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Southend-on-Sea Borough Council

Department of the Chief Executive
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Our ref:		Telephone:	**01702 215000**
Your ref:		Fax:	**01702 215994**
Date:	2nd October 2018	E-mail:	**committeesection@southend.gov.uk**
Contact Name:	Fiona Abbott	DX 2812 Southend	

PEOPLE SCRUTINY COMMITTEE
- TUESDAY, 9TH OCTOBER, 2018

Please find enclosed, for consideration at the next meeting of the People Scrutiny Committee taking place on Tuesday, 9th October, 2018, the following report which was unavailable when the agenda was printed.

Agenda No	Item
6.	**Mid and South Essex STP (Pages 1 - 84)**

Report of Deputy Chief Executive (People)

Please note - this is the link to the document referred to at **Appendix 6** in the report:-

http://www.nhsmidandsouthessex.co.uk/have-your-say/outcome-of-consultation/

Fiona Abbott
Principal Democratic Services Officer

Southend-on-Sea Borough Council

Report of Deputy Chief Executive (People)
to
People Scrutiny Committee

On 9th October 2018

Report prepared by:
Nick Faint, Integration Programme Lead &
Fiona Abbott, Principal Democratic Services Officer

Agenda Item No.
6

Council Motion re Mid and South Essex Sustainability and Transformation Partnership

A Part 1 (Public Agenda Item)

1 Purpose of Report

1.1 To provide a report for the People Scrutiny Committee (Scrutiny) to consider regarding the Mid and South Essex Sustainability & Transformation Partnership (STP) Council motion, which was previously considered at both the Council meeting on 19 July 2018 and Cabinet on 18 September 2018.

2 Recommendations

2.1 That Scrutiny notes the Resolution made by the Council at its meeting on 19 July 2018 where the Council unanimously agreed that Scrutiny should "give due consideration to referral to the Secretary of State (SoS), taking these objections and other relevant factors into account" (see section 4).

2.2 That Scrutiny consider the options outlined in section 6 of this report.

2.3 That Scrutiny agree the preferred option to refer the STP to the SoS as outlined in Option C, section 6.

3 Background

3.1 During the process of public consultation re the proposals for the STP Southend Borough Council (SBC) formally responded. In summary, the report acknowledged the need for transformation within health services across the STP footprint and offered support for the STP proposals once the proposals had been sufficiently developed to address areas of particular concern for SBC.

3.2 The areas of concern expressed were; (1) stroke services; (2) investment in Localities; (3) transfers and transport; (4) consolidated discharge and repatriation; (5) capital investment; and (6) workforce.

3.3 On 6 July 2018 the CCG Joint Committee made decisions following recommendations made by the STP programme. These recommendations were made following consideration of the public consultation, clinical senate reports and developed proposals for each of the recommendations. The decisions taken by the CCG Joint Committee are outlined in a formal letter from the CCG Joint Committee Chair to the Chair of the Joint Health Overview and Scrutiny Committee (JHOSC), see **Appendix 1**.

The role of the Joint Health and Overview Scrutiny Committee (JHOSC)

3.4 The JHOSC was formed between SBC, Essex County Council and Thurrock Council and held its' first formal meeting on 20 February 2018. Further formal meetings have been held on 13 March, 6 June and 30 August. A further JHOSC meeting will be held on 30 October 2018.

3.5 On 22 March 2018 the Chair and Vice Chairs of JHOSC wrote to the STP stating their formal position regarding the proposals for consultation. In summary the JHOSC noted a number of concerns regarding the STP and offered support for the STP.

3.6 Scrutiny will be aware that the power of referral to the SoS was not delegated by the three participating Local Authorities to the JHOSC.

4 Council Motion

4.1 Following the CCG Joint Committee decision outlined in **Appendix 1**, a motion was considered at the SBC Full Council meeting of 19 July for consideration. The details of the motion are in **Appendix 2**.

4.2 In summary, the motion reiterated the concerns outlined in the Council's response to the STP proposals and further expressed concern at the public consultation process and how it had reached only a small fraction of the population within the STP footprint.

4.3 The motion was unanimously supported by all Members present and was carried (Minute 182, Council 19 July 2018 refers).

4.4 On 30 August 2018 JHOSC considered the decisions made by the CCG Joint Committee. The JHOSC further considered SBC's motion and noted the following;

4.4.1 That the JHOSC take full account of SBC's continued objections to the STP; and

4.4.2 That SBC's Full Council had requested that SBC's Scrutiny give due consideration to a referral to the SoS, taking into account SBC's continued objections to the STP, the progress made by the STP regarding SBC's objections and any other relevant factors.

5 Making a referral

Process

5.1 In guidance published by the Department of Health (DoH) the process to make a referral to SoS is clearly outlined, full guidance is detailed in **Appendix 3**.

5.2 In summary; if a Local Authority is minded to refer a proposed health service change to the SoS an information pack containing the following information would need to be compiled. The expectation is that any referring Local

Authority will be expected to provide very clear evidence-based reasons for the referral;

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

5.3 Upon receipt of referral the SoS has the option of seeking the advice from the Independent Reconfiguration Panel (IRP) who are an independent expert on NHS service change. The IRP is an advisory, non-departmental public body, sponsored by the Department of Health and Social Care. A document describing who the IRP are and how the IRP advises the SoS is detailed in **Appendix 4**.

5.4 There is no time limit in which the SoS would seek the advice of the IRP. The majority of referrals made by Local Authorities to SoS are subsequently referred to the IRP.

5.5 Once the advice of the IRP has been sought the IRP will attempt to provide written advice to SoS within 20 working days. The majority of cases are responded to within this time limit. However, the IRP makes it clear that they accept information from a wide range of stakeholders and any information submitted for the IRP to consider by the referring authority (or other interested stakeholders) will be duly considered. This may have an impact on the 20 working day timescale, subject to volume of information.

