators for inpatients, setting up lived experience groups in the community, providing new IAPT services, setting up a virtual wellbeing group for IDD patients and yoga sessions for CAMHS inpatients.

(o) National staff surveys have shown that the Trust is the most improved mental health organisation across all domains in the country after several years of increasing dissatisfaction. Despite this significant improvement, the Trust demonstrates only average satisfaction compared with its peers (eg, Northamptonshire, Leicestershire) and continues to work to improve staff satisfaction levels.

(p) Transformation work in 2020 has included the following achievements:

(i) The Early Intervention in Psychosis services is now NICE compliant.
(ii) Individual Placement and Support investment to support people to get into work and/ or stay in work.
(iii) Crisis core staffing levels are now fully compliant.

(iv) The Street Triage Service has been expanded to include a day car as well as out of hours services.
(v) The Intensive Home Treatment Team (Mental Health Services for Older People) is offering age appropriate support.
(vi) The crisis service for children and young people, introduced during the pandemic has been expanded to 24/7 and will be retained post-pandemic.
(vii) A new Attention Deficit Hyperactivity Disorder pathway has been introduced.

(q) The Trust has secured £3.1m in national bids for funding and has secured £49m of capital funds over three years to eradicate dormitories for inpatients by 2024.

(r) Plans for 2021 include:

(i) Improved pathways for those suffering severe mental illness, eg personality disorder community support pilot; investing in more substance misuse workers, peer support workers and transition workers (to support 18-25 year olds); placing Eating Disorder clinical leads in community teams; expanding the voluntary and community sector offer; and introducing Primary Care Mental Health Practitioners to all Primary Care Networks.
(ii) Increased crisis support (including that for children and young people) to meet local demand and reduce waiting lists.
(iii) Further work on a new model offering specialist diagnostic and treatment support for those with Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder.
(iv) Opening Sherwood Oaks with 14 new acute beds.

In response to questions from the Committee and in the subsequent discussion the following points were made:

(s) Anyone waiting over six months for Step 4 Psychotherapy and Psychological Therapies will have a further review, which will look at other options available while they are waiting, for example online Cognitive Behavioural Therapy (CBT), and IAPT may also be able to give some support while a patient is waiting. The Trust is investing this year in capacity and other forms of broader support (eg social prescribing) to provide psychotherapy and is confident that the waiting list will have come down significantly by the end of this financial year.

(t) Committee members expressed concern about the length of the waiting time for psychological therapeutic support. They were also concerned that support offered during the waiting period would not hold up the referral for specialist psychological support nor result in removing people from the waiting list (because they are receiving some form of treatment) before having the chance to access specialist psychological support.

(u) Workforce sickness absence rates are at the lowest for a long period of time – 4% and the vacancy rate, at 10%, is the lowest it has been in the last two years.

(v) The Trust will be piloting a Single Point of Access (SPA) in the autumn to manage the plethora of pathways to treatment, which can feel complicated to patients, especially where there are multiple referrals. This should streamline some of the

issues around access to services, although complex cases may take longer to resolve.

(w) The Trust is looking at the learning from the pandemic. Many patients have preferred remote contact for support, particularly children and young people. A mixed model will continue to be offered, ensuring face to face and remote services to enable availability and accessibility.

(x) The CQC exposed a closed culture at Wells Road Low Secure Service, ie a service not open to learning from evidence and good practice. In the light of this, the Trust is looking at its other services to see if there are pockets of closed cultures elsewhere.

(y) Staff sickness absence rates at Rampton Hospital have decreased and retention rates have increased. This may have been impacted by the threat to jobs during the pandemic, but it is hoped that it is also as a result of improvements to the working environment. Recruiting more staff is a key priority for 2021/22.

(z) Sherwood Oaks, near Mansfield, is a relatively new building, previously operating as a forensic facility, which the Trust is now converting into an open acute facility for the transfer of Adult Mental Health inpatient services from Millbrook Mental Health Unit, Mansfield.

(aa) GPs have all been made aware of the new ADHD pathway.

(bb) £16m is being invested into Nottinghamshire Mental Health Services (including the Voluntary and Community Sector as well as the Trust). This will enable significant changes, eg in the last year, the workforce has been expanded by 150 and will continue to be expanded by a further 250. Implementing changes will be challenging, but the Trust is confident that the first significant investment for many years will have a positive impact. The Trust is committed to carrying out these changes in an open and publicly accountable way.

(cc) At the beginning of the pandemic, there was a high number of referrals to Local Mental Health Teams (LMHTs) and the Department of Psychiatric Medicine (DPM), and numbers were difficult to manage. The number of referrals has now reduced.

(dd) There is an urgent referral route to Eating Disorder Services, so there is no wait if immediate access is needed. BMI (body mass index) is still used as a threshold for treatment but there is flexibility to consider other factors. Members were concerned that continuing to use BMI as a threshold for treatment meant that many people with eating disorders who do not drop below the BMI threshold have no access to treatment.

(ee) Both Children and Adult Eating Disorder Services are being expanded. In response to members' concerns that there is no adult inpatient provision for Eating Disorder treatment in the city, the Trust responded that there is not the critical mass of patients which would justify creating this provision locally. Patients are placed in the region where possible. The Trust agreed to provide more information to Committee members on Eating Disorder Services.

(ff) The Mental Health Teams in Schools Service covers approximately one third of all schools across Nottinghamshire and will be further expanded with a second wave of funding. There is a lead-in time as Emotional Wellbeing Practitioners take a year to train. The Committee was particularly interested in which city schools are in receipt of this support. The Trust agreed to provide this information to Committee members.

(gg) The Trust is working on how to provide female Psychiatric Intensive Care Unit services without having to place patients out of area, as there is currently no provision for this in the city.

(hh) Given time constraints, the Chair asked that members with outstanding questions on this item send them to her for referral to the Trust for a response.

The Chair thanked the Trust's colleagues for attending the meeting and noted that the Committee would discuss future visits to the Committee under the Work Programme item on the agenda.

