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HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 19th September, 2013
at 6.00 pm

PLEASE NOTE TIME OF MEETING

COUNCIL CHAMBER - CIVIC CENTRE

This meeting is open to the public

Members

Councillor Stevens (Chair)
Councillor Chaloner (Vice-Chair)
Councillor Claisse
Councillor Cunio
Councillor Laming
Councillor Parnell
Councillor Spicer

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the halth Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview & Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2013/14

2013	2014
23 May 2013	31 January 2014
18 July	20 March
19 September	
21 November	

Council's Priorities:

- **Economic**: Promoting Southampton and attracting investment; raising ambitions and improving outcomes for children and young people.
- **Social**: Improving health and keeping people safe; helping individuals and communities to work together and help themselves.
- **Environmental**: Encouraging new house building and improving existing homes; making the city more attractive and sustainable
- **One Council:** Developing an engaged, skilled and motivated workforce; implementing better ways of working to manage reduced budgets and increased demand.

CONDUCT OF MEETING

Terms of Reference

Details above
The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTEREST

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Personal Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PERSONAL INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:
(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value for the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the Minutes of the meetings held on 18th July 2013 and to deal with any matters arising, attached.

7 EXCLUSION OF THE PRESS AND PUBLIC - CONFIDENTIAL PAPERS INCLUDED IN THE FOLLOWING ITEM

To move that in accordance with the Council's Constitution, specifically the Access to Information Procedure Rules contained within the Constitution, the press and public be excluded from the meeting in respect of any consideration of the following Item

Confidential Report contains information deemed to be exempt from general publication based on Category 1 and 2 of paragraph 10.4 of the Council's Access to Information Procedure Rules.

8 SOUTHAMPTON LOCAL CHILDREN'S SAFEGUARDING BOARD

Confidential report of the Director of People detailing an update on the Local Board, attached.

9 QUALITY ASSURANCE OF HEALTH AND SOCIAL CARE PROVISION

Report of the Director, People outlining work being undertaken to ensure safety and quality in adult health and care provision, attached.

10 BUILDING ON SUCCESS - LYMINGTON NEW FOREST HOSPITAL - THE NEXT TEN YEARS: LISTENING EXERCISE UPDATE

Report of the Programme Director of Clinical Commissioning, outlining the events and responses to date from the Listening Exercise in relation to the Lymington New Forest Hospital Strategic Review, attached.

11 UPDATE ON THE ESTABLISHMENT OF THE CCG, KEY NATIONAL DEVELOPMENTS AND WORKING WITH THE WIDER HEALTH AND SOCIAL CARE SYSTEM.

Report of the Chief Officer of Southampton Clinical Commissioning Group (CCG), updating the Panel on progress in the establishment of the CCG, key national developments and working with the wider health and social care system, attached.

12 UNIVERSITY HOSPITAL SOUTHAMPTON; UPDATE ON EMERGENCY DEPARTMENT / MONITOR AND THE CHILD HEART SURGERY REVIEW

Report of the Chief Operating Officer and the Director of Communications and Public Engagement for University Hospitals Southampton, updating the Panel on progress to date, attached.

13 OPERATING PROTOCOL BETWEEN HEALTH AND WELLBEING BOARD, HEALTH OVERVIEW AND SCRUTINY PANEL, AND HEALTHWATCH SOUTHAMPTON

Report of the Director of Public Health, setting out the roles and responsibilities of Health and Wellbeing Boards and local Healthwatch, attached.

Wednesday, 11 September 2013 HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 18 JULY 2013

Present: Councillors Cunio, Parnell, Spicer, Laming and Stevens

Apologies Councillors Chaloner and Claisse

11. **ELECTION OF CHAIR**

RESOLVED that Councillor Stevens be elected Chair for the 2013-14 municipal year.

12. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Panel noted apologies from Councillors Claisse and Chaloner and that Councillor Stevens and Councillor Laming replaced Councillors Jeffery and Lewzey respectively, as members of the Panel in accordance with Procedure Rule 4.3

13. **STATEMENT FROM THE CHAIR**

In accordance with accepted practice a statement was made by the Chair.

14. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that :-

i. the minutes of the meeting held on 23rd May 2013 be signed as a correct record (Copy of the minutes circulated with the agenda and appended to the signed minutes); and
ii. the following comments/requests from Southampton Keep our NHS Public Group (SKONP) were agreed:-

- Page 1 – second bullet point – that officers follow up with the previous Chair to investigate whether he had agreed to write to the three Southampton MP's expressing the Council's concern with the revised National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013.
- Page 3 – Item 7 – Southampton Clinical Commissioning Group (CCG) : Annual Plan and Priorities 2013/14 – 4th bullet point – that the Southampton CCG would provide a list of contracts awarded to every other HOSP meeting.

15. **CARE QUALITY COMMISSION - A NEW START: CONSULTATION ON THE WAY CQC REGULATES, INSPECTS AND MONITORS CARE**

The Panel received and noted the report of the Head of Communities, Improvement and Partnerships detailing the principles for inspection of all care services and monitoring of acute NHS Trusts. Alex Whitfield, Chief Operating Officer, Solent and Rob Kurn, Healthwatch provided the Panel with further information. (Copy of report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- that the deadline for consultation comments was Monday 12th August 2013;
- CQC inspections - that existing CQC staff would be utilised and would be directed towards their actual expertise rather than general inspections; in addition quality risk profiles would be produced which would enable any emerging concerns to be highlighted;
- that CQC visits would be unannounced which would prevent service disruptions prior to an announced visit;
- that holding a 3-way meeting with HOSP, Healthwatch and the Health and Wellbeing Board would be investigated; and
- integration of social care with home health care and the quality of communication between hospitals, patients and the community were core issues;

RESOLVED:-

i. that the principles underlying how the CQC proposed to inspect services, regulate care services and specifically how it intended to monitor and judge acute NHS trusts be noted; and
ii. that any feedback from the consultation be reported to Healthwatch.

16. **PATIENTS FIRST AND FOREMOST: THE INITIAL GOVERNMENT RESPONSE TO THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY**

The Panel considered the report of the Chair, Southampton City Clinical Commissioning Group detailing the Government's response to the report by Mid Staffordshire NHS Foundation Trust Public Inquiry, the Francis Report and the work going on locally to respond to the challenges of the Francis Report. (Copy of report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- The Government response set out a 5-point action plan :
  - Preventing problems
  - Detecting problems quickly
  - Tackling action promptly
  - Ensuring robust accountability
  - Ensuring staff were trained and motivated.
- the importance of a change in culture which focused on patients' care needs and not on the organisation's business and finance;
- the importance of acknowledging potential problems as this was vital information for improvement;
- there needed to be a balance between a "no blame culture" and accountability with the prime consideration being the patient's safety at all times;
- that the CCG had their own internal quality department which scrutinised systems being set up, visited hospitals and monitored reports;
- that the HOSP should adopt a more forensic approach to scrutinising quality accounts from the various health providers and the following indicators, which all

should be publically accessible in board papers, would provide information on the organisation's culture :-

- staff and patient surveys;
- board papers and agendas to detect whether quality of care and service as opposed to finances was being highlighted;
- HR and whistle blowing policies – constraints on duty of disclosure; and
- reporting of complaints and serious incidents or lack of.

RESOLVED

i. that the issues highlighted in the "Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry" and the work being undertaken locally within the NHS and partner organisations to respond to the challenges of the Francis Report be noted ; and

ii. that a more forensic approach to scrutinising quality accounts be investigated as detailed in bullet point 6 above.

17. **HEALTHWATCH SOUTHAMPTON**

The Panel considered the report of the Commissioner for Supporting People and Adult Care Services and received a presentation from Rob Kurn, Healthwatch Manager, detailing the contract, functions and role of Healthwatch Southampton. (Copy of report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- the Healthwatch contract had been awarded on 1 July 2013 and was a 3-year contract;
- the Voluntary Community Sector would be heavily involved in the delivery of Healthwatch functions;
- a Healthwatch Strategic Group would set the strategic direction and operational priorities and the process would be overseen by an independent nominations committee;
- development and delivery of Healthwatch Southampton would be conducted over two phases – 1st phase - July – September and 2nd phase - October – December; and
- in order for Healthwatch to be effective, joint working with partners was essential.

RESOLVED

i. that the commencement of the Healthwatch contract and the functions and role of Healthwatch Southampton be noted; and

ii. to note that:-
    - protocol between HOSP, the Health and Wellbeing Board and Healthwatch was in the process of being drafted and it was important that discussions were held to establish the relationships between the 3 bodies and ensure that their respective roles did not overlap or were duplicated;
    - there was a standing invitation for a Healthwatch representative to attend HOSP meetings; however the representative had no voting rights; and

- Healthwatch would be responsible for reporting health issues and information for HOSP to scrutinise and would not be part of the scrutiny process itself.

18. **GP SERVICES, PORTSWOOD**

The Panel considered the report of the Director of Commissioning, NHS England outlining the issues, options considered and recommended for replacing GP services in Portswood. (Copy of report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- Appendix 1 page 2 – the following note to be removed "Dr Gallagher has indicated he will resign rather than accept dispersed patients."
- a number of GPs were unhappy as they had not been made aware of the situation, had not been consulted and had not been able to provide any feedback; A patient from the Portswood Road practice attended the meeting and provided further information in this regard;
- that only expressions of interest had been sent out to GPs and the consultation process had not yet commenced;
- that the primary care commissioning team had recommended Option 4 which was the extension of current contract to provide branch surgery;

RESOLVED

i. that NHS England in conjunction with the CCG be requested to ensure that all GP's were provided with the relevant information so that feedback could be provided;
ii. that any group/community/organisational body being discussed in any report tabled at a HOSP meeting should be invited to attend the meeting ; and
iii. that an update report on the outcome of the consultation be tabled by NHS England.

19. **UNIVERSITY HOSPITAL SOUTHAMPTON: UPDATE ON EMERGENCY DEPARTMENT / MONITOR AND THE CHILD HEART SURGERY REVIEW**

The Panel received and noted the report of the UHS Chief Operating Officer and the UHS Director of Communications and Public Engagement detailing the progress made in achieving A&E targets at the University Hospital Southampton and the changes to the child heart surgery review. (Copy of the report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- improvements had been made following the prolonged period of underperformance against the 4-hour A&E operating standard and achievements were up to 97%;

- there would be more capacity and better quality of care this winter with the introduction of 70 extra beds, reducing patients' length of stay, improved flow of patients and improved partnership working with social care;
- that University Hospital Southampton had not been close to the 14 hospitals being investigated by Monitor in relation to the standardised mortality ratio;
- that the child heart surgery review had been suspended as the Independent Reconfiguration Panel had recommended that the proposals could not go ahead in their current format;
- that as a result of the closure of the Oxford Service 100 heart surgery cases had been transferred to Southampton and the Southampton Children's Heart Surgery Unit now catered for adults as well as children. The resultant increase in surgical cases might improve Southampton's chances of keeping the Unit in the future; and
- that a paper had been presented to the NHS England Board outlining principals for taking the service forward.

RESOLVED

i. that a further update report would be tabled at the next HOSP meeting; and
ii. that the Southampton Health Overview and Scrutiny Panel write to the Secretary of State asking what plans and decisions there were likely to be in terms of the review of the Child Heart Surgery Reform.

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by virtue of paragraph number 1, 2 of the Council's Access to information Procedure Rules

Document is Confidential

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		QUALITY ASSURANCE OF HEALTH AND SOCIAL CARE PROVISION		
DATE OF DECISION:		19 SEPTEMBER 2013		
REPORT OF:		ALISON ELLIOTT		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY

This report outlines work being undertaken to ensure safety and quality in adult health and care provision.

The quality of provision is crucial in ensuring service users are safe, that care is of good quality and needs are met effectively. There is an expectation that providers of health and social care services will monitor the safety and quality of their provision. The quality is also externally monitored in a number of ways to ensure there is a good understanding of individual providers and overarching market management issues.

All providers of care services are required to register with the Care Quality Commission (CQC). In addition to CQC inspections, Southampton City Council (SCC) and Southampton City Clinical Commissioning Group (CCG) manage contracts with providers ensuring quality standards are met. There has been some joint working between the two Quality Assurance teams, but it is proposed that these are amalgamated within an Integrated Commissioning Unit to further improve a co-ordinated, comprehensive approach to quality improvement and assurance.

RECOMMENDATIONS:

(i) That the Panel notes the report.

(ii) That the Panel requests regular exception reports on the quality and safety of health and social care provision in Southampton that highlight key areas of concern and actions.

REASONS FOR REPORT RECOMMENDATIONS

1. The provision of good quality, safe care services are key elements in achieving positive outcomes for residents and improvements in core services. There are different regimes in place to ensure quality standards

are enforced and to support improved quality of care. Providing information of quality and safety issues and their outcomes will provide assurance to HOSP that processes are in place to support the development of high quality services and to identify, monitor and challenge issues which lead to speedy change and improvements if necessary.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. To provide exception reports on CQC inspection outcomes, however this would give only one indicator of quality concerns.

DETAIL

QUALITY OF CARE

CURRENT ISSUES OF CONCERN WITHIN SOUTHAMPTON

3. There are 10 Registered Nursing Homes in Southampton, of these 3 have Safeguarding Suspension status and 2 have Safeguarding Caution status. SCC also contract with a number of Nursing Homes close to the City and of these, 3 are suspended and one has caution status. Several of the suspended homes belong to the same company. There are 32 Registered Residential Care Homes in Southampton. Of these 3 have Safeguarding Suspension status; 2 other have Safeguarding Caution status. The 3 Suspended Care Homes belong to the same small company. There are no other Residential Homes close to Southampton with a Safeguarding status. There are 16 Registered Care Homes providing care to younger adults. None have Safeguarding status. There are approximately 30 Registered Domiciliary Care Providers in Southampton. Currently 1 of these has a Safeguarding Caution status, none are Suspended. Not all of these providers contract with SCC. SCC also use a number of providers, who are based outside but close to the City. None of these have Safeguarding status.

