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AGENDA PAPERS FOR

HEALTH SCRUTINY COMMITTEE MEETING

Date: Wednesday, 23 July 2014

Time: 6.30 pm

Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford M32 0TH

A G E N D A **PART I** **Pages**

1. **ATTENDANCES**

To note attendances, including Officers, and any apologies for absence.

2. **CHAIRMAN AND VICE-CHAIRMAN OF THE COMMITTEE 2014/15**

To note that Council has appointed Councillors Lloyd and Patricia Young as Chairman and Vice-Chairman respectively of this committee for the Municipal Year 2014/15.

3. **MEMBERSHIP OF THE COMMITTEE 2014/15** 1 - 2

To note the membership of this Committee, as determined by Council, for the Municipal Year 2014/15.

Please note that since the Annual Meeting, the Chief Executive has been notified that Councillor Higgins has replaced Councillor Barclay as a Member of the Committee.

4. **TERMS OF REFERENCE FOR THE COMMITTEE 2014/15** 3 - 6

To note the terms of reference for the Committee, as determined by Council, for the Municipal Year 2014/15.

5. **MINUTES** 7 - 10

To receive and, if so determined, to agree as a correct record the Minutes of the meeting held on 5 March 2014

6. **DECLARATIONS OF INTEREST**

Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

7. **HEALTHIER TOGETHER - CONSULTATION** 11 - 18

To receive a presentation on the Healthier Together proposals.

A summary of the consultation paper is attached. More information about Healthier Together can be found at https://healthiertogethergm.nhs.uk/

8. **CCG PERFORMANCE REPORT** 19 - 38

To discuss any issues arising from the performance report to Trafford CCG on 26 June 2014

9. **SCRUTINY ARRANGEMENTS** 39 - 40

To receive a report, recently referred to Council, of the Corporate Director, Transformation and Resources / Statutory Scrutiny Officer.

Members will be invited to consider potential issues to be incorporated within the Scrutiny Work Programme.

10. **HEALTH SCRUTINY REGULATIONS - GUIDANCE** 41 - 70

To note the Health Scrutiny Regulations recently issued by the Department of Health.

11. **NW AMBULANCE SERVICE - QUALITY ACCOUNTS**

To note the response made by the Chairman and Vice Chairman.

12. **SPECIALISED CANCER SERVICES** 71 - 76

To note the consultation document and to ask NHS colleagues to attend the September meeting to provide a more detailed briefing.

13. **HEALTHWATCH ANNUAL REPORT**

To receive the first annual report of Healthwatch Trafford

14. **JOINT HEALTH SCRUTINY COMMITTEE** 77 - 80

To receive the minutes of the meeting on the 7 April 2014.

15. **URGENT BUSINESS (IF ANY)**

Any other item or items (not likely to disclose "exempt information") which, by reason of special circumstances (to be specified), the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

16. **EXCLUSION RESOLUTION (REMAINING ITEMS)**

Motion (Which may be amended as Members think fit):

That the public be excluded from this meeting during consideration of the remaining items on the agenda, because of the likelihood of disclosure of "exempt information" which falls within one or more descriptive category or categories of the Local Government Act 1972, Schedule 12A, as amended by The Local Government (Access to Information) (Variation) Order 2006, and specified on the agenda item or report relating to each such item respectively.

THERESA GRANT
Chief Executive

Membership of the Committee

Councillors J. Lloyd (Chairman), Mrs. P. Young (Vice-Chairman), J. Brophy, Mrs. A. Bruer-Morris, R Chilton, J. Harding, D. Higgins, K. Procter, B. Shaw, S. Taylor, Mrs. V. Ward and A. Mitchell (ex-Officio)

Further Information
For help, advice and information about this meeting please contact:

Democratic Services,
Tel: 0161 912 1229

This agenda was issued on **Tuesday, 15 July 2014** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford M32 0TH.

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TRAFFORD COUNCIL

MEMBERSHIP OF COMMITTEES 2014/15

Notes on Membership:

(1) The Scrutiny Committee shall have a membership of 11, or, where this does not achieve the political balance required under the Local Government and Housing Act 1989, whatever figure is necessary to reflect the proportional representation of political groups.

(2) The Scrutiny Committee shall be chaired by a Councillor who is a member of the largest political group on the Council. The person appointed as Vice-Chairman shall not be a member of the same political group as the person appointed as Chairman.

(3) The Chairmen of both the Scrutiny Committee and the Health Scrutiny Committee shall be appointed as ex-officio Members of the opposite scrutiny committee.

(4) The Scrutiny Committee shall appoint co-opted Members when that committee considers education matters.

COMMITTEE	NO. OF MEMBERS
SCRUTINY COMMITTEE	11 (plus the Chairman of the Health Scrutiny Committee as an ex-officio Non-Voting Member) + 5 CO-OPTED MEMBERS + 3 NON-VOTING MEMBERS (when considering Education matters)

CONSERVATIVE GROUP	LABOUR GROUP	LIBERAL DEMOCRAT GROUP
Councillors:-	Councillors:-	Councillors:-
Dylan Butt	Karina Carter	Ray Bowker
Mrs. Pamela Dixon	Mike Cordingley **V-CH**	
Mrs. Laura Evans	Louise Dagnall	
John Holden	Denise Western	
Alan Mitchell **CH**		
Mrs. June Reilly		
TOTAL 6	**4**	**1**

SCRUNTINY COMMITTEE CO-OPTED MEMBERS FOR EDUCATION MATTERS

Church of England (VOTING MEMBER): Vacancy

Roman Catholic (VOTING MEMBER): **Sister P. Goodstadt**

Parent-Governor Representatives

Primary (VOTING MEMBER): Vacancy

Secondary (VOTING MEMBER): **Mrs. D. Haddad**

Special (VOTING MEMBER): Vacancy

Teacher Representatives

(NON-VOTING MEMBER): **Mr. D. Kitchen**

(NON-VOTING MEMBER): Vacancy

(NON-VOTING MEMBER): Vacancy

HEALTH SCRUTINY COMMITTEE

Terms of Reference

1. To act as the Council's Overview and Scrutiny Committee for the purposes of all relevant legislation including, but not limited to the Health and Social Care Act 2001 and the National Health Service Act 2006.

2. All health scrutiny powers provided under the Health and Social Care Act 2001 are delegated to the Health Scrutiny Committee.

3. The Health Scrutiny Committee will have the power to refer a proposed substantial variation in service delivery to the Secretary of State. If the Committee wish to exercise this power, then this must also be agreed by the Chairman of the Scrutiny Committee who will be an ex-officio member of the Health Committee and will hold the power of veto in respect of any proposed referral of a substantial variation to the Secretary of State.

General Role

4. Subject to statutory provision, to review and scrutinise decisions made or actions taken in connection with the discharge by the Council of its functions and by relevant partner authorities in relation to health and well-being issues.

5. In relation to the above functions:

   a) to make reports and/or recommendations to the full Council, Executive of the Council, any joint committee or any relevant partner authority as appropriate

   b) to consider any matter affecting the area or its inhabitants

6. To put in place and maintain a system to ensure that referrals from the Health Scrutiny Committee to the Executive, either by way of report or for reconsideration, are managed efficiently and do not exceed the limits set out in the Constitution.

7. At the request of the Executive, to make decisions about the priority of referrals made in the event of reports to the Executive exceeding limits in the Constitution, or if the volume of such reports creates difficulty for the management of executive business or jeopardises the efficient running of Council business.

8. To report annually to full Council on its workings, set out their plans for future work programmes and amended working methods if appropriate.

Specific functions

9. Maintain a strategic overview of progress towards the achievement of the ambitions and priorities within Trafford's Sustainable Community Strategy in relation to health and well-being matters.

10. Identify the Committee's strategic priorities and determine the Overview and Scrutiny work programme to facilitate constructive evidence based critical-friend challenge to policy makers and service providers within the resources available.

11. Assist and advise the Council in the continued development of the Overview and Scrutiny function within Trafford.

12. Receive, consider and action as appropriate requests:

    a) from the Executive in relation to particular issues; and

    b) on any matters properly referred to the Committee

13. Identify areas requiring in-depth review and allocate these to an appropriate Topic Group. The Committee in consultation with the leader of the relevant Topic Group will set the terms of reference, scope and time frame for the review by the Topic Group.

14. In relation to the terms of reference of the Committee it may:

    a) assist the Council, Executive and shadow Health and Well-being Board in the development of its budget and policy framework by in-depth analysis of policy issues;

b) review and scrutinise the decisions made by and performance of the Executive and/or committees and Council officers both in relation to individual decisions and over time;

c) review and scrutinise the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas;

d) review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the overview and scrutiny committee and local people about their activities and performance;

e) conduct research, community and other consultation as it deems appropriate in the analysis of policy issues and possible options;

f) question and gather evidence from any other person with their consent.

g) consider and implement mechanisms to encourage and enhance community participation in the development of policy options;

h) question members of the Executive and/or committees, senior officers of the Council and representatives of relevant partner authorities on relevant issues and proposals affecting the area and about decisions and performance;

i) liaise with other external organisations operating in the area, whether national, regional or local, to ensure that the interests of local people are enhanced by collaborative working; and

j) undertake any other activity that assists the Committee in carrying out its functions.

Delegation

15. The Health Scrutiny Committee shall have all delegated power to exercise the power and duties assigned to them in their terms of reference.

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HEALTH SCRUTINY COMMITTEE

5 MARCH 2014

PRESENT

Councillor J. Lloyd (in the Chair).
Councillors J. Lamb (Vice-Chairman), Mrs. A. Bruer-Morris, J. Harding, J. Holden, K. Procter, S. Taylor, Mrs. J. Wilkinson, Mrs. P. Young and B. Shaw (ex-Officio)

In attendance

Joseph Maloney	Senior Democratic Services Officer
Sharman Frost	
Kylie Thornton	Commissioning & Service Development Manager

APOLOGIES

Apologies for absence were received from Councillors J. Brophy and Mrs. V. Ward

57. MINUTES

RESOLVED: That the Minutes of the meeting held on 4th December 2013 be agreed as a correct record and signed by the Chairman.

58. DECLARATIONS OF INTEREST

The following declarations of personal interests were reported to the meeting:

Councillor Lloyd in relation to the Stroke Association.
Councillor Harding in relation to her role with the Save Trafford General campaign.
Councillor S.Taylor in relation to her employment within the NHS.
Councillor Mrs. Bruer-Morris, in relation to her employment within the NHS.
Councillor Mrs. Wilkinson in relation to VCAT.

59. NORTH WEST AMBULANCE SERVICE - COMMUNITY STRATEGY UPDATE

The Committee received a presentation from the North West Ambulance Service, outlining their services, performance and information relevant to the borough of Trafford. It was noted that there are 4 stations within Trafford, including Stretford where the station is successfully co-located with GMP, and other stations located at Urmston, Sale, and Altrincham. Members were advised that the NWAS was committed to working with the community in Trafford with Community Responder teams made up from volunteers, and had many links where AED's (Automatic External Defribrillator) were installed.

The Committee was informed that the NWAS was currently reviewing its estates portfolio with reference to ambulance stations, and looking at opportunities for refurbishment, closure, relocation, and co-location with other frontline services. It was also seeking to maximise opportunities for integration with complementary community-based provision.

Members were also provided with an update on the service's plans for achieving Foundation Trust status.

Discussions followed including current resources in transporting patients to Wythenshawe Hospital following the downgrading of A&E services at Trafford General Hospital, working with hospital triage methods, and GP referral patterns. It was identified that there was a need for educating the public concerning their initial decision to ring for an ambulance, other than in an emergency; and Members were advised of initiatives in place in this regard.

As part of the ongoing dialogue with NWAS, Members raised long-standing concerns regarding the recorded levels of performance at Trafford, in comparison with all other areas of Greater Manchester and the wider region, and requested further information in this area.

The Chairman concluded by thanking the representatives from the North West Ambulance Service for attending the Health Scrutiny Committee Meeting, and for their ongoing commitment to providing services for the residents of Trafford.

RESOLVED:

(1) That the content of the presentation be noted and welcomed.

(2) That further information be sought on NWAS' performance levels, in comparison with other areas of Greater Manchester and the wider region.

60. ALCOHOL SERVICE PERFORMANCE UPDATE

The Commissioning and Service Development Manager was in attendance to introduce an updated report of the Executive Member, Community Health and Wellbeing. The report gave a comprehensive update on performance over the previous six months, including the refreshed arrangements for the delivery of commissioned alcohol services aimed at meeting the needs of Trafford residents, in line with the updated Alcohol Strategy.

The report stated that Trafford continues to be the only Greater Manchester area to be better than the England average for Alcohol Treatment Prevalence. However, alcohol misuse continues to be a high priority for the borough in the Joint Strategic Needs Assessment, and has now become a strategic priority for Trafford's Health and Wellbeing Board, the Safer Trafford Partnership, and Trafford's Clinical Commissioning Group.

The Committee was advised that the Drug and Alcohol Team works closely with the police, probation and health services to monitor and restrict the offending behaviour of individuals through Integrated Offender Management (Trafford Spotlight).

It was noted that the Alcohol Strategy had now been updated to take into account the recent changes in legislation and policy direction, and that a multi-agency response to tackling these issues had been further embedded.

In discussing the report and presentation, Members did express concern at a lack of clarity regarding the statistical information presented in relation to detoxification programmes, and expressed the hope that future reports would address this issue, not least because the issue of the effectiveness of different detoxification programmes was not uncontroversial.

The Chairman thanked the Officer presenting the report and indicated that the Committee would like to be kept informed of further progress at a future date.

RESOLVED:

(1) That the report be noted and welcomed.

(2) That a further report on the work to address alcohol problems in the Borough, including updated and clarified statistics in relation to detoxification programmes, be submitted to the Committee at a future meeting.

61. UPDATE ON THE WORK OF THE JOINT HEALTH SCRUTINY COMMITTEE

The Committee received an update on outcomes from the meeting of the Joint Health Scrutiny Committee held at Manchester Town Hall on 21 January 2014. Members expressed concerns about some of the discussions which had taken place in that forum regarding the performance levels of University Hospital South Manchester, and the reasons and evidence base underlying this. It was noted that correspondence had already been received from the hospital in consequence; and that Members were likely to raise their concerns further at the next meeting of the Joint Committee scheduled for 7th April 2014, and seek further explanation from the hospital.

RESOLVED: That the outcome of the meeting held on 21 January 2014, and the next steps to be taken, be noted.

62. TOPIC GROUP UPDATES

Councillor Holden reported on the progress of, and emerging outcomes from, the Personalisation Review, and advised Members that the final report would be presented to the next meeting of the Committee.

The Committee received an update on the Healthy Weight Review from Councillor Mrs. Young, who advised Members that a brief introductory review would be undertaken, with the aim of completion by the end of April. This would provide a basis for scoping a potential wider review in the following municipal year.

Councillor Mrs. Young briefed the Committee on responses received from the hospitals whose performance had featured in the Dignity in Care Scrutiny Report, and advised Members that an update report would be presented to a future meeting of the Committee. A range of issues was then discussed by Members including how best to monitor progress of the recommended improvements at the hospitals, including cleaning services at Trafford General Hospital following notification that there was to be a cutback in this area. Comments were received

from a representative of Trafford Healthwatch, and it was noted that this organisation had a significant and ongoing role in supporting and monitoring these issues.

RESOLVED: That the content of the update reports be noted.

The meeting commenced at 6.30 pm and finished at 9.20 pm.

Healthier Together
A review of health & care in Greater Manchester

NHS
Greater Manchester Association of Clinical Commissioning Groups

Healthcare in Greater Manchester is changing

What care would you want for your...

Tell us what you think and help change the future of your health service

www.healthiertogethergm.nhs.uk

Why healthcare in Greater Manchester needs to change

Best care for me

"Getting high quality hospital care every day of the week."

We are reviewing health and care in Greater Manchester and looking at how to provide the best care for you and your family.

We want to take out the variations in the quality of care across Greater Manchester. We believe by doing this we can save more lives. This document describes the work that is already happening with your GPs to improve standards, and the joining up of local authority and health services. These changes will allow us to make changes to hospital care.

We have a legal duty to consult you on changes to hospital services. The questionnaire at the back asks you for your opinion on the things we've already started to change in the community and on the proposed changes to the way hospitals in Greater Manchester are organised.

We need help to shape our plans and we are specifically asking you about proposed changes to how we look after the (small number of) sickest people in hospital.

As the clinical leaders of Greater Manchester we plan to change Greater Manchester's NHS so that it helps people to stay well and provides the best health and care every time people need it. In the future, just like other countries with better health outcomes, **much more care will be delivered by a high quality, responsive, care system which is easy to access**. Specialist care in hospitals will be reliable and excellent.

At the moment our NHS often provides excellent care, but it hasn't been designed to help people to stay well or prevent ill health. It doesn't consistently provide the right care every time to everyone who needs it. Too often people suffer ill health when it's avoidable and experience care that's less effective than it should be, whether in their GP's surgery, community nursing, social care or hospital. The health of Greater Manchester's people is by many measures the worst in England.

Right care, right place, right time.

By changing our NHS so that it actively helps everyone to prevent long-term conditions, like high blood pressure and diabetes, by detecting them much sooner and improving the quality and standards of hospital care, we can change Greater Manchester from having 'some of the poorest health outcomes' in England to having the best health care in England.

> *Nearly 1,500 lives could be saved over five years if all our hospitals achieved the best standard of care in the country.*

We are fully committed to leading this programme for change. These changes will make sure that health and care services are high quality, safe, accessible and sustainable for us now and for our future patients and communities.

We have spent many months meeting people and discussing our ideas which have helped shape our proposals. However, before any changes take place we want to hear your views.

Please tell us what you think of our proposals by filling in the questionnaire. Your views will help shape the future of health services in Greater Manchester.

Dr Wirin Bhatiani	**NHS Bolton CCG**
Dr Kiran Patel	**NHS Bury CCG**
Dr Mike Eeckelaers	**NHS Central Manchester CCG**
Dr Chris Duffy	**NHS Heywood, Middleton & Rochdale CCG**
Dr Martin Whiting	**NHS North Manchester CCG**
Dr Ian Wilkinson	**NHS Oldham CCG**
Dr Paul Bishop	**NHS Salford CCG**
Dr Bill Tamkin	**NHS South Manchester CCG**
Dr Ranjit Gill	**NHS Stockport CCG**
Dr Alan Dow	**NHS Tameside & Glossop CCG**
Dr Nigel Guest	**NHS Trafford CCG**
Dr Tim Dalton	**NHS Wigan Borough CCG**

Members of the Association of Greater Manchester Clinical Commissioning Groups and Healthier Together Committees in Common.

"Leaders of Greater Manchester Councils know how important health is for local people and for our area. We believe our citizens are entitled to good quality health care wherever they live and whenever they need it. We have worked with Healthier Together to achieve these aims and support its principles.

"Each Greater Manchester local authority is working with local health partners to provide more effective joined-up health and social care. **This will allow those who don't need to go into hospital to receive the treatment they need in their own homes, or closer to home** and make sure those who are leaving hospital receive adequate support to get well. This support will meet individual patient needs and may come from GPs, community nurses, social care workers or the voluntary sector.

> *We are clear that this improvement in integration and in GP services needs to be up and running before the changes to the hospital services are introduced.*

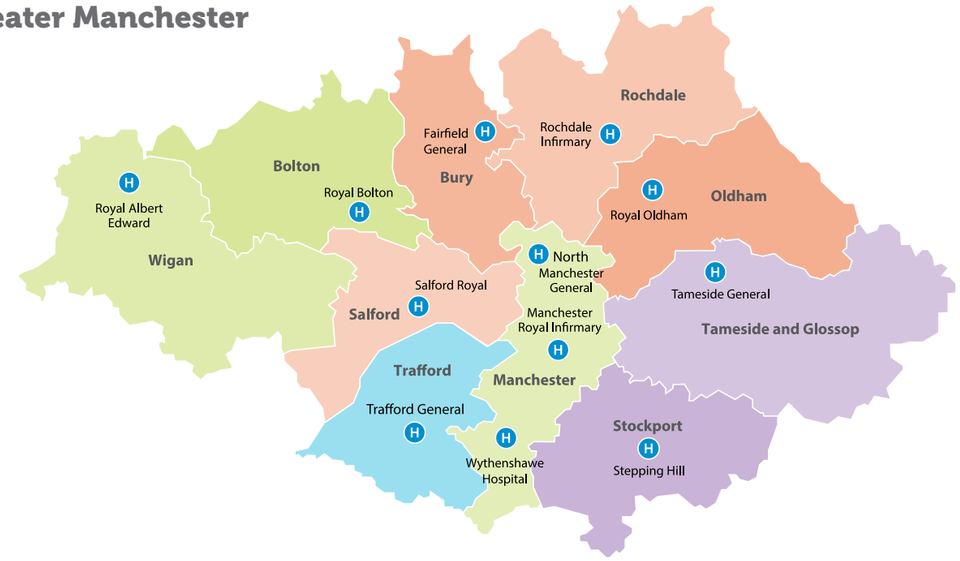
"We are pleased that Healthier Together recognises that **the overwhelming majority of hospital treatment should be at a local General Hospital.** This is better for patients and for family and friends. However there will be times when rare conditions need to be treated and need specialist care. Patients will travel to a specialist centre to receive care from medical staff who deal with these rare problems much more often and so are more expert at dealing with these problems. My family and I are grateful for the exceptional treatment we have received at the world-class facilities we are fortunate to have in Greater Manchester. I want every family to have that opportunity, no matter which hospital they go to and no matter the time of day.