7 Platform One - Progress Towards Transition/ Dispersal Launch Date

Joe Lunn, Associate Director of Primary Care, Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) and Lynette Daws, Head of Primary Care, CCG, attended the meeting to discuss progress towards the end of the Platform One contract for a GP practice and the start of the new contract for a GP practice on Parliament Street; and the dispersal of patients to their local practice where they live outside the new practice boundary. They highlighted the following information:

(a) Plans are progressing well towards the transfer/ dispersal of patients when the contract with NEMS for the Platform One GP practice finishes at the end of June.

(b) The CCG has requested the most current patient list at the end of May so that all patients can be checked to ensure that arrangements for them are correct and appropriate. Colleagues are also liaising with Primary Care Networks to capture those patients who will already have started the process of moving practice themselves.

(c) Communications and engagement continue to be as robust as possible with both patients and staff who will be working with vulnerable patients. The new Parliament Street practice now has a phone number and leaflets/ information cards are ready to go to print.

(d) The Severe Multiple Deprivation (SMD) Locally Enhanced Service (LES) can now start to deliver to patients. A good percentage of GP practices across the city and county are already signed up to the service.

Ajanta Biswas, who chairs the Platform One Stakeholder Task and Finish Group, added the following:

(e) Feedback from the Task and Finish Group, which has all relevant stakeholders around the table now, indicates that things are progressing smoothly. The Group has influenced communications with patients to ensure that they are accessible and is now monitoring the transition, liaising with the new provider (Nottingham City GP Alliance) to mitigate risks raised in the EQIA (Equality Impact Assessment). Patients will continue to need good communications and engagement as the transition date nears and in the months once it has passed and new arrangements embed.

In response to questions from the Committee and in the subsequent discussion the following points were made:

(f) Contract changes always take place at a single point in time, ie the Platform One contract ceases on 30 June 2021 and the Parliament Street contract starts on 1 July 2021. All changes, including dispersal of patients outside the boundary, will take place on 1 July. Letters will be sent to all patients during June, with full details about the new arrangements.

(g) Patients have the right to choose their practice (where eligible to register with that practice) and a few patients have already contacted the CCG about where they want to go. This will be confirmed in their letters and all patients will continue to be alerted to their right to choose, even though they will have been allocated a practice if they haven't contacted the CCG directly.

(h) Parliament Street has in hand security arrangements to address any potential issues that may arise with patients with complex needs. As much information on patients, where there may be security concerns, will be passed on to their new practices, which will already have security in place in relation to existing patients.

(i) Sofa surfers/ transient patients are difficult to track. Those patients whose current registered address is Platform One will automatically transfer to Parliament Street. If such patients move to an address outside the boundary for Parliament Street and they alert the practice, then they will need to move to a practice based on their new address.

(j) In response to concerns from Committee members that not all practices will have the specialist experience to work with vulnerable patients, the CCG noted that it is part of their contract that all GPs are skilled in dealing with patient complexity and that they are used to dealing with vulnerable people's needs and referring them to specialist services. There are no practices rated as 'Inadequate' by the CQC, so they should all be equipped to manage such patients.

(k) The CCG cannot track patients who move address frequently. However, practices have ways of coding patients in clinical systems, which means that new practices are alerted to specific issues when a new patient registers with them.

(l) Patients who are transferred to Parliament Street who alert the practice that they have moved at some point in the future will be able to discuss remaining as an out of area patient with Parliament Street.

(m)There will be no process for automatically allocating patients outside Covid rules. If they notify their current practice that they have moved outside its boundary, the patient has to make a choice about which new practice to register with, local to their new address. The Parliament Street practice and the CCG would support a patient in making that choice. The requirement to follow up a patient to make sure that they don't fall through the gap will sit with the receiving practice.

(n) GPs are expected to check the number of patients seen and to monitor their vulnerable patients against the quality outcomes framework. In addition, most GPs have good relationships with the voluntary and community sector providers in their area and with multi-disciplinary teams working across their area. While a patient may not be in contact with their GP, their GP will be alerted to them if they are liaising with others.

(o) While the CCG commissions a GP practice, that practice decides its own staffing complement with the skill mix required to deliver the contract.

(p) The CCG is working with the Nottinghamshire Healthcare NHS Foundation Trust to ensure that patients in the Platform One cohort who access mental health services are supported to continue to access these. Patients will be able to stay with their current Local Mental Health Team (LMHT) until they are in a position to move. At that point LMHTs and the new GP practice will work together to ensure all needs are taken into account, eg the need to see a female psychiatrist.

(q) CCG colleagues agreed that it would be possible to arrange a visit for Committee members to the SMD LES when such visits are possible.

The Chair thanked the CCG colleagues for attending and detailed a number of recommendations to be forwarded to the CCG for response.

RESOLVED to recommend that

1) all patients who are being transferred from the Platform One practice to the new Parliament Street practice, who move out of the new practice catchment area at some point in the future are

   a) offered the option to remain with the Parliament Street practice as an out of area patient if they choose to do so; or
   b) if they choose not to remain with the Parliament Street practice, the CCG provides information about choice of which practices are available to the patient and considers introducing automatic allocation of a practice on behalf of the patient;

2) the CCG monitors Accident and Emergency attendance to identify whether there is an increase in the attendance of patients who have been transferred or dispersed from Platform One, so that they can be supported to access appropriate services;

3) the CCG considers introducing a means of flagging on a patient's record that they are vulnerable and find it difficult to engage with new services/ relate to new people in their lives and explores a range of methods of communicating with such patients, ie not relying on sending letters.

8 Work Programme

(a) Following the discussion with colleagues from Nottingham and Nottinghamshire Healthcare Trust, the Committee agreed to request that the Trust returns

(i) as soon as possible (17 June 2021) to further discuss its management of waiting lists for Step 4 Psychotherapy and Psychological Therapies; and
(ii) to a later meeting to further discuss Eating Disorder Services and the implications for city patients.

(b) Ajanta Biswas, Healthwatch, agreed that Healthwatch would request written contributions from interested stakeholders for the Maternity Services item due to be discussed with Nottingham University NHS Hospitals at the 15 July meeting.

(c) Items were agreed for the 17 June meeting as follows:

(i) Integration and Innovation White Paper
To consider the implications of proposed reforms to health and care and the potential local impact
(ii) Quality Accounts 2020/21
To note the scrutiny comments to be included in provider Quality Accounts on behalf of the Committee.