CARE QUALITY COMMISSION

4. The Care Quality Commission inspects care in hospitals, care homes, people's own homes, dental and general practices, and other services against national standards. Most are inspected at least once a year, and dental services at least once every two years. Services are re-inspected if a provider has been deemed as non-compliant and CQC will inspect services more often if they think they are providing poor care that might be putting people at risk.

5. During inspections the assessors ask people about their experiences of receiving care, talk to frontline staff, check that the right systems and processes are in place and look for evidence that the service is meeting national standards.

6. Inspection Reports are published on the CQC Website, under the name of the Registered Provider. The level of non-compliance is judged by its impact on the people who use the service, either minor, moderate or major. A timescale is set for the Provider to carry out the required improvements. Where CQC judge that the non-compliance of an individual provider requires more formal action, Warning notices are issued. These advise the provider in detail of their failures and a timescale for rectification/compliance is set. Warning notices are copied to Councils and to the local press. CQC will re-inspect to judge whether the provider is compliant. Failure to comply with Warning Notices will be likely to result in severe action against a provider. CQC can also take legal action against a provider, where criminal acts are judged to have been carried out.

7. The CQC website map should be updated weekly with newly published inspection reports and information sent direct to local authorities. The SCC Quality team monitor the website on a weekly basis to identify newly published inspection reports. This information is considered by the internal quality teams and actions and monitoring implemented. To ensure effective communication and sharing of key concerns CQC meet quarterly with the SCC Director of People Services. CCG Quality leads are members of the Southampton Adult Safeguarding board and the Wessex Quality Surveillance group.

ADULT SOCIAL CARE QUALITY ASSURANCE PROCESSES

8. Adult Social Care provides and commissions a range of services to meet the assessed needs of people requiring social care services. These include registered residential and nursing settings as well as a range of services to support people in the community and in their own home. A fundamental part of ensuring these services provide care of an appropriate quality to vulnerable people is a proactive contract monitoring process. The aim is to support the providers in achieving and improving quality and safety.

9. Quality audit visits consider management of the home, skills and training of care staff, supervision, dignity of users, care planning competency as well as the physical nature of the building/service. From this information the team can determine whether the provider is delivering a good service and where improvements can be made. Following visits, reports are compiled with recommendations for improvements, including for training and other staff development needs. This may result in ongoing visits dependent upon the actions taken by providers. Performance data is also monitored.

10. The Quality Assurance team has a significant role with regard to the safeguarding of vulnerable service users, and joint visits to homes and services are carried out with the safeguarding team if required. Information on quality assurance visits is made available to CQC to enable the proper sharing of information in order to further protect individuals

CCG QUALITY ASSURANCE PROCESSES

11. Southampton City CCG commissions healthcare provision ranging from nursing homes through to hospital and community health services. Quality elements are agreed within each contract. All commissioned services have clear outcomes for quality and understand the escalation process if standards fall below what is defined. Clinical Quality Review Meetings (CQRM) are held monthly with the main providers to monitor all aspects of the quality element of

the contract (including patient survey outcomes) and receive assurance on compliance.

12. There is a detailed process for monitoring Serious Incidents (SIRI's). A serious incident is defined nationally and includes unexpected or avoidable death or severe harm of a service user, staff member or member of the public, allegations of abuse, significant loss of confidence in a service, or a scenario that prevents a providers ability to continue to deliver healthcare services. The provider is required to inform the CCG of the incident within 48 hours and submit an initial review of what happened, followed by a more detailed analysis normally within 45 working days. Serious incidents are monitored on an individual basis to ensure investigations are comprehensive and actions are completed. They are also considered as a group of incidents to identify any emerging trends. Lessons learnt from serious incidents may result in changes to policies and procedures and will be incorporated into contract requirements where necessary. In some instances the outcomes of serious incidents can result in capability or disciplinary action being taken against staff where appropriate.

SAFEGUARDING ADULTS

13. Any safeguarding alert about a health or social care provider is captured in a central database and alerts raised are discussed at a multi-agency meeting where the response to alerts is agreed. A safeguarding process which is proportionate to the concerns raised is undertaken ranging from oversight of the providers own investigation and plan for improvement to a police led investigation. Decisions are made on appropriate plans to protect the individual affected and this can include whether placements with the service can continue or in extreme cases if there is a need to consider moving individuals to another provider. When the safeguarding concern has been resolved quality assurance monitoring of the provider ensures continued compliance with required standards.

14. The Southampton Safeguarding Adults Board (SSAB) role is to provide independent governance and assurance on the safety of vulnerable residents locally. The Board has developed an integrated performance dashboard which holds Board members who commission or provide services to account. This includes information about the number of providers where there are safeguarding concerns. The Board also reviews the local implications of national safeguarding issues, for example it has recently examined the action plans in response to the Frances Report (into the care at Staffordshire Hospital) of all the providers of hospital care locally. CQC are members of this Board.

INTEGRATED COMMISSIONING UNIT

15. The proposal in the development of an Integrated Commissioning Unit across SCC and Southampton City CCG is to integrate quality assurance across the two organisations and some elements of the safeguarding work undertaken with provider organisations. This will allow for streamlining of processes and improved communication. High profile cases, such as Winterbourne and the Francis inquiry and local serious case reviews have emphasised the need for this area of work to be thorough and co-ordinated.

16. Quality is the key driver in the contracting process and as part of this commissioners want to facilitate a two way dialogue with providers about quality in all aspects to enhance and strive further for higher standards of care wherever possible. This can only be achieved by moving to a culture of quality improvement, supported by quality monitoring and open and honest conversations between all parties about good practice and the challenges facing providers.

17. The Integrated Commissioning Unit will be able to ensure effective performance and outcome monitoring and from this provide an exception report that will inform governance and assurance processes in the City. This could be used iota inform an overview report for Overview and Scrutiny Committee with ad hoc reports as required for serious issues

HEALTH AND SOCIAL CARE WORKERS

18. Assurance about quality of staff within individual health and social care services is the responsibility of each provider. However this is also externally monitored as part of the processes outlined above.

19. CQC have a key role in ensuring providers meet nationally set standards for staff in regulated services. This includes ensuring providers have robust recruitment processes, training, supervision, the provision of guidance for staff to deliver their role effectively and effective oversight and assurance processes of the work they do.

20. Health and social care contracts specify requirements regarding staffing. These contracts are regularly monitored including reviewing staff recruitment, training records, customer comments and complaints. More importantly the outcomes for customers are monitored. This includes using feedback from health and social care staff and direct feedback from customers and carers gathered both by the provider and by commissioners.

21. As more people contract their own health and social care support in response to the Personalisation agenda a range of services have been developed to ensure quality and safety in this emerging market.

22. Contracts with local User Led Organisations (ULO) also provide training and support to Personal Assistants (PAs). Local self-assessment against national markers are underway to ensure the City is progressing towards high quality person centred services. This includes commitments set out in regards to Adult Social Care through Think Local Act Personal (TLAP) Making it Real programme and the Makers of Progress, set out by NHS England for the roll out of Personal Health Budgets. As this progresses the service will be able to show not only its own quality and standard of personalised care offered, but benchmark against many other areas undertaking the same approach.

23. Individuals who choose to take a Direct Payment have access to support through the ULO to help with a number of aspects (for example managing budgets and recruitment). These are monitored through contract arrangements and individual packages reviewed by trained and competent staff. Regular checks on expenditure and purchases are also undertaken through internal audit processes to ensure quality and appropriate care is secured.

24. Whilst social care providers have responsibility for ensuring staff are adequately trained the Council provides funding via a national grant to support care staff training. This programme is agreed with Provider Services forums and is developed with reference to overarching issues highlighted via quality assurance reviews and provider safeguarding investigations. Recent programmes have included “managing to care safely” course targeted at care home managers.

25. Commissioners are currently working with CAPITA colleagues to review the implications of introducing a living wage requirement within contracts

SERIOUS INCIDENTS INVOLVING INDIVIDUALS WITH MENTAL HEALTH CONDITIONS

26. Mental health services for adults of working age in the City are jointly provided between the Council and Southern Health NHS Trust under a Section 75 Health Act Flexibilities arrangement, with Southern Health as the lead agency. The CCG commissions the health element of the service and supports the partnership arrangements, as integrated care provides the best experience for service users.

27. Following a number of serious incidents and deaths of users of adult mental health services, including individuals who had recently been detained by the police service pending a Mental Health Act assessment actions are underway which are over and above the usual monitoring requirements. This includes a number of thematic reviews of service provision, site visits and additional scrutiny of SIRIs. The actions are being undertaken jointly with Southern Health, the CCG as commissioner of the health element of the service and the City Council. An action plan has been developed focusing on the immediate safety of the service in addition to a medium term review of the operating model. This is being monitored in fortnightly meetings and the need for an increased level of City Council oversight of the service is being built into the remodelling proposals for Adult Social Care. Southern Health have introduced a number of changes including stringent governance model and have increased clinical oversight of assessments.

28. The Southampton Safeguarding Adults Board has received 2 reports on Southern Health incidents. The October meeting of the Board will consider the root cause analysis and action plan. The Board will monitor the work being undertaken and require Southern Health to provide assurance on the outcomes of the action being taken.

RESOURCE IMPLICATIONS

Capital/Revenue

29. All of the work described will be undertaken within current health and social care resources.

Property/Other

30. There are no other implications.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

31. As described in "No Secrets" guidance 2003 the local authority is required to take the lead agency role in ensuring effective arrangements are in place to secure the safety of vulnerable adults in Southampton.

Other Legal Implications:

32. None

POLICY FRAMEWORK IMPLICATIONS

33. National Quality Board: Quality in the new health system – maintaining and improving quality from April 2013

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		BUILDING ON SUCCESS – LYMINGTON NEW FOREST HOSPITAL – THE NEXT TEN YEARS: LISTENING EXERCISE UPDATE		
DATE OF DECISION:		19 SEPTEMBER 2013		
REPORT OF:		CATHERINE BOWELL, PROGRAMME DIRECTOR OF CLINICAL COMMISSIONING		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Eleanor Freeman** **Pam Sorenson**	**Tel:**	02380 627456
	E-mail:	Eleanor.Freeman@westhampshireccg.nhs.uk Pamela.Sorensen@southernhealth.nhs.uk		
Director	**Name:**	**Dr Simon Hunter**	**Tel:**	

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

This paper outlines the events and responses to date from the Listening Exercise in relation to the Lymington New Forest Hospital Strategic Review. The Listening Exercise, which took place during June 2013, was a crucial way of gathering feedback from our stakeholders. Their views will feed into our work to review the range of services at Lymington New Forest Hospital to ensure it meets the needs of patients over the next ten years.

It was important to undertake this piece of work as it offers assurance to the Board, and as we move forward, to Hampshire Health Overview and Scrutiny Committee, that we have met our statutory duty to involve and engage with a wide group of people. It will also aid future engagement and potential consultation activity, and will significantly support our plans to develop the hospital by being able to evidence robust and continuous involvement of stakeholders.

RECOMMENDATIONS:

(i) That the Panel notes the issues outlined in the report.

(ii) That the Panel agrees the impact on Southampton health services and how it wishes to be involved in the decision making process for the Lymington New Forest Hospital changes going forward/

REASONS FOR REPORT RECOMMENDATIONS

1. The Panel has a responsibility to respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

INTRODUCTION

3 This paper outlines the events and responses to date from the Listening Exercise in relation to the Lymington New Forest Hospital Strategic Review. The Listening Exercise, which took place during June 2013, was a crucial way of gathering feedback from our stakeholders. Their views will feed into our work to review the range of services at Lymington New Forest Hospital to ensure it meets the needs of patients over the next ten years.

11. It was important to undertake this piece of work as it offers assurance to the Board, and as we move forward, to Hampshire Health Overview and Scrutiny Committee, that we have met our statutory duty to involve and engage with a wide group of people. It will also aid future engagement and potential consultation activity, and will significantly support our plans to develop the hospital by being able to evidence robust and continuous involvement of stakeholders.

WHO WAS ENGAGED?

12. Working jointly with Southern Health NHS Foundation Trust, key stakeholders were identified. A Communications and Engagement Plan was drafted collaboratively.

We identified our key audiences as follows:

- Patients, Carers and Public;
- Voluntary Organisations;
- General Practitioners;
- Staff within Southern Health NHS Foundation Trust;
- Staff (including clinical staff) from other provider organisations such as University Hospital Southampton NHS Foundation Trust and the Royal Bournemouth and Christchurch NHS Foundation Hospital;
- Health Overview and Scrutiny Committee (HOSC) - Hampshire and Southampton;
- Members of Hampshire County Council;
- Local Members of Parliament;
- Patient Participation Group (PPG) leads from Totton and Waterside and South West New Forest Localities; and
- Key hospital stakeholders i.e. Lymington New Forest Hospital League of Friends, Hospital radio etc.

WHAT DID WE DISCUSS WITH OUR STAKEHOLDERS?

13. This was an engagement/listening exercise that set out to gather initial feedback on views of the current services and ideas for future services. However, as community hospitals in the New Forest were subject to a wider consultation eight years ago, it was important to reassure stakeholders and not make them anxious about the future of their hospital. We also wanted to ensure hospital staff did not feel there was any criticism of the current services provided. The aim was to take clear and simple messages to our stakeholders. Our core messages were:

a. We want to make the best use of Lymington New Forest Hospital for the people who use it.
b. We have looked at the different people who use the hospital and at the way the local population is changing over time. We need to develop our hospital to continue meeting your needs.
c. We want to listen to your views to help us shape the future 'mix' of services at Lymington New Forest Hospital.