5.6 The IRP will publish its' advice to the SoS once it has been submitted to the SoS.

5.7 On receipt of advice from the IRP the SoS will consider the advice and provide a written response to the referring authority either upholding the

referral or otherwise. There is no time limit within which the SoS must provide a written response.

5.8 A recent example of advice provided by the IRP is detailed in **Appendix 5**.

Criteria for making a referral

5.9 Within the Guidance there are four broad circumstances for a referral to be made. A referring authority may report to the SoS, in writing, if;

- It is not satisfied with the adequacy of content of the consultation;
- It is not satisfied that sufficient time has been allowed for consultation (NB the referral power in the context of inadequate consultation only relates to the consultation with the local authority, and not consultation with other stakeholders);
- It considers that the proposal would not be in the interests of the health service in its area; or
- It has not been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate

Adequacy of content of the consultation

5.10 This criteria for referral will only apply if a referring authority agrees that it is not satisfied with the adequacy of consultation. To support this debate it is appropriate for both the process and outcome of the public consultation to be considered.

5.11 An independent report looking at responses to the CCG Joint Committee public consultation (Your Care in the Best Place) was published on 22 May 2018, full report is detailed in **Appendix 6, click here for link**. The report, produced by specialist consultation analysts, The Campaign Company, provides a breakdown of both the process and responses to proposals aimed at strengthening and improving health and care services in the community and in the three hospitals serving mid and south Essex.

5.12 The analysis indicates there is broad agreement with the overall principles described in the consultation, these were;

- The majority of hospital care will remain local and each hospital will continue to have a 24-hour A&E department that receives ambulances
- Certain, more specialist, services which need a hospital stay should be concentrated in one place, where this would improve your care and chances of making a good recovery
- Access to specialist emergency services, such as stroke care, should be via your local (or nearest) A&E, where you would be treated and, if needed, transferred to a specialist team, which may be in a different hospital
- Planned operations should, where possible, be separated from patients who are coming into hospital in an emergency
- Some hospital services should be provided closer to you, at home or in a local health centre. The specific proposal within the consultation concentrated on moving services currently provided from the Orsett

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Hospital site into centres closer to where people live, enabling the closure of Orsett Hospital

5.13 The analysis identifies some local differences, particularly that there was less general agreement with the proposals from those living in the Southend CCG area.

5.14 The analysis report has also shown key themes of concern particularly in the areas of;

- Transport and accessibility of services
- Shortages in workforce to deliver a sustainable service
- Financial constraint

5.15 The 16-week consultation saw 16 large scale public meetings with circa 700 people attending in total, and 40 deliberative workshops and specific events for people who were most likely to be affected by the proposals.

5.16 750 people took part in an independently commissioned telephone survey conducted with a demographically-balanced section of the population across Mid and South Essex.

5.17 In total it is estimated that circa 3,500 (total population of circa 1.2M) people took the opportunity to participate. This equates to circa 0.3% of the mid and south Essex population having engaged in the public consultation.

5.18 The independent report outlines the process conducted by the CCG Joint Committee and recognises that the overall response cannot be seen as representative of the population but is representative of interested parties who were made aware of the consultation and were motivated to respond. The report further recognises that a telephone survey was undertaken with a randomly selected and representative cross section of residents to ensure that the consultation process accurately captured the views of the wider population of mid and south Essex. The report notes that 7% of respondents had heard of the consultation and 29% had read the consultation document. The report comments that this is in line with other known NHS consultations where telephone surveys had taken place.

5.19 Whilst circa 0.3% is a small proportion of the population it would be considered a difficult case to argue that both the process conducted to consult and the small proportion of those consulted would support a referral to the SoS on the basis of inadequate consultation.

Sufficient time allowed for consultation with Local Authority

5.20 Where an NHS body consults with more than one local authority on a proposal for substantial development of a health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. For the purposes of the Mid and South Essex STP the JHOSC (refer to paragraph 3.4) was created early 2018.

5.21 Since its' first formal meeting in February 2018 the JHOSC has engaged with the STP on a number of occasions to scrutinise the proposals for health services in mid and south Essex.

5.22 At the request of the JHOSC the time allowed by the CCG Joint Committee to consult with the JHOSC was extended. Originally, the consultation was due to

close on 9 March 2018. At the JHOSC meeting on 13 March the STP advised that the CCG Joint Committee had extended the close date for consultation to 23 March 2018. This, then, allowed for the JHOSC to formulate a response.

5.23 The regulations did not require for the CCG Joint Committee to formally consult with the local scrutiny committees. Notwithstanding this the STP has engaged with SBC via a number of different means since early 2016; including engagement with People Scrutiny Committee, Southend Health and Wellbeing Board, STP Health and Wellbeing Boards Chairs' meeting and a facilitated visit to Southend Hospital to visit stroke services. This engagement has taken place on numerous occasions and focused on STP related issues.

5.24 In consideration of the circumstances it would be considered a difficult case to argue that insufficient time was allowed to consult.

Proposals not in the interest of the health service

5.25 As stated in paragraph 3.6 the power of referral was not delegated by the three participating local authorities to the JHOSC.

5.26 The IRP have therefore advised that any referral to the SoS could be considered in the context of whether the STP proposals are not in the interests of the health service in the Southend area rather than the health service in the mid and south Essex area.

5.27 It could, therefore, be possible to construct an argument that supports a referral to the SoS based on the STP not being in the interests of local health. This is explored in greater detail in Section 6.

No consultation

5.28 The regulations set out criteria on which consultation with health scrutiny is not required (**in full pp 24-25 Appendix 3**). These are;

- A risk to safety or welfare of patients;
- Where the proposals are to establish or dissolve the constitution of a CCG; or
- Where proposals are part of a trusts special administrators report.

5.29 It was considered by the CCG Joint Committee that the above criteria did not apply in the deliberations about whether or not to consult.

5.30 The CCG Joint Committee decided to formally consult with the public. The 'no consultation' criteria to make a referral to SoS is therefore, considered to not be relevant in the deliberations of Southend Scrutiny.