9 Future Meeting Dates

The Committee agreed to meet on the following dates in 2021/22:

2021 – 17 June, 15 July, 16 September, 14 October, 11 November, 16 December
2022 – 13 January, 17 February, 17 March, 14 April

HEALTH SCRUTINY COMMITTEE
17 JUNE 2021
INTEGRATION AND INNOVATION WHITE PAPER
REPORT OF HEAD OF LEGAL AND GOVERNANCE

Report of the Head of Legal and Governance

1. Purpose

1.1 To consider the proposals contained in the Integration and Innovation White Paper and their potential impact.

2. Action required

2.1 The Committee is asked to note the proposals contained in the Integration and Innovation White Paper and consider the potential impact of these on the health of the population and local health services in Nottingham City.

3. Background information

3.1 The Integration and Innovation White Paper, published by the Department of Health and Social Care on 11 February 2021, sets out legislative proposals for a Health and Care Bill.

3.2 The White Paper brings together proposals which build on recommendations made by NHS England and NHS Improvement, with additional proposals relating to the Secretary of State's powers over the system and targeted changes to public health, social care, and quality and safety matters.

3.3 The White Paper groups the proposals under the following themes:

- working together and supporting integration;
- stripping out needless bureaucracy;
- enhancing public confidence and accountability; and
- additional proposals to support public health, social care and quality and safety matters.

3.4 The proposals represent a move away from the focus on competition that underpinned the coalition government's 2012 reforms, towards a new model of collaboration, partnership and integration. Removal of some of the competition and procurement is seen to provide the NHS and its partners greater flexibility to deliver joined-up care to the increasing number of people who rely on multiple services.

3.5 The proposed legislation aims to avoid a one-size-fits-all approach, leaving many decisions to local systems and leaders in recognition of the wide variation across England in terms of history, demography and local health challenges.

3.6 With so much to be left to local discretion, it will be essential that local services collaborate and are co-ordinated. Implementation will need to be very carefully planned and managed.

3.7 Some of the proposals seek to give ministers greater powers over NHS England and other arm's length bodies and give ministers the power to intervene earlier in local decisions about the opening and closing of NHS services, ie it is proposed to reduce accountability systems at the local level and broaden those of the Secretary of State. This includes removing the local scrutiny power of referral to the Secretary of State.

3.8 Colleagues from the Nottingham and Nottinghamshire Integrated Care System (ICS) and Clinical Commissioning Group (CCG) will be attending the meeting to provide a presentation on the White Paper, to respond to the Committee's questions and to participate in discussion on the implications and potential impacts of the proposals.

4. List of attached information

4.1 Briefing on the White Paper Integration and innovation: working together to improve health and social care for all, report of Dr Amanda Sullivan, Accountable Officer Nottingham and Nottingham Clinical Commissioning Group and Interim Executive Lead for the Nottingham and Nottinghamshire Integrated Care System

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

5.1 None

6. Published documents referred to in compiling this report

6.1 Integration and innovation: working together to improve health and social care for all, Department of Health & Social Care, 11 February 2021

7. Wards affected

7.1 All

8. Contact information

8.1 Kim Pocock, Scrutiny Officer
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Nottingham City Health Scrutiny Committee

Briefing on the White Paper
Integration and Innovation: working together to improve health and social care for all

Introduction

1. This paper provides Nottingham City Health Scrutiny Committee with an overview of the Department of Health and Social Care's White Paper entitled *Integration and Innovation: working together to improve health and social care for all*.

2. This paper also confirms opportunities, arising from this White paper, for local citizens.

Background

3. Health and care systems need to continually develop and evolve to remain fit for purpose in an ever changing landscape. As the NHS and Social Care services in England look to recover from the Covid-19 global pandemic, national policy centres on Integrated Care Systems (ICSs) as providing the best route to improving population health and wellbeing, quality of service provision and achieving the most effective use of resources.

4. An ICS brings together citizens, NHS, Local Authority and wider partners to meet the health and care needs in an area, to co-ordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

5. Integrated care is not new but rather has a long history. Over recent years, Nottingham City residents have benefitted from tangible improvements brought about by an Integrated Care Pioneer programme; a Vanguard focused on Support to Care Homes; and collective endeavours across the Nottingham and Nottinghamshire ICS in responding to Covid-19.

6. To date, the NHS and Social Care system has not been fully configured to accommodate the development of ICSs. The White Paper aims to go some way to addressing this.

Working Together to Integrate Care

7. Subject to legislation, ICSs will be established on a statutory footing as ICS Bodies across England from 1st April 2022, bringing partners together to support integration of health and social care.

8. Strengthened decision making and accountability for system performance will be embedded into the NHS accountability structure through an NHS ICS Board and ICS Health and Care Partnership. This dual structure recognises that there are two forms of integration which will be underpinned by legislation: integration within the NHS to remove some of the cumbersome barriers to collaboration and to make working together across the NHS an organising principle; and the integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people. The approach is framed by:

    - The importance of shared purpose within places and systems;
    - The recognition of variation – some of it warranted – of form and in the potential balance of responsibilities between places and the systems they are part of;
    - The reality of differential accountabilities, including the responsibility of Local Authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.

9. The NHS ICS Board (including representatives from NHS bodies and Local Authorities) will be responsible for the day-to-day running of the ICS, NHS planning and allocation decisions merging some of the current ICS and CCG functions:

    - Developing a plan to meet the health needs of the population within their defined geography;
    - Developing a capital plan for the NHS providers within their health geography;
    - Securing the provision of health services to meet the needs of the system population.

10. The NHS ICS Board will, as a minimum, include a chair, a chief executive officer, and representatives from NHS Trusts, General Practice, and Local Authorities, non-executives and others determined locally. ICSs will also need to ensure they have appropriate clinical advice when making decisions.

11. The ICS Health and Care Partnership will bring together the NHS, local government and wider partners such as those in the voluntary sector. This Partnership will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the ICS NHS Body and Local Authorities will have to have regard to this plan when making decisions.

12. Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards (HWBs) within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). Local areas can appoint members and delegate functions as they think appropriate.

13. The ICS will also have to work closely with local Health and Wellbeing Boards as they have the experience as 'Place-based' planners, and the ICS NHS Body will be required to have regard to the Joint Strategic Needs assessments (JSNAs) and Joint Health and Wellbeing Strategies that are being produced at Health and Wellbeing Board level (and vice-versa).