14. Through our discussions, meetings, focus groups and questionnaires we aimed to ascertain:

- What services work well for those who use the hospital?
- Reasons why the hospital is not always the place of choice?
- What services do not work so effectively and why?
- Within specific parameters, what services which are currently not provided at Lymington New Forest Hospital would the population like to see there? Note: We set parameters being mindful that some services could never be provided from Lymington e.g. complex heart surgery, and so did not wish to raise expectations

HOW DID WE ENGAGE WITH OUR STAKEHOLDERS?

15. It was clear that to ensure effective engagement we needed to use a variety of engagement channels. We therefore planned a multi-faceted approach to effectively capture feedback from all of our audiences. The following methods were used:

- Social media – principally Twitter (we regularly tweeted about our events and the questionnaire was available on Twitter).
- A specific email address set up buildingonsuccess@WestHampshireCCG.nhs.uk this was advertised through leaflets, story boards, website etc.
- 3,000 leaflets distributed
- Story Boards – which were within the Hospital and also a portable set used for the roaming events
- Specific telephone line (advertised in newspaper stories, Twitter, website, on flyers and storyboards)
- Survey monkey set up – three online surveys in situ one for the General Practitioners, one for the staff who work at Lymington New Forest Hospital and one for the patients and the public.
- A variety of focus groups. These were held at either Hythe Hospital or Lymington New Forest Hospital.
- A staff drop in session from 7.00 am to 9.00 pm to ensure all shifts had the opportunity to feed in their ideas.
- General Practitioner Locality meetings
- Attendance at the Fusion meeting – gathering information from representatives of local nursing homes.
- Attendance at local town markets, garden parties

- PPG representatives handing out questionnaires in local surgeries e.g. Ringwood Medical Centre
- Individual meetings with specific organizations i.e. Hampshire HOSC (informal), Councilors

RESPONSES TO DATE AND NEXT STEPS

16. The responses have being collated from the following sources:
    - 319 responses received to the patient questionnaire – majority by paper rather than on line;
    - 2 written letters received;
    - 14 Voluntary organisations were represented through the focus group;
    - 13 PPG representatives attended the focus groups;
    - Over 120 individuals were asked their views face to face;
    - 27 members of staff attended the drop in session; and
    - Over 160 General Practitioners/ Clinicians have contributed ideas for the future clinical service provision.

    The board are grateful to all those who participated in the above events and to Southern Health NHS Foundation Trust for all their support.

NEXT STEPS

17. A Clinical Reference Group made up of General Practitioners and clinical representatives from the West Hampshire Clinical Commissioning Group, Southern Health NHS Foundation Trust, Southampton University Hospitals NHS Trust, The Royal Bournemouth and Christchurch NHS Trust, Solent NHS Trust and Oakhaven Hospice met on the 25th of July to commence reviewing the information.

18. Early analysis of the information has defined six specific areas to review specifically which are:
    - Acute Medicine – a single access point;
    - Surgery and Endoscopy;
    - Out patients and diagnostics;
    - Frail Elderly – including end of life and dementia care;
    - Transport; and
    - Enhancing patient experience

19. The outcomes from the Clinical Reference Group will be recommendations on what the future range of services should/could look like to meet the population needs; which will be presented to the West Hampshire Clinical Cabinet and CCG Board in late September.

20. Note: We are committed to ensuring both Hampshire and Southampton HOSCs are involved and informed informally at this stage, and will be guided by them as to when it may be necessary to present proposals more formally. If HOSC deem our proposals constitute substantial service change it will be likely that formal consultation will be necessary although robust engagement work may negate the need for that.

RESOURCE IMPLICATIONS

Capital/Revenue

21. There are no capital / revenue implications in this report.

Property/Other

22. No impact

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

23. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

24. None

POLICY FRAMEWORK IMPLICATIONS

25. Improving health and keeping people safe is identified as a council priority within the 2013-16 Council Plan.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON THE ESTABLISHMENT OF THE CCG, KEY NATIONAL DEVELOPMENTS AND WORKING WITH THE WIDER HEALTH AND SOCIAL CARE SYSTEM.		
DATE OF DECISION:		19 SEPTEMBER 2013		
REPORT OF:		JOHN RICHARDS, SOUTHAMPTON CLINICAL COMMISSIONING GROUP (CCG) CHIEF OFFICER		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dawn Buck**	**Tel:**	023 8029 6932
	E-mail:	**dawn.buck@southamptoncityccg.nhs.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

This report gives the Panel a general update on progress in the establishment of the CCG, key national developments and working with the wider health and social care system.

RECOMMENDATIONS:

(i) That the Panel notes the issues identified in the report and considers if there are any matters for further consideration.

REASONS FOR REPORT RECOMMENDATIONS

1. The Panel has a duty to undertake the scrutiny of Social Care issues in the City.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. Set out in the following sections

RESOURCE IMPLICATIONS

Capital/Revenue

1. **CCG Authorisation.** It is understood that the Area and Regional teams have recommended, upon review of the latest submission from the CCG, that the one remaining condition (2.4.1B) should be discharged. Confirmation of the outcome is expected week commencing 22 July.

2. **Comprehensive Spending Review.** The letter from Debbie Fleming (attached at Appendix 1) outlines the impact of the Treasury spending review for the NHS. In 2015/16, growth will be 1.9%. With inflation forecast at 1.8%, this means a real terms increase for the NHS of 0.1%. The Government will create a £3.8Bn Integration Transformation Fund, to which

the NHS will contribute £3.4Bn. This builds substantially upon the approach adopted over the last three years in the social care transfer fund.

3. **Refreshing the Mandate to NHS England 2014/15: Consultation.** The Secretary of State has set out his proposals to refresh the mandate in the attached document (Appendix 2) published on 5 July. The consultation runs until the end of September.

4. **CCG Assurance Framework.** NHS England has published an interim assurance framework for CCGs. The Chair and Chief Officer attended a regional workshop on 10 July and salient issues will be reported back to the meeting.

5. **Recruitment of Clinical Leaders.** A number of clinical lead roles have been created to work alongside the management team in support of key clinical roles on the Governing Body. These include urgent care, integrated person centred care and quality. The response from interested parties has been very encouraging and an update will be provided at the meeting.

6. **Delivery of the A&E 4 Hour standard – NHS England Improvement Plan and Current Performance.** An initial joint plan for the South West Hampshire system was duly submitted by both CCGs to NHSE by the end of May. This incorporated the existing ECIST whole system plans, proposals based on local observation and ideas for consideration arising from the King's Fund checklist. The contract query raised with UHSFT during Q4 has now been concluded satisfactorily, with the Trust having provided various assurances and performance throughout June substantially improved, comfortably in excess of the 95% standard and therefore the quarterly position, whilst still short of the agreed trajectory of 93.97%, achieving 93% and showing a trend of strong improvement. The position nevertheless remains under close scrutiny and is the focus of joint improvement efforts.

7. **Procurement Decisions.**
   a. **Minor Injuries Unit (MIU) Royal South Hants.** It has been agreed that the current pilot, involving extended opening times and access to radiology, should be extended for at least the remainder of the financial year 2013/14 whilst preparations are made to invite competitive tenders for the provision of the service in future. The rationale for this decision is set out at Appendix 3.
   b. **Wheelchair services.** Following the receipt of notice served by the current provider, Solent NHS Trust, it has been agreed to undertake a single collaborative procurement between NHS Southampton City CCG and neighbouring CCGs, with NHS Portsmouth CCG acting as the lead for the scoping and procurement phase. It is proposed that this is offered with a contract length of 5 years with the option to extend for 2 years; it is intended that there should be a separate SCCCG contract with NHS England listed as an Associate to the contract. Appendix 4 sets out the rationale for this approach
   c. **Direct access diagnostics**. The CCG intends to re- procure Direct Access Diagnostic Imaging services rather than to extend existing AWP contracts and to specify that the new guidance and standards in the recently published *"Quality Imaging Services for Primary Care*" document

are phased in over a period of time.

d. **Insulin Pump Services for Adults with Type 1 Diabetes.** Further to the CCG's published commissioning intentions to commission a local service, it has been agreed to award a contract without competition to UHSFT. The rationale for this decision, assessed against the requirements of the Procurement Regulations (SI 2013/500).

8. **Securing Commissioning Support.** NHSE have produced a document which says that current service agreements cannot be extended beyond September 2014. Our existing agreement runs to November 2014. By autumn 2013 the CCG will need to set out our intentions around securing commissioning support. Local CCGs are going to hold a half day workshop towards the end of September.

9. **Working Together – Southampton and South West Hampshire.** The system chiefs group continues to develop its joint programme of work and this has included reviewing the various proposals to improve the capacity and capability of the unscheduled care system. Finnamore have concluded their assignment and it has been agreed that the Chief Officer, SCCCG, will chair this group going forward. The membership of the group has also been extended to incorporate the Wessex Area Team.

10. **TARGET Event 19th June.** The first city-wide primary care event was undertaken on the 19th June. The Chief Officer will update the Panel at the meeting.

Property/Other

11. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

12. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

13. None

POLICY FRAMEWORK IMPLICATIONS

14. Improving health and keeping people safe is identified as a council priority within the 2013-16 Council Plan.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1	NHS England letter: Spending Round: Health Settlement 2015-16
2	Department of Health. Refreshing the Mandate to NHS England: 2014 – 2015 Consultation
3	Minor Injuries Unit (MIU) Royal South Hants - rationale for decision
4	Wheelchair services - rationale for decision

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Annex A

Agenda Item 11

Appendix 1

Gateway number: 00211

NHS England (Wessex)
Oakley Road
Southampton
Hampshire
SO16 4GX

Email: debbie.fleming@nhs.net
Telephone: 023 8072 5600

To: CCG Clinical Leads,
cc: CCG Accountable Officers
Wessex Area Team Directors

27 June 2013

Dear Colleague

SPENDING ROUND: HEALTH SETTLEMENT 2015-16

I am writing to you following the Chancellor's announcement of the Health Settlement for 2015-16 to share with you the initial NHS England response (see annex A) and to outline some further detail on what the settlement means for you. This letter is for your information.

Spending Round Headlines

- NHS funding will grow in real terms, consistent with the government commitment to protect the NHS;
- This is a challenging settlement:
    - Given rising demand and inflation pressures, we expect the NHS would have needed to deliver c4% efficiency in order to maintain current services;
    - In addition, however the NHS, DCLG and the DH will pool c£3.8bn of funds for investment in the integration of health and social care (the "Integration Transformation Fund"). The NHS will contribute £3.4bn towards the integration fund. This compares to the £0.9bn the NHS currently transfers to support integration with social care.

Social Care Integration Fund breakdown

The £3.8bn Integration Transformation Fund will be a pooled fund, held by local authorities and funded from:

- the £0.9bn of funding NHS England planned to transfer to fund social care in 2014-15;
- an additional £0.2bn of investment in 2014-15 (to be agreed as part of mandate discussions for 2014-15 with DH);
- DH and other Government Department transfers of £0.4bn (capital grants);

- CCG pooled funding of:

    - reablement funding of £0.3bn;
    - carers' break funding of £0.1bn;
    - core CCG funding of £1.9bn.

The intention is to give NHS and Social Care commissioners greater influence over this funding in the future to ensure it is optimised to support local integration of health and care services. To enhance this funding further, the funding CCGs currently hold for reablement and carers' breaks will also be included in the pooled budget, alongside other grants that the DH and Department of Communities and Local Government currently fund to support Social Care. The integration fund budget will represent a significant share of spend on health and care services and will give CCGs greater influence over how care services are integrated with health services.

It is vital that the NHS realises the benefits of integration in terms of reducing demand on health services, improving outcomes for patients and other efficiencies. Hence, there will be conditions attached to the pooled funding and the creation of new incentives to support integration and the delivery of improved outcomes for both health and care.

Conditionality on integration fund

The pooled funding will formally sit with local authorities but will be subject to plans being agreed by local Health and Wellbeing Boards (H&WBs) and signed off by CCGs and Council Leaders. Plans would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is envisaged that plans would be developed this year, signed-off and assured over the winter and would be implemented from 2014/15.

Plans and assurance would need to satisfy nationally prescribed conditions, including:

- protection for social care services (rather than spending) with the definition determined locally;
- seven day working in social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number;
- plans and targets for reducing A&E attendances and emergency admissions;
- risk sharing principles and contingency plans for if/when targets are not being met;
- agreement on consequential impacts of changes in the acute sector.

Impact of this settlement on CCGs

The overall impact of the settlement on CCGs will be confirmed in allocations. It is NHS England's intention to explore the scope to give CCGs 2 year allocations for 2014-15 and 2015-16 to support commissioners to deliver the changes required in the NHS to realise the necessary efficiencies.

For the average CCG, the establishment of the integration fund will mean £10m of allocated funding will be transferred to the pooled budget (in addition to the pooling of reablement and carers' breaks funding that is currently within CCG baseline allocations). This is in the context that the average CCG was allocated c£300m in 2013-14 and hence the figure is equivalent to around 3% of CCG allocations.

Under current Section 256 requirements, NHS England has to make transfers to local authorities on behalf of CCG commissioners. We believe it would be helpful to route the funding for the Integration Transformation Fund through CCGs – this will require changes to primary legislation.

Clearly, this is a very important development and it is timely that we have a Wessex Commissioning Assembly on 3 July. Therefore, I will ensure that this is included as an agenda item for that meeting.

With best wishes.

Yours sincerely

D M Fleming (Mrs)
Area Director (Wessex)
NHS England

Enc.