"We accept the case for change made in this consultation document and look forward to hearing your views during the consultation period. We will be making contributions as individual authorities and collectively for Greater Manchester. The consultation provides a range of ways that people can respond and we hope as many of you can do so. Remember it is not buildings that deliver good health care, it is the dedicated NHS staff who make it possible."

Lord Peter Smith, Chairman, Association of Greater Manchester Authorities (AGMA)

AGMA
ASSOCIATION OF GREATER MANCHESTER AUTHORITIES

Greater Manchester



2.8 million population	**5** Community & Mental Health Providers	**22.3%** of adults are obese**
12 Hospital sites	**10** Local Authorities	**23.4%** smoking prevalence**
9 Acute Hospital Providers	**£6 Billion** annual health and social care budget	**23.9%** of children under 16 are growing up in poverty**
503 GP Practices	**1.3 million** attendances to A&E in 2012/13*	
12 Clinical Commissioning Groups (CCGs)		

*Hospital Episode Statistics
**Public Health Outcomes Framework (PHOF)

Tell us what you think by filling in the enclosed questionnaire. **www.healthiertogethergm.nhs.uk**

How primary care is changing

Best care for us

"Being able to see a GP when we need to."

Why primary care needs to change

What do we mean by primary care?
Primary care refers to the services you get from GP surgeries, as well as dentists, pharmacists and optometrists.

For most people in Greater Manchester, contact with health and social-care services begins with a visit to the GP. People have told us they want to be able to see a GP more easily, at a time that suits them.

In Greater Manchester, we are committed to improving and expanding primary care. We have developed challenging standards and we are committed to working to deliver them over the next two years. We are making good progress, with a number of areas in Greater Manchester already benefitting from some of the new and extended services.

Our plans describe:
- a movement of patient care away from hospitals into local primary and community care services,
- a significant increase in investment in primary and community care; and
- changes to the way we use information technology.

"We are transforming GP and other primary care services to improve availability, make better use of technology and improve the quality of care for you and your family."

Clinical commissioning groups (CCGs) are working in each area of Greater Manchester to deliver these plans in a way which fits best with local circumstances. New services are being designed around local needs and are being introduced alongside other changes described in this document.
The plans will be informed by the Greater Manchester Primary Care Strategy, together with guidance from national professional bodies and other expert sources.

We are developing investment programmes in each area, to take into account local plans. £20 million has been allocated next year to support these developments in primary care, with further investment scheduled over the following years.

The primary care standards

All of our plans will focus on supporting people in managing their own health and in making the most of the role of the full primary care system.

Our main aims for primary care include:
- by the end of 2015, everyone living in Greater Manchester who needs medical help, will have same-day access to primary care services, supported by diagnostics tests, seven days a week;
- by the end of 2015, people with long-term, complex or multiple conditions such as diabetes and heart disease will be cared for in the community where possible, supported by a care plan which they own;
- community-based care will focus on joining up care with social care and hospitals, including sharing electronic records which residents will also have access to; and
- by the end of 2016, residents will be able to see how well GP practices perform against local and national measurements.

We believe that if primary care services are improved, it will help you and your family stay healthy and independent. By improving access, you will be able to see a GP more easily. This will mean less chance of people developing the kind of serious illness that needs hospital treatment.

Delivering these plans will mean a joint effort from all those involved in commissioning and designing the primary care system. The Greater Manchester CCGs and NHS England commissioners will continue to work together to make sure the best care is provided to everyone living in Greater Manchester.

"Changes to primary care services allow us to consider changes to hospital services especially for A&E and children's services."

How we are joining up care

Best care for me

"Knowing the council and the NHS will work together to look after mum."

Why are we joining up care?

People have told us they do not feel like the health and care system works well for them. The system is complicated and delivered in an unco-ordinated way. Health and care professionals often work independently instead of together to look after patients.

"Some services which are currently delivered in hospitals would be better delivered in the community."

Making changes to primary care and community-based care will allow us to support people and communities to be healthy, independent and in control of their lives.

What do we mean by joined-up care?
Joined-up care, or integrated care means different health services and care services working together, with services delivered locally where possible.

What we want to achieve through joined-up care

We want to make sure services work together to support you and your family. Organisations across Greater Manchester including the NHS, local councils, voluntary organisations and other public-sector organisations, are working together to deliver more joined-up health and care. The coming together of services that were previously fragmented will improve the quality and experience of care for people. They are focusing on four critical areas.

Prevention and early intervention
We want to prevent people from getting ill and needing health and care services in the first place. When people do have health and social care needs, we want to deal with issues as soon as possible to stop matters getting worse.

Supporting people to look after themselves
We want to support people to take control of their own health and care needs. We will give people the knowledge and advice they need to help them stay healthy and independent.

Creating a single point of contact
We are streamlining the way people access health and care services. This will prevent people having to speak to a number of different organisations, and fill in a number of forms.

Setting up locally based teams
New teams are being formed across Greater Manchester that will work together to join up services that are involved with a person's care.

What do we mean by community-based care?
The term community-based care is a broad term which describes all of the care that people receive outside of the hospital setting, such as district nursing services and home care.

Community-based care for children

Hospitals are not always the best places for children and their carers. In Greater Manchester we already have some excellent community health services that help children and their families to manage long-term conditions, like asthma and diabetes, in familiar surroundings and at home. However, this is not the case for all of Greater Manchester.

We want to improve community-based care so that fewer children need to go to hospital. This means that some services currently provided in hospitals will be provided in the community. We have developed care to allow children in Greater Manchester to access community-based care, including children's community nurses, when they need it.

"Specialist doctors and nurses will work with children and their families in the community, to avoid visits to hospitals."

Some examples of joined-up health and care across Greater Manchester

GPs are using new technology to look after residents in care homes. GPs and care-home teams are supporting residents to review medication and manage their conditions themselves. This has reduced the number of people being admitted to hospital.

In Bolton 44,000 people are aged 65 and over. A new team of workers are dedicated to supporting older residents who may be struggling to feel safe and secure at home so they can stay independent in their communities for as long as possible.

Frank's story

Frank was an 87-year-old gentleman and had been married to Irene for over 60 years when he was diagnosed with terminal cancer. Frank was Irene's main carer as she had dementia and needed support with everyday tasks. Although he coped well initially, as his illness progressed he became less able to care for Irene.

Professionals in Stockport, including the cancer specialist nurse, Frank's GP, hospital staff, voluntary and community organisations involved in their care and support would meet regularly to make sure they were all communicating well, and that their care was joined up. They helped to arrange the support that Frank, Irene and their family needed at home and also made sure that they were getting all the benefits and allowances they were entitled to.

When Frank sadly died, Irene was admitted to residential care as planned. Frank died knowing Irene was being well cared for.

We want to make sure every patient is at the centre

Extended GP opening hours have been introduced alongside enhanced community services, increased support for carers and more home-based care to improve the health of people living in Radcliffe, Bury.

Over **190,000** residents have access to their GP from 8am to 8pm weekdays and at weekends, as well as consultations by video to support their needs. Services for vulnerable patients are better co-ordinated between healthcare professionals and patients are supported to stay in control of their illness.

Bolton

Bury

Wigan

For people most at risk of going into hospital (often those with long-term conditions) teams of staff from different agencies (district nursing, mental-health staff, social care and others) are working together with GP practices to help people stay out of hospital by putting in place care plans. Since April last year, over **2,900** patients have been reviewed and early results suggest fewer people are being admitted to hospital unnecessarily.

Salford

The Integrated Care Programme for Older People will give older people more control over their health and care. Patients tell their story once to one service, have one assessment and one key worker.

Elderly residents and their carers have one number to ring when they need advice on health issues.

A new hospital discharge team has been set up to help people receive the right kind of care as they leave hospital. This means patients can get home quickly. It also means there will be fewer people falling ill and being admitted to hospital again.

Diabetes patients can now book appointments nearer to their home instead of making a trip to the hospital.

There is now specialised care provided at some health centres which means less waiting for outpatient appointments and more opportunities for an appointment at the weekend or during the evening.

Heywood, Middleton and Rochdale

North Manchester

Oldham

GPs, nurses and care workers are working together on new ways to support people when they leave hospital, so they can be cared for in their community.
This co-ordinated approach to a patient's care is preventing the need for them to go back into hospital.

Children's community teams are being developed. This involves GPs, nurses, therapists, social care and education services working together to identify children's needs early and make sure they receive the appropriate support in their local community and avoid unnecessary stays in hospital.

GP practices are offering **appointments from 8am to 8pm** in the week and for three hours on Saturdays and Sundays.
Over 3,000 people have been to these new appointments and **20%** of people said they would have had to go to A&E if the appointments hadn't been available.

Central Manchester

Tameside and Glossop

Over 22,000 people who have long-term health conditions are being supported by joined-up GP and community teams to help them manage their conditions better and improve their health and wellbeing.

Trafford

South Manchester

Stockport

GPs in Stockport are working together to allow residents to get immediate help when they need it and book urgent appointments within 24 hours.

Teams of professionals such as GPs, nurses and care workers are working together to help vulnerable people stay out of hospital by co-ordinating care in people's homes.

We have developed a patient care co-ordination centre to join up care and allow patients easier access to treatment.

New technology is being used to help people receive more care at home or in their GP practice instead of in hospital.

Janet's story

During Janet's recent stay in hospital she told us she wanted to go home as soon as possible to begin her recovery. Discharge co-ordinators, nurses, social workers and the hospital departments who had cared for Janet worked together to make sure she was cleared to leave hospital at the right time so her recovery was supported at home.

The Tameside Integrated Transfer Team put Janet at the centre of her discharge and recovery plan. They were the point of contact for all services and made sure that Janet was involved with every decision. This is a good example of how the council and other local health organisations can work together to make services all about the patient.

We have already seen an impact with a reduction in how long people stay in the hospital and a reduction in the number of people who have come back to the hospital unnecessarily.

To find out more about what is happening in your area, go to www.healthiertogethergm.nhs.uk/local

How hospital services could change

Best care for me

"Knowing that my patients will get the specialist care they need in an emergency."

To provide the best care for you and your family, hospital services need to change

Greater Manchester has some of the best hospitals in the country. However, not all patients experience the best care all of the time.

There is strong evidence to suggest that for the sickest patients who need emergency general surgery in Greater Manchester, the risk of dying may be twice as likely at some of our hospitals compared to others.

We know that the best results are seen when hospital care is delivered by experienced doctors and nurses working together in a close team. However, there is a shortage of the most experienced doctors in important services such as A&E and general surgery. This means that some hospitals do not have enough staff.

Only a third of our hospitals can make sure that a consultant (the most qualified and experienced doctor) surgeon operates on the sickest of patients every time. Similarly only a third of our hospitals can make sure that a consultant is present in A&E, 16 hours a day, seven days a week.

We also know that patients are more likely to die in the evenings and at weekends when fewer doctors are available.

We believe that this is not acceptable and that all patients deserve the safest and highest quality of care. That's why over the past two years, senior doctors and nurses across Greater Manchester have developed and agreed over **500 quality and safety standards**. These standards are designed to make sure **all** patients receive reliable and effective care every time. Currently, **no** hospital in Greater Manchester meets all these quality and safety standards.

Our proposals for how hospital services could change

The changes that are happening in primary care and integrated care will mean fewer people needing to go to hospital.

"Changes proposed to hospital services will need the changes in integrated and primary care to be successful."

For hospital services, we are proposing changes to A&E, acute medicine, and general surgery. These changes are supported by the principle that everyone in Greater Manchester should have access to the highest standards of care wherever they live, whatever time of day or night, or whether it is a weekday or the weekend.

A&E - Accident and Emergency, the hospital department where people with serious injuries or illness are assessed and treated
Acute medicine - the area of medicine that treats adult patients with a wide range of conditions who arrive in hospital in an emergency and need immediate specialist care
General surgery - includes abdominal surgery, both emergency and planned operations. It also includes the assessment and treatment of patients with abdominal pain.

To provide the best care for you and your family, we would like to combine medical teams from separate hospitals into **Single Services**. This would mean providing care at two types of hospital: a local **General Hospital** and a **Specialist Hospital**. Both types of hospital will work together and be staffed by a single team of medical staff.

"A Single Service will mean hospitals, both General and Specialist, working together."

Local General Hospitals will provide the best care for most patients who live locally. All local General Hospitals will provide an A&E department, full acute medical care and planned surgery.

In A&E, local General Hospitals will have a consultant present 12 hours a day, seven days a week. In Specialist Hospitals, this will be extended to at least 16 hours a day, seven days a week to deal with the sickest of patients. Stronger leadership will mean we can make the best treatment decisions for patients.

In acute medicine, the Greater Manchester quality and safety standards will **raise the standard of care for our patients across all hospitals in Greater Manchester**, both General and Specialist.

"These changes will make sure every hospital has a strong future. This includes keeping each of our A&E departments open."

For a small number of patients (those who are the most unwell) a smaller number of hospitals will provide the most specialised care. These Specialist Hospitals will provide emergency and high-risk general surgery as well as the services a local General Hospital provides. The 12 clinical commissioning groups will be making a decision on the way these hospital services are organised depending on what you tell us during this consultation.

"Patients will continue to receive most of their care in the community or in their local General Hospital."

In an emergency, people will not have to worry about going to the right hospital for their care. Ambulance paramedics and hospital staff will assess and treat you as needed. If you need urgent specialised care, they will make sure you are immediately transferred to a Specialist Hospital. There will be a system in place to make sure that you see the right doctor, at the right time, in the right place – no matter how you arrive at hospital.

How will these changes improve care?

In Greater Manchester we have already changed the way we treat some specialist conditions. For things that you may only experience once in a lifetime such as stroke and major trauma, there is evidence that putting these services onto a smaller number of hospital sites has saved lives and improved patient care and we want to do more of this.

We have used learning from these changes to design the Single Service. We believe that providing specialist care at a smaller number of hospitals in Greater Manchester will raise standards of care and save more lives.

How hospitals will work together

Every local General and Specialist hospital will have:
- an A&E department and only the very sickest patients will go to a Specialist Hospital;
- an acute medical unit caring for adults who need to receive care from hospital teams;
- general surgery operations for adults (high-risk surgery will be provided at Specialist Hospitals);
- screening, diagnostic tests and outpatient appointments;
- rapid-access clinics for urgent surgical assessment by a consultant.

Ambulance staff will assess patients and take them to the most appropriate hospital, as they do now. People with life-threatening conditions, who need emergency general surgery, will be taken to a Specialist Hospital to receive their care.

In a Single Service:
- every Specialist Hospital will partner with one or two local General Hospitals to provide the highest quality care to all residents;
- there will be one team of doctors and nurses working across the local General Hospitals and the Specialist Hospital;
- patients will move between the local General Hospital and Specialist Hospital to receive the best care for their needs.

Pat's story, from Manchester

"After I unexpectedly fell at home, my husband noticed I was slurring my speech. He quickly called 999 and within minutes the ambulance service crew had arrived.

"The ambulance drove past my local hospital (Manchester Royal Infirmary) and took me to the specialist stroke centre at Salford Royal Hospital. When I arrived I could hardly speak and my face was drooping. I couldn't move my right arm and leg at all. It was very scary, but the staff were really kind and supported me the whole way.

"Immediately they took me to the onsite brain specialists for an emergency CT scan. The doctors confirmed that a blood clot had caused the stroke and I was quickly given a clot-busting injection called 'thrombolysis' to break it up.

"I recovered on the stroke ward for two weeks before returning home with the help of the rehab team who arranged regular physiotherapy visits.

Doctors said I made a full recovery because I was taken quickly to the specialist stroke centre at Salford Royal, which meant they could spot and treat my stroke as soon as possible."

How hospital services could change

Best care for me

"Being treated by the most experienced doctor when I need life-saving surgery."

How hospital services could be organised?

There are lots of ways, or options, for how hospitals in Greater Manchester could be organised into local General or Specialist Hospitals. We have spent a long time considering a number of factors to decide which of these are possible.

The factors we have considered are:

- the amount of money needed to set up and run a local General and a Specialist Hospital;
- the number of doctors and nurses we have available to work in each Single Service;
- the travel time to get to Specialist Hospitals, and how it will affect patients; and
- the hospital buildings, wards and operating theatres that we have.

We are asking for your views on eight options for the proposed changes to hospital services. We have chosen the options that allow an even spread of Specialist Hospitals across Greater Manchester to make sure we can provide the best care for all patients. These options are the ones with the lowest effect on travel time for patients and are the most cost-effective to deliver.

The eight options are presented in the table on the opposite page. Each column shows which hospitals would be Specialist and which ones would be General. We have also provided an assessment of the strengths of each option on page 13. To do this we have looked at the effect of each option under specific headings for example, patient experience. We would like to know how important these factors are to you.

Hospitals that are the same in every option

Three hospitals have been designated Specialist Hospital sites in all of the options. These are Manchester Royal Infirmary (MRI), Salford Royal Hospital, and the Royal Oldham Hospital. The first two must be Specialist Hospitals to continue to provide services that are not provided anywhere else – specialist paediatric services at the Royal Manchester Children's Hospital (located with MRI) and the adult neuroscience service at Salford Royal. Royal Oldham Hospital also needs to be a Specialist Hospital to reduce, as far as possible, the effect of the proposed changes for people who live in Greater Manchester and need to travel to a Specialist Hospital using public transport.

Three hospitals have also been designated as local General Hospitals in all of the options. These are North Manchester General Hospital, Fairfield General Hospital (Bury) and Tameside General Hospital. This is due to decisions that have already been agreed by local clinical commissioning groups.

Rochdale Infirmary and Trafford General Hospital are shown but these hospital sites don't currently provide the services under review, so won't change.

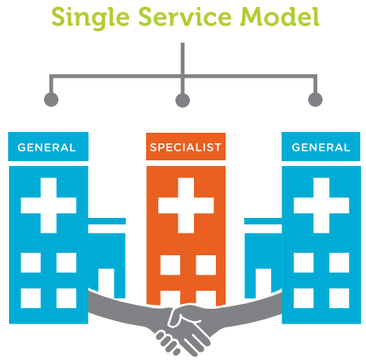
Four Specialist Hospital sites or five?

There are four hospitals left to be considered, Royal Bolton Hospital, Royal Albert Edward Infirmary, Stepping Hill Hospital and Wythenshawe Hospital. Depending on whether we choose four or five Specialist Hospitals in Greater Manchester, either one or two of these hospitals could be a Specialist Hospital. We are asking for your views on which of these four hospitals should be local General and which should be Specialist.

Options which include four Specialist Hospitals need fewer doctors and nurses to deliver specialist care than options with five Specialist Hospitals. They are also more cost effective to run each year and will be quicker to put into practice. However, having four Specialist Hospitals rather than five will mean that some patients will have to travel further to get their specialist care.

All eight options for organising Specialist and General Hospitals across Greater Manchester are shown in the table opposite.

The eight options for organising our hospitals



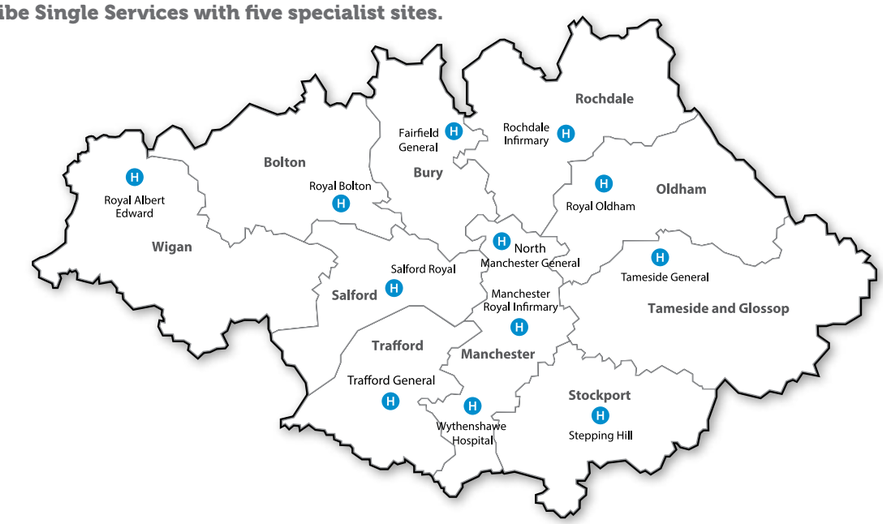
Key:

- Specialist Hospital
- General Hospital
- No change

Hospital site	Option 4.1	Option 4.2	Option 4.3	Option 4.4	Option 5.1	Option 5.2	Option 5.3	Option 5.4
Central Manchester Manchester Royal Infirmary								
Salford Salford Royal Hospital								
Oldham Royal Oldham Hospital								
Bury Fairfield General Hospital								
Tameside and Glossop Tameside General Hospital								
North Manchester North Manchester General Hospital								
Wigan Royal Albert Edward Infirmary								
Bolton Royal Bolton Hospital								
South Manchester Wythenshawe Hospital								
Stockport Stepping Hill Hospital								
Trafford Trafford General Hospital								
Rochdale Rochdale Infirmary								

Options 4.1 to 4.4 describe Single Services with four specialist sites.