6 Options for Scrutiny to consider

Option A – SBC do not make a referral to the SoS, accept the decisions made by the CCG Joint Committee and continue to work in partnership with the STP to ensure the concerns highlighted by SBC re the STP are addressed

Assessment

6.1 The CCG Joint Committee have acknowledged that the STP plans are not finalised and require further development prior to implementation. The CCG Joint Committee have particularly acknowledged that the plans for workforce,

capital investment, implementation and transport (treat & transfer, family, friend and carer) plans will evolve throughout the planning for implementation.

6.2 On a number of issues the CCG Joint Committee have been able to circulate more detailed proposals to both the JHOSC and local scrutiny committees. On other issues detailed proposals have not been made available to either JHOSC or local scrutiny committees, these issues include workforce, capital investment and implementation.

6.3 As referenced in paragraphs 3.1 and 3.2 SBC responded to the public consultation and expressed a number of concerns. The concerns were, and remain; (1) stroke services; (2) investment in Localities; (3) transfers and transport; (4) consolidated discharge and repatriation; (5) capital investment; and (6) workforce.

6.4 Since the CCG Joint Committee made its' decision and through continued pressure from both the JHOSC and SBC the plans for transfers and transport and primary care have been developed further and been made available for public scrutiny.

Benefit

6.5 Capital investment for the STP proposals will be made available.

6.6 The relationship built between SBC and the STP will be further strengthened through working in partnership.

Risk

6.7 Concerns raised by SBC (paragraph 6.3) would only be addressed in a timescale and manner that aligns with the STP programme.

6.8 There is no guarantee that the concerns would be resolved to the satisfaction of SBC and its residents and if they were not satisfactorily resolved it would be deemed too late in the process to change course.

Option B – refer the STP in its' entirety to the SoS on the basis of 'inadequate consultation' and 'not in the interests of local health services'

Assessment

6.9 In its' response to the CCG Joint Committee, SBC, at the end of public consultation, highlighted a number of areas that are positive for the local resident of Southend. SBC fully recognised the need for change to the provision of acute services in mid and south Essex and recognised that the current model was unsustainable for reasons of recruitment, retention, financial sustainability. SBC further recognised that, due to changing demand and innovations in technology there was a need to change and improve services. In its' report SBC welcomed the additional capital investment that would support the STP proposals.

6.10 To refer the STP to the SoS in its' entirety (on the basis of 'not in the interests of local health services') would require SBC to disagree with all of the decisions made by the CCG Joint Committee. Eg, quicker access to the range of treatments offered at the existing Essex Cardiothoracic Centre in Basildon, the enhancement of operations at Southend A&E department 24hrs a day and the development of trained specialist teams.

6.11 To refer the STP to the SoS in its' entirety (on the basis of 'inadequate consultation') would require SBC to challenge the independent report

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produced following the public consultation. Whilst the public consultation reached a small proportion of the mid and south Essex population it is credible to suggest that the STP made every effort to consult with local residents and hard to reach groups. As noted in the independent report the volume of response is a difficult issue to influence and is not considered to be grounds for an 'inadequate consultation' referral.

Benefit

6.12 A benefit of adopting this approach would be that the referral would represent the views of a small proportion of Southend residents.

Risk

6.13 The STP have already indicated that the hospitals are unable to progress the capital bid process to draw down the £118m (c£40m for Southend Hospital). The process to draw down capital funding within the health service is long and complex (approximately 12-18 months taking into account strategic outline case, outline business case and full business case, and various approval routes (NHS Improvement, DH, Treasury)). Any delay in commencing this process will have a significant impact on accessing capital for schemes such as the additional hospital wards at Southend.

6.14 Development of detailed implementation, finance and workforce plans (per pathway) will be delayed, with impacts on:

- Patient benefits that would occur as a result of service changes
- Staff - continued uncertainty, and resultant impact on recruitment and retention.
- Services where there are issues with sustainability (eg. because of rota gaps or increased demand) remain fragile
- Financial sustainability of the system

6.15 The cost of referral (both financial and human resource), for both SBC and NHS England.

6.16 Potential delay in implementation of the locality approach (if identified investment requirements are reliant on bringing activity (and funding) from the acute sector).

Option C – refer decision #12 re Stroke Services on the basis that the hyperacute clinical treatment model is acceptable (subject to appropriate resourcing) but that the development of a specialist team in Basildon Hospital to provide intensive nursing support and rehab is not.

Assessment

6.17 As outlined in paragraphs 3.1 and 3.2, SBCs formal response to the public consultation was that whilst the STP proposals were broadly supported there were significant areas of concern that SBC still had which were not in the interests of local health services, that impacted on the sustainability of health services in Southend and delivered reduced outcomes for the residents of Southend. The issues were, and remain; (1) stroke services; (2) investment in

Localities; (3) transfers and transport; (4) consolidated discharge and repatriation; (5) capital investment; and (6) workforce.

6.18 Since the CCG Joint Committee decision on 6 July 2018 a number of steps have been taken by the STP to address SBC's concerns. Steps which have included developing the proposals for treat and transfer, friends, family and carer transport, clinical pathways, primary care and the out of hospital community model.

6.19 It is important to acknowledge that there are some decisions that have been made by the CCG Joint Committee that will improve health outcomes for Southend patients. For example quicker access to the range of cardiology services offered at the existing Essex Cardiothoracic Centre in Basildon and the earmarking of £118M in capital funding from central funds, of which circa £40M is allocated to Southend Hospital.

6.20 The five principles consulted on included the principle that certain, more specialist, services which require an inpatient stay should be concentrated in one place, where this would improve care and chances of a good recovery.

6.21 This model / principle is supported by the East of England Clinical Senate who confirmed that the proposals for service change would deliver improvements to patient care. The proposals / service model developments were developed by leading front-line consultants and have been recognised as improving the quality, outcome and safety of care.