14. Creation of statutory ICS NHS Bodies will allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system level. There will be a duty placed on the ICS NHS Body to meet system financial objectives supplemented by a new duty to compel providers to have regard to the system financial objectives. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged.

15. The allocative functions of CCGs will be held by the ICS NHS Body. The ICS NHS Body will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries, as well as CCGs' responsibilities in relation to Oversight and Scrutiny Committees. The Chief Executive will become the Accounting Officer for the NHS money allocated to the NHS ICS Body.

16. A duty to collaborate will be introduced for NHS and Local Authorities to support collaboration across the health and care system and a triple aim duty placed on health bodies, including ICSs covering: better health and wellbeing for everyone; better quality of health services for all individuals; and sustainable use of NHS resources.

17. Barriers to integration will be removed through making provisions for joint committees, collaborative commissioning approaches and guidance on joint appointments. The legislation will also ensure more effective data sharing across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways.

18. There will be increasing collaboration between ICSs and with NHS England on commissioning to make decisions, pool funds and facilitate services to be arranged for their combined populations. This will include primary care services (e.g. dentistry, community optometry, pharmaceutical services) as well as public health and specialised services.

19. Requirements for Place will not be set in legislation with the recognition that Places vary by population and geography. However, there is an expectation that the statutory ICSs' will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues. Health and Wellbeing Boards will remain in place and will continue to have a role at Place level.

20. A key responsibility for an ICS will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Place level

commissioning within an integrated care system will most likely align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities.

21. To support patient choice, section 75 of the Health and Social Care Act 2012 (including the Procurement, Patient Choice and Competition Regulations 2013) will be repealed and replaced with a new procurement regime, alongside a bolstered process for Any Qualified Provider (AQP).

Reducing Bureaucracy

22. The White Paper sets out significant changes to procurement with an end to mandatory competitive procurements, instead only tendering for healthcare and public health services when there is potential to lead to better outcomes for patients.

23. The Competition Market Authority (CMA) will no longer be involved in NHS oversight. Instead there will be the creation of a bespoke health services provider selection regime to give greater flexibility to commissioners in how they arrange services.

24. Changes to the national Tariff (the NHS financial framework) will allow more flexibility and support system approaches. In addition, the White Paper sets out new powers to be given to the Secretary of State to create new Trusts for the purpose of providing integrated care.

Improving Accountability and Enhancing Public Confidence

25. A newly merged national NHS body formally merging Monitor and the Trust Development Authority (NHS Improvement) into NHSE. Complemented by enhanced powers of direction for the government to support greater collaboration, information sharing and aligned responsibility and accountability.

26. As an ICS becomes established there is an expectation that it will have greater autonomy and hold a greater level of responsibility enabled by a more flexible mandate for NHS England. This new mandate will set direction over a longer term and in a more strategic way than currently permitted in an annual cycle. NHS England's capital and revenue resource limits will continue to be set within annual financial directions, which are routinely published and will now be set before Parliament.

27. There will be new powers for the Secretary of State for Health and Social Care over the NHS and other arm's-length bodies (ALBs). Under the proposals, the Secretary of State will be able to intervene in service reconfiguration changes at any point without need for a referral from a local authority. The Department of Health and Social Care will also be able to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation.

28. Certain new duties on the Secretary of State will also be introduced. This will include a statutory duty to publish a report in each parliament on workforce planning responsibilities across primary, secondary and community care, as well as sections of the workforce shared between health and social care.

Additional Measures

29. Reforms to social care, public health and mental health will be dealt with outside the Health and Care Bill addressed in the White Paper, with some minor exceptions (as set out below) and proposals will be published later this year.

Social Care

30. A new assurance framework will be introduced together with powers to collect data from providers in social care. An improved level of accountability will be introduced within social care, with a new assurance framework allowing greater oversight of Local Authority delivery of care, and improved data collection to better understand capacity and risk in the social care system (including for self-funders).

31. Powers will be included enabling the Secretary of State to make emergency payments directly to all social care providers when needed to prevent instability in care.

32. There will be a defined role for social care within the ICS NHS Board and guidance on how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs' deliver for the Adult Social Care sector.

33. A new legal framework for Discharge to Assess will be included enabling person-centred models of hospital discharge and greater flexibility to when assessments for care can be made. Discharge to Assess will not change the thresholds of eligibility for Continuing Health Care (CHC) or support through the Care Act or increase financial burdens on Local Authorities. The system of discharge notices, and associated financial penalties, will no longer be required.

34. The White Paper includes a new standalone legal basis for the Better Care Fund, separate from the NHS Mandate setting process, removing the need for annual planning cycles. It also includes a new duty for the Care Quality Commission (CQC) to assess local authorities' delivery of adult social care services, and a power for the Secretary of State to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their responsibilities.

Public Health

35. Alongside the Government's proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP) and the closure of Public Health England (PHE), the White Paper sets out new measures to make it easier for the Secretary of State to direct NHS England to take on specific public health functions (section 7a services).

36. The White Paper details the introduction of new public health requirements conveying a new power on ministers to alter certain food labelling requirements, in addition to already announced further restrictions on the advertising of high fat, salt and sugar foods including before the 9pm watershed; and the responsibility for the process to directly introduce, vary or terminate fluoridation of water to be moved from Local Authorities to the Secretary of State for Health and Social Care.

Quality and Safety

37. The White Paper details:

- Enshrining the Healthcare Safety Investigations Branch (HSSIB) into law as a statutory Body to reduce risk and improve safety;
- Enabling improvements to the current regulatory landscape for healthcare professionals with a view to reducing the number of regulators following further work;
- Establishing a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths that do not involve a coroner, to increase transparency for the bereaved;
- Allowing the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries in order to provide patients and prescribers, as well as regulators and the NHS, with the information they need to make evidence-based decisions;
- Bringing forward measures to enable the Secretary of State to set requirements in relation to hospital food;
- Powers to implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland to support the health of citizens when they travel abroad, subject to bilateral agreements.

Opportunities for Local Citizens

38. The Nottingham and Nottinghamshire ICS is working to the shared purpose of every citizen enjoying their best possible health and wellbeing.