Options 5.1 to 5.4 describe Single Services with five specialist sites.



Tell us what you think by filling in the enclosed questionnaire.

Assessment of the options

How we have assessed the options

In the lead up to this consultation we have held workshops with patients, the public and major organisations to understand the things that are important to them when making decisions. A number of themes emerged which allowed us to develop criteria to assess our proposals. We began the process with a large number of possible options, but were able to reduce them to eight possible options using the criteria the public and patients had given us. These criteria are outlined below.

Quality and safety
People have told us that quality and safety is important and we should use the following criteria to assess the options.

- **Clinical effectiveness and outcomes** – which options will consistently provide the high standard of care patients deserve, and meet the Greater Manchester quality and safety standards?
- **Patient experience** – which options are the best, based on the NHS Friends and Family Test? This asks patients whether they would recommend services to their friends and family if they needed similar care or treatment.

Affordability and value for money
People have told us that making the best use of taxpayer's money is important and we should use the following criteria to assess the options.

- **Investments (buildings, cost of change)** – which options will have the lowest one-off costs, for example to invest in buildings, or training staff?
- **Yearly cost of running services** – which options will have the lowest yearly running costs?

Transition
People have told us that it's important that changes should be easy to put into practice and we should use the following criteria to assess the options.

- **Workforce** – which option is easiest to achieve with the number of senior doctors available?
- **Expected time to deliver** – how long will it take to make the proposed changes in each option? A shorter time means that benefits can be delivered earlier.
- **Links with other strategies** – how well do each of our options fit with what is happening (or may happen) in Greater Manchester?

Travel and access
People have told us that being able to get to services easily is a big issue for them as well as for friends, carers and relatives, who may need to visit someone in hospital. We have given a lot of thought to travel and transport in developing the options for change. For each option, we have compared the effect on travel and transport for patients. For example, where possible the nearest Specialist Hospital should be within one hour and 15 minutes on public transport for anyone.

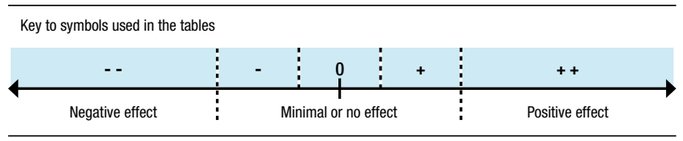
Our standard for travel is that your local General Hospital must be within 20 minutes by ambulance, and a Specialist Hospital within 45 minutes by ambulance.

We have ruled out many options to change services if they do not meet our standard and we continue to look at any other effects the changes might have, in particular for vulnerable groups who may find it more difficult to access services.

We have used the below criteria shown below to understand the effect that each option will have on how far people will need to travel, and the choices available to patients.

- **Distance and time to access services – by ambulance** – which options will result in the lowest increase in journey time by ambulance to a Specialist Hospital for those people who need specialist care?
- **Distance and time to access services – public transport** – which options will result in the lowest increase in journey time by public transport for friends and family visiting patients at Specialist Hospitals?
- **Patient choice** – which options will give the people of Greater Manchester the greatest choice of hospitals for planned care?

We have used the symbols in the key opposite to show how we have assessed each option. For example, an option with a '+ +' for patient experience, would have a more positive effect on patient experience, than an option with just a '+'.



Options for the Single Services with four specialist hospitals

Sites which would be Specialist Hospitals for each option		Quality and safety: Clinical effectiveness and outcomes	Quality and safety: Patient experience	Travel and access: Distance and time to access services – by ambulance	Travel and access: Distance and time to access services – public transport	Travel and access: Patient choice	Affordability and value for money: Investment (buildings, cost of change)	Affordability and value for money: Yearly cost of running services	Transition: Workforce	Transition: Expected time to deliver	Transition: Links with other strategies
Option 4.1	• Manchester Royal Infirmary • Salford Royal Hospital • Royal Oldham Hospital • Royal Bolton Hospital	+ +	+ +	- -	-	- -	- -	+ +	+ +	+ +	-
Option 4.2	• Manchester Royal Infirmary • Salford Royal Hospital • Royal Oldham Hospital • Royal Albert Edward Infirmary (Wigan)	+ +	+ +	-	-	- -	- -	+ +	+ +	+ +	-
Option 4.3	• Manchester Royal Infirmary • Salford Royal Hospital • Royal Oldham Hospital • Wythenshawe Hospital	+ +	+ +	- -	- -	- -	-	+ +	+ +	+ +	+
Option 4.4	• Manchester Royal Infirmary • Salford Royal Hospital • Royal Oldham Hospital • Stepping Hill Hospital (Stockport)	+ +	+	- -	- -	- -	-	+ +	+ +	+ +	+

Options for the Single Services with five specialist hospitals

Sites which would be Specialist Hospitals for each option		Clinical effectiveness and outcomes	Patient experience	Distance and time to access services – by ambulance	Distance and time to access services – public transport	Patient choice	Investment (buildings, cost of change)	Yearly cost of running services	Workforce	Expected time to deliver	Links with other Strategies
Option 5.1	• Manchester Royal Infirmary • Salford Royal Hospital • Royal Oldham Hospital • Stepping Hill Hospital (Stockport) • Royal Albert Edward Infirmary (Wigan)	+ +	+ +	-	-	-	- -	+	+	+	+
Option 5.2	• Manchester Royal Infirmary • Salford Royal Hospital • Royal Oldham Hospital • Royal Albert Edward Infirmary (Wigan) • Wythenshawe Hospital	+ +	+ +	-	- -	-	- -	+	+	+	+
Option 5.3	• Manchester Royal Infirmary • Salford Royal Hospital • Royal Oldham Hospital • Royal Bolton Hospital • Wythenshawe Hospital	+ +	+ +	0	-	-	- -	+	+	+	+
Option 5.4	• Manchester Royal Infirmary • Salford Royal Hospital • Royal Oldham Hospital • Royal Bolton Hospital • Stepping Hill Hospital (Stockport)	+ +	+ +	0	0	-	- -	+	+	+	+

Healthier Together
A review of health & care in Greater Manchester

What happens next

Healthier Together is a review of health and care in Greater Manchester, we are looking at how to provide the best care for you and your family. Please tell us what you think by filling in the form opposite. Please remember that this is a consultation and not a 'vote'. We will be taking into account your responses along with a wide range of other information, including the views of, staff, professional groups and key organisations.

The consultation period will last for 12 weeks from: July 8th 2014 to September 30th 2014. We have planned a range of activities in your local area which will allow us to hear your views. This will include events in each of the 10 Greater Manchester districts and a touring bus. You can find full details of when and where the events will be held and the location of the bus on our website, or by calling our freephone number. **Please come along and help us to improve our ideas by telling us what you think.**

Opinion Research Services (ORS), an independent research company, will process the completed questionnaires. Only the ORS research team will see your questionnaire. We may have to release the information you provide (except your personal information) to other people or organisations under the Freedom of Information Act 2000, the Data Protection Act 1998 or the Environmental Information Regulation 2004.

Views from individuals will be completely anonymous and we will only publish in summary format, however we may publish views from organisations in full.

For more detailed information about our plans, please visit
www.healthiertogethergm.nhs.uk/guide

How to get in touch

Call us free on: 0800 888 6789

Email us at: healthier.together@nhs.net

Visit our website: www.healthiertogethergm.nhs.uk

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Email: healthier.together@nhs.net

Call us on: 0800 888 6789

NHS Trafford Clinical Commissioning Group

Agenda Item No. 13

Part 1 [x] Part 2 [ ]

NHS TRAFFORD CLINICAL COMMISSIONING GROUP GOVERNING BODY 24th JUNE 2014

Title of Report	Performance and Quality Report.
Purpose of the Report	This paper updates the Governing Body on the performance challenges at the CCG's two main acute providers, University Hospital South Manchester (UHSM) and Central Manchester Foundation Trust (CMFT). Unfortunately, CCG performance information is not available for inclusion in this report. The Trafford server, on which all performance and quality work is stored, crashed at the end of May. The Information Technology (IT) Service has advised the CCG it will not be possible to recover all performance data files. Work has now begun to re-establish the data flows into the warehouse and re-develop performance scorecards. In view of this, there is no CCG scorecard but the team will be back in a position to report by the first week in July. This paper also provides an update in relation to quality issues for commissioned providers.

Actions Requested	**Decision**		**Discussion**	**x**	**Information**	**x**
Strategic Objectives Supported by the Report	1. Consistently achieving local and national quality standards.					✓
	2. Delivering an increasing proportion of services from primary care and community services from primary care and community services in an integrated way.					✓
	3. Reduce the gap in health outcomes between the most and least deprived communities in Trafford.					✓
	4. To be a financial sustainable economy.					✓

Recommendations	The NHS Trafford Governing Body is asked to note the contents of this report and support the improvement work taking place.

Discussion history prior to the Governing Body	N/A
Financial Implications	Some indicators carry a financial penalty for non delivery.
Risk Implications	There is a risk that providers do not achieve all contractual targets. Where this is the case, these have been identified on the CCG's risk register and remedial action plans at the Trusts are in place.
Impact Assessment	N/A
Communications Issues	N/A
Public Engagement Summary	N/A

Prepared by	Zoe Mellon, Performance Lead. Kate Lord, Quality Lead
Responsible Director	Michelle Irvine, Associate Director of Performance and Quality.

PERFORMANCE REPORT

1.0 INTRODUCTION AND BACKGROUND

1.1 This paper updates the Governing Body on the performance challenges at the CCG's two main acute providers, University Hospital South Manchester (UHSM) and Central Manchester Foundation Trust (CMFT).

1.2 Unfortunately, CCG performance information is not available for inclusion in this report. The Trafford server, on which all performance and quality work is stored, crashed at the end of May. The Information Technology (IT) Service has advised the CCG it will not be possible to recover all performance data files.

1.3 Work has now begun to re-establish the data flows into the warehouse and re-develop performance scorecards. In view of this, there is no CCG scorecard but the team will be back in a position to report by the first week in July.

1.4 Attached in Appendix A is a scorecard of the contractual targets and performance in April 2014. This paper highlights three areas of underperformance at each Trust, these areas are:

UHSM

- Access to A&E
- The number of days lost to delayed transfers of care
- Waiting times for diagnostic tests

CMFT

- Access to A&E
- Waiting times for diagnostic tests
- Stroke care

2.0 UNIVERSITY HOSPITAL SOUTH MANCHESTER

A&E Waiting Times

2.1 In April 2014, the Trust achieved 90.2% against an operational standard of 95%. Daily monitoring throughout May and June shows it is now impossible for the Trust to achieve the target across quarter 1.

2.2 An organisational action plan has been agreed by the Trust's Executive Team and shared with the CCG. This action plan focuses on the distinct areas:

- processes and practices in the A&E department.
- flow through the hospital.
- ensuring effective patient discharges and reducing patient delays.

Delayed Transfer of Care

2.3 It has been agreed that the health economy, facilitated by the Urgent Care Operational Group, will work together providing an intensive focus on reducing the current levels of delayed transfers of care.

2.4 As at the 4th June, when this work began, there were 34 Trafford and Manchester patients in hospital beds who were medically fit for discharge. The Urgent Care Operational Group has identified the main issues and immediate actions:

Manchester CCGs

- 17 Manchester patient delays, primarily for issues relating to social services.
- Additional funding has been secured for two social workers to speed up assessments and access to re-ablement.

Trafford CCG

- 17 Trafford delays, primarily due to a delay in receiving the final decision on CHC funding and the speed of assessment by the RAID Team.
- Commitment has been made to review the process and communication issues in both these areas.
- Additional social services support will be available.

2.5 The Urgent Care Operational Group has also initiated the following key actions to be completed over the coming weeks:

- Hold daily tactical meetings to look at patient level issues.
- Review all patients with a length of stay over 14 days and those medically fit for discharge on a daily basis.
- Assign an owner to each patient delay. The owner has the responsibility of unblocking barriers to discharging the patient.
- Re-look at the standard operating procedure that was developed a couple of years ago to support effective discharge procedures.
- Re-look at the daily processes of pulling patients through the system to prevent patients being in hospital beds longer than necessary.
- Identify and escalate to the Urgent Care Board any issues that cannot be resolved at the daily tactical meetings on a fortnightly basis.
- Produce a daily progress report to key senior staff.

Diagnostic Waits

2.6 UHSM has failed this target in April and expects to do so in May, this is due to long waiting times for Neurophysiology Testing.

2.7 UHSM has an SLA with Salford for the provision of this service. The service is run on a small number of staff which means at times of staff absences, there is a gap in provision.

2.8 Salford has been asked for an action plan, however, it is felt this is a short term capacity constraint and not an ongoing problem.

3.0 CENTRAL MANCHESTER FOUNDATION TRUST

A& E Waiting Times

3.1 In April 2014, the Trust achieved 93.3% against an operation standard of 95%.

3.2 The Trust has confirmed it expects to achieve quarter 1 performance and daily monitoring shows improvement. As at 4th June performance was 94.45%.

3.3 The Trust is undertaking some specific actions to help achieve and maintain performance. These include:

- Reviewing and implementing the recommendations by Finnamore Consulting who recently undertook a number of rapid improvement events with clinicians.
- Middle grade staff available to assist in the overnight management of the minor's stream.
- On-call managers are on site until 2am.
- Continuing to house a booking clerk in A&E to divert appropriate patients to primary care by booking patients into GP appointment slots.

Diagnostic Waiting Times

3.4 Delays in Adult MRI scanning and children's endoscopies is now resolved. However, waiting times for children's MRI scans is an issue. The waiting times will reduce throughout quarter 1, with achievement of the target from July onwards. Contractual penalties will apply for non-delivery of the 6 week standard.

Stroke care

3.5 CMFT presented to the CCG the findings of the most recent Sentinel Stroke National Audit programme (SNNAP) audit. Encouragingly, the Trust has improved from an E to a D rated organisation. There is a comprehensive action plan in place to improve across all the SNNAP indicators. The CCG has agreed some additional immediate actions, these include:

- The Trust will ensure their internal action plan is aligned to the contractual indicators as well as the SNNAP standards.
- The Stroke Improvement Forum chaired by the Performance & Quality Team will be re-established.
- The Trust will ensure a Route Cause Analysis (RCA) is undertaken for all patients not completing 90% of their stay on a stroke unit. The outcome of these will be discussed at the Stroke Improvement Forum.
- The Trust will submit SNNAP data to the CCG on a monthly basis in advance of the quarterly audits being published.

3.6 The Trust plan will continue to be a one year plan until the longer term future of stroke services across Greater Manchester is determined.

4.0 CONCLUSION

4.1 The NHS Trafford Governing Body is asked to note the contents of this report and support the improvement work taking place.

QUALITY REPORT

5.0 INTRODUCTION AND BACKGROUND

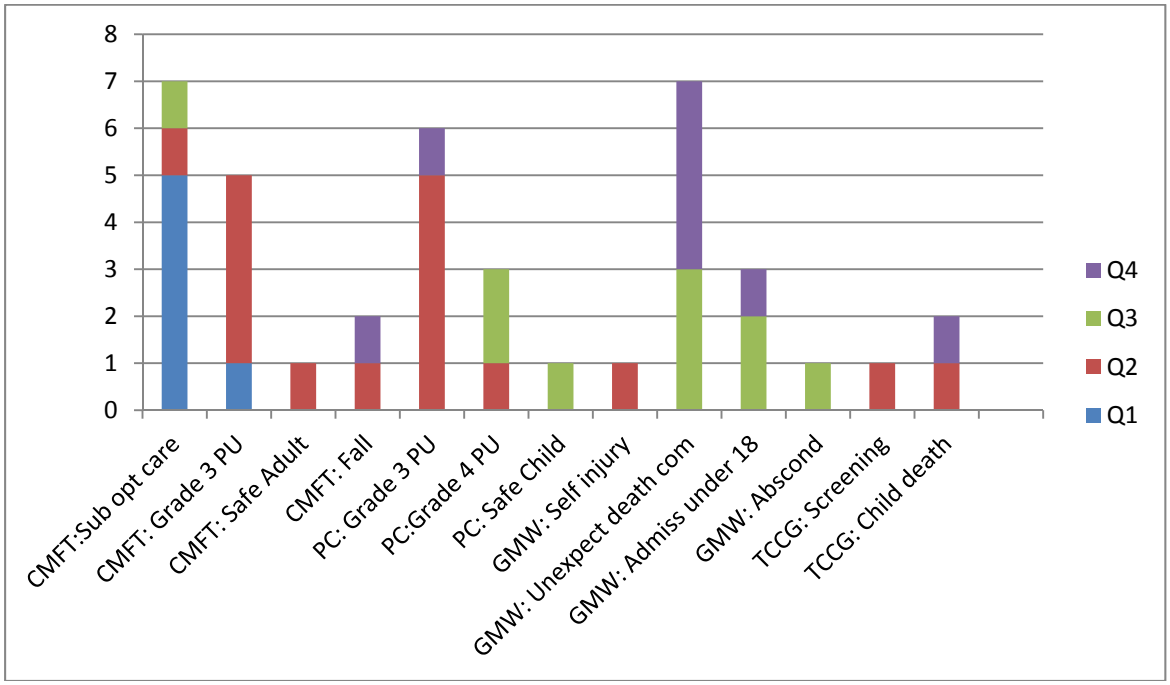
5.1 The purpose of this paper is to provide an update in relation to quality issues for commissioned providers.

6.0 SERIOUS INCDIENT QUARTER 1-4 2013/14

6.1 Serious incidents in healthcare are uncommon but when they occur the National Health Service (NHS) has a responsibility to ensure there are systematic measures in place for safeguarding people, property, NHS resources and reputation. This includes responsibility to learn from these incidents to minimise the risk of them happening again.

6.2 The following graph shows serious incidents involving Trafford CCG patients from quarter 1-4 2013/14. Please note up until April 2014, UHSM did not identify within serious incident reports which CCG the patient was under. They have now agreed to do this and these figures will be included in any serious incident update moving forward.

TCCG Serious Incidents Q1-Q4



7.0 QUALITY ISSUES CMFT

7.1 There were concerns raised following a National Peer Review Visit of Paediatric Diabetes Services to CMFT. In relation to the Trafford division the reviewers were concerned that the service did not have sufficient clinical support. This was raised formally with the Trust at the Quarterly Quality Monitoring Meeting and the CCG will receive a copy of the response to the Peer Review Team on the 20th of June in line with the timeframes as outlined in the letter to the Trust.

7.2 There are two historic alerts outstanding on the national patient safety agency (NPSA) system from 2011 and 2012 in relation to Trafford General Hospital prior to the Trust being acquired by CMFT. CMFT have provided assurance that these alerts have been implemented. They have now closed these alerts.

7.3 CMFT were inspected by the CQC in December, the report was released on the 12th of April. They were served an improvement notice in relation to two standards Outcome 5 (Nutrition) and Outcome 21 (Records). The CQC judged the findings in respect of both Outcome 5 and Outcome 21 as having a minor impact on people who use the service. An action plan has been received from the Trust in respect to both outcomes.

7.4 CMFT have received a CQC Maternity outlier alert in relation to puerperal sepsis within 42 days of delivery The deadline for response back to CQC is the 19th of June and the CCG will be copied into this response

8.0 QUALITY ISSUES UHSM

8.1 Monitor have placed UHSM in breach. UHSM have appointed a turnaround director to help it deal with short-term financial problems. UHSM has also undertaken a review of its leadership and how it is run. Monitor will continue to review the Trusts action plan in relation to A&E performance.

8.2 UHSM were inspected by CQC. The themed inspection was undertaken in January 14 against the Essential Standards of Care. UHSM were issued a compliance action in relation to Outcome 16- Assessing and monitoring the quality of service provision. The areas of concern identified were in relation to Dementia Strategy and care. The CCG have received the Trusts action plan in relation to this and it will be the focus of the next walk round visit.

8.3 UHSM is not compliant with its statutory or contractual duties in respect of equality and diversity. It has developed an action plan which will be overseen by South Manchester CCG until this plan is fully implemented.

9.0 RECOMMENDATIONS

9.1 The Governing Body is asked to note the contents of this report, the approach that is being taken presently to manage quality within Commissioned Providers and consider any further assurance that they would like in relation to the issues highlighted in this report.