Annex A

Media briefing on Spending Round 2015/16

Commenting on the establishment of the new Health and Social Care Integration Fund and the overall settlement for the NHS, Sir David Nicholson, the Chief Executive of NHS England, said:

“This is a very significant settlement for the NHS. It presents both opportunities and challenges. It is a potential ‘game changer’ as it gives us the opportunity to accelerate the development of integrated services. It means we can provide more joined-up care for care for patients with complex needs, enabling them to be supported at home.

Merging health and social care budgets to support integrated care at a time when resources are constrained will require us to rethink how we organise services around patients. We need to begin formulating plans as soon as possible so that we are ready to take full advantage of the opportunities offered by the 2015/16 settlement.”

Department of Health

Refreshing the Mandate to NHS England: 2014 - 2015

Consultation

July 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Contents

1. Refreshing the Mandate

1. The Mandate to NHS England[1] sets the Government's ambitions for the NHS, as well as the funding available to achieve and deliver the kind of care people need and expect. It is how the NHS is accountable to Parliament, and therefore the public.

2. The first Mandate[2] to NHS England set objectives from April 2013 to March 2015 to provide greater stability for the NHS to plan ahead. It was drawn up following consultation with the public, health professionals and key organisations across the health and care system over the summer of 2012. It brings together the NHS Outcomes Framework[3] and commitments in the NHS Constitution[4], and challenges NHS England to deliver the best possible care and treatment for all. The current Mandate sets 24 objectives and the following five priority areas identified by the Government:

    i. Improving standards of care and not just treatment, especially for older people and at the end of people's lives
    ii. The diagnosis, treatment and care of people with dementia
    iii. Supporting people with multiple long-term physical and mental health conditions, particularly by embracing opportunities created by technology, and delivering a service that values mental and physical health equally
    iv. Preventing premature deaths from the biggest killers
    v. Furthering economic growth, including supporting people with health conditions to remain in or find work

3. Every year, the Secretary of State must publish a mandate to ensure that NHS England's objectives remain up to date and relevant following consultation.[5] In doing so, the Government is committed to providing constancy of purpose to enable the NHS to plan ahead.

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[1] Legally known as the National Health Service Commissioning Board

[2] *The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015* https://www.gov.uk/government/publications/the-nhs-mandate

[3] https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014

[4] http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

[5] In accordance with section 13A(1) of the National Health Service Act 2006

Assessing progress

4. The current Mandate sets an ambitious agenda for two years. It demands a new type of leadership from the Government and NHS England to deliver this. Only by promoting and strengthening the autonomy of local organisations, clinicians, nurses and other frontline professionals to improve and innovate, can the NHS achieve the best health and care outcomes in the world. The Government expects NHS England to demonstrate significant progress against all the objectives by March 2015 and we will hold them to account for doing so, including the areas where the Government is expecting particular progress to be made.

5. The Government is keeping progress under review through regular meetings with NHS England. To support openness and transparency, the Government will publish progress updates throughout the year on NHS England's performance against the objectives set in the Mandate.

6. In assessing NHS England's progress, success will be measured not only by the average level of improvement, but also by progress in reducing health inequalities and unjustified variation.

7. NHS England have published a business plan, setting out how they intend to deliver the objectives in the Mandate and the Government will assure itself of progress against the actions they have set out:

   http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

8. Every year, NHS England must report on progress and the Government will publish an annual assessment of their performance. Whilst the Government recognises that 2013 is a transition year, we fully expect NHS England to make progress this year. To ensure the assessment is fair, the Government will invite feedback from clinical commissioning groups (CCGs), local councils, patients and any other people and organisations that have a view, so that successes are recognised and areas for improvement can be identified and acted upon.

Updating the Mandate

9. A core aim of the Mandate is to provide constancy of purpose by setting the strategic direction for NHS England. The Government is therefore proposing to carry forward all of the existing objectives in the current Mandate. However, the scale of the challenge facing the NHS and wider health and care system is becoming increasingly clear. In addition, new developments and evidence have come to light since the publication of the Mandate in November 2012, which call on the Government and NHS England to act, in particular:

    - After the Government published the current Mandate, Robert Francis QC published his report and recommendations from the Mid-Staffordshire NHS Foundation Trust Public Inquiry. The appalling care that was exposed by both Francis inquires and the abuse at Winterbourne View, are failings of the NHS which the Government and the wider health and care system must learn from. The refreshed Mandate proposes to reflect the recommendations to transform patient care and safety over the coming year.

    - The NHS must respond to these challenges at a time of significant pressure on public finances. The recent spending round re-affirmed the Government's commitment to protecting funding for healthcare, it also demonstrates the scale of the ongoing financial challenge the NHS faces in continuing to meet demand and improve services within available resources. The Government is proposing that the Mandate will set our expectations for NHS England, as a leader of the health system, to lead the way in making the best use of resources and contributing to the growth of the economy. This includes working with social care and other key partners to drive better integration of care across different services so that taxpayer's money is spent effectively.

    - The unprecedented pressures on Accident and Emergency (A&E) services have posed a significant test to the NHS. Plans are now being put in place by NHS England to manage such demand more effectively.[6] It is important that the NHS and maintains performance

[6] http://www.england.nhs.uk/2013/05/09/sup-plan/

standards for this coming winter and beyond. However, demands on A&E are symptomatic of longer-term pressures on the NHS. Too many people are not getting the support they need to stay healthy creating pressures on existing services. To help address these challenges, the Department of Health is working with NHS England to develop a vulnerable older people's plan, which will explore how the NHS can improve out-of-hospital care. This work is considering the pivotal role that general practice plays within communities, along with how to improve urgent and emergency care, and how to remove the barriers to integration. The Government is proposing to use the refreshed Mandate to set out its ambitions for this plan.

10. By refreshing the Mandate, our aim is to provide the stability needed for NHS England to make measurable progress towards improving health and care outcomes. Where the Government is proposing to make changes, these are considered essential and are intended to provide the clarity and focus NHS England need to deliver the improvements in people's care. Where there are additional cost implications as a result of the proposals, the Government will need to consider how these can be managed within existing resources by adapting existing priorities.

Have your say

11. The Government wants to listen to your views. This consultation document sets out proposed changes to the current objectives. To help you understand the proposed changes to the objectives, this consultation document should be read together with the current Mandate which has been published as a separate annex alongside the consultation document. It can be accessed electronically via:

    https://www.gov.uk/government/publications/the-nhs-mandate

12. Alongside the Mandate refresh, the Government is proposing to update the NHS Outcomes Framework to reflect progress made in developing the placeholder outcome indicators. These will be published in the autumn.

13. The Government welcomes your views on the consultation questions we have set out throughout this document. The questions are summarised in section 4.

14. You can find out more and respond to this consultation at: https://www.gov.uk/government/consultations/refreshing-the-nhs-mandate. You can contact us via: mandate-team@dh.gsi.gov.uk.

15. **Please respond by Friday 27 September 2013.**

Question 1: *What views do you have on the proposed approach to refreshing the Mandate?*

Question 2: *What views do you have on assessing NHS England's progress to date against the objectives?*

2. Delivering improvement

Helping people live well for longer

16. Too many lives are cut short by causes which could be prevented or avoided. In recognition of this, the current Mandate sets NHS England the objective to make measurable progress towards England becoming one of the most successful countries in Europe at preventing premature deaths by 2016 (see current Mandate paragraph 1.2). In pursuit of this goal, the Secretary of State for Health in March this year, challenged the whole of the health system to work together to avoid an additional 30,000 premature deaths per year by 2020, primarily by tackling the five big killers but also childhood mortality. [7]

17. **The Government therefore proposes to update the current objective to challenge NHS England to make measurable progress towards avoiding at least 10,000 excess deaths per year by 2018, through healthcare interventions, as part of their contribution to the new system-wide ambition of avoiding an additional 30,000 premature deaths per year by 2020.**

18. It is envisaged that considerable progress could be made by NHS England working with CCGs to implement recommendations from existing strategies, such as the Cancer Outcomes Strategy and the Cardiovascular Disease Outcomes Strategy, as well as supporting Public Health England with the full roll out of the Bowel Scope Screening programme by 2016. Progress is also expected from reducing excess mortality in people with mental health problems and from suicide.

19. By supporting prevention services and earlier diagnosis of illness, through general practice and the wider primary care team, the Government expects significant progress can be made to avoid premature deaths. This includes working with Public Health England to tackle the growing problem of obesity which is linked to increasing levels of diabetes.

[7] Living Well for Longer: A call to action to reduce avoidable premature mortality: 5 March 2013

Question 3: *What views do you have on the proposal to help people live well for longer?*

Managing ongoing physical and mental health conditions

20. The current Mandate sets the objective for NHS England '*to make measurable progress towards making the NHS among the best in Europe at supporting people with ongoing health problems to live healthily and independently, with much better control over the care they receive'* (see current Mandate paragraph 2.3).

21. To achieve this goal, services must be able to respond to new and emerging challenges such as the recent unprecedented pressures on A&E. Long waiting times in A&E departments can compromise patient safety and reduce clinical effectiveness. This is unacceptable – the NHS must be able to maintain performance standards when under pressure. Plans are now in place to meet the short-term pressures and strengthen A&E services so a repeat of last winter is avoided. NHS England will also reflect on their review of the roll out of the new 111 phone line for non-emergency care to strengthen this service.

22. **The Government proposes using the refreshed Mandate to reflect the specifics of the plans to strengthen A&E services.**

Question 4: *What views do you have on using the refreshed Mandate to reflect the plans to strengthen A&E services?*

23. In tackling the issues which an ageing society presents, we need to confront the growing problem of dementia. The Prime Minister's Challenge on Dementia has shown how dementia is affecting the lives of people with the condition. In response, the current Mandate sets the objective to make measurable progress towards making the diagnosis, treatment and care for people with dementia, including support for carers, among the best in Europe by March 2015 (see current Mandate paragraph 2.11).

24. **The Government proposes updating this objective to reflect the ambition agreed by NHS England that by 2015 two-thirds of the estimated number of people with dementia in England should have a diagnosis, with appropriate post-diagnosis support.**

Question 5: *What views do you have on the proposal to reflect NHS England's ambition to diagnose and support two-thirds of the estimated number of people with dementia in England?*

Helping people to recover from episodes of ill health or following injury

25. To ensure mental health is given the same priority afforded to physical health, the current Mandate set the objective '*to put mental health on a par with physical health*, *and close the health gap between people with mental health problems and the population as a whole'* (see current Mandate paragraph 3.5). The Government expects to see improvements in the full range of mental health services for children and adults.

26. Since publication of current Mandate, it has become even more evident that there is a particular challenge around mental health crisis intervention. Often services are disjointed and we have continued to hear reports of people with acute mental health problems inappropriately spending a night in a police cell rather than getting the support and treatment they need in an appropriate setting. The Royal College of Psychiatrists' and the Independent Commission on Mental Health and Policing reports have echoed this. [8] [9] [10]

27. **The Government therefore proposes to add to the current objective by asking NHS England to:**
    - **ensure acute and emergency care for people in mental health crisis is as accessible and high-quality as for physical health emergencies. This will include close cooperation with A&E services as well as working with the police and other key partners to ensure people get the care they need in the most appropriate setting;**
    - **ensure that there is adequate liaison psychiatry services to support effective crisis care.**

[8] Whole-person care: From Rhetoric to Reality - Achieving parity between mental and physical health – published March 2013
http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx
[9] Published May 2013 http://www.wazoku.com/independent-commission-on-mental-health-and-policing-report/
[10] Published June 2013 http://www.hmic.gov.uk/publication/a-criminal-use-of-police-cells/

Question 6: *What views do you have on updating the Mandate to make it a priority for NHS England to focus on mental health crisis intervention as part of putting mental health on a par with physical health?*

28. The annual cost to the country of absence from work due to ill-health is estimated to be over £100bn.[11] We must do more to reduce this impact on business whilst improving people's lives. In the last three years, the Improving Access to Psychological Therapies (IAPT) programme has helped more than 45,000 people to come off sick pay and benefits. IAPT has wider benefits and supports other services such as health visiting. To support people with mental health problems gain and remain in employment, they need timely access to services. In the current Mandate, NHS England has been asked to comprehensively identify levels of access to and waiting times for children's and adult mental health services so the necessary improvements can be made (see current Mandate paragraph 4.15).

29. **In proposing to update the current objective, the Government is proposing to ask NHS England to take the following action:**
    - **to work with the Department and other stakeholders to develop a range of costed options for funding and implementing new access and / or waiting time standards for mental health services by the end of March 2015, and be prepared and committed to introducing those standards as they are agreed - to be announced before the end of March 2015;**
    - **to continue to extend and offer more open access to IAPT including, particularly for children and adults of working age, planning for country wide service transformation.**

Question 7: *What views do you have on the proposals to ask NHS England to take forward action around new access and / or waiting time standards for mental health services and IAPT services?*

[11] Working for a Healthier Tomorrow (2008)
http://www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf

Making sure people experience better care

30. People rightly expect the NHS to provide consistently safe and high quality service. Whilst the recent unprecedented pressures on A&E can in part be explained by the harsh winter, they are symptomatic of longer-term pressures on the NHS, driven by increasing life expectancy and increasingly complex medical conditions. Too often, it is vulnerable older people for whom the NHS is not providing effective services, with confusion and fragmentation over how care is provided. Our ambition is for improved health for the whole population, and providing excellent care for vulnerable older people, will help us get care right for everyone.

31. The Government has announced its intention to publish a plan for vulnerable older people in autumn 2013. It will set out our expectations for primary care, urgent and emergency care, and for the integration of services for the benefit of everyone. The Department of Health and NHS England will seek views on how to achieve this ambition over the summer. The initial proposals for the priority areas for action are:

    - **Better early diagnosis and support to stay healthy** – The ambition is to strengthen the GPs' role in supporting people to stay healthy, taking a proactive role in managing the health of their local populations. This management would involve identifying the people most at risk in the communities they serve and ensuring fast access to specialist care, but also supporting people to better manage their own care.