39. The ICS creates the conditions in which health and care professionals – working at neighbourhood, place and whole system level – are able to come together maximising the use of our energies and resources; seeking out and

implementing the types of change that deliver enduring improvements in population health and wellbeing across:

- Primary and secondary care;
- Physical and mental health services; and
- Health, social care and wider public and community services.

40. To date, the NHS and Social Care system has not been fully configured to accommodate the development of ICSs. Policy, delivery and assurance mechanisms have not been fully aligned, which has resulted in barriers to improvement.

41. The removal of many barriers, as proposed in the White Paper, provides renewed impetus for collaborative working. Whilst the move to put ICSs onto a statutory footing from April 2022, subject to legislation, is a step forward, recognition is given to the fact that structural change alone is no guarantee of success in bringing about a high performing system that is agile, adaptive and therefore best able to serve its population needs.

42. The local health and care system therefore continues to build on work to date, including learning from joint working in response to Covid19, to ensure maximum benefit for the population served from integrated care.

Dr Amanda Sullivan
Accountable Officer Nottingham and Nottingham Clinical Commissioning Group and Interim Executive Lead for the Nottingham and Nottinghamshire Integrated Care System
June 2021

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HEALTH SCRUTINY COMMITTEE
17 JUNE 2021
INTEGRATED CARE SYSTEM: COMMUNITY CARE WORKSTREAM
REPORT OF HEAD OF LEGAL AND GOVERNANCE

Report of the Head of Legal and Governance

1. Purpose

1.1 To consider the Nottingham and Nottinghamshire Integrated Care System (ICS) plans and approaches for Community Care Transformation.

2. Action required

2.1 The Committee is asked to note the current proposals of the Nottingham and Nottinghamshire Integrated Care System (ICS) for Community Care Transformation.

3. Background information

3.1 The ICS has agreed that Community Care Transformation is a system priority for 2021/22 and has commenced engagement with partners with a view to launching the programme.

3.2 The report 'ICS Outcomes Framework and Service Transformation', presented to the ICS Board Meeting, 6 May 2021 notes the following:

> 'Community care aims to optimise people's independence by addressing physical health, mental health and social needs, delivering care to meet local population needs. Our current community care offer provides the building blocks of integration which will be enhanced at pace to deliver a single ICS model of care, adopting a strengths based approach flexible to local population need.'

3.3 Colleagues from the ICS have provided a briefing note to the Committee's 17 June meeting to outline transformation proposals for Community Care and will respond in writing to any immediate questions. Colleagues are happy to attend future meetings to ensure that the Committee is fully involved as plans are rolled out.

4. List of attached information

4.1 Appendix 1 – Community Care Briefing, Lucy Dadge, Chief Commissioning Officer, Nottingham and Nottinghamshire CCG

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

5.1 None

6. Published documents referred to in compiling this report

6.1 'ICS Outcomes Framework and Service Transformation' - report presented to the ICS Board Meeting, 6 May 2021

7. Wards affected

7.1 All

8. Contact information

8.1 Kim Pocock, Scrutiny Officer
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Community Care Transformation Programme

Briefing for Health Scrutiny Committee

Dear Colleagues

The Community Care Programme has been established to plan for and deliver a future sustainable model of community care provision that aims to optimize people's independence by addressing physical and mental health and social needs, delivering care to meet the needs of the Nottingham and Nottinghamshire population.

Through co-production with citizens, staff, partners and stakeholders, the programme will develop an approach focused on:

1. The alignment of health and social care resources and workforce to implement neighbourhood/placed based Community Teams, delivering a consistent model of care across the ICS whilst ensuring services are responsive to local population need.

2. Levels of support and care are driven by population health data and intelligence, with a focus on delivering outcomes that reduce inequalities in health and wellbeing.

3. Personal and community assets are fully utilised and developed to support outcomes, using a practice framework for an integrated health and social care personalised, strengths and asset-based approach that empowers individuals and communities to take control of their own health and care.

4. Develop an organisational development approach for all community care staff to empower practitioners and to support the implementation of the new care model, irrespective of employing organisation and role.

5. Adopt a transparent approach across commissioners and providers to ensure we deliver best value for money, moderating costs of care and maximising value (the relationship between quality, outcomes and resources).

The Community Care programme is one of the key transformation workstreams for the Nottingham and Nottinghamshire Integrated Care System (ICS). The programme is led by a Sponsorship Group consisting of senior representation from Nottingham City Council, CityCare, Nottingham and Nottinghamshire CCG, Nottinghamshire County Council and Nottinghamshire Healthcare Trust.

There are three phases to the programme of work:

Phase 1: Stakeholder Engagement - May to June 2021

A series of six engagement events is being undertaken to shape the transformation programme. To date, over 100 people have attended the events with representation from partner organisations, Healthwatch and voluntary sector organisations.

Phase 2: Design Phase – July to September 2021

The feedback from the stakeholder engagement events will form part of a design phase to take place during the summer. The design phase will adopt a co-production approach with citizens, partners and stakeholders to develop the principles for the future delivery of community care services. This phase will focus on the outcomes we want to achieve for our citizens and use evidence from national and international transformation to help to shape future service provision.

Phase 3: Place Based Transformation – September 2021 to April 2022

The transformation of community care services and support at a place level (likely to be based on a Primary Care Network footprint) will be undertaken through 100 day improvement cycles. This will be phased between September 2021 and April 2022, to allow for progress to be monitored and learning applied at each stage.

Over the coming months, the Sponsorship Group will be presenting outputs of the programme to the Health Scrutiny Committee including the approach to citizen co-production, design proposals for the future care model, and the engagement that is taking place across the system to ensure that partners in health and local authorities are working together to understand the impact of any changes.

For more information on the changes described in this briefing, please contact:

Lucy Dadge, Chief Commissioning Officer
lucy.dadge@nhs.net

June 2021

HEALTH SCRUTINY COMMITTEE
17 JUNE 2021
QUALITY ACCOUNTS 2020/21
REPORT OF HEAD OF LEGAL AND GOVERNANCE

Report of the Head of Legal and Governance

1. Purpose

1.1 To note the comments submitted to provider trusts on behalf of the Health Scrutiny Committee for inclusion in their published Quality Accounts 2020/21.