APPENDIX A

UHSM KPIs 2014-15

CMCCG.ManchesterCCGsSLAM@nhs.net

Code - Provider Contracts	Area	Indicator name	Detail	Threshold	Frequency	Number Type	Completed Fields	Data Input Line	Year to Date Performance	2014-15 (Annual Indicator)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
													Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
CB_B1	A	Referral to Treatment	The Percentage within 18 weeks for Completed Admitted RTT Pathways	90%	Monthly	Percent	Apr-14		91.9%		91.9%												
						Numerator	*Apr-14*	*Y*	*2,043*		*2,043*												
						Denominator	*Apr-14*	*Y*	*2,224*		*2,224*												
CB_B2	A	Referral to Treatment	The Percentage within 18 weeks for Completed Non-Admitted RTT Pathways	95%	Monthly	Percent	Apr-14		97.2%		97.2%												
						Numerator	*Apr-14*	*Y*	*2,489*		*2,489*												
						Denominator	*Apr-14*	*Y*	*2,562*		*2,562*												
CB_B3	A	Referral to Treatment	The Percentage within 18 weeks for Incomplete RTT Pathways	92%	Monthly	Percent	Apr-14		95.3%		95.3%												
						Numerator	*Apr-14*	*Y*	*18,164*		*18,164*												
						Denominator	*Apr-14*	*Y*	*19,057*		*19,057*												
CB_S6	B	Referral to Treatment	The Number of RTT Pathways > 52 weeks for Incomplete Pathways	0	Monthly	Number	Apr-14	*Y*	0		0												
CB_B4	A	Diagnostic Test Waiting Times	The Percentage of Patients waiting less than 6 weeks for a Diagnostic Test (15 Key Diagnostic Tests)	99%	Monthly	Percent	Apr-14		1.7%		1.7%												
						Numerator	*Apr-14*	*Y*	*72*		*72*												
						Denominator	*Apr-14*	*Y*	*4,275*		*4,275*												
CB_B5	A	A&E Waiting Times	Percentage of Patients spending 4 hours or less in A&E NB Reported Performance each Month is YTD to that Month	95%	Monthly	Percent	Apr-14		90.2%		90.2%												Monthly reported figure is the YTD activity
						Numerator	*Apr-14*	*Y*	*7,254*		*7,254*												
						Denominator	*Apr-14*	*Y*	*8,038*		*8,038*												
CB_B6	A	Cancer 2 Week Waits	Percentage of Patients seen within two weeks of an urgent GP Referral for Suspected Cancer	93%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B7	A	Cancer 2 Week Waits	Percentage of Patients urgently referred for Evaluation/Investigation of "Breast Symptoms" seen within 14 days	93%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B8	A	Cancer 31 Day Waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 31 days of a Cancer Diagnosis	96%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B9	A	Cancer 31 Day Waits	Percentage of Patients Receiving Subsequent Surgery within a maximum Waiting Time of 31 Days	94%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B10	A	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Anti-Cancer Drug Regimen within a maximum Waiting Time of 31 Days	98%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B11	A	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Radiotherapy Treatment within a maximum Waiting Time of 31 Days	94%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B12	A	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of an Urgent GP Referral for Suspected Cancer	85%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B13	A	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of Referral from an NHS Cancer Screening Service	90%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B14	A	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of a Consultant Decision to Upgrade	85%	Monthly	Percent	na																Reported 1 month retrospectively
						Numerator	*na*	*Y*															
						Denominator	*na*	*Y*															
CB_B17	A	Mixed Sex Accommodation	MSA Breaches - No of Patients	0	Monthly	Number	Apr-14	*Y*	0		0												

UHSM KPIs 2014-15

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Code - Provider Contracts	Area	Indicator name	Detail	Threshold	Frequency	Number Type	Completed Fields	Data Input Line	Year to Date Performance	2014-15 (Annual Indicator)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
													Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
	A	Mixed Sex Accommodation	MSA Breaches - No of Days	0	Monthly	Number	Apr-14	Y	0		0												For calculation of Financiol Penalty
CB_B18	A	Cancelled Operations	Percentage of Patients not offered another Binding Date within 28 days of a Cancelled Operation	0	Quarterly	Percent	na																
						Numerator	*na*	Y															
						Denominator	*na*	Y															
CB_S10	B	Cancelled Operations	Number of Urgent Operations Cancelled for a Second Time	0	Monthly	Number	Apr-14	Y	0		0												
CB_A15	B	HCAI	Overall Number of Cases of MRSA Bacteraemia - AVOIDABLE	0	Monthly	Number	Apr-14	Y	0		0												
CB_A15	B	HCAI	Overall Number of Cases of MRSA Bacteraemia - UNAVOIDABLE	0	Monthly	Number	Apr-14	Y	0		0												
CB_A16	B	HCAI	Overall Number of Cases of C. Difficile - NHS Patients	39	Monthly	Number	Apr-14	Y	3		3												
CB_S7a	B	Ambulance Handover	Ambulance Handover Delays of over 30 minutes	0	Monthly	Number	Apr-14	Y	47		47												
CB_S7b	B	Ambulance Handover	Ambulance Handover Delays of over 1 hour	0	Monthly	Number	Apr-14	Y	1		1												
NWA1		Ambulance	Compliance with Recording Patient Handover between Ambulance and A&E		Monthly	Percent	Apr-14		78.4%		78.4%												
						Numerator	*Apr-14*	Y	*1,648*		*1,648*												
						Denominator	*Apr-14*	Y	*2,101*		*2,101*												
NWA3		Ambulance	Excessive Delays (>2hrs) on the part of Ambulance of Acute Trusts (minutes)		Monthly	Number	Apr-14	Y	0		0												
CB_S9	B	Trolley Waits in A&E	Number of Patients who have waited over 12 hours in A&E from Decision to Admit to Admission	0	Monthly	Number	Apr-14	Y	0		0												
No Ref01	B	VTE Risk Assessment	Percentage of all adult patients who have had a VTE risk assessment using an assessment tool approved by the commissioner	95%	Monthly	Percent	Apr-14		95.1%		95.1%												
						Numerator	*Apr-14*	Y	*6,700*		*6,700*												
						Denominator	*Apr-14*	Y	*7,045*		*7,045*												
No Ref02	B	Formulary	Failure to publish Formulary		Monthly	Rating	na	Y			Yes												
No Ref03	B	Duty of Candour	Duty of Candour		Monthly	Rating	Apr-14	Y	0		0												
No Ref04	B	NHS Number	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	99%	Monthly	Percent	Apr-14		99.8%		99.8%												
						Numerator	*Apr-14*	Y	*57,351*		*57,351*												
						Denominator	*Apr-14*	Y	*57,477*		*57,477*												
GM06	C1	Stroke	Quality stroke care - patients who spend at least 90% of their inpatient stay on a stroke unit	80%	Monthly	Percent	Apr-14		80.6%		80.6%												
						Numerator	*Apr-14*	Y	*25*		*25*												
						Denominator	*Apr-14*	Y	*31*		*31*												
GM07	C1	Stroke	Quality stroke care - proportion of patients arriving in a designated stroke bed within 4 hours of arrival	80%	Monthly	Percent	Apr-14		72.7%		72.7%												
						Numerator	*Apr-14*	Y	*16*		*16*												
						Denominator	*Apr-14*	Y	*22*		*22*												
GM08	C1	Stroke	Quality stroke care - proportion of high risk TIA cases investigated and treated within 24 hours	60%	Monthly	Percent	Apr-14		100.0%		100.0%												
						Numerator	*Apr-14*	Y	*13*		*13*												
						Denominator	*Apr-14*	Y	*13*		*13*												
GM14	C1	Pharmacy	All patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 48 hours of admission and have agreed data recorded on admission	Q1/2: 70% Q3/4: 75%	Monthly	Percent	Apr-14		77.4%		77.4%												
						Numerator	*Apr-14*	Y	*1,500*		*1,500*												
						Denominator	*Apr-14*	Y	*1,937*		*1,937*												
GM13	C1	Pharmacy	All patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 24 hours of admission and have agreed data recorded on admission	Q1/2: 65% Q3/4: 70%	Quarterly	Percent	na																
						Numerator	*na*	Y															
						Denominator	*na*	Y															

UHSM KPIs 2014-15

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Code - Provider Contracts	Area	Indicator name	Detail	Threshold	Frequency	Number Type	Completed Fields	Data Input Line	Year to Date Performance	2014-15 (Annual Indicator)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
													Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
D03	D	Pharmacy	Continue to improve compliance with provision of shared care protocols for amber drugs (amber drugs as defined in the GMMMG RAG list)		Quarterly	Percent	na																
						Numerator	*na*	Y																
						Denominator	*na*	Y																
D02	D	Pharmacy	Evidence of a strategy to bring arrangements for homecare medicines in line with nationally agreed best practice		Quarterly	Percent	na																
						Numerator	*na*	Y																
						Denominator	*na*	Y																
RHB1	C2	Readmissions	Readmissions within 28 days - COPD patients		Monthly	Percent	Apr-14		9.3%		9.3%												
						Numerator	*Apr-14*	Y	*4*		*4*												
						Denominator	*Apr-14*	Y	*43*		*43*												
RHB3	C2	No Admissions to hospital within 91 days of Referral - Stroke patients	Percentage of COPD patients on a caseload who have not been admitted to hospital within 91 days following referral (TCS 25)		Monthly	Percent	Apr-14		0.0%		0.0%												
						Numerator	*Apr-14*	Y	*0*		*0*												
						Denominator	*Apr-14*	Y	*12*		*12*												
STP1	C2	DNA Rates	% Did not attend (DNA) rate for all clinic based appointments - COPD & Physiotherapy Patients		Monthly	Percent	Apr-14		11.3%		11.3%												
						Numerator	*Apr-14*	Y	*32*		*32*												
						Denominator	*Apr-14*	Y	*284*		*284*												
STP2	C2	CNA Rates	% Could not access (CNA) rate for all home based visits - COPD & Physiotherapy Patients		Monthly	Percent	Apr-14		3.1%		3.1%												
						Numerator	*Apr-14*	Y	*9*		*9*												
						Denominator	*Apr-14*	Y	*293*		*293*												
D05	D	Complaints	% of complaints responded to within timescale agreed at the outset upon receipt of the complaint with the complainant	90%	Monthly	Percent	Apr-14		89.7%		89.7%												
						Numerator	*Apr-14*	Y	*52*		*52*												
						Denominator	*Apr-14*	Y	*58*		*58*												
D06	D	Complaints	% of complaints acknowledged in 3 working days of the day following receipt of the complaint	90%	Quarterly	Percent	na																
						Numerator	*na*	Y																
						Denominator	*na*	Y																
D07	D	Complaints	% of complaints where, following investigation, an action plan has been put in place, acted upon, completed within an agreed timescale and reported back to the complainant	90%	Quarterly	Percent	na																
						Numerator	*na*	Y																
						Denominator	*na*	Y																
D09	D	Delayed Transfers	Delayed transfers of care (lost bed days/nights) - NB - Report: Number of Days; NHS Only; Acute+Non-Acute		Monthly	Number	Apr-14	Y	334		334												

APPENDIX A

CMFT KPIs 2014-15

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Code - Provider Contracts	Area	Indicator name	Detail	Threshold	Frequency	Number Type	Completed Fields	Data Input Line	Year to Date Performance	2014-15 (Annual Indicator)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
													Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
CB_B1	A	Referral to Treatment	The Percentage within 18 weeks for Completed Admitted RTT Pathways	90%	Monthly	Percent	Apr-14		91.0%		91.0%												
						Numerator	*Apr-14*	Y	*1,902*		*1,902*												
						Denominator	*Apr-14*	Y	*2,091*		*2,091*												
CB_B2	A	Referral to Treatment	The Percentage within 18 weeks for Completed Non-Admitted RTT Pathways	95%	Monthly	Percent	Apr-14		95.3%		95.3%												
						Numerator	*Apr-14*	Y	*12,762*		*12,762*												
						Denominator	*Apr-14*	Y	*13,394*		*13,394*												
CB_B3	A	Referral to Treatment	The Percentage within 18 weeks for Incomplete RTT Pathways	92%	Monthly	Percent	Apr-14		92.5%		92.5%												
						Numerator	*Apr-14*	Y	*39,142*		*39,142*												
						Denominator	*Apr-14*	Y	*42,328*		*42,328*												
CB_S6	B	Referral to Treatment	The Number of RTT Pathways > 52 weeks for Incomplete Pathways	0	Monthly	Number	Apr-14	Y	0		0												
CB_B4	A	Diagnostic Test Waiting Times	The Percentage of Patients waiting less than 6 weeks for a Diagnostic Test (15 Key Diagnostic Tests)	99%	Monthly	Percent	Apr-14		2.6%		2.6%												
						Numerator	*Apr-14*	Y	*238*		*238*												
						Denominator	*Apr-14*	Y	*9,067*		*9,067*												
CB_B5	A	A&E Waiting Times	Percentage of Patients spending 4 hours or less in A&E NB Reported Performance each Month is YTD to that Month	95%	Monthly	Percent	Apr-14		93.3%		93.3%												Monthly reported figure is the YTD activity
						Numerator	*Apr-14*	Y	*22,973*		*22,973*												
						Denominator	*Apr-14*	Y	*24,620*		*24,620*												
CB_B6	A	Cancer 2 Week Waits	Percentage of Patients seen within two weeks of an urgent GP Referral for Suspected Cancer	93%	Monthly	Percent	na																
						Numerator	*na*	Y			*Data not available until June*												
						Denominator	*na*	Y															
CB_B8	A	Cancer 31 Day Waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 31 days of a Cancer Diagnosis	96%	Monthly	Percent	na																
						Numerator	*na*	Y			*Data not available until June*												
						Denominator	*na*	Y															
CB_B9	A	Cancer 31 Day Waits	Percentage of Patients Receiving Subsequent Surgery within a maximum Waiting Time of 31 Days	94%	Monthly	Percent	na																
						Numerator	*na*	Y			*Data not available until June*												
						Denominator	*na*	Y															
CB_B10	A	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Anti-Cancer Drug Regimen within a maximum Waiting Time of 31 Days	98%	Monthly	Percent	na																
						Numerator	*na*	Y			*Data not available until June*												
						Denominator	*na*	Y															
CB_B11	A	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Radiotherapy Treatment within a maximum Waiting Time of 31 Days	94%	Monthly	Percent	na																
						Numerator	*na*	Y			*Data not available until June*												
						Denominator	*na*	Y															
CB_B12	A	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of an Urgent GP Referral for Suspected Cancer	85%	Monthly	Percent	na																
						Numerator	*na*	Y			*Data not available until June*												
						Denominator	*na*	Y															
CB_B13	A	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of Referral from an NHS Cancer Screening Service	90%	Monthly	Percent	na																
						Numerator	*na*	Y			*Data not available until June*												
						Denominator	*na*	Y															
CB_B14	A	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of a Consultant Decision to Upgrade	85%	Monthly	Percent	na																
						Numerator	*na*	Y			*Data not available until June*												
						Denominator	*na*	Y															
CB_B17	A	Mixed Sex Accommodation	MSA Breaches - No of Patients	0	Monthly	Number	Apr-14	Y	0		0												
	A	Mixed Sex Accommodation	MSA Breaches - No of Days	0	Monthly	Number	Apr-14	Y	0		0												For calculation of Financial Penalty
CB_B18	A	Cancelled	Percentage of Patients not offered	0	Quarterly	Percent	Apr-14		0.0%		0.0%												

CMFT KPIs 2014-15

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Code Provider Contracts	Area	Indicator name	Detail	Threshold	Frequency	Number Type	Completed Fields	Data Input Line	Year to Date Performance	2014-15 (Annual Indicator)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
		Operations	another Binding Date within 28 days of a Cancelled Operation										Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
						Numerator	*Apr-14*	Y	*0*		*0*												
						Denominator	*Apr-14*	Y	*69*		*69*												
CB_S10	B	Cancelled Operations	Number of Urgent Operations Cancelled for a Second Time	0	Monthly	Number	Apr-14	Y	0		0												
CB_A15	B	HCAI	Overall Number of Cases of MRSA Bacteraemia - AVOIDABLE	0	Monthly	Number	Apr-14	Y	1		1												
CB_A15	B	HCAI	Overall Number of Cases of MRSA Bacteraemia - UNAVOIDABLE	0	Monthly	Number	Apr-14	Y	0		0												
CB_A16	B	HCAI	Overall Number of Cases of C. Difficile - NHS Patients	66	Monthly	Number	Apr-14	Y	6		6	all cases unavoidable											
CB_S7a	B	Ambulance Handover	Ambulance Handover Delays of over 30 minutes - MRI	0	Monthly	Number	Apr-14	Y	152		152												
CB_S7a	B	Ambulance Handover	Ambulance Handover Delays of over 30 minutes - TGH	0	Monthly	Number	Apr-14	Y	0		0												
CB_S7b	B	Ambulance Handover	Ambulance Handover Delays of over 1 hour - MRI	0	Monthly	Number	Apr-14	Y	47		47												
CB_S7b	B	Ambulance Handover	Ambulance Handover Delays of over 1 hour - TGH	0	Monthly	Number	Apr-14	Y	0		0												
NWA1		Ambulance	Compliance with Recording Patient Handover between Ambulance and A&E		Monthly	Percent	Apr-14		80.6%		80.6%												
						Numerator	*Apr-14*	Y	*1,817*		*1,817*												
						Denominator	*Apr-14*	Y	*2,254*		*2,254*												
NWA3		Ambulance	Excessive Delays (>2hrs) on the part of Ambulance of Acute Trusts (minutes)		Monthly	Number	na	Y															
CB_S9	B	Trolley Waits in A&E	Number of Patients who have waited over 12 hours in A&E from Decision to Admit to Admission	0	Monthly	Number	Apr-14	Y	0		0												
No Ref01	B	VTE Risk Assessment	Percentage of all adult patients who have had a VTE risk assessment using an assessment tool approved by the commissioner	95%	Monthly	Percent	Apr-14		95.8%		95.8%												
						Numerator	*Apr-14*	Y	*10,403*		*10,403*												
						Denominator	*Apr-14*	Y	*10,855*		*10,855*												
No Ref02	B	Formulary	Failure to publish Formulary		Monthly	Rating	na	Y			Last published May 2014	http://www.cmft.nhs.uk/royal-infirmary/our-services/pharmacy											
No Ref03	B	Duty of Candour	Duty of Candour		Monthly	Rating	na	Y															
GM06	C1	Stroke	Quality stroke care - patients who spend at least 90% of their inpatient stay on a stroke unit	80%	Monthly	Percent	Apr-14		65.2%		65.2%												
						Numerator	*Apr-14*	Y	*15*		*15*												
						Denominator	*Apr-14*	Y	*23*		*23*												
GM07	C1	Stroke	Quality stroke care - proportion of patients arriving in a designated stroke bed within 4 hours of arrival	80%	Monthly	Percent	Apr-14		28.6%		28.6%												
						Numerator	*Apr-14*	Y	*2*		*2*												
						Denominator	*Apr-14*	Y	*7*		*7*												
GM08	C1	Stroke	Quality stroke care - proportion of high risk TIA cases investigated and treated within 24 hours	60%	Monthly	Percent	Apr-14		66.7%		66.7%												
						Numerator	*Apr-14*	Y	*2*		*2*	*waiting for central - Elliot shuttleworth*											
						Denominator	*Apr-14*	Y	*3*		*3*												
GM09a	C1	Maternity	% Women who have seen a midwife or a maternity healthcare professional by 12 weeks and 6 days of pregnancy	90%	Monthly	Percent	Apr-14		76.5%		76.5%												
						Numerator	*Apr-14*	Y	*436*		*436*												
						Denominator	*Apr-14*	Y	*570*		*570*												
GM09b	C1	Maternity	% Women (who present within 12 weeks) who have seen a midwife or a maternity healthcare professional by 12 weeks and 6 days of pregnancy	90%	Monthly	Percent	Apr-14		95.2%		95.2%												
						Numerator	*Apr-14*	Y	*418*		*418*												
						Denominator	*Apr-14*	Y	*439*		*439*												
GM13	C1	Pharmacy	All patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 24 hours of admission and have agreed data recorded on admission: (Where no	95%	Monthly	Percent	Apr-14		62.5%		62.5%												
						Numerator	*Apr-14*	Y	*110*		*110*												
						Denominator	*Apr-14*	Y	*176*		*176*												