    - **Named accountable clinician** – giving patients more control over their own care will require clearer roles and responsibilities for overseeing care outside hospitals, starting with vulnerable older people. The Government proposes that the most vulnerable elderly would benefit from having someone in primary care taking responsibility for ensuring that their care is coordinated and proactively managed. Just as patients in hospitals are under the care of a named consultant, we need to ensure that when a vulnerable older patient needs follow-up or ongoing support having left hospital, that somebody is accountable for their care. Although this clinician may not provide the care directly themselves, they would be the

person with whom the buck stops and would be an identifiable point of contact for a patient or their family.

- **Improved access** – we want to improve people's access to primary care through new forms of provision including rapid walk-in access. New technologies such as e-consultations, telecare and web consultations offer new ways for people to connect with their GP and local services. We also want to make it easier for people to book appointments, for example online, as well as building on existing services and extended hours.

- **Consistent and safe out-of-hours services** – alongside improved access to GP services, we need consistent and safe urgent care services. People often need out-of-hours care but are unable to access support or know who to turn to for advice. We want better access for patients across primary care and hospital services, including 111 and emergency services.

- **Enhanced choice and control** – delivering our ambition will mean offering more choice and control to patients, carers and families. We will consider how the findings of the evaluation of the recent GP patient choice pilot can help extend choice more widely. To help exercise choice, people also need clear and accurate information about the quality and availability of services. The new Chief Inspector of General Practice will help bring greater transparency over the assessment of general practice. Feedback from patients is an important part of this. The 'friends and family test' will be introduced for general practice as part of the wider roll out for all services by end of December 2014. We will explore how we can go further in encouraging new provider models that will offer meaningful choice about the location and types of service people need, including choice of seeing your preferred GP or nurse. This includes having the option to speak with them over e-mail, telephone, video or face-to-face consultations.

- **Better information sharing** – people often require a range of services from the NHS and social care to help them live well and independently. People should not have to repeat their information. It should be shared between services and people providing the care in

a coordinated and timely way. We will explore how all clinicians and carers have access to the same information about patients regardless of setting. Better information sharing will also help people and carers to manage their own care more effectively.

32. Achieving this change would mean a stronger role for general practice, given the prominent role they play in communities and their local NHS. It will require placing general practice at the heart of out-of-hospital services, holding on to the strong relationships and values of the family doctor.

33. Improving primary care may require changes in the way services are currently commissioned and provided. Building on existing examples of innovation from general practice and wider community services, we want to stimulate new models of provision. We will be reviewing how to secure more integrated out-of-hospital care, which will involve existing commissioning bodies, NHS England and CCGs, working together to commission services collaboratively. We will also work with NHS England to explore opportunities through the CCG planning guidance and GP contracts to support integrated out-of-hospital care. The Government and NHS England will also need to work closely with Health Education England to identify how to support the workforce and encourage innovation.

34. Achieving our ambition for joined-up care is not just for general practice and will need to be considered alongside other out-of-hospital and hospital services. In particular, changes to general practice will need to build on the work of the NHS Medical Director's review of urgent and emergency care services to ensure that services are best equipped to meet modern demand and provide consistently high quality care to patients.

35. Finally, more flexible and joined up ways of working across health and care settings are needed. Too often there are real or perceived barriers to closer integration between services. We need to ensure that incentives between services providers are aligned, including removing particular barriers, for example, pricing and charging as well as using alternative models such as the year of care approach, competition and procurement. The integration pioneers provide the opportunity to test out these approaches, as part of a wider change to the way services are provided. We will also look at how we can encourage closer working between primary care and care homes.

36. **The Government is proposing to use the refreshed Mandate to ask NHS England to reflect the ambitions of the vulnerable older people's plan, with an expectation of rapid progress from April 2014.**

Question 8: *What views do you have on the ambitions and expectations for the vulnerable older people's plan?*

Question 9: *What views do you have on how we should achieve our ambitions on the vulnerable older people's plan, particularly on how to strengthen primary care?*

Question 10: *How should the ambitions for vulnerable older people be reflected in the refreshed Mandate?*

37. Robert Francis QC made public the recommendations from the inquiry into the lessons from Mid-Staffordshire NHS Foundation Trust after the Government had published the current Mandate. In the refresh, the Government proposes to reflect the five point plan in *Patients First and Foremost,* as part of our ambition to improve the care that people receive from the NHS. [12]

38. In the *Statement of Common Purpose*, NHS England signed up along with all the key organisations in the healthcare system, to learn the lessons from Mid Staffordshire NHS Trust. This includes helping to build better care for every patient and do everything in their power to ensure it does not happen again. This must be a priority for NHS England, working with partners and CQC to ensure inspection, regulation and commissioning supports frontline staff in delivering consistently safe, effective and compassionate care in line with people's needs and wishes. To help drive up standards of care, the Government has committed to introducing a Chief Inspector of Hospitals and a Chief Inspector of Social Care. In addition to this, the Secretary of State for Health has announced a new post of Chief Inspector of General Practice.

[12] Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry – Published March 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

39. **The Government is proposing a new objective for NHS England to meet their commitments in response to the Francis report, and as part of *Patients First and Foremost,* working closely with CCGs and others to implement both the substance and the spirit of the system wide response. This includes promoting and encouraging healthy open cultures, where staff are engaged and motivated to do the right thing.**

40. The shocking events that occurred at Winterbourne View hospital, as well as recent and on-going inquiries into cases of sexual violence and abuse of adults and children are an important reminder that the NHS, in partnership with local government, the police and other agencies, has responsibilities for vulnerable individuals and their safety right across the health and care system. This includes by identifying concerns, sharing information and taking prompt action.

41. **The current objective *'to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate, high quality care',* (see current Mandate paragraph 4.5). We propose to update this to reflect the actions which NHS England signed up to in the final report and concordat that was developed in response.**[13] [14]

Question 11: *What views do you have on updating the Mandate to reflect the Francis Inquiry and the review of Winterbourne View Hospital?*

42. A current objective for NHS England is to improve the way care is coordinated and delivered (see current Mandate paragraph 2.9). NHS England along with key partners across the health and care system are working together to enable and encourage local innovation, address barriers, and disseminate and promote learning in support of better integrated services for the benefit of patients, carers and local

[13] Winterbourne View Review Concordat: Programme of Action – Published December 2012
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf.pdf

[14] Transforming care: A national response to Winterbourne View Hospital. Department of Health: Final Report
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127310/final-report.pdf

communities, consistent with the proposals in the vulnerable older people's plan.

43. At the Spending Round for 2015/16 the Government announced the creation of a £3.8bn pooled health and social care budget.[15] The pool will make funding available to deliver integrated services between the NHS and local authorities more efficiently for those with complex needs based on local integrations plans which are being put in place by the end of 2013. Around half of the £1bn Payment by Results component of the pool will be dependent on performance for local areas in 2014/15. In addition, the transfer from the NHS to social care is being increased by £200m in 2014/15 to support this.

44. The Government therefore expects NHS England to support the development of integration plans in each local area in partnership with local authorities and local Health and Wellbeing Boards, with an ambition that each area moves to a wholly integrated approach to health and care by 2018.

45. **As such, the Government proposes to update the current objective to reflect *Integrated Care and Support: Our Shared Commitment*[16] and the pooled health and social care budget announced at Spending Round 2013.**

Question 12: *What views do you have on updating the objective to reflect NHS England's role in supporting person centred and coordinated care?*

46. To achieve our vision for the NHS, the Government set NHS England the objective *'to improve standards of care and experience for women and families during pregnancy and in the early years for their children'* (see current Mandate paragraph 4.11). Our ambition is to give children the best start in life and promote their health and resilience as they grow up. Since the current Mandate was published, NHS England and the Government signed up to the pledges in *Better health outcomes for children and young*

[15] Spending Round 2013 – published 26 June 2013
https://www.gov.uk/government/topical-events/spending-round-2013
[16] Integrated Care and Support: Our Shared Commitment – Published 13 May 2013
https://www.gov.uk/government/publications/integrated-care

people.[17] This seeks to improve physical and mental health outcomes for all children and young people including those with special educational needs. For NHS England this means:

- listening to and acting on what pregnant women, children, young people and their families say;
- working with partners to ensure better integrated, personalised maternity and child health services, delivered at the right time in the right place, with seamless support through key transition points from pregnancy through to adulthood;
- improving the quality of care and demonstrating improved outcomes for pregnant women, children, young people and their families.

47. **Therefore the Government proposes to update the existing objective to reflect the pledges made by NHS England to work with others to improve support for children, particularly for those most in need**.

Question 13: *What views do you have on updating the existing objective to reflect the pledges in Better health outcomes for children and young people?*

48. In the current Mandate, the Government set NHS England an objective to *'make rapid progress in measuring and understanding how people really feel about the care they receive and taking action to address poor performance*' (current Mandate paragraph 4.8). As part of this objective, NHS England was tasked with introducing the 'friends and family' test for patients across the country; starting with all acute hospital inpatients and A&E patients from April 2013 and for women who have used maternity services from October 2013.

49. **The Government is proposing to update the Mandate with progress and update the objective to challenge NHS England to introduce the 'friends and family' test to:**
    - **general practice and community and mental health services by the end of December 2014;**
    - **the rest of NHS funded services by the end of March 2015.**

[17] Better health outcomes for children and young people – published 19th February 2013 https://www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths

Question 14: *What views do you have on updating the existing objective to reflect the challenge NHS England to introduce the 'friends and family test' to general practice and community and mental health services by the end of December 2014 and the rest of NHS funded services by the end of March 2015?*

Providing safe care

50. Patient safety is critical to providing high quality care. It ranges from tackling the inappropriate use of antibiotics which are essential for managing infection to minimise antimicrobial resistance, to treating people with dignity and respect. NHS England should have stretching plans in place to significantly reduce the incidence of people catching infections, such as MRSA, whilst in hospital. This all forms part of the challenge in the objective to NHS England '*to continue to reduce avoidable harm and make measurable progress by 2015 to embed a culture of patient safety in the NHS including through improved reporting of incidents*' (see current Mandate paragraph 5.3).

51. Following Robert Francis QC's report, Professor Don Berwick, an international expert, has been asked to lead a national advisory group to review patient safety. The review will report in July on how best to quickly and efficiently ensure patient safety is an ever-present and constant feature in every NHS organisation and for every member of staff.

52. As part of the initial response to the Francis Inquiry, the Department of Health announced a review of complaints and how this information is shared and used to protect patients. It will report in the summer. The NHS Confederation is also undertaking a review of bureaucratic burdens on NHS providers so that clinicians, nurses and other health professionals can focus on delivering safe, effective and compassionate care. The Government will consider the review findings when it reports in full in September 2013.

53. **In refreshing the Mandate, the Government will consider the findings carefully including where the Government can provide leadership and appropriate challenge to ensure that NHS England achieves the current objective. We are also proposing to take account of the**

recommendations of Dame Fiona Caldicott's Information Governance Review and the Government's response.

Question 15: *What views do you have on these proposals to improve patient safety?*

Transforming services

54. To achieve these priorities will mean changing the way the NHS thinks about and provides services to people, carers and families. NHS England has a crucial role as a system leader in setting the tone for the behaviours and change we want to see from the NHS. This includes promoting autonomy of organisations and professionals and supporting local innovation to flourish. NHS England also has an important role in making partnership with other organisations a success and contributing to the delivery of key Government priorities in recognition of the broader role of the NHS in society.

55. Providers of NHS services have an important role to play in helping NHS England to deliver the objectives in the Mandate. As part of the current objective for the NHS to become more responsive and innovative (see current Mandate paragraph 6.5), NHS England is working with Monitor to create a fair playing field for providers to ensure the best possible care is offered and provided by organisations of all sizes (including small and medium enterprises) and from all sectors. This includes major improvements in procurement by the NHS.

56. **Following the publication of the Fair Playing Field Review by Monitor, the Government proposes updating the objective for NHS England to work with Monitor to drive progress towards a fair playing field for the benefit of people receiving NHS care, including through setting clear expectations for commissioners on the approach to procuring services.**[18]

Question 16: *What views do you have on the proposal to update the Mandate for NHS England to work with Monitor towards a fair playing field for providers?*

[18] Published 26th March 2013 http://www.monitor-nhsft.gov.uk/fpfr

57. To transform services, NHS England agreed to the delivery of pre-existing Government commitments that were not specifically mentioned in the Mandate itself, prior to its introduction in April 2013. This includes ensuring access to innovative radiotherapy from April 2013, where clinically appropriate, safe and cost-effective; and the commitment to an extra 4,200 health visitors by 2015 to support children and families.

58. **The Government is proposing, as part of the refreshed Mandate, to explore where additional leadership is required to support NHS England in their delivery.**

Question 17: *What views do you have on the proposal for Government to provide additional leadership on delivery of agreed pre-existing Government commitments?*

59. Technology has the potential to revolutionise the care and treatment people receive and the way patients interact with the NHS. The current Mandate sets NHS England the objective '*to achieve a significant increase in the use of technology to help people manage their health and care*' (see current Mandate paragraph 2.6). As part of achieving this, people's records should be linked in a secure way and with their consent within hospitals, between primary and secondary care, and between the NHS and wider care & support services.

60. In January 2013, the Secretary of State for Health, Jeremy Hunt, challenged the NHS to 'go digital by 2018'. The Government wants to move to paperless referrals in the NHS so that patients and carers can easily book appointments in primary and secondary care and for people to benefit from electronic prescribing in primary and secondary care.[19]

61. **The Government therefore proposes to update the existing technology objective to challenge NHS England to support the NHS to go digital by 2018.**

Question 18: *What views do you have on the proposal to update the objective to challenge NHS England to support the NHS to go digital by 2018?*

[19] http://systems.hscic.gov.uk/eps

62. The current Mandate sets the objective '*to shine a light on variation and unacceptable practice, to inspire and help people to learn from the best. The Government wants a revolution in transparency – so that the NHS leads the world in the availability of information about the quality of services*' (see current Mandate paragraph 3.3).