2. Action required

2.1 The Committee is asked to note the comments submitted to provider trusts on behalf of the Health Scrutiny Committee for inclusion in their published Quality Accounts 2020/21.

3. Background information

3.1 Quality Accounts are reports about the quality of services offered by NHS care providers (including the independent sector) and are published annually.

3.2 The Quality Account should include:

- what an organisation is doing well;
- where improvements in service quality are required;
- what an organisation's priorities for improvement are for the coming year;
- what actions an organisation intends to take to secure these improvements; and
- how the organisation has involved people who use their services, staff and others with an interest in their organisation in determining their priorities for improvement.

3.3 It is a requirement that providers send their Quality Accounts to their local overview and scrutiny committee responsible for health scrutiny and that the relevant committee has an opportunity to comment, if it chooses to do so, on the Quality Account, with these comments to be included in the final document.

3.4 The Committee agreed to consider the Quality Accounts of the following providers:

- Nottinghamshire Healthcare Foundation Trust
- Nottingham University Hospitals Trust
- Nottingham CityCare Partnership
- East Midlands Ambulance Service (EMAS)

3.5 The Committee agreed to scrutinise these provider Quality Accounts 2020/21 by establishing small groups of approximately three Committee members for discussion with each individual provider. These meetings were held between 11 and 24 May 2021.

3.6 The comments drawn up and submitted to each individual Trust are attached at Appendix 1.

4. List of attached information

4.1 Appendix 1 – Health Scrutiny Committee comments to be included in provider trusts' Quality Accounts 2020/21.

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

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

8.1 Kim Pocock, Scrutiny Officer
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Appendix 1

Health Scrutiny Committee comments to be included in provider trusts' Quality Accounts 2020/21.

Nottinghamshire Healthcare Trust Quality Account 2020/21

Comment from Nottingham City Council Health Scrutiny Committee

The Nottingham City Health Scrutiny Committee (the Committee) welcomed the opportunity to discuss its Quality Account 2020/21 with colleagues from Nottinghamshire Healthcare NHS Foundation Trust and is pleased to be able to comment on it. The Committee's comments focus on areas in which it has engaged with the Trust in 2020/21.

As in previous years, the Committee appreciates the Trust's willingness to engage with scrutiny when requested to do so and the open discussions which have taken place.

The Committee recognises the pressures of the pandemic on the Trust, both in terms of service provision and the impact on patients and staff, and how this will have influenced the way services have been provided in 2020/21.

While the Committee welcomes the move towards clearer strategic frameworks for managing its work and the strengthening of leadership, it remains concerned about staffing levels on the front line. It recognises the challenges faced in recruitment, particularly in relation to nurses and the work being carried out to offer different levels of nursing qualifications, including the ability to train 'on the job' with release for academic study. However, the Committee is concerned about the lack of progression and development opportunities for those who are not academically inclined, but whose wealth of experience is a valuable asset to patient care and support, for example Health Care Assistants. The Committee would suggest that the Trust considers creating roles which develop these skills and experience (without the need for academic qualification) and which offer progression and appropriate remuneration, as one means to attract staff to meet front line shortages.

The Committee is particularly keen to ensure that pathways to treatment and support are clear. In its scrutiny work during 2020/21 it has identified concerns about the complexity of pathways and confusion about how to access the right service, resulting in a sense of powerlessness for the service user. The Committee is interested in further discussions with the Trust about increasing accessibility to services via a Single Point of Access to manage the plethora of pathways to treatment.

The Committee has been concerned about long waiting times and the potential for mental ill health to worsen as people wait to access services. The Committee welcomes the Trust's commitment to looking at what support can be offered to people during waiting times to prevent conditions deteriorating.

The Committee is also keen to be reassured that all of those seeking mental health support are offered parity of service quality and support within different strands of mental health services; ie that no one particular mental health condition is perceived by staff to be more acceptable than another, leading to negative attitudes towards patients.

The Committee looks forward to working with the Trust in the future and on focusing its scrutiny in 2021/22 on the priority areas of the Trust's work and plans for improvements, particularly in relation to access to mental health services and the specific impact of the pandemic on Child and Adolescent Mental Health.

Nottingham University Hospitals Trust Quality Account 2020/21

Comment from Nottingham City Council Health Scrutiny Committee

The Nottingham City Health Scrutiny Committee (the Committee) welcomed the opportunity to discuss its Quality Account 2020/21 with colleagues from Nottingham University Hospitals NHS Trust and is pleased to be able to comment on it. The Committee's comments focus on areas in which it has engaged with the Trust in 2020/21.

As in previous years, the Committee appreciates the Trust's willingness to engage with scrutiny when requested to do so and the open discussions which have taken place.

The Committee recognises the pressures of the pandemic on the Trust, both in terms of service provision and the impact on patients and staff, and how this will have influenced the way services have been provided in 2020/21.

Maternity service remain of key concern to the Committee. Representatives of the Trust attended the Committee's 14 January 2020 meeting to respond to the Committee's concerns in relation to the findings of the Care Quality Commission, published in December 2020 and resulting in an 'Inadequate' rating. The Committee remains concerned that as much is being done as is possible to address the failings, particularly in relation to the change of culture which is essential to support frontline staff, so that they are listened to, and which is likely to impact on retention rates in a field which is nationally under-staffed.

NUH colleagues are due to return to the Committee in July 2021. While recognising the task ahead to introduce and see the real impact of changes, members hope to see continuing improvements and evidence to demonstrate these.

The Committee welcomes all measures which are taken to encourage and act on staff feedback in relation to all NUH services and administrative functions.

Standards of cleanliness at Trust sites have clearly improved considerably, not least because of the additional staffing which has been introduced to ensure compliance with Covid 19 safety regulations. Cleanliness has been a concern of the Committee in previous years and it is pleased to both see evidence of improvement (in the reduction of hospital acquired infections) and to be reassured that the Trust is committed to maintaining these resources and standards to the best of its ability. The Committee also asked that its thanks are passed on to all staff who have made such a significant impact on cleansing.

The Committee was pleased to hear that the pharmacy delivery service, introduced to manage effective social distancing during the pandemic, has been well-received by patients and that it will be extended and continued.