CMFT KPIs 2014-15

CMCCG.ManchesterCCGsSLAM@nhs.net

Code Provider Contracts	Area	Indicator name	Detail	Threshold	Frequency	Number Type	Completed Fields	Data Input Line	Year to Date Performance	2014-15 (Annual Indicator)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
													Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
E08	D	Pharmacy	Monthly Medication Management Lead Meetings to address and resolve pharmacy issues		Quarterly	Percent	na																
						Numerator	*na*	Y			*Meetings in dairies*												
						Denominator	*na*	Y			*Richard Hey & Jane Law with CCG Medicines Management Lead.*												
CHF1	C2	Children's Urgent Referrals	Urgent referrals (inc safeguarding) must receive same day or next wkg day response to the referrer and contact with family within 2 wkg days.	95%	Monthly	Percent	na																
						Numerator	*na*	Y			*Definitions to be confirmed with CCG*												
						Denominator	*na*	Y															
CHF3	C2	LAC Assessments	% of initial assessments for Looked After Children completed within statutory time frame	95%	Monthly	Percent	na																
						Numerator	*na*	Y			*Definitions to be confirmed with CCG*												
						Denominator	*na*	Y															
LTC2	C2	LTCs	Screening of Stroke patients with LTCs for anxiety/depression		Monthly	Percent	na																
						Numerator	*na*	Y			*Definitions to be confirmed with CCG*												
						Denominator	*na*	Y															
LTC3	C2	LTCs	Self Care for Stroke Patients to cope with LTCs		Monthly	Percent	na																
						Numerator	*na*	Y			*Definitions to be confirmed with CCG*												
						Denominator	*na*	Y															
D06	D	Complaints	% of complaints acknowledged in 3 working days of the day following receipt of the complaint	90%	Quarterly	Percent	na																
						Numerator	*na*	Y															
						Denominator	*na*	Y															
D07	D	Complaints	% of complaints where, following investigation, an action plan has been put in place, acted upon, completed within an agreed timescale and reported back to the complainant	90%	Quarterly	Percent	na																
						Numerator	*na*	Y															
						Denominator	*na*	Y															
D08	D	Delayed Transfers	Delayed transfers of care (lost bed days/nights) - NB - Report: Number of Days; NHS Only; Acute+Non-		Monthly	Number	Apr-14	Y	**122**		**122**												
D30	D	SSNAP-Stroke	Submit SSNAP data in line with national submission	95% within ?	Quarterly	Percent	na																
						Numerator	*na*	Y															
						Denominator	*na*	Y															
E02	E	Choose & Book	Slot Issues		Monthly	Percent	Apr-14		**16.8%**		**16.8%**												
						Numerator	*Apr-14*	Y	*985*		*985*												
						Denominator	*Apr-14*	Y	*5,850*		*5,850*												
E07	E	Outpatients- CCG outcomes indicator set 1314	Provider cancellation of new outpatient appointments. Provider cancellation of OP follow up appts.		Quarterly	Percent	na																
						Numerator	*na*	Y															
						Denominator	*na*	Y															
E09	E	UM Review	Zero Day Length of Stay Review: Adults		Monthly	Percent	na																
						Numerator	*na*	Y			*corrently in progress will end 6th June*												
						Denominator	*na*	Y															
E10	E	UM Review	Zero Day Length of Stay Review: Children		Monthly	Percent	na																
						Numerator	*na*	Y			*starts 9th June and ends 27th June*												
						Denominator	*na*	Y															

CMFT Quality on a Page

Harm Occurred

SHMI	● →
Harm Free Care	● →
MRSA	● →
C.Difficile	● →
All Incidents	● ↓
Serious Incidents	● ↑
Never Events	● →

Safe Systems

Advancing Quality

AMI	CABG	HF	H&K	Pn	Stk
●	●	●	●	●	●

Nutritional Assessments:

Completed

Treatment agreed

Medicines Reconciled:

within 24 hrs

within 48 hrs

Stroke SSNAP ● ↑

Patient Experience

Friends and Family	● ↑
Mixed Sex Acc.	● →
PLACE:	

Clean	Food	Dignity	Facilities
●	●	●	●

Patient Stories in development

Surveys:

Hospital Care	● →
Outpatients	● ↑
A&E	in development
Personal Needs	in development

Complaints:

Acknowledged

Responded

Action Plan

Satisfied

Future Safety

Staff Sickness	● ↑
Bed Occupancy	in development
Trainee Supervision	● →
Staff Survey:	
Place to Work	● →
Friends & Family	● ↓

Mandatory Training:

Safeguarding Adult

Safeguarding Child

Domestic Abuse

Infection Control

Regulators

Monitor Risk Ratings:

Governance	● →
Finance	● →
CQC:	
Registration	● ↓
IM Banding	● →

KEY

RAG Rating: based on individual indicator thresholds (see detail pages)

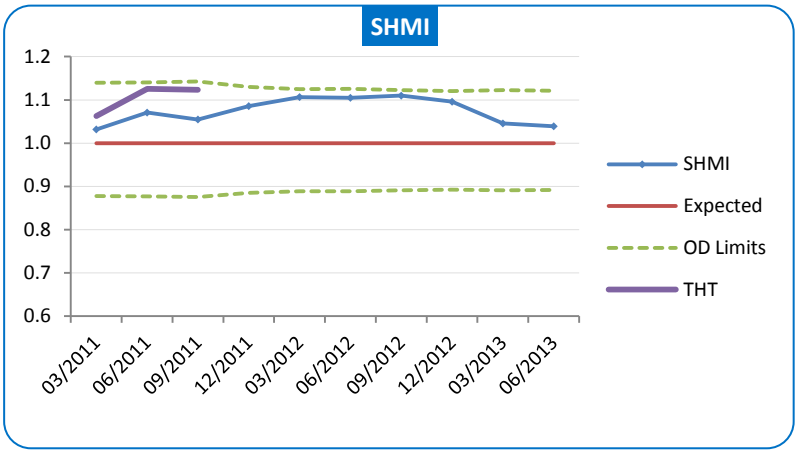
● Threshold to be agreed/developed

Arrows: current performance compared to previous result

↑ improved → unchanged ↓ worsened

CMFT Mortality

SHMI



There have been two distinct strands of work in relation to mortality at CMFT-one strand has been in relation to the clinical review of all deaths by a mortality review panel and an in depth look at this alongside the information from High Level Incidents (including never events and serious incidents). This has led to service improvements across the patch and has involved an in depth review of different clinical areas as highlighted through the mortality reviews. The other strand focused on the accuracy of clinical coding within notes and there has been a large push to review and improve clinical coding within the Trust.

CMFT have recieved a CQC Maternity outlier alert for puerperal sepsis within 42 days of delivery
The deadline for response back to CQC is the 19th of June and the CCG will be copied into this response.

The CCG will continue to monitor all sources of data in relation to mortality and are hoping that the clinical mortality reviews and ongoing work on coding the Trust is undertaking will have a positive impact on the SHMI figure as well as the HSMR.

Thresholds	1.1 or less	Expected but > 1.1	> upper limit

CMFT Regulators

Monitor **Q4 13/14**

Governance Risk ➔

Green

The governance rating for this foundation trust remained "No Evident Concerns" in Q4 2013/14.

Continuity of services ➔

3

A new rating system is in place from Q4 2013/14 and CMFT are rated 3 with 1 being the most serious and 4 the least risk.

CQC **Q4 13/14**

Registration 2 improvement(s) and 0 enforced action(s) ➔

Quality Score Band 6 ➔

CMFT were inspected by the CQC in December, the report was released on the 12th of April. They were served an improvement notice in relation to two standards Outcome 5 (Nutrition) and Outcome 21 (Records). The CQC judged the findings in respect of both Outcome 5 and Outcome 21 as having a minor impact on people who use the service.

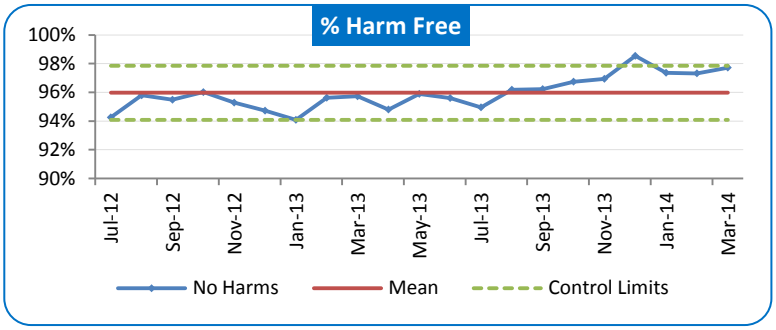
The concerns in respect of nutrition were related to the choice of food that patients have, and were a particular issue in the Royal Manchester Children's Hospital. CMFT has submitted an action plan to CQC in respect of this. The CCG have received a copy of this and this was discussed at the Quarterly Quality Monitoring Meeting with the provider. As part of this work CMFT have engaged and involved younger people from the Youth Forum in respect of this work and are developing "child friendly" questions in relation to food using the patient tracker system in place.

The concerns raised in relation to clinical record keeping were known to the Trust and are reviewed on a regular basis at Board level. The Trust has invested a huge amount in the management of risks associated with the fact that the records are still, largely, paper based. The Trust is working hard to develop a bespoke electronic record which will meet the needs of patient care delivery for all specialties. The work to address this problem is overseen by the Trust Risk Management Committee and was already well underway at the time of the CQC visit

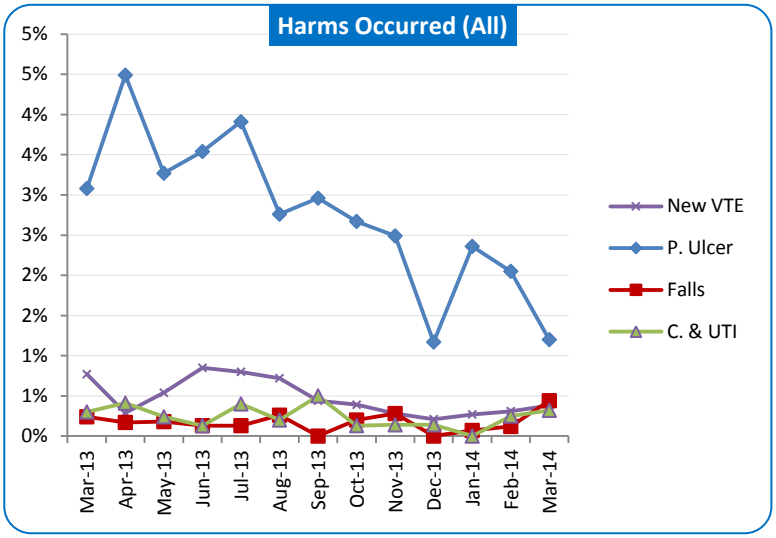
Thresholds				
Monitor Continuity	4	3 to 2	1
Governance	no concerns	under review	enforcement

CQC Reg	No concerns	Improvements	Enforcements
Quality	5-6	3-4	1-2

CMFT Harm Free Care



% Harm Free (HFC1)



CMFT have undertaken a large programme of work in relation to harm free care, and the progress is reflected on the graphs above. CMFT have had no grade 4 pressure ulcers since the 24th of January 2014 and are working very hard to maintain this figure.

However the quality of the root cause analysis reports for pressure ulcers has been sub-standard and formal feedback has been given to the Trust in relation to this. CMFT have acknowledged the poor reports and the CCG feedback and have undertaken a full review of the investigation process for pressure ulcers.

As part of this CMFT have undertaken a deep dive into all CMFT attributed Grade 4 pressure ulcers in the past year and has used this to inform the action plan in relation to pressure ulcers. Through this deep dive CMFT also identified an immediate concern in relation to the timely provision of pressure relieving mattresses and have gone through a re-procurement process to address this.

CMFT have also developed a template to investigate pressure ulcers along similar principles to the investigation of MRSA and Cdiff. They are also in the process for agreeing trajectories for improvement with each division and an overall Trust trajectory- this is alongside the trajectory that has been agreed as part of the National CQUIN. The pressure ulcer action plan and trajectories will be signed off at the CMFT Harm Free Care Summit on the 16th of June. This area will continue to be monitored closely through the CCG quality review and assurance process.

Thresholds	Harm Free	95% or more	92% or more	less than 92%

UHSM Quality on a Page

Harm Occurred

SHMI	→
Harm Free Care	→
MRSA	→
C.Difficile	↓
All Incidents	↓
Serious Incidents	↓
Never Events	↓

Safe Systems

Advancing Quality

AMI	CABG	HF	H&K	Pn	Stk

Nutritional Assessments:

Completed	→
Treatment agreed	

Medicines Reconciled:

within 24 hrs	→
within 48 hrs	→

Stroke SSNAP ↑

Patient Experience

Friends and Family	↓
Mixed Sex Acc.	→

PLACE:

Clean	Food	Dignity	Facilities

Patient Stories in development

Surveys:

Hospital Care		↓
Outpatients		↑
A&E	in development	
Personal Needs	in development	

Complaints:

Acknowledged	↑
Responded	→
Action Plan	→
Satisfied	

Future Safety

Staff Sickness		↓
Bed Occupancy	in development	
Trainee Supervision		↑
Staff Survey:		
Place to Work		↑
Friends & Family		↑

Mandatory Training:

Safeguarding	Adult	↓
Safeguarding	Child	↑
Domestic Abuse		↑
Infection Control		↑

Regulators

Monitor Risk Ratings:

Governance	→
Finance	→

CQC:

Registration	↓
IM Banding	→

KEY

RAG Rating: based on individual indicator thresholds (see detail pages)

Threshold to be agreed/developed

Arrows: current performance compared to previous result

↑ improved → unchanged ↓ worsened

UHSM Regulators

Monitor **Q4 13/14**

Governance Risk ➔

Red

Following investigation the governance rating for this trust is now "subject to enforcement action".

Continuity of services ➔

2

From May 2014 UHSM have been found to be in breach of their licence and enforcement action has been applied due to concerns over the trust's short term financial sustainability.

CQC **Q4 13/14**

Registration 1 improvement(s) and 0 enforced action(s) ➔

Quality Score Band 4 ➔

Monitor have placed UHSM in breach. UHSM have appointed a turnaround director to help it deal with short-term financial problems. UHSM has also undertaken a review of its leadership and how it is run. Monitor will continue to review the Trusts action plan in relation to A&E performance. The CCG have reported this and are monitoring this as a risk.

CQC inspection

The themed inspection was undertaken in January 14 against the Essential Standards of Care. UHSM were issued a complaince action in relation to Outcome 16- Assessing and monitoring the quality of service provision. Areas for improvement that did raise a compliance action

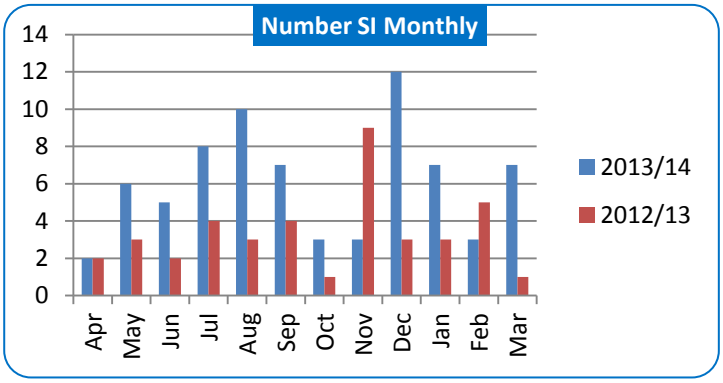
- Lack of dementia strategy evident;
- Evidence that action plan regarding dementia needed to be more robustly monitored;
- NICE quality standards re dementia not discussed within the governance structure;
- Whilst the Trust is a middle reporter for incidents, the CQC spoke to staff caring for those with dementia had not reported incidents where they were injured;
- Trust incident system categories need to be reviewed;
- Investigations of SIs found to be variable and actions not completed to timeframes;
- Careplans inconclusive as to whether patients/carers/advocates views always taken into account;
- DNACPR- issues were raised regarding the Trust's form, compliance with its policy and a recent audit.

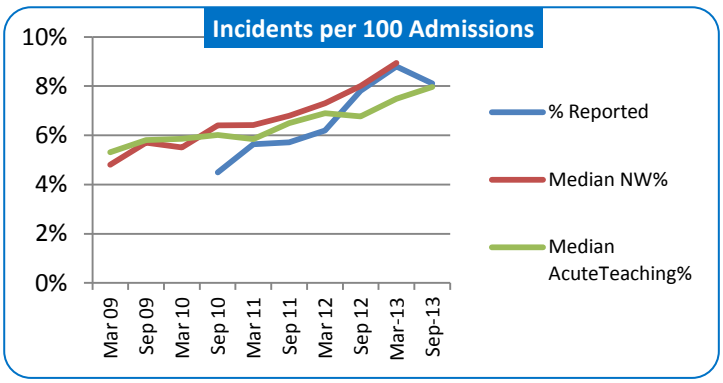
The Trust have produced an action plan that has been shared with the CCG.

Thresholds				
Monitor Continuity	4	3 to 2	1
Governance	no concerns	under review	enforcement

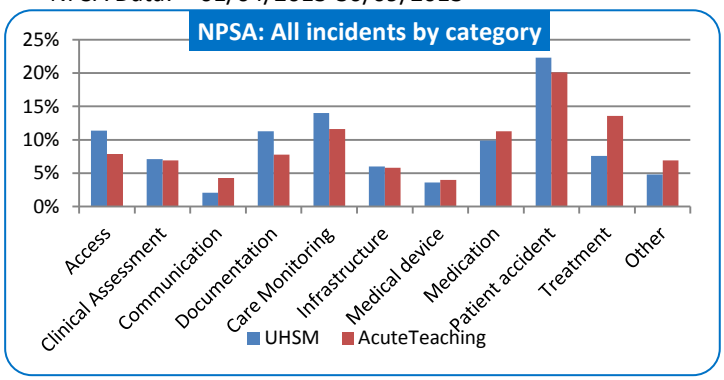
CQC Reg	No concerns	Improvements	Enforcements
Quality	5-6	3-4	1-2

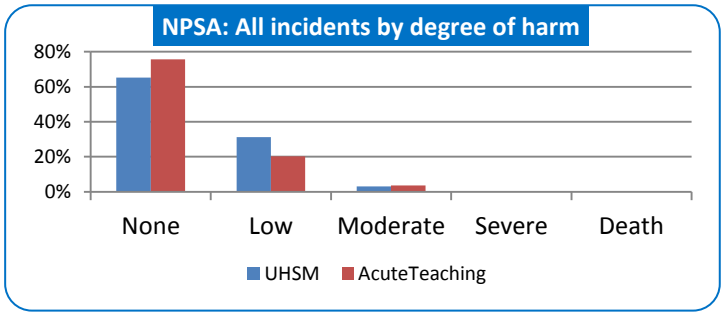
UHSM Incidents





NPSA Data: 01/04/2013-30/09/2013





There have been concerns raised with UHSM in relation to the number of non-valid extensions requested in 2013_14. The CCG has set criteria agreed with the Trust under which extensions will be granted.

The CCG has worked closely with the provider to resolve this issue as there were extensions that did not meet the agreed criteria for 32 investigations in 2013_14. Thus far in 2014_15 there have been 2 extensions granted, both of which meet the criteria for an extension. This is a vast improvement.

UHSM have undertaken a detailed training programme to ensure more senior managers and clinicians are able to undertake root cause analysis investigations and have put more robust governance structures in place to monitor the status of Serious Incident investigations. This is now monitored on a weekly basis and the CCG receives assurance in relation to this on a monthly basis. This includes the monitoring of compliance with the Duty of Candour requirements.

UHSM are also now identifying the CCG from which the patinet comes from when they report serious incidents. This will enable Trafford CCG to have better oversight of serious incidents that affect Trafford patients.

Performance No thresholds agreed; good performance equals increase in incident reporting and reduction in Serious Incidents.

TRAFFORD COUNCIL

Report to: **Council**
Date: **16 July 2014**
Report for: **For approval**
Report of: **Corporate Director of Transformation and Resources/Statutory Scrutiny Officer**

Report Title

Scrutiny Arrangements

Summary

The report sets out recommendations about the operation of Scrutiny Committees following the abolition of the role of Scrutiny Topic Group Chairmen at the Annual Meeting.

Recommendation(s)

1. That Scrutiny Topic Groups be abolished and that the arrangements for dealing with issues be decided upon by the relevant Scrutiny Committee.

2. That the Director of Legal and Democratic Services make any necessary constitutional changes as a result of these changes.

Contact person for access to background papers and further information:

Name: Peter Forrester, Democratic and Performance Services Manager

Extension: 1815

Background Papers:

None

1.0 Background

1.1 The Council agreed the current model for Scrutiny at its meeting on 19 September 2012. This model included the formation of four Topic Groups with a Chairman who was paid an allowance to lead the work of the Group.

1.2 The role of Topic Group Chairman was abolished at the Annual Meeting on the 11 June and the Council asked for a report on future arrangements to be brought to this meeting.

1.3 Topic Groups were intended to be Member led and adopted a work programme in October 2012. They completed reviews and work on the following:

- Review of Doorstep Crime
- Review of Community Asset Framework
- Review of Investment in Street Lighting
- Review of Environmental Enforcement
- Secondary school place sufficiency review
- Review of Cycling in Trafford
- Dignity Review

2.0 Proposed Way of Working

2.1 The abolition of the Topic Group Chairman role provides an opportunity to review the approach. The main principle behind the Topic Group model was that they could respond flexibly and quickly to issues rather than do long and detailed pieces of work. A number of the reviews above, were short, focused reviews involving a group of interested members. This model can be carried forward.

2.2 The proposed future model of operation is:

- The general principle is that Scrutiny Committees should be flexible in their approach and consider issues at the most appropriate and relevant time.

- Scrutiny Committees should prepare an overview work programme for the year at their first meeting. This will include any significant items on the horizon and any follow up issues. However, the work programme should provide sufficient capacity for ad hoc and current issues to be added to the agenda as and when they arise.

- Scrutiny Committees should be free to decide the most appropriate approach to their consideration of items. Some items may be best dealt with at a full Committee or a special meeting. Others might be best dealt with by a few Members in a “task and finish” group. The outputs should generally be short and to the point to have maximum impact, although there might be occasions where a longer report is felt to be necessary.

2.3 The Chairman and Vice Chairman will be responsible for developing the work programme and recommending the most appropriate way of considering items. Scrutiny support work will continue to be provided by Democratic Services and the service is developing a more flexible working model to achieve this.