6.22 Whilst it is recognised that specialist services, which require an inpatient stay, would benefit from being concentrated in one place there is very little evidence to support the location of a number of the CCG Joint Committee decisions in Basildon. For example decision #12 which refers to the care for patients showing symptoms of a stroke continuing to be via the nearest A&E, where patients will be assessed, stabilised and treated, if clinically appropriate. Patients who have had a stroke will then transfer to Basildon Hospital for a short period of intensive nursing and therapy support. The decision further recognises that where a patient is confirmed as suffering from a bleed on the brain, they will continue to be transferred to a designated centre, as now. The CCG Joint Committee strongly supported the ambition to develop a mechanical thrombectomy service but makes no recognition that a thrombectomy service (on a best endeavour approach) is currently provided from Southend Hospital.

6.23 During the course of public consultation locally elected Members from a number of different political parties from SBC visited the stroke unit at Southend Hospital to discuss the STP proposals.

6.24 Members left the visit very clear that a model had been developed between the lead consultants for each acute site that places the patient at the centre. The immediate and timely hyperacute clinical intervention is paramount to the delivery of a successful model. The fast reaction of the model to identify patients with strokes (using hyperacute imaging), the ability to quickly identify the cause of the stroke and hyperacute clinical intervention delivered thereafter are all primary considerations of the model.

6.25 The resourcing of the hyperacute clinical intervention model was also a topic of conversation and Dr Guyler (Lead Consultant for Stroke Medicine) outlined the required resource at each site for the model to function effectively. Clare

Panniker (Chief Executive Mid, Southend and Basildon Hospital Group) confirmed to the Members and assured the meeting that the STP proposals committed to resourcing each site appropriately as defined by the model Dr Guyler outlined.

6.26 The decision for the reconfiguration of stroke services and development of a hyperacute clinical intervention model is supported with clinical evidence. However the rationale to incorporate a specialist stroke unit at Basildon Hospital, where patients will receive a short period of intensive nursing and therapy is less clear and poorly documented in the CCG Joint Committee Decision Making Business Case.

6.27 The Stroke Association supports the proposals for stroke services as agreed by the CCG Joint Committee, report is detailed in **Appendix 7**. In summary, the report specifically supports the development of the model outlined in the CCG Decision Making Business Case. The Stroke Association further support the development of a specialised stroke service which will provide intensive nursing and therapy. Whilst the report supports the development of the specialist service at Basildon Hospital the Stroke Association were not asked to appraise any alternatives. For example, the Stroke Association were not requested to comment on whether or not the specialist stroke service should be based at Southend.

Not in the interests of local health services

6.28 It is arguable to suggest that the decision to locate a specialist stroke service at Basildon Hospital that will provide intensive nursing and therapy is not in the interests of local Southend health services.

Evidence to support location of Specialist Stroke service at Basildon Hospital

6.29 Throughout the numerous engagement events held between Southend and the STP requests were made for the rationale and evidence base that supported the location of a specialist stroke service, providing intensive nursing and therapy support, at Basildon Hospital. The evidence base that supports the CCG Joint Committee decision has never been made available to either Officers or Members at SBC.

6.30 The limited evidence that has been published in the CCG Joint Committee Decision Making Business Case indicates that there are clinical connections between a cardio thoracic centre and stroke services. The clinical evidence to support this has not been made available.

6.31 The CCG Joint Committee Decision Making Business Case also makes reference to the fact that workforce issues will be resolved as a result of locating specialist stroke services at Basildon Hospital. Both the JHOSC and Southend Scrutiny have requested the evidence to support this rationale. The evidence has not been made available.

Strokes in Southend

6.32 Southend has the highest number of strokes (within the STP footprint) per 1,000 population over the age of 65. The data (17/18) shows that the Southend rate is 7.5 which is significantly higher than Basildon and Mid Essex. Not only does Southend have the highest rate of strokes within the STP, the rate has been steadily increasing (15/16, 16/17 & 17/18) as

compared to Basildon and Mid Essex which have been steadily decreasing or remaining constant.

6.33 Stroke Admissions for Southend Hospital have been steadily increasing year on year. The rate of admissions to Southend Hospital that have been classed as a 'stroke admission' has grown from 694 (14/15) to 734 (16/17). This equates to SUHFT admitting circa 14 stroke cases per week as compared to circa 11 per week each for both Broomfield and Basildon Hospitals, taken from 16/17 data.

Existing infrastructure

6.34 Southend Hospital is audited by the Sentinel Stroke National Audit Programme (SSNAP). The most recent audit demonstrates that all three acute hospitals in the mid and south Essex STP have similar audit reports. The evidence and rationale to support the locating of a Specialist Stroke service at Basildon Hospital is not available and raises questions as to why the locating of Specialist Stroke service at Southend Hospital has been over looked.

6.35 Southend has an international airport and a Medical Technical campus which would allow Southend Hospital to attract research funding. There are concerns over whether or not this issue has been considered in the CCG Joint Committee decision making process. In addition, Southend Hospital have consistently demonstrated leadership with regards to the development of stroke services, for example; a mobile stroke unit and a best endeavour thrombectomy service.

Workforce

6.36 Both the CCG Joint Committee and SBC have recognised the significant challenge associated with workforce which will need to be addressed to enable the successful implementation of the STP.

6.37 Despite numerous requests from both JHOSC and SBC the detailed workforce information which is required to provide assurance has not provided by the CCG Joint Committee. As noted in paragraph 6.25, the Chief Executive of Mid, Southend and Basildon Hospital Group confirmed to SBC's locally elected Members that resourcing for the clinical hyperacute intervention model (both at local sites and specialist stroke services) would be made available. To date, neither the JHOSC nor SBC have received any information to provide assurance that this commitment is robust.