The Committee looks forward to working with the Trust in the future, focusing particularly on Maternity Services, discharge and after care (including work with social care) and how Tomorrow's NUH will contribute towards improved services and patient outcomes.

24 May 2021

CityCare Partnership Quality Account 2020/21

Comment from Nottingham City Council Health Scrutiny Committee

The Nottingham City Health Scrutiny Committee (the Committee) welcomed the opportunity to discuss its Quality Account 2020/21 with colleagues from Nottingham CityCare Partnership and is pleased to be able to comment on it.

As the Committee has not undertaken any scrutiny of CityCare during 2020/21, its comments are restricted to planned priorities for 2021/22.

The Committee recognises the pressures of the pandemic on the organisation, both in terms of service provision and the impact on patients and staff, and how this will have influenced the way services have been provided in 2020/21.

The Committee welcomes CityCare's continuing commitment to focus on staff retention and its recognition that the care it provides is only as good as the workforce which delivers it.

Considering more varied ways of encouraging existing staff to obtain the required skills and abilities to develop and progress, without having to follow a purely academic route, is very much supported by the Committee. In addition, the Committee welcomes plans to provide staff with the time to discuss and reflect on their practice, the impact on the patient of team culture and how they manage their most challenging cases. This investment of time in staff will contribute to patient safety and a more positive experience for both the patient and the staff caring for them.

Addressing health inequalities is one of the Committee's priorities for 2021/22. It welcomes the explicit mention of this as a priority for CityCare in 2021/22 and looks forward to working with the Partnership on this the future.

24 May 2021

East Midlands Ambulance Service Account 2020/21

Comment from Nottingham City Council Health Scrutiny Committee

The Nottingham City Health Scrutiny Committee (the Committee) welcomed the opportunity to discuss its Quality Account 2020/21 with colleagues from East Midlands Ambulance Service (EMAS) and is pleased to be able to comment on it.

As the Committee has not undertaken any scrutiny of EMAS during 2020/21, its comments are restricted to planned priorities for 2021/22.

The Committee recognises the pressures of the pandemic on the organisation, both in terms of service provision and the impact on patients and staff, and how this will have influenced the way services have been provided in 2020/21. While, these have been challenging times, it was refreshing to hear that some of the changes brought in to adapt to the pandemic will continue, given their positive impact, eg introducing the role of specialist paramedics who are able to prescribe and liaise with GPs to support patients without Covid symptoms.

The Committee welcomes the Trust's vision to develop its quality improvement strategy based on delivering caring and compassionate, responsive, effective, well-led and safe services. These aspirations also underpin the work of the Committee which is committed to using its scrutiny powers to meet the needs of services users in the best possible way, and to achieve the best possible outcomes for them.

The Committee also welcomes the Trust's commitment to providing more diverse ambulance teams (eg including ambulance nurses) and reducing the pressure on Emergency Departments by increasing the opportunities to deliver patients to the service most appropriate for their needs.

The Committee looks forward to working with EMAS in the future on the specific needs and experiences of people living and working within Nottingham city.

24 May 2021

HEALTH SCRUTINY COMMITTEE
17 JUNE 2021
WORK PROGRAMME 2021/22
REPORT OF HEAD OF LEGAL AND GOVERNANCE

Report of the Head of Legal and Governance

1. Purpose

1.1 To consider the Committee's work programme for 2021/22 based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

2. Action required

1.1 The Committee is asked to note the work that is currently planned for the remainder of the municipal year 2021/22 and make amendments to this programme as appropriate.

3. Background information

3.1 The purpose of the Health Scrutiny Committee is to act as a lever to improve the health of local people. The role includes:

- strengthening the voice of local people in decision making, through democratically elected councillors, to ensure that their needs and experiences are considered as part of the commissioning and delivery of health services;
- taking a strategic overview of the integration of health, including public health, and social care;
- proactively seeking information about the performance of local health services and challenging and testing information provided to it by health service commissioners and providers; and
- being part of the accountability of the whole health system and engaging with the commissioners and providers of health services and other relevant partners such as the Care Quality Commission and Healthwatch.

3.2 As well as the broad powers held by all overview and scrutiny committees, committees carrying out health scrutiny hold the following additional powers and rights:

- to review any matter relating to the planning, provision and operation of health services in the area;
- to require information from certain health bodies[1] about the planning, provision and operation of health services in the area;
- to require attendance at meetings from members and employees working in certain health bodies[1];

[1] This applies to clinical commissioning groups; NHS England; local authorities as commissioners and/or providers of NHS or public health services; GP practices and other providers of primary care including pharmacists, opticians and dentists; and private, voluntary sector and third sector bodies commissioned to provide NHS or public health services.

- to make reports and recommendations to clinical commissioning groups, NHS England and local authorities as commissioners of NHS and/or public health services about the planning, provision and operation of health services in the area, and expect a response within 28 days (they are not required to accept or implement recommendations);
- to be consulted by commissioners of NHS and public health services when there are proposals for substantial developments or variations to services, and to make comment on those proposals. (When providers are considering a substantial development or variation they need to inform commissioners so that they can comply with requirements to consult.)
- in certain circumstances, the power to refer decisions about substantial variations or developments in health services to the Secretary of State for Health.

3.3 While a 'substantial development or variation' of health services is not defined in legislation, a key feature is that there is a major change to services experienced by patients and/ or 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. Health scrutiny committees have statutory responsibilities in relation to substantial developments and variations in health services. These are to consider the following matters in relation to any substantial development or variation that impacts on those in receipt of services:

- whether, as a statutory body, the relevant overview and scrutiny committee has been properly consulted within the consultation process;
- 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; and
- whether the proposal for change is in the interests of the local health service.

Where there are concerns about proposals for substantial developments or variations in health services, scrutiny and the relevant health body should work together to try and resolve these locally if at all possible. Ultimately, if this is not possible and the committee concludes that consultation was not adequate or if it believes the proposals are not in the best interests of local health services then it can refer the decision to the Secretary of State for Health. This referral must be accompanied by an explanation of all steps taken locally to try and reach agreement in relation to the proposals.

3.4 The Committee is responsible for setting and managing its own work programme to fulfil this role.

3.5 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately.

3.6 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 Committee.