2.4 The proposals outlined above will require some changes to the procedure rules and scrutiny protocols and it is recommended that the Director of Legal and Democratic Services be authorised to make any necessary amendments as a result of these changes.

Department of Health

Local Authority Health Scrutiny

Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

June 2014

Title: **Local Authority Health Scrutiny:** Guidance to support Local Authorities and their partners to deliver effective health scrutiny
Author: SCLGCP/PCLG/18280
Document Purpose: Guidance
Publication date: June 2014 To be reviewed in June 2015
Target audience: • Local Authorities • Local Government Association • Health and Wellbeing Boards • Clinical Commissioning Groups • NHS trusts (acute, community, mental health) • NHS England • Healthwatch
Contact details: Local Government Team Department of Health Room 330, Richmond House 79 Whitehall London SW1A 2NS

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Local Authority Health Scrutiny

Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

Prepared by the People, Communities and Local Government Division of the Department of Health.

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Key messages

- The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function.

- Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration - and in making recommendations about how it could be improved.

- At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service ("relevant NHS bodies and relevant health service providers"[1]) and in testing this information by drawing on different sources of intelligence.

- Health scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

- Effective health scrutiny requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local Healthwatch.

- In the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although health scrutiny functions are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends.

- Furthermore in the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

[1] In this guidance, "health service commissioners and providers" is a reference to:
a) certain NHS bodies, (i.e. NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) and
b) providers of NHS and public health services commissioned by NHS England, clinical commissioning groups and local authorities.
Each of these is "a responsible person", as defined in the Regulations, on whom the Regulations impose certain duties for the purposes of supporting local authorities to discharge their health scrutiny functions.

- Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.

- Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible. If external support is needed, informal help is freely available from the Independent Reconfiguration Panel (IRP)[2] and/or the Centre for Public Scrutiny[3]. If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals.

- In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.

- Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny. Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings. This will be in line with the new transparency measure in the Local Audit and Accountability Act 2014 and will allow local people, particularly those who are not present at scrutiny hearing-meetings, to have the opportunity to see or hear the proceedings.

[2] Independent Reconfiguration Panel website: www.irpanel.org.uk/view.asp?id=0
[3] Centre for Public Scrutiny website: www.cfps.og.uk

1. Introduction

This guidance is intended to support local authorities, relevant NHS bodies and relevant health service providers in discharging their responsibilities under the relevant regulations; and thereby supporting effective scrutiny. The guidance needs to be conscientiously taken into account. However, the guidance is not intended to be a substitute for the legislation or to provide a definitive interpretation of the legislation. Only the courts can provide a definitive interpretation of legislation. Anyone in doubt should seek legal advice.

1.1 Background

1.1.1 The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services. For some time, local authority overview and scrutiny[4] of health has been an important part of the Government's commitment to place patients at the centre of health services. It is even more important in the new system.

1.1.2 Health scrutiny is a fundamental way by which democratically elected local councillors are able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account. To this end, it is essential that health scrutiny functions are also carried out in a transparent manner, so that local people have the opportunity to see and hear proceedings, in line with the new transparency measure in the Local Audit and Accountability Act 2014. Local government itself is making an even greater contribution to health since taking on public health functions in April 2013 (and will itself be within the scope of health scrutiny). Social care and health services are becoming ever more closely integrated and impact on each other, with the result that scrutiny of one may entail, to a certain extent, scrutiny of the other. In many cases, health scrutiny reviews will be of services which are jointly commissioned by the NHS and local government.

1.1.3 Within the NHS, there has been increasing emphasis on the need to understand and respond to the views of patients and the public about health and health services: the NHS Constitution, the Government's Mandate to NHS England and the NHS Operating Framework together provide a strong set of principles underpinning the NHS's accountability to the people it serves. Responding positively to health scrutiny is one way for the NHS to be accountable to local communities.

1.1.4 This is an important and challenging time for local authority scrutiny of the health service in England. The wider context includes huge financial pressures on the public services and the challenges of an ageing society in which more people are living for longer with illness and long-term medical conditions and disability. The NHS and local government are operating in a completely new health landscape underpinned by new legislation; with care commissioned and, in many cases, potentially delivered, by more and varied organisations. New health scrutiny legislation permits greater flexibility in the way that local authorities discharge their health scrutiny functions. Local government is working ever more closely with the NHS through health and wellbeing boards, taking a holistic view of the health, public health and social care system.

[4] Referred to as 'review and scrutiny' in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

1.1.5 At the same time, the whole health and care system and the public accountability mechanisms that surround it are grappling with the implications of the Francis inquiry into the shocking failure of care at Mid-Staffordshire NHS Trust. Among many other recommendations, the Francis report says that:

- The Care Quality Commission should expand its work with overview and scrutiny committees.
- Overview and scrutiny committees and local Healthwatch should have access to complaints information.
- The "quality accounts" submitted by providers of NHS services should contain observations of commissioners, overview and scrutiny committees and local Healthwatch.

1.1.6 Following the Francis report and recommendations, the role and importance of effective health scrutiny will become more prominent. The Francis inquiry increased expectations for local accountability of health services. It is expected that health scrutiny will develop working relationships and good communication with Care Quality Commission local representatives, NHS England's local and regional Quality Surveillance Groups as well as with local Healthwatch. While there is no legislative stipulation as to the extent of support that should be made available for the health scrutiny function, the health and social care system as a whole will need to think about how the function is supported nationally, regionally and locally to enable the powers and duties associated with the function to be exercised appropriately.

1.2 Purpose of guidance

1.2.1 It is against this background that this guidance has been prepared. It is intended to provide an up-to-date explanation and guide to implementation of the regulations under the National Health Service Act 2006 governing the local authority health scrutiny function. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Regulations"), which came into force on 1st April 2013[5]. They supersede the 2002 Regulations under the Health and Social care Act 2001[6]. The Regulations have implications for relevant NHS bodies and relevant health service providers, including local authorities carrying out the local authority health scrutiny function[7], health and wellbeing boards and those involved in patient and public engagement activities. The duties in the Regulations are aimed at supporting local authorities to discharge their scrutiny functions effectively. Failure to comply with those duties would place the relevant NHS body or relevant health service provider in breach of its statutory duty and render it at risk of a legal challenge.

1.2.2 This guidance is, therefore, of relevance to:

- Local authorities (both those which have the health scrutiny functions and district councils).
- Clinical commissioning groups (CCGs).
- NHS England.

[5] References to numbered Regulations throughout this guide are to the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013.
[6] These had effect as if made under the National Health Service Act 2006.
[7] The health scrutiny function is conferred on the152 councils with social services responsibilities.

- Providers of health services including those from the public, private and voluntary sectors.
- Those involved in delivering the work of local Healthwatch.

The guidance should be read alongside other guidance issued by the Department of Health and NHS England, such as the guidance on the NHS duty to involve[8], and guidance for NHS commissioners on the good practice principles and process for planning of major service change.

1.3 Scope of the Regulations

1.3.1 The Regulations explained in this guidance relate to matters relating to the health service, i.e. including services commissioned and/or provided by the NHS as well as public health services commissioned by local authorities. This includes services provided to the NHS by external non-NHS providers, including local authorities (this is discussed in more detail in section 3).

1.3.2 The NHS Constitution, the Mandate to NHS England, and the NHS Outcomes Framework provide a set of guiding principles and values for the NHS which indicate that the NHS is not just a sickness service, but is there to improve health, wellbeing and to address health inequalities: "to pay particular attention to groups or sections of society where improvement in health and life expectancy are not keeping pace with the rest of the population[9]". The Mandate makes clear that one of NHS England's priorities should be a focus on "preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health[10]". Since the creation of the health scrutiny functions under the Health and Social Care Act 2001, local authority scrutiny committees have prioritised issues of health improvement, prevention and tackling health inequalities as areas where they can add value through their work. In their reviews, local authorities have looked at the wider social determinants of health and health inequalities, not least because of local government's own contribution through the whole range of its services.

1.3.3 NHS services can themselves impact on health inequalities and general wellbeing of communities, for example, by improving access to services for the most deprived and least healthy communities. Moreover the Department of Health has always advised and local authorities have recognised that the best use of their health scrutiny powers will depend on scrutiny extending to health issues, the health system and health economy rather than being limited to services commissioned or managed by the NHS or local authorities.

1.3.4 The duties of health service commissioners and providers under the Regulations apply to NHS commissioners and to providers of health services as part of the health service, including NHS bodies and local authorities, as discussed below. However, local authority health scrutiny committees have often drawn on their wider powers to promote

[8] http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf
[9] NHS Constitution, *The NHS belongs to us all*, March 2013: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf
[10] The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015, p8: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf

community wellbeing to carry out overview and scrutiny of a range of health issues which go beyond NHS services. In the new health landscape, public health is a responsibility of local government and health and wellbeing boards provide strategic leadership of the health system through partnership, with a specific duty to encourage integrated working across health and social care. We can expect an increasing number of services to be jointly commissioned between local authorities and the NHS. Any health scrutiny exercise may therefore include reviewing the local authority's own contribution to the health of local people and the provision of health services, as well as the role of the health and wellbeing board, and of other agencies involved in the health care of local people.

1.3.5 Responses to matters that are scrutinised may therefore be the responsibility of a number of stakeholders. In this light, the power to scrutinise the health service should be seen and used in the wider context of the local authority role of community leadership and of other initiatives to promote and facilitate improvement and reduce inequalities. In the context of the NHS reforms, this includes:

- A greater emphasis on involving patients and the public from an early stage in proposals to improve services.
- The work of health and wellbeing boards as strategic bodies bringing together representatives of the whole local health and care system.
- The work of other relevant local partnerships, such as community safety partnerships and partnerships with the community and voluntary sectors.

1.3.6 The new legislation in the 2012 Act lays increased emphasis on the role of patients and the public in shaping services. This is recognised in the introduction of local Healthwatch organisations and their membership of health and wellbeing boards. The Regulations make provision about the referral of matters by local Healthwatch to local authority health scrutiny. This is discussed in section 3 below.

1.3.7 Section 2 below outlines those aspects of the health scrutiny system that remain the same for each of the key players: local authorities, the NHS and the patient and public involvement system. Section 3 discusses in detail what has changed following the new legislation for each of these key players and how the changes should be implemented. Section 4 discusses the important issue of consultation on substantial reconfiguration proposals (i.e. proposals for a substantial development of the health service or for a substantial variation in the provision of such service). Section 5 provides references and links to relevant additional documents.

2. What remains the same following the new legislation?

2.1 For local authorities

2.1.1 Under the Regulations, local authorities in England (i.e. "upper tier" and unitary authorities[11], the Common Council of the City of London and the Council of the Isles of Scilly) have the power to:

- Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services.
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:

    - The consultation has been inadequate in relation to the content or the amount of time allowed.
    - The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
    - A proposal would not be in the interests of the health service in its area.

(In the case of referral, the Regulations lay down additional conditions and requirements as to the information that must be provided to the Secretary of State – these are listed in section 4.7 below.)

2.1.2 As previously, executive members may not be members of local authority overview and scrutiny committees, their sub-committees, joint health overview and scrutiny committees and sub-committees. Overview and scrutiny committees may include co-opted members i.e. those who are not members of the relevant local authority (for example, co-opted members of overview and scrutiny committees of district councils or representatives of voluntary sector organisations). Co-opted members may not be given voting rights except where permitted by the relevant local authority in accordance with a scheme made by the local authority[12].

[11] i.e. county councils, district councils other than lower-tier district councils and London Borough councils. However, in general, health scrutiny functions may be delegated to lower-tier district councils (except for referrals – see regulations 28 and 29) or their overview and scrutiny committees, or carried out by a joint committee of those councils and another local authority.

[12] Section 9FA of and Schedule A1 to the Local Government Act 2000, Regulations 5 and 11 of the Local Authorities (committee system) (England) Regulations 2012 and Regulation 30 of the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013.

2.1.3 The position of councils which have returned to a committee system of governance is discussed in section 3 below.

2.1.4 The position in relation to these matters remains following the new legislation, but the legislation is extended to cover additional and new organisations and diverse local authority arrangements, as described in section 3 below.

2.2 For the NHS

2.2.1 Regulations under the Health and Social Care Act 2001 created duties on the NHS which mirror the powers conferred on local authorities. These duties are carried forward into the new legislation, and require the NHS to:

- Provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny (section 3 lists all those now covered by this requirement).
- Attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny.
- Consult on any proposed substantial developments or variations in the provision of the health service[13].
- Respond to health scrutiny reports and recommendations: NHS service commissioners and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request. This applies to requests from individual health scrutiny committees or sub-committees, from local authorities and from joint health scrutiny committees or sub-committees.

2.2.2 These duties remain in place, and (following the abolition of PCTs and Strategic Health Authorities) now apply to CCGs; NHS England; local authorities as providers of NHS or public health services; and providers of NHS and public health services commissioned by CCGs, NHS England and local authorities. Additional responsibilities are described in section 3 below.

2.3 For patient and public involvement

2.3.1 Legislation has created a number of far-reaching requirements on the NHS to consult service users and prospective users in planning services, in the development and consideration of proposals for changes in the way services are provided and in decisions affecting the operation of those services.

2.3.2 For NHS trusts, the duty as to involvement and consultation is set out in section 242 of the 2006 Act (as amended by the Health and Social Care Act 2012). The public involvement duties of NHS England and of CCGs are set out in sections 13Q and 14Z2 respectively of the 2006 Act. These are separate duties from those set out in the Regulations discussed here. Together they add up to a web of local accountability for health services.

2.1.1 The Health and Social Care Act 2012 introduced local Healthwatch to represent the voice of patients, service users and the public; and health and wellbeing boards to promote partnerships across the health and social care sector. The Regulations set up formal relationships between local Healthwatch and local authority health scrutiny, to ensure

[13] Subject to exceptions as set out in the 2013 Regulations.

that the new system reflects the outcomes of involvement and engagement with patients and the public, as described in section 3 below.

3. Changes arising from the new legislation

3.1 Powers and duties – changes for local authorities

Councils as commissioners and providers of health services

3.1.1 As commissioners or providers of public health services and as providers of health services to the NHS, services commissioned or provided by local authorities are themselves within the scope of the health scrutiny legislation.

3.1.2 To that end local authorities may be bodies which are scrutinised, as well as bodies which carry out health scrutiny.

3.1.3 The duties which apply to scrutinised bodies such as the duty to provide information, to attend before health scrutiny and to consult on substantial reconfiguration proposals will apply to local authorities insofar as they may be "relevant health service providers"[14].

3.1.4 Being both scrutineer and scrutinee is not a new situation for councils. It will still be important, particularly in making arrangements for scrutiny of the council's own health role, to bear in mind possible conflicts of interest and to take steps to deal with them.

Councils as scrutineers of health services

3.1.5 The Local Government Act 2000 (as amended by the Localism Act 2011) makes provision for authorities:

- To retain executive governance arrangements (i.e. comprising a Leader and cabinet or a Mayor and cabinet).
- To adopt a committee system of governance.
- To adopt any other form of governance prescribed by the Secretary of State.

3.1.6 Health scrutiny arrangements will differ in some respects depending on the system that the council chooses to operate. Most importantly:

- Councils operating executive governance arrangements are required to have at least one overview and scrutiny committee. In this case, the scrutiny is independent of the executive.
- If a council adopts a committee system, they can operate overview and scrutiny committees if they choose, but are not required to do so.

3.1.7 At present, most local authorities are retaining executive governance arrangements. For those councils moving to a committee system, a further discussion of the differences and implications for health scrutiny is included on page 16 below.

3.1.8 Generally health scrutiny functions are in the form of powers. However, there are certain requirements under the Regulations as follows. Local authorities on whom health scrutiny functions have been conferred should:

- Have a mechanism in place to deal with referrals made by Local Healthwatch organisations or contractors[15].

[14] See section 244 of the NHS Act and Regulation 20 of the 2013 Regulations for the meaning of "relevant health service provider".
[15] See Regulation 21 of the 2013 Regulations.

- Have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals. Such responses could be made through the full council, an overview and scrutiny committee with delegated powers from the full council, a joint overview and scrutiny committee or a committee appointed under s101 of the Local Government Act.
- Councils also need to consider in advance how the members of a joint health scrutiny committee would be appointed from their council where the council was required to participate in a joint health scrutiny committee with other councils to respond to substantial reconfiguration proposals covering more than one council area.

Conferral of health scrutiny function on full council

3.1.9 The National Health Service Act 2006, as amended by the Health and Social Care Act 2012, confers health scrutiny functions on the local authority, as distinct from any overview and scrutiny committee or panel within the local authority section 244 (2ZD). This new provision is designed to give local authorities greater flexibility and freedom over the way they discharge health scrutiny functions. The full council of each local authority will determine which arrangement is adopted. For example:

- It may choose to continue to operate its existing health overview and scrutiny committee, delegating its health scrutiny functions to the committee.
- It may choose other arrangements such as appointing a committee involving members of the public and delegating its health scrutiny functions (except the function of making referrals) to that committee.
- It may operate its health scrutiny functions through a joint scrutiny committee with one or more other councils.

3.1.10 As indicated above local authorities may delegate their health scrutiny functions under section 101 of the Local Government Act 1972 but are not permitted to delegate the functions to an officer (Regulation 29).

3.1.11 Executive members of councils operating executive governance arrangements (that is a Leader and cabinet or a Mayor and cabinet) may not be members of local authority overview and scrutiny committees or of their sub-committees or of joint health overview and scrutiny committees and sub-committees.

3.1.12 Overview and scrutiny committees are a proven model offering a number of benefits that other structures may not, including having a clear identity within the local authority, political balance and, in many cases, an established reputation within the local community for independence and accessibility.

Delegation of health scrutiny function by full council

3.1.13 The legislation enables health scrutiny functions to be delegated to:

- An overview and scrutiny committee of a local authority or of another local authority (Regulation 28).
- A sub-committee of an overview or scrutiny committee (Local Government Act 2000).
- A joint overview and scrutiny committee (JOSC) appointed by two or more local authorities or a sub-committee of such a joint committee.
- A committee or sub-committee of the authority appointed under section 102 of the Local Government Act 1972 (section 101 of the Local Government Act 1972) (except for referrals).
- Another local authority (section 101 of Local Government Act 1972) (except for referrals).

3.1.14 Local authorities may not delegate the health scrutiny functions to an officer – this option under the Local Government Act 1972 is disapplied (disallowed) by Regulation 29.

3.1.15 If a council decides to delegate to a health scrutiny committee, it need not delegate *all* of its health scrutiny functions to that committee (i.e. it could retain some functions itself). For example, it might choose to retain the power to refer issues to the Secretary of State for Health as discussed below. Equally, it might choose to delegate that power to the scrutiny committee.

Joint health scrutiny arrangements

3.1.16 As before, local authorities may appoint a discretionary joint health scrutiny committee (Regulation 30) to carry out all or specified health scrutiny functions, for example health scrutiny in relation to health issues that cross local authority boundaries. Establishing a joint committee of this kind does not prevent the appointing local authorities from separately scrutinising health issues. However, there are likely to be occasions on which a discretionary joint committee is the best way of considering how the needs of a local population, which happens to cross council boundaries, are being met.

3.1.17 Regulation 30 also requires local authorities to appoint joint committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals (referred to below as a mandatory joint health scrutiny committee). In such circumstances, Regulation 30 sets out the following requirements (see section 4 on consultation below for more detail).

- Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation.

3.1.18 These restrictions do not apply to referrals to the Secretary of State. Local authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so. If a local authority had already appointed a discretionary committee, they could even delegate the power to that committee if they choose to.

3.1.19 If the local authority has delegated this power, then they may not subsequently exercise the power of referral. If they do not delegate the power, they may make such referrals.

3.1.20 A situation might arise where one of the participating local authorities had delegated their power of referral to the joint committee but not the other(s). In such a case a referral could be made by: the JOSC or any of the authorities which had not delegated their power of referral to the JOSC, but not the authorities which had delegated their power of referral to the JOSC.

Reporting and making recommendations

3.1.21 Regulation 22 enables local authorities and committees (including joint committees, sub-committees and other local authorities to which health scrutiny functions have been delegated) to make reports and recommendations to relevant NHS bodies and health

service providers. The following information must be included in a report or recommendation:

- An explanation of the matter reviewed or scrutinised.
- A summary of the evidence considered.
- A list of the participants involved in the review or scrutiny.
- An explanation of any recommendations on the matter reviewed or scrutinised.

3.1.22 A council can choose to delegate to an overview and scrutiny committee (including joint committee, sub-committee or another local authority) the function of making scrutiny reports and recommendations to relevant NHS bodies and health service commissioners. Alternatively, a council can choose to delegate only the function of *preparing* such reports and recommendations, and retain for itself the function of actually *making* that report or recommendation. The latter approach would give the full council the opportunity to endorse the report or recommendation before it was sent to the NHS.

3.1.23 Where a local authority requests a response from the relevant NHS body or health service provider to which it has made a report or recommendation, there is a statutory requirement (Regulation 22) for the body or provider to provide a response in writing within 28 days of the request.