63. **The Government proposes clarifying this objective to make more explicit the Government's expectation that this must include reporting on the quality of services at GP practice level and also at the level of consultant-led teams for a number of specific specialties.**

Question 19: *What views do you have on the proposal to be more explicit on the expectation around reporting?*

Supporting economic growth

64. In helping to secure the recovery of the economy, NHS England has to contribute to economic growth as part of its objectives in the current Mandate (see current Mandate paragraph 7.2). NHS England can make a significant contribution in a number of ways, for example, supporting services which get people back to work; through greater and more creative collaborations with healthcare partners in industry and academia; and helping to translate research findings into health and economic benefits. NHS England also has an important leadership role, such as continuing to support the Strategy for UK Life Sciences and Healthcare UK [20] and in spreading innovation throughout the NHS to improve outcomes for patients and deliver value for money in line with *Innovation, Health and Wealth.*[21]

65. In a digital age, Government expects NHS England, CCGs, other Arm's Length Bodies and partners to maximise the opportunities technology presents, including anonymised health and care information, for the benefit of patients. This would help create an environment that supports economic growth, research and innovation. For example, genomics technology is recognised as one of the most important health care opportunities of modern times. It has the potential to revolutionise cancer treatments,

[20] https://www.gov.uk/government/news/life-sciences-strategy-one-year-on
[21] https://www.gov.uk/government/publications/creating-change-innovation-health-and-wealth-one-year-on

improve early diagnosis of rare diseases and management of infectious diseases.

66. **The Government therefore proposes updating the objective (see current Mandate paragraph 7.2), by asking NHS England to:**
    - **Support innovation by working with the Department of Health and others to help drive forward the Prime Minister's initiative, announced in December 2012, to sequence 100,000 whole genomes over the next three to five years by supporting its implementation and delivery and by preparing the NHS for the adoption of genomic technologies.**[22]

Question 20: *What views do you have on the proposals to update the objective in asking NHS England to support the recovery of the economy where they can make an important contribution?*

Making better use of resources

67. At a time of significant pressure on public finances, it is crucial that NHS England makes every pound count towards providing high quality care. The Mandate currently sets an objective for NHS England *'to ensure good financial management and unprecedented improvements in value for money across the NHS'* (see current Mandate paragraph 8.1).

68. The Government wants to make sure NHS money is spent on providing the best possible care. This requires NHS England to stamp out poor practice, eliminate waste and inefficiency and make the best use of clinical audit data, from both children and adults, to drive improvements in services.

69. As part of this, the Government feels that the current system for charging overseas visitors for NHS care does not work as well as it should and we want to change it to be more effective. Visitors and temporary migrants should make a fair contribution to any care they receive from the NHS. In particular, it is important to ensure that those who come to the UK with the intention of seeking free NHS treatment to which they are not entitled (often referred to as 'health tourists') are identified and charged. Currently the NHS does not do enough to recover these costs. It is important to

[22] https://www.gov.uk/government/news/dna-tests-to-revolutionise-fight-against-cancer-and-help-100000-nhs-patients

service users and taxpayers that NHS England should have measures in place to ensure that they do. The Government and the NHS are looking into the scale of the problem, and we are consulting separately over the summer on a package of measures for a fair and transparent payment system for overseas visitors accessing the NHS.

70. **Subject to the consultation and independent audit, the Government proposes updating the current objective so that it includes NHS England taking steps to ensure NHS organisations recover the costs they incur from overseas visitors where appropriate. The Government also proposes asking NHS England to take more effective action to reduce fraud and unlawful activity affecting the NHS.**

Question 21: *What views do you have on the proposals to make better use of resources?*

3. Getting involved

71. **This consultation will run from 5 July 2013 to 27 September 2013.**

72. You can find out more and respond to this consultation at: https://www.gov.uk/government/consultations/refreshing-the-nhs-mandate. You can contact us via: mandate-team@dh.gsi.gov.uk

Comments on the consultation process itself

73. If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
2e08, Quarry House
Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk
Please do not send consultation responses to this address.

Confidentiality of information

74. The Department will manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter[23].

75. Information the Department receives, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

76. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If the Department receives a request for disclosure of the

[23] http://transparency.dh.gov.uk/dataprotection/information-charter/

information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

77. The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

4. Consultation questions

- **Question 1:** What views do you have on the proposed approach to refreshing the Mandate?
- **Question 2:** What views do you have on assessing NHS England's progress to date against the objectives?

Helping people live well for longer

- **Question 3:** What views do you have on the proposal to help people live well for longer?

Managing ongoing physical and mental health conditions

- **Question 4:** What views do you have on using the refreshed Mandate to reflect the plans to strengthen A&E services?
- **Question 5:** What views do you have on the proposal to reflect NHS England's ambition to diagnose and support two-thirds of the estimated number of people with dementia in England?

Helping people recover from episodes of ill health or following injury

- **Question 6:** What views do you have on updating the Mandate to make it a priority for NHS England to focus on mental health crisis intervention as part of putting mental health on a par with physical health?
- **Question 7:** What views do you have on the proposals to ask NHS England to take forward action around new access and / or waiting time standards for mental health services and IAPT services?

Making sure people experience better care

- **Question 8:** What views do you have on the ambitions and expectations for the vulnerable older people's plan?
- **Question 9:** What views do you have on how we should achieve our ambitions on the vulnerable older people's plan, particularly on how to strengthen primary care?
- **Question 10:** How should the ambitions for vulnerable older people be reflected in the refreshed Mandate?
- **Question 11:** What views do you have on updating the Mandate to reflect the Francis inquiry and the review of Winterbourne View Hospital?
- **Question 12:** What views do you have on updating the objective to reflect NHS England's role in supporting person centred and coordinated care?
- **Question 13:** What views do you have on updating the existing objective to reflect the pledges in *Better health outcomes for children and young people*?

- **Question 14:** What views do you have on updating the existing objective to reflect the challenge for NHS England to introduce the 'friends and family test' to general practice and community and mental health services by the end of December 2014 and the rest of NHS funded services by the end of March 2015?

Providing safe care

- **Question 15:** What views do you have on these proposals to improve patient safety?

Transforming services

- **Question 16:** What views do you have on the proposal to update the Mandate for NHS England to work with Monitor towards a fair playing field for providers?
- **Question 17:** What views do you have on the proposal for Government to provide additional leadership on delivery of agreed Government pre-existing commitments?
- **Question 18:** What views do you have on the proposal to update the objective to challenge NHS England to support the NHS to go digital by 2018?
- **Question 19:** What views do you have on the proposal to be more explicit on the expectation around reporting?

Supporting economic growth

- **Question 20:** What views do you have on the proposals to update the objective in asking NHS England to support the recovery of the economy where they can make an important contribution?

Making better use of resources

- **Question 21:** What views do you have on the proposals to make better use of resources?

Southampton City
Clinical Commissioning Group

EXTRACT

MIU Pilot Evaluation and Options for the Future
June 2013

1 Introduction:

In response to winter pressures, CCG's agreed a QIPP plan to increase the number of minor injuries seen at the RSH MIU to support a corresponding reduction in the attendances at the UHS ED, and the key driver was identified as a mismatch between the availability of Radiology services and the opening hours of the existing nurse-led service. Patients who could clinically have attended the RSH were attending UHS instead in order to have an X-Ray., Furthermore, audits by GP practices in Southampton City identified a cohort of patients who were attending the MIU initially and then being redirected to UHS. The view from practices was that this was not good patient experience. The pilot would also help to flex staffing skills, training and capacity across a wider pool with Solent.

A three month pilot was established to extend the radiology opening hours at the MIU for 5 hours per day from 5pm to 10pm. It was agreed as part of the pilot that UHSFT would deliver the Radiology service and pick up the total MIU activity as Type 3 attendances, with a short-term contractual agreement between commissioners and Solent. The pilot was funded by SC CCG out of winter pressures monies to UHSFT, and by West Hampshire CCG as non-contracted activity under PbR.

Early indications showed success in diverting activity away from UHS as well as reducing the level of people being redirected from the MIU to UHS. The initial evaluation also showed that the revised service was popular with patients and the ambulance service, so it was agreed to extend the pilot to the end of Q1 2013-14 to thoroughly evaluate the benefits in May.

2 Evaluation report

Key findings from the evaluation report were:

- The data from the evaluation period (between Feb – May) has shown that 494 x-rays have been carried out after 5pm. This would produce an assumed annual minimum activity figure of 1482, or approximately 30 per week, although it is clear that activity is increasing the longer the service remains available.

- It is agreed by everyone involved in the evaluation that the patients x-rayed at the MIU would otherwise have attended the UHS ED if this extended radiology service was not available.

- The difference in cost of patients attending the MIU as opposed to ED is £74,100 (full year). The ED cost is £158,574 against the MIU cost of £84,474 – assuming a tariff rate is charged at both

- Patient and staff feedback was positive, including feedback from ambulance crews.

Stakeholders concluded that the continuation of an extended Radiology service as part of the MIU service had proved popular and effective.

3 Options for CCG consideration

The proposed costs (from UHS) to extend the radiology service between 5pm – 10pm for a full year were £76,600 with a one off payment of £20,000 for equipment purchases. Part year, from 1st July the costs would be £57,450. The tariff cost at the same rate of activity for 9 months would be £63, 356.

The increase in patient attendances during the pilot had arisen from a limited amount of publicity. If these extended hours were to continue a communications plan would be in place to increase appropriate attendances at MIU.

Procurement advice was clear that the revised service would need to be tendered in due course.

The three options following the MIU Pilot Evaluation are:

Option 1: Stop the extended hours radiology and return to previous arrangements (radiology stopping at 5pm; Solent providing nurse-led MIU)

Option 2: Continue the extended hours service: Request that Solent provides extended hours radiology within its existing MIU contract

Option 3: Continue the extended hours service: Request UHSFT to continue piloting the service for the remainder of the year, while serving notice on the existing Solent contract and going out to tender a comprehensive MIU service to a revised specification

4. Decision

Option 1 has higher risks than Options 2 and 3; Option 3 has slightly lower risk and higher benefits

SMT considered that Option 1 was not preferred and that Option 3 was more favourable than Option 2, in light of risks and benefits.

SMT recommends that the CCG go out to tender for a comprehensive MIU service to start from 1 April 2014, and that UHSFT be asked to continue running the service for the remainder of the year.

Southampton City
Clinical Commissioning Group

Senior Management Team 4th July 2013

Procuring a local Wheelchair Service

Background

The Wheelchair Service, currently located at the Josian Centre, Empress Road, Southampton, provides the clinical assessment and provision of wheelchairs to Southampton clients over 2 ½ years of age who have a condition affecting their mobility. Once provision of service is established, the Wheelchair Service will continue to support and reassess the clients' and maintain the equipment provided.

Referrals are made in to the service primarily by primary care clinician's and General Practitioners although some are made by secondary care clinician's.

The current provider of Wheelchair Services for Southampton city is Solent NHS Trust however the provider has given twelve months' notice to Southampton City CCCG and the other CCG's for whom it is also the provider, of its intention to cease providing the service on 31st March 2014. This decision necessitates a re-procurement of the Wheelchair Service and discussions have taken place with neighbouring CCG's to investigate the feasibility of a collaborative procurement.

NHS Southampton City CCG, NHS Portsmouth CCG, NHS Fareham and Gosport CCG, NHS South Eastern Hampshire CCG, West Hampshire CCG and NHS England, Specialised Commissioning have all expressed a desire for a single collaborative procurement. NHS Portsmouth CCG has expressed a desire to take a leading role in the procurement and the organisation of the working group.

Offering a contract length of 5 years with the option to extend for 2 years is recommended by the Project Group with a view to generating interest from prospective providers as well as negating the necessity for a re-procurement 18 – 24 months into a 3 year contract.

A number of options regarding the structure of the contract are available namely one large contract with separate partnership arrangements for all parties, one large contract with one named lead CCG or separate CCG contracts with NHS England listed as an Associate to each contract.

Benefits

The principal benefits relate to:

- Provider engagement:
    - Greater interest in one large tender, particularly at a time when there are an unprecedented number (18) of similar services out to tender across the UK.
- Service economies of scale:
    - Single overhead costs;
    - Bulk supply economies;
    - Aligned service specification;
    - Aligned equipment/wheelchair catalogue;
    - Shared bespoke/non-contract wheelchair opportunities;
    - Single referral route.

- Procurement savings:
  - Single tender:
    - Cost;
    - Time.
  - Single evaluation panel;
  - Shared experience and expertise.
- Public perception regarding collaborative, joined up NHS working;
- Financial control and stability of price.

Primary Objectives

To enter into a collaborative procurement for a single Wheelchair Service with one Provider:

- Agree the contract length:
  - It is recommended that a 5 year contract with an option to extend for 2 years is entered in to:
    - Increased provider investment;
    - Stabilised local services;
    - Reduced procurement time.
- Agree the contract structure:
  - One large contract with separate partners and leads;
  - One large partnership contract but with one overall lead;
  - Separate contracts with NHS England an associate to each contract.
- Engage in discussion and consultation with all parties interested in engaging in a collaborative procurement to agree:
  - an identical and aligned service specification by agreement;
  - an identical and aligned equipment/wheelchair catalogue by agreement;
  - jointly prepare a restricted tender;
    - agree PQQ detail;
    - agree ITT detail.
- Evaluation panel members
- Commission/procure a service to deliver that service

Secondary Objectives

- Consult with clinicians and patients to identify how the Wheelchair Service is received currently, how it should be received in the future and the level of support that should be provided to patients;
- Undertake a procurement that identifies the most appropriate provider for the provision of a Wheelchair Service, with consideration given to value for money
- Following the procurement, mobilise the preferred bidder to implement the Wheelchair Service with a start date of 1st April 2014;
- Support the preferred bidder to start receiving referrals for new patients through the agreed pathway;
- Review and/or develop an appropriate reporting suite demonstrating the on-going quality of Wheelchair Service provision and ensuring performance data is robust and provided within agreed timescales.