6.38 By creating a specialist stroke service evidence suggests that lives will be saved and disabilities will be reduced. Access to and availability of a specialist stroke workforce continues to be a problem for delivering high quality evidence based stroke care. The British Association of Stroke Physicians has stated 'Clinical developments in UK stroke services have overtaken the specialist resource needed to support them'. The creation of a specialist stroke service (irrespective of location) will allow for the existing specialist workforce in mid and south Essex STP to be used more effectively to provide evidence based interventions that save lives and reduce disabilities.

6.39 Additionally, there is no published evidence that addresses the workforce challenges that would be created as a result of the additional transport requirement (patient, friends, family, carer etc) following the implementation of specialist stroke services at Basildon Hospital.

Benefit

6.40 Southend residents will receive better outcomes as a result of developing a hyper acute clinical treatment model based at Southend and also a specialist rehab centre located on an evidence base that is transparent.

Risk

6.41 The hospitals cannot progress the capital bid process to draw down the investment aligned to stroke services from the £118m investment (c£40m for Southend Hospital). The development of a specialist stroke service for the STP is towards the end of the STP implementation programme. Other decisions made by the CCG Joint Committee can be implemented (including the drawdown of capital funding) whilst a referral of Stroke services is being considered by the SoS.

6.42 Development of detailed implementation, finance and workforce plans (per pathway) associated with the development of stroke services will be delayed.

6.43 The cost of referral (both financial and human resource), for both SBC and NHS England

6.44 Potential delay in implementation of the locality approach (if identified investment requirements are reliant on bringing activity (and funding) from the acute sector).

7 Preferred Option

7.1 In consultation with colleagues from Southend Public Health the options outlined above have been considered which support Scrutiny to respond to the Full Council Motion (detailed in **Appendix 2**). For the reason that it is not in the interests of local health it is recommended that Scrutiny adopt Option C, as outlined and detailed in paragraphs 6.17 - 6.446.44.

8 Other options

8.1 There are no other options for consideration.

9 Corporate Implications

9.1 Contribution to the Council's Vision and Critical Priorities – Becoming an excellent and high performing organisation.

9.2 Financial Implications – The financial risks to Southend Council, should the STP proposals be delivered, are yet to be identified.

9.3 Legal Implications – Where an NHS body consults with more than one local authority on a proposal for substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. Only that joint committee may - make comments on the proposal to the NHS body; require the provision of information about the proposal; require an officer of the NHS body to attend before it to answer questions in connection with the STP proposals

9.4 People Implications – The expectation is that the STP proposals will address the workforce (recruitment and retention) issues highlighted in the case for

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change. There is a significant risk that this is not the case which could lead to greater challenges for workforce and finance.

9.5 Property Implications – as described in the report.

9.6 Consultation – as described in the report.

9.7 Equalities Assessment (EA) – an EA was published by the STP during spring 2018. The Directors for Public Health, across the STP worked in partnership with the STP to develop the EA.

9.8 Risk Assessment – The risks associated with the options are outlined in this report. There is a risk to the local health and social care system of not doing anything.

10 Background Papers

11 Appendices

11.1 Appendix 1 – CCG Joint Committee decisions taken re STP proposals 6 July 2018

11.2 Appendix 2 – Minute 182, Council 19 July 2018

11.3 Appendix 3 – DoH guidance for Local Scrutiny

11.4 Appendix 4 – Who are the IRP

11.5 Appendix 5 – IRP advice examples

11.6 Appendix 6 – Independent STP consultation report (click here) (report otherwise available in Member room).

11.7 Appendix 7 – Stroke Association letter

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Sent via email

Mid and South Essex
Joint Commissioning Team

Tel: 01245 398760

Cllr Bernard Arscott
Chair, Joint Health Overview & Scrutiny Committee

9th July 2018

Dear Cllr Arscott

Re: Your Care in the Best Place – CCG Joint Committee Decision-Making

Thank you for attending on the CCG Joint Committee meeting on Friday 6th July. As such, I recognise that you are aware of the outcome, however I am now pleased to write to you formally to confirm the decisions made by the CCG Joint Committee following the public consultation Your Care in the Best Place.

I have listed below the recommendations made and the decisions reached by the CCG Joint Committee.

I understand that the next formal meeting of the Joint HOSC will be 30 August 2018. It would be very helpful if the Committee could consider the decisions made in advance of that meeting and share with us the areas of focus for the Joint HOSC. This will enable the meeting on 30 August to be a productive one where we can hope to resolve any issues that the Joint HOSC may have and move forward into implementation.

Please could you respond to Jo Cripps at your earliest convenience so that system partners can prepare for the next meeting with you and your colleagues.

If you have any queries, please do not hesitate to contact me.

Yours sincerely

Mike Bewick
Independent Chair of CCG Joint Committee

cc. Caroline Rassell, Lead AO for the CCG Joint Committee
Jo Cripps, Interim Programme Director, Mid & South Essex STP

Joint Commissioning Team

Accountable Officer: Caroline Rassell

Decisions made by CCG Joint Committee, 6 July 2018

Rec No.	Area	Recommendation	CCG Joint Committee Decision
1	Consultation Process	The CCG Joint Committee is requested to **confirm** that the Committee and its constituent Clinical Commissioning Groups have met their statutory duties and ensured that an effective and robust public consultation process has been undertaken and will be used to inform the decisions made.	Confirmed
2	Consultation principles	The CCG Joint Committee is requested to **note** the five principles underpinning the future provision of hospital services for mid and south Essex, upon which the public consultation was based: 1. The majority of hospital care will remain local and each hospital will continue to have a 24-hour A&E department that receives ambulances. 2. Certain, more specialist, services which require an inpatient stay should be concentrated in one place, where this would improve care and chances of a good recovery. 3. Access to specialist emergency services, such as stroke care, should be via the nearest A&E department, where patients would be assessed, treated, stabilised, and if needed, transferred to a specialist team, which may be in a different hospital. 4. Planned operations should, where possible, be separate from patients arriving at hospital in an emergency. 5. Some hospital services should be provided closer to home (with specific changes to the services currently provided from Orsett Hospital).	Noted
3	A&E Departments	The CCG Joint Committee is asked to **approve** that: 3.1 Each of the three A&E departments (at Broomfield Hospital, Southend Hospital and Basildon Hospital) continue to operate 24 hours/day and receive blue light ambulances.	Approved
		3.2 Each of the three hospitals (Broomfield Hospital, Southend Hospital and Basildon Hospital) develops	Approved