Conflicts of interest

3.1.24 Councils should take steps to avoid any conflict of interest arising from councillors' involvement in the bodies or decisions that they are scrutinising. A conflict might arise where, for example, a councillor who was a full voting member of a health and wellbeing board was also a member of the same council's health scrutiny committee or of a joint health scrutiny committee that might be scrutinising matters pertaining to the work of the health and wellbeing board.

3.1.25 Conflicts of interest may also arise if councillors carrying out health scrutiny are, for example:

- An employee of an NHS body.
- A member or non-executive director of an NHS body.
- An executive member of another local authority.
- An employee or board member of an organisation commissioned by an NHS body or local authority to provide services.

3.1.26 These councillors are not excluded from membership of overview and scrutiny committees, and, clearly, where the full council has retained the health scrutiny function, they will be involved in health scrutiny. However they will need to follow the rules and requirements governing the existence of interests in matters considered at meetings. Where such a risk is identified, they should consult their monitoring officer for advice on their involvement.

Councils operating a committee system

3.1.27 Councils which have returned to a committee system under the Local Government Act 2000 may or may not have retained a council-wide overview and scrutiny function. If they have retained such function, they will be able to delegate their health scrutiny functions to overview and scrutiny committees in the same way as those councils operating executive arrangements that have executive and scrutiny functions.

3.1.28 Councils with a committee system that have not retained a council-wide scrutiny function will need to decide what to do about their health scrutiny functions. The health scrutiny function is conferred on the full council but delegation to a committee, joint committee, sub-committee or another local authority is permitted (except in the case of referrals in relation to which delegation under section 101 of the Local Government Act 1972 is not permitted). Therefore such a council might retain health scrutiny functions or delegate these to a committee, joint committee or sub-committee (or indeed to another council or its overview and scrutiny committee).

3.1.29 In deciding how to operate a health scrutiny function, councils operating a committee system will need to consider issues of potential conflicts of interest. Like upper tier and unitary councils, they will need to have a health and wellbeing board whose work will be within the scope of health scrutiny insofar as it relates to the planning, provision and operation of the health service. They may also have a health and social care committee or a stand-alone health committee which makes decisions about the commissioning of public health services. A conflict might arise where, for example, under a committee system, the members of any committee of the council which is taking commissioning decisions on public health services, are also members of its health scrutiny committee or where a health and social care committee of a council operating a committee system is also acting as a health overview and scrutiny committee. The solution might be to have a separate health overview and scrutiny committee, with different members.

3.1.30 Regardless of the governance arrangements being operated by a council, the health scrutiny function may not be delegated to an officer (Regulation 29).

The role of district councils

3.1.31 As previously, under the new Regulations (Regulation 31), district councillors in two tier areas, who are members of district overview and scrutiny committees, may be co-opted by the upper tier county council onto health overview and scrutiny committees of those councils or other local authorities. Such co-option may be on a long term (i.e. for the life of the overview and scrutiny committee or until the county council decides) or ad hoc basis (i.e. for review and scrutiny of a particular matter) (Regulation 31).

3.1.32 District councillors in two tier areas may also (Regulation 30 read with the Local Government Act 2000) be co-opted onto joint health scrutiny committees between the upper tier county councils and other local authorities.

3.1.33 District councillors in two tier areas may also be on joint health scrutiny committees of the relevant district council and the upper tier county council (Regulation 30).

3.1.34 Many county councils have taken the opportunity to co-opt district councillors onto their scrutiny committees, as district councillors bring very local knowledge of their communities' needs and may also provide a useful link to enhance the health impact of district council services. Health and wellbeing strategies in two-tier areas are likely to include reference to the role of district councils in improving health and reducing inequalities, for example through their housing and leisure functions. As health and wellbeing boards' functions including their strategies (insofar as related to the planning, provision and operation of the health service) will be within the scope of health scrutiny, this provides an additional reason for considering the co-option of district councillors.

3.2 Powers and duties – changes for the NHS

Extension of scope of health scrutiny

3.2.1 A significant change for the NHS in the new health landscape is the extension of certain duties in the Regulations to cover providers of health services (commissioned by NHS England, CCGs or local authorities) who are not themselves NHS bodies. Together with relevant NHS bodies these are known as 'responsible persons' in the legislation and these include:

- CCGs
- NHS England
- Local authorities (insofar as they may be providing health services to CCGs, NHS England or other local authorities).
- NHS trusts and NHS foundation trusts.
- GP practices and other providers of primary care services (previously not subject to specific duties under health scrutiny regulations as independent contractors, they are now subject to duties under the new Regulations as they are providers of NHS services).
- Other providers of primary care services to the NHS, such as pharmacists, opticians and dentists.
- Private and voluntary sector bodies commissioned to provide NHS or public health services by NHS England, CCGs or local authorities.

3.2.2 Under the Regulations, 'responsible persons' are required to comply with a number of duties to assist the health scrutiny function. These duties are underpinned by the duty of co-operation which applies between the NHS and local authorities under section 82 of the NHS Act 2006 which requires them, in exercising their respective functions, to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

Required provision of information to health scrutiny

3.2.3 Regulation 26 imposes duties on 'responsible persons' to provide a local authority with such information about the planning, provision and operation of health services in the area of the authority as it may reasonably require to discharge its health scrutiny functions. All relevant NHS bodies and health service providers (including GP practices and other primary care providers and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority) have a duty to provide such information.

3.2.4 In addition, the duty of candour under the NHS Standard Contract is also relevant in relation to the provision of information to patients generally.

3.2.5 The type of information requested and provided will depend on the subject under scrutiny. It may include:

- Financial information about the operation of a trust or CCG, for example budget allocations for the care of certain groups of patients or certain conditions, or capital allocations for infrastructure projects, such as community facilities.
- Management information such as commissioning plans for a particular type of service.
- Operational information such as information about performance against targets or quality standards, waiting times.

- Patient information such as patient flows, patient satisfaction surveys, numbers and types of complaints and action taken to address them.
- Any other information relating to the topic of a health scrutiny review which can reasonably be requested.

3.2.6 Confidential information that relates to or identifies a particular living individual or individuals cannot be provided unless the individual or individuals concerned agree to its disclosure. However, the information can be disclosed in a form from which identification is not possible. In such a situation, health scrutiny bodies (i.e. councils or council health overview and scrutiny committees or sub-committees carrying out delegated health scrutiny functions) can require that the information be put in a form from which the individual cannot be identified in order that it may be disclosed.

3.2.7 In some cases, information, such as financial information, may be commercially sensitive. In such cases, it may be possible for health scrutiny to receive this information in confidence to inform, but not be directly referred to in, its reports and recommendations.

Required attendance before health scrutiny

3.2.8 Members and employees of a relevant NHS body or relevant health service provider have a duty to attend before a local authority when required by it (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions. This duty now applies to all those listed at the beginning of this section. So, for example, if a local authority were to require the attendance of a member of a CCG, or of a private company commissioned to provide particular NHS services, it could do so under the Regulations. Bodies, the employees or members of which are required to attend by local authority health scrutiny, are expected to take the appropriate steps to ensure the relevant member or employee complies with this requirement[16].

3.2.9 As regards the attendance of particular individuals, identification of the appropriate member or employee to attend will depend on the type of scrutiny review being undertaken and its aims. By way of example, where the local authority has required attendance of a particular individual, say the accountable officer of a clinical commissioning group, and it is not practicable for that individual to attend or if that individual is not the most suitable person to attend, the CCG would be expected to suggest another, relevant individual. Thus, in such situations, both the local authority and the commissioner or provider (as the case may be) would be expected to co-operate with each other to agree on a suitable person for attendance and, in doing so, to act reasonably at all times.

Responding to scrutiny reports and recommendations

3.2.10 Depending on the topic being reviewed, reports and recommendations by local authority health scrutiny bodies may be made to any of the relevant NHS bodies or health service providers covered by the legislation (and, in the case of health scrutiny by a body to which the function has been delegated, to the delegating authority e.g. the relevant local authority or in the case of a sub-committee appointed by a committee, that committee or its local authority).

[16] The meaning of 'member' is given in section 244 of the NHS Act 2006 and includes people who are members of committees or sub-committees of CCGs who are not members of the CCG, directors of NHS trusts and directors and governors of NHS foundation trusts. They also include directors of bodies which provide health services commissioned by NHS England, CCGs and local authorities.

3.2.11 Relevant NHS bodies and health service providers to which a health scrutiny report or and recommendation has been made must by law, if a response is requested, respond within 28 days of the request. Reports and recommendations are expected to be based on evidence. Respondents should take the evidence presented seriously, giving a considered and meaningful response about how they intend to take forward reports or recommendations. Meaningful engagement is likely to lead to improvements in quality and access to services.

3.2.12 Many local authorities, as part of their work plan, return to completed scrutiny reviews after a certain period – usually 6 months or a year – to find out whether and how their recommendations have been implemented and how they have influenced improvements. Relevant NHS bodies and health service providers to whom scrutiny reports have been presented should be prepared for this kind of follow-up and be able to report on progress and improvements resulting from scrutiny reviews.

3.3 Powers and duties – referral by local Healthwatch

3.3.1 Local Healthwatch organisations and contractors have specific roles which complement those of health scrutiny bodies. For example, they can “enter and view” certain premises at which health and social care services are provided. This can enable local Healthwatch to act as the “eyes and ears” of patients and the public; to be a means for health scrutiny to supplement and triangulate information provided by service providers; and to gain an additional impression of quality of services, safety and issues of concern around specific services and provider institutions. Health scrutiny bodies and local Healthwatch are likely each to benefit from regular contact and exchange of information about their work programmes. It may also be helpful in planning work programmes, to try to ensure that certain aspects are aligned. For example, if a health scrutiny body is planning a review of a certain service, it might be useful if local Healthwatch plans to visit the service in a timely way to inform the review.

3.3.2 Local Healthwatch organisations and their contractors carry out certain statutory activities including that of making reports and recommendations concerning service improvements to scrutiny bodies. This would cover the provision of information and the referral of matters relating to the planning, provision and operation of health services in their area (which could potentially include concerns about local health services or commissioners and providers) to local authority health scrutiny bodies.

3.3.3 Regulation 21 sets out duties that apply where a matter is referred to a local authority by a local Healthwatch organisations or contractors. The local authority must:

- Acknowledge receipt of referrals within 20 working days.
- Keep local Healthwatch organisations (or contractors as the case may be) informed of any action it takes in relation to the matter referred.

4.Consultation

4.1 The context of consultation

4.1.1 The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public. Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS's public involvement and consultation duties as these are separate. The NHS should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed.

4.1.2 The backdrop to consultation on substantial reconfiguration proposals is itself changing. The ideal situation is that proposals for change emerge from involving service users and the wider public in dialogue about needs and priorities and how services can be improved. Much of this dialogue may take place through representation of service users and the public on health and wellbeing boards and through the boards' own public engagement strategies. With increasing integration of health and care services, many proposals for change may be joint NHS-local authority proposals which may have been discussed at an early stage through the health and wellbeing board. Health scrutiny bodies should be party to such discussions – local circumstances will determine the best way for this to happen. If informally involved and consulted at an early enough stage, health scrutiny bodies in collaboration with local Healthwatch, may be able to advise on how patients and the public can be effectively engaged and listened to. If this has happened, health scrutiny bodies are less likely to raise objections when consulted.

4.1.3 NHS England has published good practice guidance for NHS commissioners on the planning and development of proposals for major service changes and reconfigurations. The guidance is designed to support commissioners, working with local authorities and providers, to carry out effective service reconfiguration in a way that puts quality of care first, is clinically evidence-based and which involves patients and the public throughout. It is intended to be used as a reference guide to help develop and implement plans in a clear and consistent way. The guidance is available at:

http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

4.2 When to consult

4.2.1 Regulation 23 requires relevant NHS bodies and health service providers to consult a local authority about any proposal which they have "under consideration" for a substantial development of or variation in the provision of health services in the local authority's area. The term "under consideration" is not defined and will depend on the facts, but a development or variation is unlikely to be held to be "under consideration" until a proposal has been developed. The consultation duty applies to any "responsible person" under the legislation, i.e. relevant NHS bodies and health service commissioners which now come under the scope of health scrutiny as described above.

4.2.2 As previously, "substantial development" and "substantial variation" are not defined in the legislation. Many local authority scrutiny bodies and their NHS counterparts have developed joint protocols or memoranda of understanding about how the parties will

reach a view as to whether or not a proposal constitutes a “substantial development” or “substantial variation”. Although there is no requirement to develop such protocols it may be helpful for both parties to do so. The local authority may find a systematic checklist, of the kind often contained in such protocols, useful in reaching a view about whether a proposed development or variation is substantial and, for example, NHS commissioners may find it helpful in explaining to providers what is likely to be regarded as substantial.

4.3 Who consults

4.3.1 In the case of substantial developments or variation to services which are the commissioning responsibility of CCGs or NHS England, consultation is to be done by NHS commissioners rather than providers i.e. by the relevant CCG(s) or NHS England. When these providers have a development or variation “under consideration” they will need to inform commissioners at a very early stage so that commissioners can comply with the requirement to consult as soon as proposals are under consideration.

4.4 Timescales for consultation

4.4.1 The Regulations now require timescales to be provided to health scrutiny bodies and to be published by the proposer of substantial developments or variations, (Regulation 23). When consulting health scrutiny bodies on substantial developments or variations, a relevant NHS body or health service provider is required by the Regulations to notify the health scrutiny body of the date by which it requires the health scrutiny body to provide comments in response to the consultation and the date by which it intends to make a decision as to whether to proceed with the proposal[17]. These dates must also be published. This is so that local patients and communities are aware of the timescales that are being followed. Any changes to these dates must be notified to the relevant health scrutiny body and published. Constructive dialogue between relevant NHS bodies and health service providers on the one hand, and health scrutiny bodies on the other, when communicating on timescales for comments or decisions in relation to substantial developments or variations should help ensure that timescales are realistic and achievable.

4.4.2 It is sensible for health scrutiny to be able to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion.

4.5 When consultation is not required

4.5.1 The Regulations set out certain proposals on which consultation with health scrutiny is *not* required. These are:

- Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might for example cover the situation where a ward needs to close immediately because of a viral outbreak) – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this.

[17] Government guidance on consultation principles was published in July 2012 (see references).

- Where there is a proposal to establish or dissolve or vary the constitution of a CCG or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.
- Where proposals are part of a trusts special administrator's report or draft report (i.e. when a trust has financial difficulties and is being run by an administration put in place by the Secretary of State) – these are required to be the subject of a separate 30-day community-wide consultation.

4.6 Responses to consultation

4.6.1 Where a health scrutiny body has been consulted by a relevant NHS body or health service provider on substantial developments or variations, the health scrutiny body has the power to make comments on the proposals by the date (or changed date) notified by the body or provider undertaking the consultation. Having considered the proposals and local evidence, health scrutiny bodies should normally respond in writing to the body undertaking the consultation and when commenting would need to keep within the timescale specified by them.

4.6.2 Where a health scrutiny's body's comments include a recommendation and the consulting organisation disagrees with that recommendation, that organisation must notify the health scrutiny body of the disagreement. Both the consulting organisation and the health scrutiny body must take such steps as are reasonably practicable to try to reach agreement. Where NHS England or a clinical commissioning group is acting on behalf of a provider, in accordance with the Regulations, as mentioned above, the health scrutiny body and NHS England or the CCG (as the case may be) must involve the provider in the steps they are taking to try to reach agreement.

4.6.3 Where a health scrutiny body has not commented on the proposal or has commented but without making a recommendation, it must notify the consulting organisation as to its decision as to whether to refer the matter to the Secretary of State and if so, the date by which it proposes to make the referral or the date by which it will make a decision on whether to refer the matter to the Secretary of State.

4.7 Referrals to the Secretary of State

4.7.1 Local authorities may refer proposals for substantial developments or variations to the Secretary of State in certain circumstances outlined below. The circumstances remain largely the same as in previous legislation.

4.7.2 The new Regulations set out certain information and evidence that are to be provided to the Secretary of State and the steps that must be taken before a referral can be made. On receiving a referral from a local authority, overview and scrutiny committee, joint committee or sub-committee, the Secretary of State may ask for advice from the Independent Reconfiguration Panel (IRP), an advisory non-departmental public body. The new Regulations do not affect the position of the IRP. The IRP will undertake an initial assessment of any referral to the Secretary of State for Health where its advice is requested**.** It may then be asked to carry out a full review. Not all referrals to the Secretary of State for Health will automatically be reviewed in full by the IRP – this is at the Secretary of State's discretion. The IRP has published a summary of its views on what can be learned from the referrals it has received and the reviews it has undertaken from the perspective both of the NHS and of health scrutiny. The IRP also offers pre-

consultation advice and support to NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change - including advice and support on methods for public engagement and formal public consultation.

Relevant NHS bodies, health service providers and local authority scrutiny may also find it helpful to read its report on the *Safe and Sustainable* review of children's heart surgery, the first national reconfiguration proposal referred to the IRP, whose recommendations were accepted by the Secretary of State (see references).

4.7.3 The powers under the previous Regulations to refer matters relating to NHS foundation trusts to Monitor have been removed, as this was not considered appropriate to the role of Monitor and the new licensing regime.

Circumstances for referral

4.7.4 The circumstances for referral of a proposed substantial development or variation remain the same as in previous legislation. That is, where a health scrutiny body has been consulted by a relevant NHS body or health service provider on a proposed substantial development or variation, it may report to the Secretary of State in writing if:

- It is not satisfied with the adequacy of content of the consultation.
- It is not satisfied that sufficient time has been allowed for consultation.[18]
- It considers that the proposal would not be in the interests of the health service in its area.
- It has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

4.7.5 However, there are certain limits on the circumstances in which a health scrutiny bodies may refer a proposal to the Secretary of State.

In particular, where a health scrutiny body has made a recommendation and the relevant NHS body or health service provider has disagreed with the recommendation, the health scrutiny body may not refer a proposal unless:

- it is satisfied that reasonably practicable steps have been taken to try to reach agreement (with steps taken to involve the provider where NHS England or a CCG is acting on the provider's behalf) but agreement has not been reached within a reasonable time; or
- it is satisfied that the relevant NHS body or health service provider has failed to take reasonably practicable steps to try to reach agreement within a reasonable period.

In a case where a health scrutiny body has not commented on the proposal or has commented without making a recommendation, the health scrutiny body may not refer a proposal unless:

- It has informed the relevant NHS body or health service provider of-
  - its decision as to whether to exercise its power of referral and, if applicable, the date by which it proposed to exercise that power, or
  - the date by which it proposes to make a decision as to whether to exercise its power of referral.

- In a situation where it informed the relevant NHS body or health service provider of the date by which it proposed to decide whether to exercise the power of referral, it has made that decision by that date and informed the body or provider of the decision.

[18] The referral power in the context of inadequate consultation only relates to the consultation with the local authority, and not consultation with other stakeholders.

Who makes the referral?

4.7.6 Where a local authority has a health overview and scrutiny committee (e.g. under section 9F of the Local Government Act 2000, as amended by the Localism Act 2011) as the means of discharging its health scrutiny functions, the health overview and scrutiny committee may exercise the power of referral on behalf of the local authority where this has been delegated to it. The power of referral may also be delegated to an overview and scrutiny committee of another local authority in certain circumstances (Regulation 28). Where a local authority has retained the health scrutiny function for the full council to exercise, or where it has delegated some health scrutiny functions, but not the power of referral to a committee, the full council would make the referral.

4.7.7 Where a local authority has established an alternative mechanism to discharge its health scrutiny functions, such as delegation to a committee, sub-committee or another local authority under section 101 of the Local Government Act 1972, the referral power cannot be delegated to that committee, sub-committee or other local authority but must instead be exercised by the local authority as a function of the full council (or delegated to an overview and scrutiny as above, although local authorities would need to consider the appropriateness of separate delegation to an overview and scrutiny committee in such circumstances)[19].

4.7.8 Where a local authority is participating in a joint overview and scrutiny committee (JOSC) (see pages 14-15), who makes the referral will depend on whether the power to refer has been delegated to the joint committee or retained by the local authority.

4.7.9 The following applies to both discretionary joint committees (i.e. where councils have chosen to appoint the joint committee to carry out specified functions) and mandatory joint committees (i.e. where councils have been required under Regulation 30 to appoint a joint committee because a local NHS body or health service provider is consulting more than one local authority's health scrutiny function about substantial reconfiguration proposals):

- Where the power to refer has been delegated to the joint committee, only the joint committee may make a referral.
- Where the power to refer has not been delegated to the joint committee, the individual authorities that have appointed the joint committee (or health overview and scrutiny committees or sub-committees to whom the power has been delegated) may make a referral.

4.7.10 In the case of either mandatory or discretionary JOSCs, where individual authorities have retained the power to refer, they should ensure that they are in a position to satisfy the relevant requirements under Regulation 23 to include certain explanations and evidence with the referral. They should also ensure that they can demonstrate compliance with the conditions set out in Regulation 23(10), bearing in mind that in the case of a mandatory JOSC, only that JOSC may make comments to the consulting body and that, where the JOSC makes a recommendation which is disagreed with by the consulting body, certain requirements have to be satisfied before a referral can be made.