Risks

- <u>Financial</u>
  The SCCCG 2012/13 planned budget for the Wheelchair Service was £556,697 with the actual spend £988,361 an overspend against plan of 77.5% (the provider is currently undertaking a rebasing exercise). Planned activity for 2012/13 was 2851, actual activity 5487, an over performance of 92.4% against plan.

£320,580.14 (59.4% of the budget) has been removed from the 2013/14 SCCCG budget and transferred to NHS England, Specialised Commissioning. Thus the SCCCG 2013/14 Wheelchair Service budget is £219,169.40.

Data for the current fiscal year is not yet available from the provider, as such assumptions have been made regarding the planned and actual spend and activity.

- Operational
  It is currently unclear which operational elements of the Wheelchair Service have been included within the Specialist Commissioning specification, therefore a project is currently underway (undertaken by NHS England) to determine the detail of these service elements. It is essential that these elements are identified as quickly as possible to enable the SCCCG service specification to meet the requirements of the service.

- Resource
  A working group has been established with representation from each CCG interested in a collaborative procurement. Portsmouth CCG have currently taken a lead role in setting up working meetings, taking notes and leading a large proportion of the necessary tasks.

  It should be noted however, that in order to achieve the timescales required for a restricted procurement exercise, a great deal of time will be required by the Project Lead to fulfil the relevant tasks.

- Stakeholder consultation
  SCCCG has recently engaged in consultation with Users through the utilisation of a questionnaire circulated by Portsmouth CCG but added to by SCCCG, responses are currently limited. The SCCCG Project lead also intends to consult with User Forums and Third Sector organisations as widely as is possible during the limited timescales available.

- Tender timescales

  In order to enter in to a restricted procurement exercise, the following timescales are estimated:

Tender Timescales (estimated by Solent Supplies):

Milestone	Action	Stakeholders	Timescale (by)
1	Initial OJEU advert inviting providers to comment on proposals	Project Managers Providers	22 July 2013
2	Joint pathway and service specification developed and agreed	Project Managers Commissioners Providers Patients	July 2013
3	**Tendering process**	Project Managers NHS Procurement Commissioners	July - December 2013
3a	OJEU (and others) advert asking for Expressions of Interest		
3b	PQQ and MOI		
3c	Short listing		
3d	ITT and evaluation/confirmation of outcome		
4	Contract award and Mobilisation	Project Managers Commissioners Preferred Bidder	January – March 2014
5	Service Commencement	Preferred Bidder	1st April 2014

Recommendations

SCCCG Senior Management Team is asked to give its approval for:

- single collaborative procurement between NHS Southampton City CCG, NHS Portsmouth CCG, NHS Fareham and Gosport CCG, NHS South Eastern Hampshire CCG, West Hampshire CCG and NHS England, Specialised Commissioning;
- NHS Portsmouth CCG acting as the lead for the scoping and procurement phases;
- contract length of 5 years with the option to extend for 2 years;
- a separate SCCCG contract with NHS England listed as an Associate to the contract.

Summary

A single collaborative Wheelchair Service procurement including NHS Southampton City CCG, NHS Portsmouth CCG, NHS Fareham and Gosport CCG, NHS South Eastern Hampshire CCG, West Hampshire CCG and NHS England, Specialised Commissioning would reduce tendering costs in terms of resource and time as well as taking advantage of the experience and expertise of all the CCG's.

Utilising the resource of NHS Portsmouth CCG to act as lead in the scoping and procurement of the service would greatly assist the workload of the SCCCG Project lead.

Opting for a 5 year contract with the option to extend for a further 2 years would stimulate a great deal of interest in the market place, particularly for a large multi-commissioner service therefore ensuring that a competitive value for money procurement exercise is undertaken.

Entering in to a contractual arrangement with one large service provided by one organisation but retaining a separate SCCCG contract would enable SCCCG to maintain an independent

approach whilst benefitting from the collaborative arrangements with neighbouring CCG organisations

Richard Nicholson
Interim Senior Commissioning Manager – Long Term Conditions
2 July 2013

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DECISION-MAKER:		**HEALTH OVERVIEW AND SCRUTINY PANEL**		
SUBJECT:		UNIVERSITY HOSPITAL SOUTHAMPTON; UPDATE ON EMERGENCY DEPARTMENT / MONITOR AND THE CHILD HEART SURGERY REVIEW		
DATE OF DECISION:		18th JULY 2013		
REPORT OF:		UHS CHIEF OPERATING OFFICER AND UHS, DIRECTOR OF COMMUNICATIONS AND PUBLIC ENGAGEMENT		
CONTACT DETAILS				
AUTHOR:	**Name:**	Alison Ayres	**Tel:**	023 8079 6241
	E-mail:	Alison.Ayres@uhs.nhs.uk		
Director	**Name:**	Alastair Matthews, Interim Chief Executive and Finance Director	**Tel:**	**023 80**
	E-mail:	alastair.matthews@uhs.nhs.uk		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

Following the recent underperformance of the University Hospital Southampton Emergency Department A&E targets Jane Hayward, USH Chief Operating Officer, will give the Panel an update on the progress to date.

RECOMMENDATIONS:

(i) That the panel notes the progress to achieve A&E targets at the University Hospital Southampton, and following discussions with the Chief Operating Officer agrees any issues that may need to be brought forward to a future HOSP meeting.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the HOSP's terms of reference the panel has a role to respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. Following a prolonged period of underperformance against the 4-hour A&E operating standard during Q4 11-12 and Q1 12-13, and with encouragement from the CCG, University Hospitals Southampton (UHS) commissioned the national Emergency Care Intensive Support Team (ECIST) to undertake a review of the unscheduled care pathway within trust. The review took place

in mid-June 2012 and the trust is now implementing the recommendations. The outcomes and recommendations of this review were reported to the panel on 31st January 2013.

4. Since the initial report Monitor, the health sector regulator, has announced that it is investigating whether the University Hospital Southampton NHS Foundation Trust has breached conditions of its licence due to persistent breaches of their A&E targets.

5. At the last panel meeting on 18th July 2013 the hospital outlined the latest UHS Emergency Department's performance. It was agreed by the panel to receive an update at future HOSP meeting until the situation at the emergency department is resolved. The latest update is attached at Appendix 1. A further update will be given at the panel meeting by Jane Hayward, UHS Chief Operating Officer.

6. The panel are asked to note the latest performance and consider any issues that may need to be brought forward to a future HOSP meeting.

RESOURCE IMPLICATIONS

Capital/Revenue

12. None

Property/Other

13. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

15. None

POLICY FRAMEWORK IMPLICATIONS

16. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	UHS: Update On Emergency Department Performance September 2013

Documents In Members' Rooms

	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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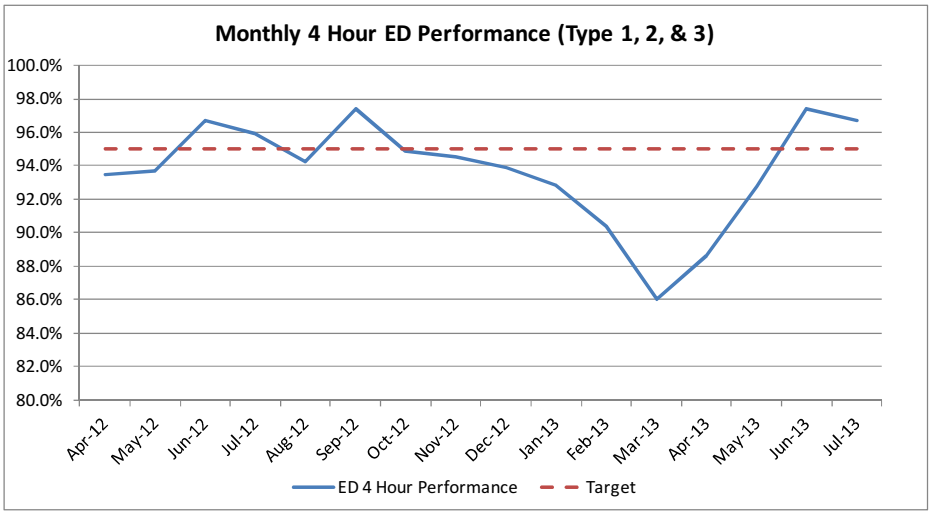
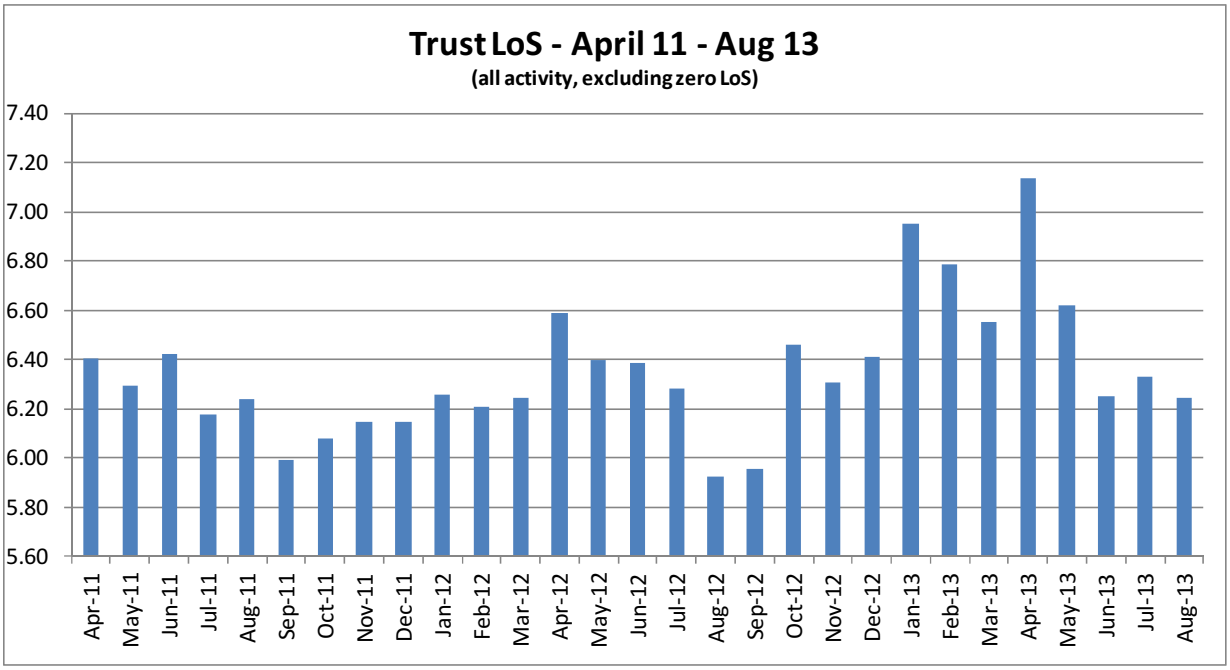
University Hospital Southampton NHS
NHS Foundation Trust

Emergency Department Report for Overview and Scrutiny Committee – September 2013

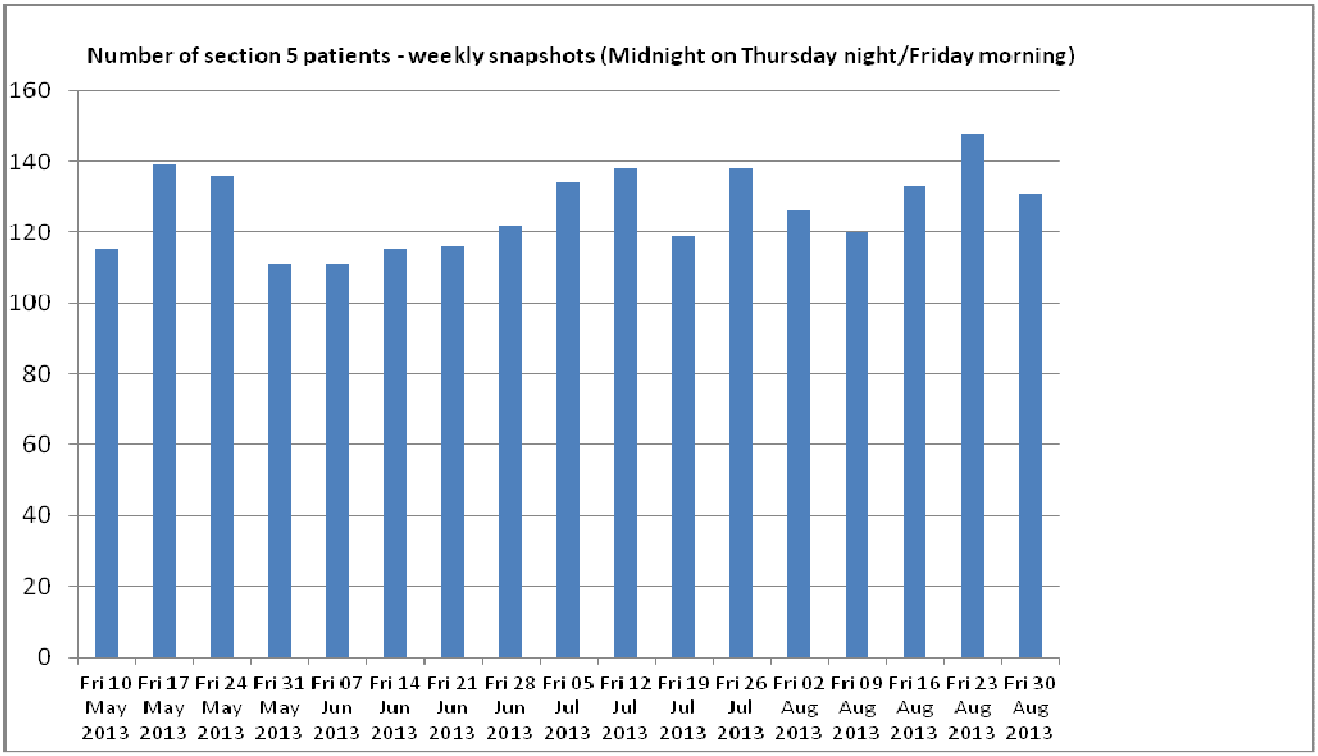
There had been significant improvement in the ED performance in the last few months and 96% of patients were treated and admitted or treated and discharged within 4 hours of arrival.