Rec No.	Area	Recommendation	CCG Joint Committee Decision
		Emergency Care Hubs with specially trained teams to meet the particular care needs of: • Older and frail people • Children • Patients in need of urgent medical treatment • Patients in need of urgent surgical treatment	
4	Treat & Transfer	The CCG Joint Committee is asked to approve: 4.1 The concept that a small number of patients with appropriate conditions who would benefit from the care and treatment of a specialist team are stabilised at their local A&E department, and if appropriate, are transferred, using a specialist Clinical Transport Service, to another acute hospital site to receive specialist care (termed the "treat and transfer" model).	Approved
		4.2 That implementation of service changes outlined in this decision-making business case are not commenced until a suitable clinical transfer service is in place that: • Has defined clinical protocols in place to ensure the safe transfer of patients • Has identified clinical leadership, both across the three acute hospitals (at group level) and at each acute hospital site • Has clear clinical governance arrangements in place • Meets the standards prescribed by national bodies in relation to workforce, skills, equipment and resources. • Has the above considered and endorsed by the STP Clinical Cabinet. • Has appropriate assurance from the Intensive Care Society of Great Britain & Ireland	Approved
5	Gynaecology	The CCG Joint Committee is requested to **approve** that: 5.1 Gynaecological cancer surgery be located at Southend Hospital, close to the existing cancer centre for mid and south Essex.	Approved

Rec No.	Area	Recommendation	CCG Joint Committee Decision
		5.2 Complex gynaecological surgery (including uro-gynaecology) requiring an inpatient stay be located at Southend and Broomfield Hospitals.	Approved
		The CCG Joint Committee is requested to **note** that all outpatient appointments, tests, scans and day case surgery for non-complex gynaecological conditions will remain available locally.	Noted
6	Respiratory	The CCG Joint Committee is requested to **approve** that inpatient care for patients with complex respiratory conditions is located at Basildon Hospital, close to the existing Essex Cardiothoracic Centre. The CCG Joint Committee is requested to **note** that all outpatient appointments, tests, scans, and short hospital stays for non-complex respiratory conditions will continue locally	Approved Noted
7	Kidney	The CCG Joint Committee is requested to **approve** that inpatient care for patients with complex kidney disease is located at Basildon Hospital, close to the existing Essex Cardiothoracic Centre. The CCG Joint Committee is asked to **note** that all outpatient appointments, tests, scans and short hospital stays for non-complex kidney conditions, including dialysis, will continue locally. The CCG Joint Committee is further asked to **note** that very complex care, such as kidney transplants, would continue to be provided in specialised centres in London and elsewhere.	Approved Noted Noted
8	Vascular	The CCG Joint Committee is requested to **approve**, in line with guidance from the Vascular Society of Great Britain and Ireland: 8.1 That a specialised vascular hub is developed at Basildon Hospital, close to the existing Essex Cardiothoracic Centre and aligned to interventional radiology services. This hub would offer a round the	Approved

Rec No.	Area	Recommendation	CCG Joint Committee Decision
		clock, consultant-led service for vascular emergencies including centralisation of complex surgery. In an emergency situation, patients would access the hub via their local A&E department, where they would receive assessment, stabilisation and initial treatment before being transferred, with appropriate support, to the specialised vascular hub.	
		8.2 That inpatient care for patients with complex vascular disease is located at Basildon Hospital, close to the existing Essex Cardiothoracic Centre.	Approved
		8.3 The Abdominal Aortic Aneurysm (AAA) Screening service will remain located at Southend for the Essex population. The CCG Joint Committee is asked to **note** that all outpatient appointments, tests, scans and short hospital stays for non-complex vascular conditions will continue locally	Approved Noted
9	Cardiology	The CCG Joint Committee is requested to **approve** that access to the range of treatments offered at the Essex Cardiothoracic Centre for patients with specialised heart disease is accelerated and that the treat and transfer model (see recommendation 4) is used to facilitate this. The CCG Joint Committee is asked to **note** that all outpatient appointments, tests, scans and short hospital stays for non-complex heart conditions will continue to be available locally.	Approved Noted
10	Gastroenterology	The CCG Joint Committee is asked to **note** that the original proposal for patients with complex gastroenterology problems to be treated at Broomfield Hospital is not put forward for decision (see section 8 for further detail). Gastroenterology services (inpatient care, day case, outpatient appointments, tests and scans) will continue to be provided on all three sites, as currently.	Noted

Rec No.	Area	Recommendation	CCG Joint Committee Decision
11	General Surgery	11.1 The CCG Joint Committee is requested to **approve**, subject to further external clinical review and validation by the East of England Clinical Senate, that: Surgery for some complex emergency general surgical conditions such as upper gastrointestinal procedures which would require the patient to stay in hospital, will be located at Broomfield Hospital, and Complex colorectal surgery requiring an inpatient hospital stay will be located at Broomfield and Southend Hospitals, provided by a dedicated emergency general surgical team.	Approved
		11.2 The CCG Joint Committee is asked to **note** that it will receive the report of the East of England Clinical Senate's further review of general surgery proposals by the end of December 2018. The CCG Joint Committee is asked to **note** that routine planned surgery, and emergency surgery which could be performed as a day case (with no requirement for a hospital stay), will continue to be undertaken at all three hospitals. Furthermore, all outpatient and follow-up appointments, tests and scans would continue to be available locally.	Noted Noted
12	Stroke Services	The CCG Joint Committee is requested to: 12.1 **Approve** that access to care for patients showing symptoms of a stroke continues to be via the local A&E department, where patients would be assessed, stabilised and, if indicated, treated with thrombolysis. After the patient was stabilised, and after discussion between the patient/family and clinicians, the patient would be transferred to Basildon Hospital for a short (approximately 72 hour) period of intensive nursing and therapy support.	Approved