Information and evidence to be sent to Secretary of State

[19] See Regulation 29.

4.7.11 When making a referral to the Secretary of State, certain information and evidence must be included. Health scrutiny will be expected to provide very clear evidence-based reasons for any referral to the Secretary of State. These requirements are new since the previous Regulations, so they are given here in full. Referrals must now include:

- An explanation of the proposal to which the report relates.
- An explanation of the reasons for making the referral.
- Evidence in support of these reasons.
- Where the proposal is referred because of inadequate consultation, the reasons why the health scrutiny body is not satisfied of its adequacy.
- Where the proposal is referred because there was no consultation for reasons relating to safety or welfare of patients or staff, reasons why the health scrutiny body is not satisfied that the reasons given for lack of consultation are adequate.
- Where the health scrutiny body believes that proposals are not in the interests of the health service in its area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area.
- An explanation of any steps that the health scrutiny body has taken to try to reach agreement with the relevant NHS body or health service provider.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has been made.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has not been made, or where no comments have been provided on the proposal.

4.7.12 The terms of reference of the IRP, in assessing proposals and providing advice to the Secretary of State, are to consider whether the proposals will provide safe, sustainable and accessible services for the local population. Referrals to the Secretary of State and information provided by consulting bodies when consulting health scrutiny will, therefore be most helpful if they directly address each of these issues.

5. References and useful links

5.1 Relevant legislation and policy

- Department of Health (2013), *The NHS Constitution: the NHS belong to us all*: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

- Department of Health (2012), *The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf

- Government guidance on consultation principles (2012): https://www.gov.uk/government/publications/consultation-principles-guidance

- Health and Social Care Act 2001, sections 7 – 10: http://www.legislation.gov.uk/ukpga/2001/15/contents

- Health and Social Care Act 2012, sections 190 – 192: http://www.legislation.gov.uk/ukpga/2012/7/contents

- Local Government Act 2000: http://www.legislation.gov.uk/ukpga/2000/22/contents

- The Localism Act 2011: http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted

- National Health Service Act 2006, sections 244 – 245: http://www.legislation.gov.uk/ukpga/2006/41/contents

- Statutory Instrument No. 2013/218 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: http://www.legislation.gov.uk/uksi/2013/218/contents/made

5.2 Useful reading

- Centre for Public Scrutiny (2013): *Spanning the system: broader horizons for council scrutiny* (based on health scrutiny work on the health reforms in 14 local authority areas)*:* http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L13_19_CfPSspanning_the_system__web.pdf

- Centre for Public Scrutiny (2012): *Local Healthwatch, health and wellbeing boards and health scrutiny: roles, relationships and adding value:* http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_693_CFPS_Healthwatch_and_Scrutiny_final_for_web.pdf

- Centre for Public Scrutiny (2011), *Peeling the Onion,* learning, tips and tools from the DH-funded Health Inequalities Scrutiny Programme: http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf

- Centre for Public Scrutiny (2007): *Ten questions to ask if you're assessing evidence:* http://www.cfps.org.uk/publications?item=209&offset=150

- Independent Reconfiguration Panel (2010): *Learning from Reviews:* http://www.irpanel.org.uk/lib/doc/learning%20from%20reviews3%20pdf.pdf

- Independent Reconfiguration Panel (2013): *Advice on* Safe and Sustainable *proposals for children's heart services*: http://www.irpanel.org.uk/lib/doc/000%20s&s%20report%2030.04.13.pdf

- Institute of Health Equity (2008), *Fair Society, Healthy Lives* (the Marmot report): http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

- LGA and ADSO (2012), *Health and wellbeing boards: a practical guide to governance and constitutional issues*: http://www.local.gov.uk/c/document_library/get_file?uuid=ca8437aa-742c-4209-827c-996afa9583ca&groupId=10171

- NHS England's guidance on the duty to involve (2013): *Transforming Participation in Health and Care* - http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

- NHS England (2013): *Planning and Delivering Service Change for Patients* - http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

NHS England

Overview and Scrutiny Committee Briefing Report

Improving Outcomes – Specialised Cancer services

THE NHS CONSTITUTION
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Overview and Scrutiny Committee Report

Improving Outcomes - Specialised Cancer Services

Foreword

The purpose of this report is to engage with the Overview and Scrutiny Committee on the proposed redesign of specialised cancer services in order to improve outcomes of treatment, enhance patients' experience and ensure safe and sustainable services are provided within Greater Manchester and East Cheshire.

In the past, as cancer treatment evolved there were many common treatments and interventions but as medicine has progressed, increasingly techniques have become more specialised.

Specialised services are those services provided in relatively few hospitals, to catchment populations of more than one million people. The number of patients accessing these services is small and a critical mass of patients is needed in each centre to achieve the best outcomes and maintain the clinical competence of NHS staff. Concentrating services in this way also ensures that specialist staff can be more easily recruited and their training maintained. It is also more cost-effective and makes the best use of resources such as specialist equipment and staff expertise.

Currently, specialist services for a number of cancers that are provided to the people of Greater Manchester and East Cheshire do not comply with national standards and guidance. There are too many teams providing specialist surgical care which means that minimum populations and therefore surgical volumes set out in national standards have not been reached. These standards are based on clinical evidence which clearly demonstrates that outcomes are improved by increasing volumes in institutions carrying out specialised cancer surgery.

This proposal relates specifically to **specialist surgery.** We want to ensure that the people of Greater Manchester and East Cheshire have access to the best possible treatment. Therefore our approach involves a concentration of surgical expertise with fewer centres carrying out specialist operations to ensure best outcomes for patients.

The location of other cancer treatment such as chemotherapy and radiotherapy services will not change and most cancer care will continue to be provided locally. Patients with suspected cancer will continue to be referred to their local hospital by their GP, for further investigation and diagnosis. Our proposal is to establish a 'single service' so that patients who need specialist treatment are managed by a single specialist team. Where appropriate, specialist surgery will be undertaken on two sites which will support patient access. This means that there will be access to the same specialist care irrespective of where patients live with clinicians working to the same guidelines and pathways across Greater Manchester. A consistent approach will also lead to better research and development along with teaching and training of specialist staff.

We are working in full partnership with local Clinical Commissioning Groups through the 'Healthier Together' programme to ensure that patients' care is streamlined from referral to follow up after treatment. Trafford CCG, as lead cancer commissioner on behalf of Greater

Manchester CCGs, is providing invaluable support in ensuring that these connections are maintained.

This report describes the commissioning approach being taken by NHS England for the following cancers;

- Urological cancers (kidney, bladder and prostate)
- Hepatobiliary (liver, bile duct and gall bladder) and Pancreas cancers
- Upper Gastro-intestinal cancers (oesophagus and stomach)
- Gynaecological cancers.

Appendix 1 provides a summary of each service.

1. Why change – the story so far

From 2002, a series of national standards for different types of cancer were developed by the National Institute for Health and Care Excellence (NICE) called 'Improving Outcomes Guidance'. These standards led to the development of multi-disciplinary teams and described the service pathways that should be in place between primary care, secondary (hospital) care and specialist care.

For rarer cancers such as those above, the standards require specialised teams to manage minimum population sizes to ensure that surgeons and teams are undertaking sufficient numbers of operations to maintain specialist skills and achieve the best outcomes for patients.

In January 2011, *Improving Outcomes: A Strategy for Cancer* was published which set an ambitious target to improve death rates from cancer and 'save 5000 lives' – which would bring English mortality rates in line with the European average. One of the main aims in this policy was to ensure patients had access to the best possible surgical treatment by a greater degree of specialisation.

In December 2013, NHS England published planning guidance for the services it is responsible for commissioning. *Everyone Counts: Planning for Patients 2014/15 to 2018/19* signalled the intention to further reduce variation by commissioning specialised services in larger centres of excellence where the highest quality can be delivered.

NHS England has undertaken a national exercise to assess whether providers of specialised services meet national clinical standards. This highlights that a number of teams within Greater Manchester do not comply.

2. What this means for local services – the vision

NHS England is working to ensure that people in Greater Manchester and East Cheshire have access to specialised services that are fully compliant with national guidance in line with clinical evidence to improve patient outcomes and mortality rates.

3. The proposal we are engaging on

The table below indicates where change will occur;

Tumour	GP Referral & diagnosis in local hospital	Complex diagnosis	Specialist surgery	Chemotherapy & radiotherapy	Follow up and supportive care
Hepatobiliary and Pancreas		Some change	Fewer sites (1)		
Gynaecology			Fewer sites (2)		
Urology			Fewer sites (2)		
Upper gastro-intestinal			Fewer sites (2)		

= no change

The concentration of surgical services in larger centres in line with national standards is a common approach and is a model that has been established in other parts of England for many years.

The following information summarises the position with each of the four cancer areas:

Hepatobiliary and Pancreatic cancer – there are currently two organisations providing specialised surgery. By October 2014, providers and commissioners have agreed to the transfer of the service from Pennine Acute Hospitals NHS Trust to Central Manchester University Hospitals NHS Foundation Trust, bringing clinical experts together in a single team that serves the population of Greater Manchester, Central and East Cheshire.

Gynaecological cancer – three organisations currently provide specialised surgery, at Central Manchester University Hospitals NHS Foundation Trust (CMFT), University Hospital of South Manchester NHS Foundation Trust (UHSM) and The Christie NHS Foundation Trust. The service at Salford Royal NHS Foundation Trust has already transferred to The Christie. UHSM has also confirmed that it no longer wishes to continue providing this service. By March 2015 it is proposed that there will be a single specialist team involving CMFT and The Christie.

Urological cancer – five organisations provide specialised services, at CMFT, Salford Royal NHS Foundation Trust (SRFT), UHSM, Stockport NHS Foundation Trust and The Christie. Although clinical and hospital staff fully support the move to fewer sites, there is no agreement about where this should be therefore the next stage is to determine where surgical services should be provided via a procurement exercise commencing in June 2014. This will lead to a single specialist team being established with operating on fewer sites to ensure that patients receive the same high quality care irrespective of where they live.

Upper Gastro-intestinal cancer – three organisations provide these specialised services, at Central Manchester University Hospitals NHS Trust, Salford Royal NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust. As with urological cancer, there is no agreement amongst providers about where this service should be provided. A procurement process will commence in September 2014.

Usually people view the establishment of world class centres as very positive as long as local hospital services are not compromised. In developing these proposals, account is being taken of the impact on other services. For example, capacity in A&E and Intensive Care Units may be freed up as a result of concentrating services in larger centres. We will continue to work alongside local Clinical Commissioning Groups to ensure that the 'single service' model for specialised cancer surgery aligns with work being undertaken through the 'Healthier Together' programme and that patient safety and quality standards are met.

4. Engagement so far

The former Greater Manchester and Cheshire Cancer Network has previously engaged with its constituent organisations involving clinicians and managers, and patient representatives regarding the provision of specialist cancer surgery. In addition;

- There has been extensive engagement on the single service model at the NHS Greater Manchester Cancer Summit (2012) and Convention (2013) at which over 140 people attended including representation from patients, GPs, chief executives, hospital clinicians and CCGs.
- Clinical teams and hospital managers support the development of a single specialised team that provides surgery on fewer sites to ensure that patients receive access to the same high quality care irrespective of where they live
- Local clinical commissioning groups are supportive of this proposal
- Close links exist with the Strategic Clinical Network who have ensured good engagement with the Greater Manchester Partnership Group on these proposals.
- National Clinical Reference groups that produced these specifications upon which our plans are based include patient/carer representatives. These have been subject to detailed public consultation
- Our proposals are a regular standing item at the Greater Manchester Association Governing Group with all CCGs present.

We are engaging with each Overview and Scrutiny Committee within Greater Manchester and East Cheshire throughout June and July to ensure that our plans are transparent going forwards.

5. What happens next

We will continue to inform and engage key stakeholders throughout this process, including patients, local Healthwatch organisations, Overview and Scrutiny Committees and providers.

We expect the procurement process to be completed by March 2015 for urology, and June 2015 for upper GI and will attend future Overview and Scrutiny Committees to inform them about mobilisation plans for these services.

Appendix 1

Summary Position on Specialised Cancer Services

Service area	Geographical area	Catchment Population	Current Providers	National Guidance on No Providers to reach compliance	Patients who have surgery and will be affected (per annum)	Rate per 100,000 (adult population)
Cancer Surgery Upper GI (O.G.)	GM	3 million	SRFT	2	87	3.68
			CMFT		39	1.64
			UHSM		24	1
Total					**150**	**6.3**
Cancer Surgery Urology	GM	3.2 million	SRFT	2	105	4.16
			Christie		71	2.8
			Stockport		176	6.9
			UHSM		61	2.41
			CMFT		133	5.2
Total					**546**	**21.6**
Cancer Surgery Gynaecology	GM	3.2 million	CMFT	2	148	5.86
			UHSM		94	3.7
			SRFT		40	1.5
			Christie		56	2.22
Total					**338**	**13.4**
Cancer Surgery HPB	GM	3.2 million	PAHT	1	194	7.6
			CMFT		142	5.63
Total					**336**	**13.3**
Grand Total					**1370**	

Source:
Upper GI/Urology/Gynaecology – surgical data based on major surgical resections defined within NHS England service specifications (B11/S/a, B14/S/a, E10/S/f). Extracted from Secondary User Service activity data 2013/14 (11 month projected)

HPB - Trust data 2012

Trafford Borough Council and Manchester City Council Joint Health Scrutiny Committee – A New Health Deal for Trafford

Minutes of the meeting held on 7 April 2014

Present:
Councillor E Newman –Chair
Councillor Lloyd – Vice Chair

Manchester City Council - Councillors M Murphy, Reid and Watson
Trafford Borough Council – Councillors Bruer-Morris, Lamb and Procter

Dr Mike Burrows, Director (North West) NHS England
Dr Nigel Guest, Chief Clinical Officer, Trafford Clinical Commissioning Group
Gina Lawrence, Director of Commissioning and Operations, Trafford Clinical Commissioning Group
Jim O'Connell, Interim Chief Operating Officer, University Hospital South Manchester
Dr Bob Pearson, Clinical Director, Central Manchester Foundation Trust

JHSC/14/04 Attendance

The Committee noted the apologies of Councillor Holden from Trafford Council and Councillors Ellison and Cooley from Manchester Council.

JHSC/14/05 Minutes

Decision

To approve the minutes of the meeting on 29 January 2014 as a correct record.

JHSC/14/06 Declarations of Interest

The following personal interests were declared:
- Councillor Lloyd declared a personal interest as an employee of the Stroke Association based at Salford Royal NHS Foundation Trust.
- Councillor Bruer-Morris declared a personal interest as a practice nurse at a GP practice in Trafford.

JHSC/14/07 Update – New Health Deal for Trafford

The Committee welcomed Dr Mike Burrows, Director (North West) NHS England, Dr Nigel Guest, Chief Clinical Officer of Trafford Clinical Commissioning Group (CCG), Gina Lawrence, Director of Commissioning and Operations of Trafford CCG, Jim O'Connell, Interim Chief Operating Officer of University Hospital South Manchester (UHSM) and Dr Bob Pearson, Clinical Director of Central Manchester Foundation Trust (CMFT) to the meeting. Dr Burrows, Mr O'Connell and Dr Pearson gave a presentation to the Committee which provided an update on the new health deal for Trafford. The key points were:

- Combined Accident and emergency (A&E) attendances at the three neighbouring hospitals for Trafford residents were 6% less than expected and

admissions were 2% less than expected in the period since Trafford A&E department had been downgraded;
- However, in the case of Wythenshawe Hospital there had been 215 more A&E admissions than expected during this period;
- Wythenshawe Hospital A&E did not meet its 4 hour performance target in 2013/14 (ie. 95% of patients to be seen, treated, admitted or discharged within 4 hours of arrival);
- In the first three months of 2014, its 4 hour performance had fallen to below 91%;
- On Monday, 31 March 2014 there had been 335 attendances at Wythenshawe Hospital's A&E, and UHSM recognised that a daily attendance greater than 300 was difficult to deal with;
- In response to their failure to build resilience for A&E winter pressures, which were exacerbated by the downgrading of Trafford A&E to an urgent care centre, UHSM introduced a number of changes that had led to improvements, though some concerns still remained;
- A key improvement at UHSM A&E was the introduction of a new performance management and monitoring system, which clarified demand and capacity;
- At CMFT, which took over the running of Trafford Healthcare Trust in March 2012, the rolling HSMR (hospital standardised mortality ratio) at both CMFT and Trafford had fallen since the acquisition, while Trafford's rolling crude mortality rates for non-elective admissions had fallen by 1%.

A member asked whether the lower than predicted A&E attendance and admissions had led to additional pressure on GPs. Ms Lawrence said there had been no significant increases in GP attendance, but there had been an increase of 10-15% in attendances at walk in centres, but they were able to accommodate this.

The Committee discussed long stay patients. Ms Lawrence clarified that there were two trigger points at which long stay patients were monitored: when they had been admitted for 14 days and at 28 days. She said not all patients in hospitals for these lengths of time were delayed in leaving and many still needed to be in hospital. Currently, UHSM had two long stay patients who were waiting for social services to find them an appropriate place to be discharged to. UHSM currently had 126 people who had been admitted for 28 days or more, 38 of whom were Trafford residents.

A member asked for more details on Alamac and what it was used for. Mr O'Connell explained it was a real time data performance dashboard, which enabled the hospital to manage patient flow. A meeting was held every morning to consider issues from the previous day and what actions were needed to address them. The Committee asked for details on all the additional funding and how it was spent, which included Alamac.

The Committee discussed the data which showed that UHSM was struggling with the additional pressures from the downgrading of the A&E department at Trafford General Hospital. Members noted the changes that were being introduced to successfully manage the increased pressures and asked why they had not been put in place before Trafford was downgraded and why UHSM A&E department were not meeting their targets. Members also noted that they needed to understand the improvements in more detail. Dr Burrows said that there had been a significant

amount of preparatory work carried out prior to the downgrading of Trafford, and NHS Greater Manchester was provided with assurances by UHSM at the time. UHSM was given additional funding so should have been able to meet its targets. He said the new team was in place to address these issues. Members expressed frustration that prior to the implementation of the change, the Committee had accepted assurances from NHS Greater Manchester that UHSM would be able to cope with the additional pressures, only to now find that their reservations were well founded.

The Committee discussed comments made by Dr Attila Vegh, Chief Executive of UHSM, at its previous meeting. He had said that admissions to UHSM had increased to 7-8 a day since Trafford A&E had been downgraded, and that UHSM required 22 extra beds to meet this demand.

He had also said that of the hospital's 38 long stay patients, 37 were Trafford residents. The Committee noted that Dr Vegh had subsequently written to the Chair concerned that his reference to the 37 long stay patients from Trafford may have been misinterpreted. He clarified that all 37 patients from Trafford with an extended length of stay had still been in hospital for clinical reasons and not due to a delayed discharge, and that 11 of them were still receiving care at Wythenshawe Hospital. He had apologised for any confusion or concerns his comments may have caused, as UHSM was proud of its excellent relationship with Trafford Council and Trafford CCG and appreciative of their support in ensuring prompt discharge planning.

The Committee felt that the pressures on admissions demonstrated that UHSM had not been able to prepare for this change adequately. Dr Burrows acknowledged the Committee's concerns, but said that the old system was not financially viable and changes would have had to be made, so comparing current performance with UHSM's performance prior to the downgrading of Trafford A&E was not a fair comparison. Dr Guest confirmed that admissions at UHSM A&E did briefly reach 7-8 a day, and UHSM was given additional funding to address this. He said the system in place had coped, as the problem was identified and subsequently managed.

A short discussion took place over whether or not it had been the right thing to do for UHSM to give assurances that it could cope with the additional patients arising from the downgrading of Trafford A&E, and why it had given those assurances. The Chair concluded that everyone accepted the increased pressure at UHSM was an issue. Members noted that, although the referral to the Secretary of State for Health had been unsuccessful in preventing the downgrading of Trafford A&E, the Committee continued to have a role monitoring the implementation of the decision. The Committee agreed that it wanted to see details of plans to make improvements to UHSM's A&E department and indicated that it may consider further representations to the Secretary of State if it was unhappy with progress.

Decision

1. The Committee agreed to:
   - note the content of the report and presentation;
   - reiterate its concerns over the downgrading of Trafford A&E to an urgent care centre and its impact on UHSM's Wythenshawe Hospital A&E department;

- note that the Committee expressed concerns about UHSM's ability to meet the increased demand when downgrading Trafford A&E was first proposed.

2. The Committee requested that the following be provided by the NHS for circulation to its members as soon as possible:
   - detail of the plans to improve the accident and emergency department at Wythenshawe Hospital;
   - breakdown of the additional funding streams which have been provided to UHSM to address the immediate issues at their A&E, and on what they have been spent, including on the Alamac company;
   - anonymised case studies on long stay patients;

3. The Committee asked for:
   - regular and frequent reports on the performance of UHSM's Wythenshawe Hospital A&E department.

4. The Committee indicated that should performance data for Wythenshawe Hospital A&E not demonstrate satisfactory improvement by the time of its next meeting, the Committee would be minded to consider making further representations to the Secretary of State for Health on this matter.