In particular the bed availability situation has improved in the hospital since the winter allowing patients to be admitted in a timely manner.



Delayed discharge of care remains of particular concern. Whilst there has been some improvement in processing patients through the system, patients remain in hospital to undertake clinical and social assessments, or while waiting for the most appropriate facility or placement to become available. On any one given day there are over 120 patients (out of 1000) who are medically fit, but not discharged for these reasons. The health and social care system's ambition is to reduce this to 50. This recently peaked at 155 patients. This is a significant cause for concern.



Looking forward a summer plan has been prepared and the hospital will be fully staffed and all ward beds will remain open. This will help support a reduction in waiting times for patients having planned surgery.

As we approach the winter we have a 4 point plan to ensure we can continue to deliver a good service to patients;

A) We will open a further 74 beds to support an increase in winter acuity and reduce occupancy. This will include a new isolation ward to mitigate the impact of any seasonal norovirus in the community.

B) We will minimise length of stay by ensuring patients do not have unnecessary waits (for things like X-ray), increase the number of times patients see doctors to ensure their care is always moving forward, improve systems on the day of discharge so that transport and medicines are in place and improve continuity of care for elderly care patients between a hospital admission and care in the community.

C) We will increase the staffing in ED and change our processes so that patients' care can be undertaken as quickly as possible.

D) We will work with our colleagues in social services, community care providers and the private sector to create new services and change processes to reduce delays. In particular we will develop new support services for patients who are non-weight bearing, those with housing issues, bariatric patients and those that need 3 or 4 times a day visits. This should create 100 virtual beds in the community system.

Our winter plan (the remedial action plan) has been approved by our commissioners (the CCGs) and shared with our regulators Monitor.

Jane Hayward
Chief Operating Officer
JH/mfh
02/09/13

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		OPERATING PROTOCOL BETWEEN HEALTH AND WELLBEING BOARD, HEALTH OVERVIEW AND SCRUTINY PANEL, AND HEALTHWATCH SOUTHAMPTON		
DATE OF DECISION:		13 AUGUST 2013		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Martin Day**	**Tel:**	**023 8091 7831**
	E-mail:	**Martin.day@southampton.gov.uk**		
Director	**Name:**	**Dr Andrew Mortimore**	**Tel:**	**023 8083 3204**
	E-mail:	**Andrew.mortimore@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The Health and Social Care Act set out the roles and responsibilities of Health and Wellbeing Boards and local Healthwatch. It also modified the responsibilities of Health Overview and Scrutiny Committees. This report contains a protocol setting out the respective roles and responsibilities of these bodies, and a framework for handling key issues.

RECOMMENDATIONS:

(i) That the draft protocol set out in Appendix 1 be approved;

(ii) That the draft protocol be referred to the Health Overview and Scrutiny Committee and Healthwatch Southampton for consideration and approval; and

(iii) That authority be delegated to Director of Public Health, after consultation with the Chair, to make any drafting or other amendments required following consideration by the Health Overview and Scrutiny Panel and Healthwatch Southampton that do not affect the spirit of the intentions of the protocol.

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure a common operational understanding between the Health and Wellbeing Board, the Health Overview and Scrutiny Panel and Healthwatch Southampton.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not to develop a protocol. The risk of following this course of action is that it is more likely to lead to opportunities for confusion and misunderstandings.

DETAIL (Including consultation carried out)

3. The Health and Social Care Act 2012 established Health and Wellbeing Boards, local Healthwatch and it amended the responsibilities of Health Overview and Scrutiny Committees. The annual meeting of the Council in May 2013 required the development of the protocol.

4. A draft protocol is attached at Appendix 1. It has been produced by officers supporting democratic services, the Health and Wellbeing Board, Health Overview and Scrutiny and Healthwatch Southampton and shared informally with Healthwatch Southampton and the chairs of the Health and Wellbeing Board and the Health Overview and Scrutiny Panel. It summarises key elements of the roles of the respective bodies, and then sets out responsibilities for:

    - Commissioning and decommissioning services
    - Significant changes and variations to services
    - Engagement with stakeholders, residents and service users
    - Quality and inspection
    - Safeguarding
    - New legislation and changes to the legal framework
    - Engagement with other health bodies

5. It is anticipated that the protocol will need to change over time in order to reflect developments across health and care systems. For this reason it is proposed that the protocol should be reviewed annually at the start of each municipal year. If there are significant changes to the health and care system architecture or the democratic or public engagement processes, then it will be reviewed as necessary during the course of the year.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None.

Property/Other

7. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. The Health and Social Care Act 2012 sets out the legal framework for the operation of Health and Wellbeing Board, local Healthwatch, and made changes to the responsibilities of Health Overview and Scrutiny Committees.

Other Legal Implications:

9. None

POLICY FRAMEWORK IMPLICATIONS

10. None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	None

SUPPORTING DOCUMENTATION

Appendices

1.	Protocol between Southampton Health and Wellbeing Board, Healthwatch Southampton and Southampton City Council Health Overview and Scrutiny Panel.

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None.	

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Appendix 1

Protocol between Southampton Health and Wellbeing Board, Healthwatch Southampton and Southampton City Council Health Overview and Scrutiny Panel

Introduction

1. The Health and Social Care Act 2012 identified a range of individual and joint responsibilities for Health and Wellbeing Boards local Healthwatch (known in the city as Healthwatch Southampton), and Health Overview and Scrutiny Committees (know in Southampton as the Health Overview and Scrutiny Panel). This paper sets out a protocol between the three bodies to facilitate an understanding of responsibilities and to identify where separate and joint working will be undertaken.

Overview of the Roles of the Three Bodies

2. The Health and Wellbeing Board, Health Overview and Scrutiny Panel and Healthwatch Southampton share a common interest in improving the health of people living in the city and in reducing health inequalities, and share a desire to engage with all communities including those identified as harder to reach.

3. The Health and Wellbeing Board (HWB) is responsible for producing a Joint Strategic Needs Assessment (JSNA), a Joint Health and Wellbeing Strategy (JHWS) and for seeking to integrate services. The Health and Social Care Act 2012 makes a representative of local Healthwatch a statutory member of the Health and Wellbeing Board.

4. Healthwatch Southampton (HWS) is independent of the Council and the NHS. It is responsible for undertaking patient and public engagement activities, providing a signposting and advice service to support individuals in exercising choice over access to and use of services, and for providing a NHS complaints advocacy service. HWS has a seat on the HWB, through which it can ensure that the patient and public views are represented when strategic decisions are taken. Currently, it also has a seat on Southampton City Clinical Commissioning Group, and a standing invitation to attend meeting meetings of the Health Overview and Scrutiny Panel.

5. The Health Overview and Scrutiny Panel has responsibility for scrutinising social care issues in the city, responding to proposals for significant variations and reconfigurations of health services, and working in partnership with other HOSC areas as appropriate.

General Principles

6. Whilst the respective roles of each body are acknowledged as respected by the others, where appropriate two or more of the bodies will work on a project or piece of work either jointly or independently. At the outset of any such work a written statement will be produced summarising the actions and areas of activities each body will pursue. Any published

material arising from the work will acknowledge the contributions of all participating bodies.

Developing the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy

7. The Health and Wellbeing Board has a legal duty to develop the JSNA and the JHWS. It will engage with Healthwatch Southampton and the Health Overview and Scrutiny Panel, initially to set out draft proposals, and then at a later stage to review a final draft. Healthwatch Southampton will be invited to collect and contribute views from the public to both the JSNA and the JHWS.

Commissioning and Decommissioning Services

8. The Health and Wellbeing Board will set a strategic direction for the commissioning of services. It will review the annual commissioning plans from the Clinical Commissioning Group, NHS England and the Council's social care services to ensure they address the needs identified in the JSNA and the actions set out in the JHWS. Changing commissioning plans may result in some services being decommissioned or being delivered differently.

9. Healthwatch Southampton will be active in assessing residents' and patients' views on proposals. The Health Overview and Scrutiny Panel will hold the Health and Wellbeing Board, the council Cabinet or the CCG to account for commissioning and decommissioning decisions. The Health Overview and Scrutiny Panel will undertake the scrutiny of social care issues, including the draft local account, unless they are Forward Plan items, in which case they .may be considered by the Overview and Scrutiny Management Committee.

Significant Changes and Variations to Services

10. Provider organisations may, from time to time, seek to re-configure services in response to commissioning plans, or to their own organisational development programmes. The Health Overview and Scrutiny Panel will use its current rules to determine whether any scenario qualifies as a "substantial variation", which would require consideration at a meeting. It will check with Healthwatch Southampton to ascertain whether there are issues that Healthwatch has existing intelligence on, or would be able to make a significant contribution to.

Engagement With Stakeholders, Residents and Service Users

11. The changes that need to be delivered to provide sustainable health and care services in the future will require input and support from a wide range of stakeholders. Each of the bodies included in this protocol will need to ensure it has the appropriate mechanisms to deliver effective engagement with the appropriate stakeholders.

12. The Health and Wellbeing Board will from time to time undertake stakeholder engagement exercises. These will seek to highlight needs and pressure, set the agenda for change in the light of national priorities and frameworks, and showcase innovation and best practice from within

the city and further afield. The stakeholders invited will vary according to the subject of each event.

13. The Health and Wellbeing Board is legally required to engage local residents and stakeholder on the development of the JSNA and the JHWS.

14. Healthwatch Southampton has at its core ongoing and meaningful engagement with people living, or receiving services, in Southampton. It will operate a range of engagement activities with a wide range of communities, using a wide range of methods, including focus groups, surveys and social media. The outcomes from engagement will be fed, as appropriate, to service providers, NHS England, the Health and Wellbeing Board, CCG and City Council. Healthwatch Southampton will also help collect views from the public as the JSNA and JHWS are developed.

15. The Health Overview and Scrutiny Panel will be able to invite any interested stakeholders to attend individual meetings where they can contribute to the business of the meeting and to engage in inquiries relating to health and wellbeing issues in the city.

Quality and Inspection

16. The Health and Wellbeing Board will take a strategic lead on ensuring quality, safe services are commissioned. It will consider findings of relevant government and other national studies. Healthwatch Southampton will develop intelligence on patient and user experiences, using its enter and view powers where appropriate. Where significant issues are identified, Healthwatch Southampton will refer the matters to the CCG or the local authority as appropriate. Both Healthwatch Southampton and the Health Overview and Scrutiny Panel will monitor reports from national inspection bodies, and where problems are identified, undertake an examination of the issues. The Health Overview and Scrutiny Panel will schedule agenda items where appropriate and request the attendance of appropriate officers from provider organisations. It may also wish to hold meeting with representatives of the Care Quality Commission (CQC) where appropriate. Healthwatch Southampton may also seek meetings with CQC. There maybe occasions when the Health Overview and Scrutiny Panel and Healthwatch Southampton may consider a joint meeting with CQC as the best means resolving a significant issue that has been identified.

Safeguarding

17. The Health and Wellbeing Board will receive the annual reports of the Southampton Safeguarding Children Board and Southampton Adult Safeguarding Board. Where significant issues are raised in the documents, it may request such further detailed reports as it deems appropriate.

18. Healthwatch Southampton will use patient complaints, advocacy and other intelligence to identify safeguarding issues. The Health Overview

and Scrutiny Panel will assess whether appropriate responses are being undertaken to any issues identified.

New Legislation and Changes to the Legal Framework

19. The Health and Wellbeing Board will consider the implications of new legislation and assess the likely impact and opportunities across health and care systems. Both the Health and Wellbeing Board and Health Overview and Scrutiny Panel may wish to respond separately to legislative proposals and consultations, where they may legitimately agree separate conclusions. Healthwatch Southampton may also choose to examine such proposals and assess the impact on patients and service users.

Other Bodies and Future Developments

20. The new landscape for health, care and wellbeing developed under the Health and Social Care Act is still embedding. NHS England Local Area Team has a seat on the Health and Wellbeing Board. The Health Overview and Scrutiny Panel and Healthwatch Southampton will monitor the quality of services of services commissioned by NHS England for the people of Southampton.

21. Public Health England (PHE) is not represented on either the Health and Wellbeing Board or Health Overview and Scrutiny Panel. The Health and Wellbeing Board and Health Overview and Scrutiny Panel may request PHEs attendance at meeting where they are considering issues which PHE has responsibility for delivering.

Conclusion

22. This protocol has been considered and agreed by the Health and Wellbeing Board, Health Overview and Scrutiny Panel and Healthwatch Southampton. It is advisory, and for the Health and Wellbeing Board and Health Overview and Scrutiny Panel is a subsidiary document to the Council Constitution. The protocol will be reviewed at the start of each municipal year and updated in the light of experience and wider developments.