3.7 The current work programme for the municipal year 2021/22 is attached at Appendix 1.

4. List of attached information

4.1 Appendix 1 – Health Scrutiny Committee Work Programme 2021/22

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

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

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Health Scrutiny Committee 2021/22 Work Programme

Date	Items
13 May 2021 **Ballroom**	• **Terms of Reference** To note the terms of reference for the Committee • **Platform One** To assess progress towards the transition date of 1 July 2021, particularly in relation to vulnerable patients to be dispersed to local practices (to include reference to how the EQIA is evolving, being monitored and responded to) • **Nottinghamshire Healthcare NHS Foundation Trust Strategy** To consider the Trust's strategy in order to identify a focus for any further scrutiny of mental health issues in 2021/22 • **Work Programme 2021/22**
17 June 2021 **Ballroom**	• **Integration and Innovation White Paper** To consider the implications of proposed reforms to health and care and the potential local impact • **Integrated Care System: Community Care Transformation** To consider and comment on this ICS priority which will involve a review of all community services • **Quality Accounts 2020/21** To note the scrutiny comments on each Quality Account (if any submitted) • **Work Programme 2021/22**
15 July 2021 **Dining Room or GFCR, Loxley**	• **Maternity Services** To review the action taken by NUH over the last six months to improve maternity services • **Tomorrow's NUH**[1] To consider progress to date and plans for consultation and engagement.

[1] Informal meeting to be held to do some deep dive consideration of the Tomorrow's NUH programme 30 June 2021 (Phil Britt, Nina Ennis, Lucy Dadge) to focus on maternity and cancer services. A further deep dive meeting to be held later in the year to focus on outpatients' care and splitting elective/ emergency services.

Date	Items
	• **Scrutiny Review** To consider the outcomes of the Review of Scrutiny carried out by the Centre for Governance and Scrutiny • **Work Programme 2021/22**
16 September 2021	• **Assessment, Referrals and Waiting Lists for Psychological Support** To consider the Nottinghamshire Healthcare NHS Foundation Trust's plans for managing access to psychological support, particularly in relation to step 4 psychotherapy and psychological therapies. • **Reconfiguration of Acute Stroke Services** To consider proposals for making changes to the configuration of acute stroke services permanent. Changes were made on a temporary basis to support the response to the Covid pandemic. If it is proposed to make the changes permanent, then this is likely to be a substantial variation to services and the Committee will need to carry out its statutory role as a consultee • **Covid 19 Local Vaccination Programme** To assess progress with local delivery of the vaccination against national targets (at 23/03/21 the whole population should have had at least one dose by the end of July 2021) • **Work Programme 2021/22**
14 October 2021	• **Eating Disorder Services** To assess the impact of expansion to workforce capacity to services and to consider the impact of out of area inpatient placements. • **Management of Winter Pressures** To scrutinise plans for managing winter pressures across health and adult social care services • **Flu Immunisation Programme** To review provision, and uptake of the flu immunisation programme, particularly for children • **Work Programme 2021/22**

Date	Items
11 November 2021	• **Child and Adolescent Mental Health Services (CAMHS)** (a) To consider the services provided by CAMHS in the light of the need for support as the city recovers from the pandemic; and (b) To consider systems and processes in place to ensure effective transition from CAMHS to Adult Mental Health Services (Recommendation from the Children and Young People Scrutiny Committee) • **Platform One** To assess the initial impact of the transition to the new city centre practice and to local practices, with particular reference to the experiences of vulnerable patients. • **Work Programme 2021/22**
16 December 2021	• **Safeguarding Adults Board Annual Report** To hear evidence from the Safeguarding Adults Board regarding work to safeguard adults in the City; scrutinise the work of the Board, including consideration of its 2020/21 Annual Report; and identify any issues or evidence relevant to the Committee's work programme. • **Scrutiny of Portfolio Holder(s) with responsibility for Health and for Adult Social Care** Focus to be identified (and link to above report) • **Work Programme 2021/22**
13 January 2022	• **Health Inequalities** To consider how health inequality is measured, how factors which impact on health are established (including barriers to access) and where hot spots identified (geographical and community) and to scrutinise how partners work together to tackle particular aspects of health inequality[2]

[2] Following this to identify an area where scrutiny can add value by more detailed consideration at a future meeting(s), for example: BAME health experiences and access to services/ Poverty and the impact on health and access to services/ Support for those new to the city from other countries to access available NHS services/ Access to PEP medication to prevent HIV (pilot)/ Waiting lists in the context of health inequalities (see notes below funder impact of Covid on elective services from meeting with CCG 03/04/2021)

Date	Items
	• **Work Programme 2021/22**
17 February 2022	• **Dental Services** To review access to dental services during the Covid-19 pandemic, the impact of reduced access and reinstatement of services, future dental provision contracts/ private and public treatment. • **Work Programme 2021/22**
17 March 2022	• **Work Programme 2021/22**
15 April 2022	• **Work Programme 2021/22**

Items to be scheduled

Item	Focus
1. GP Services	To review GP provision across the City, with a particular focus on GP Practice changes and the sustainability of small GP practices Pending informal session to be held in July 2021
2. Impact of Covid 19 on elective care and on health outcomes:	To scrutinise the impact of delays on elective care due to Covid 19, plans to mitigate this impact and the progress with meeting need following delays Awaiting confirmation from CCG on timing and contributors
3. Discharge and after care (including impact on Social Care)	To consider the effectiveness, including the impact on adult social care, of current plans and practice for the discharge of patients from hospital care Awaiting confirmation from CCG on timing and contributors
4. NHS and National Rehabilitation Centre (NRC)	Update on the Decision Making Business Case and implementation plans

Reserve Items

Item	Focus
5. Alcohol dependency/ Alcohol related issues	Potential role of HSC in relation to impact on health when premises are licensed for sale of alcohol
6. Carer Support Services	To review support for carers during the Covid-19 pandemic
7. Gender reassignment services	Need for scrutiny and focus to be identified
8. Impact of Covid-19 on disabled people	Need for scrutiny and focus to be identified
9. Review and consolidation of day services for people with learning disabilities	Consultation still ongoing – outcomes due to be reported to parents and carers early May.
10. 111 First	Changes to the service as a result of Covid

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