Rec No.	Area	Recommendation	CCG Joint Committee Decision
		12.2 **Note** that, following a stroke and an inpatient stay at Basildon Hospital for a short period of intensive treatment, patients would be transferred home, if their condition had improved sufficiently, or back to their local hospital or community facility for on-going care and treatment. All follow-up outpatient appointments, tests and scans will continue to be offered at all three hospital sites.	Noted
		12.3 **Note** that, should a patient be confirmed as suffering from a bleed on the brain, they would continue to be transferred to a specialised designated centre, as now. This would either be Queen's Hospital, Romford, or Cambridge University NHS Foundation Trust in Cambridge.	Noted
		12.4 **Strongly support** the ambition to develop a Mechanical Thrombectomy service in mid and south Essex, such a service may be commissioned by NHS England.	Supported
13	Orthopaedics	The CCG Joint Committee is requested to **approve** that: 13.1 Some planned orthopaedic surgery, such as hip and knee replacements requiring a hospital stay, is provided at Southend Hospital for the south Essex population, and at Braintree Community Hospital for the population in mid-Essex. As such patients who would have used Basildon Hospital for planned orthopaedic inpatient surgery will no longer be able to access this care at Basildon and will be offered surgery at Southend. Patients who would have used Broomfield Hospital for planned orthopaedic surgery, and who meet the criteria for treatment at Braintree Community Hospital will no longer be able to receive their surgery care at Broomfield. The CCG Joint Committee is asked to **note** that the above arrangement would not preclude patients from choosing to have their planned orthopaedic treatment at another hospital, as per the NHS Constitution requirements on	Approved Noted

Rec No.	Area	Recommendation	CCG Joint Committee Decision
		patient choice.	
		13.2 Some emergency orthopaedic surgery, such as open lower-limb fractures that require a hospital stay is located at Basildon Hospital (for the south Essex population), and at Broomfield Hospital (for the mid-Essex population). This would ensure that emergency surgery is separated from planned surgery, thus ensuring faster access to theatre for patients requiring urgent care, and reduced cancelled operations for patients requiring planned care.	Approved
		13.3 Elective complex wrist surgery will be provided at Southend Hospital, and complex emergency wrist surgery at Basildon and Broomfield Hospitals. The Joint Committee is asked to **note** that simple wrist surgery will continue to be maintained at all three hospital sites.	Approved
		13.4 The Trusts test the viability of elective inpatient spinal surgery being undertaken at Broomfield and Southend Hospitals. During a 24 month period following implementation, the STP Clinical Cabinet will assess the success and sustainability of this mode. The CCG Joint Committee is asked to **note** that all outpatient appointments and follow-ups, tests, scans and routine surgery for orthopaedic problems including day case knee, foot, wrist, ankle, shoulder and elbow procedures would continue to be available locally.	Approved Noted
14	Urology	The CCG Joint Committee is requested to **approve** that: 14.1 Patients requiring surgery for kidney, bladder and prostate cancer receive this at Southend Hospital, alongside the specialised cancer centre. The	Approved

Rec No.	Area	Recommendation	CCG Joint Committee Decision
		development of robotics to support this service should be an ambition aligned to the specialised cancer service commissioned by NHS England.	
		14.2 Complex (non-cancer) emergency urological conditions that require an inpatient stay be treated at Broomfield Hospital in Chelmsford, building on the specialist urological care already provided there.	Approved
		14.3 Complex uro-gynaecological treatment be located at both Southend and Broomfield Hospitals. The CCG Joint Committee is asked to **note** that all outpatient appointments, follow-ups, tests, scans and short hospital stays for non-complex, and non-cancer, urological conditions will continue to be available locally.	Approved Noted
15	Orsett Hospital	The CCG Joint Committee is asked to: 15.1 **Approve** the relocation of services currently provided at Orsett Hospital to a range of locations within Thurrock, Basildon and Brentwood, enabling the closure of Orsett Hospital.	Approved
		15.2 **Note** that there will be a period of co-production with the local community through the establishment of a "People's Panel" supported by Healthwatch organisations in Thurrock and Essex to determine the best site(s) to relocate these services to.	Noted
		15.3 **Note** that, alongside the period of co-production, further detailed assessments will be undertaken on equality and health inequality impacts, and the quality impact of proposed service relocations.	Noted
		15.4 **Note** that once the period of co-production is complete, and with the detailed work on impact assessment, the CCG Joint Committee will be asked to make a decision on which sites will provide the relocated services.	Noted

Rec No.	Area	Recommendation	CCG Joint Committee Decision
		15.5 **Note** that, in accordance with the agreement between Thurrock CCG, Thurrock Council and the three mid and south Essex hospitals, the Orsett Hospital site will not be closed until the new services are in place at the agreed new locations.	Noted
16	Family/carer Transport	In recognising that some of the proposed service changes may mean that a small number of patients and their families will need to travel further to receive specialist treatment, the CCG Joint Committee is requested to **approve** that reasonable steps are taken by the Trusts to ensure that there is support for patients (in addition to that referred to in recommendation 4), their families and carers, to travel to a more distant hospital, if required. The CCG Joint Committee is asked to **note** that the acute hospitals will consider transport for staff who may be required to work at more than one site as part of service change implementation planning.	Approved Noted
17	Capital Funding	The CCG Joint Committee is asked to **note** that the Trusts have been earmarked to receive up to £118m in capital funding to support the implementation of the proposals contained within the public consultation. This is in addition to £12m being funded through the disposal of surplus assets. The commissioners will be asked to support, at a later date, and subject to the decisions reached on these recommendations, the business cases that will enable access to these funds	Noted
18	Implementation Oversight	The CCG Joint Committee is requested to **approve** the formation of an Implementation Oversight Group. The membership of this group will be agreed in discussion with the Trusts and with patient and public representative groups, stakeholders and partners, and will include representation from the Joint Committee and Joint Commissioning Team and NHS England Specialised Commissioning for relevant pathways. It is proposed the Implementation Oversight Group will be independently chaired.	Approved

Rec No.	Area	Recommendation	CCG Joint Committee Decision
		This Group will oversee the implementation of the decisions made by the CCG Joint Committee, ensuring that decisions are implemented in a safe and sustainable way, and specifically in line with the recommendations made by the CCG Joint Committee in relation to Clinical Transport (recommendation 4), Family/Carer Transport (recommendation 16) and plans to close Orsett Hospital (recommendation 15). The Implementation Oversight Group would report in to the CCG Joint Committee, the Trust Joint Working Board and inform the STP Board.	
19	On-going Engagement	The CCG Joint Committee is requested to **approve** that the mid and south Essex system continues its communication and engagement on these plans within the STP with patients and the public, staff and key stakeholder organisations.	Approved

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Minute 182

Council 19th July 2018

Opposition Business: Latest Developments in the Mid & South Essex STP and related healthcare matters

In accordance with Standing Order 19 the Labour Group requested that the Mid & South Essex STP, be debated this evening.

Councillor Gilbert proposed and Councillor Woodley seconded the following motion:

'The proposed changes in health and care provision in Southend and across the Mid and South Essex footprint are destined to bring lasting change to care provided to patients. That change must carry a guarantee of better patient outcomes for everyone who needs care. The recent consultation on the measures in the Sustainability and Transformation Plan did not set out the impact of proposed changes and evidence of patient outcomes has not been demonstrated despite requests from the People Scrutiny Committee, the Joint Health Overview Committee, Southend Health and Wellbeing Board, and individual councillors, over a period of 18 months. Proposals by the STP Team are still unclear even though the potential for amendment of those proposals has almost concluded.

The council therefore asks for the following to be placed on record.

Earlier this year, the Council's response to the STP consultation expressed dissatisfaction with the STP proposals in a number of very important areas:

- We would not support the STP without better rationale and evidence for moving stroke services to Basildon Hospital
- We said that the proposals are weak in terms of guaranteeing investment in localities without the impact of which, the acute reconfiguration is not viable.
- We believed that proposals around transport and transfers were unclear and poorly defined, and would not be able to support the STP until detailed workable proposals were set out
- We found the proposals on consolidated discharge and repatriation arrangements unclear
- We noted the challenges in workforce recruitment, retention and long-term sustainability

This council believes that even at this late stage there is still not sufficient clarity in respect of these serious concerns. We further note that the consultation process reached only a small fraction of the population in the footprint of these proposals.

It has still not been made clear to residents that six out of the seven therapeutic areas consulted upon will be wound down at Southend Hospital, with patients being moved to Basildon and Broomfield hospitals. The consultation document made no mention of closing down services and wording is vague when publicfacing documents refer to treatment being available to patients who seek help at Southend, but don't mention they will be transferred to another hospital for that care.

Southend Borough Council understands the reasons for change - 20,000 GP appointments not provided to patients, which will rise to 60,000 within only a few years, and hospitals in the STP footprint not performing as patients expect. It disagrees with the current process for delivery of change and wants to see a true process of consultation being undertaken, setting out the full impact of proposed changes, including the impact on patients, and clarity about what will happen to current services.

The council notes that the STP proposals are now subject to a formal scrutiny procedure. The council requests that the Joint Scrutiny Committee take full account of the council's continued objections to the STP. The Council further requests that the People Scrutiny Committee gives due consideration to a referral to the Secretary of State, taking these objections and other relevant factors into account.

In accordance with Standing Order 12(a) a named vote was taken on the proposal, as follows:

For the proposal:
Cllrs Arscott, Aylen, Ayling, Borton, Boyd, Bright, Buck, Buckley, Burton, Burzotta, Byford, Chalk, Courtenay, Cox, Davidson, Dear, Dent, Flewitt, Folkard, Garne, D Garston, J Garston, Gilbert, Habermel, Hadley, Harp, Holland, Jones, Lamb, McDonald, McGlone, McMahon, Moring, Mulroney, Nelson, Nevin, Norman, Phillips, Robinson, Salter, Stafford, Walker, Ware- Lane, Wexham and Woodley (45)

Against the proposal:
None

Abstentions:
Cllr Jarvis (The Mayor) (1)

Absent:
Cllrs Evans, Terry, Van Looy, Ward and Willis (5)

Accordingly, the motion was carried.

Department of Health

Local Authority Health Scrutiny

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

June 2014

Title: **Local Authority Health Scrutiny:** Guidance to support Local Authorities and their partners to deliver effective health scrutiny
Author: SCLGCP/PCLG/18280
Document Purpose: Guidance
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Target audience: • Local Authorities • Local Government Association • Health and Wellbeing Boards • Clinical Commissioning Groups • NHS trusts (acute, community, mental health) • NHS England • Healthwatch
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Local Authority Health Scrutiny

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

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

Contents

Key messages

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Introduction

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

1.1 Background

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

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

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

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

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

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

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

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

1.2 Purpose of guidance

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

1.2.2 This guidance is, therefore, of relevance to:

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

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

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

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

1.3 Scope of the Regulations

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

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

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

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

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

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

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

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

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

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

2. What remains the same following the new legislation?

2.1 For local authorities

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

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

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

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

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

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

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

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

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

2.2 For the NHS

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

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

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

2.3 For patient and public involvement

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

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

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

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

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

3. Changes arising from the new legislation

3.1 Powers and duties – changes for local authorities

Councils as commissioners and providers of health services

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

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

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

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

Councils as scrutineers of health services

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

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

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

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

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

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

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

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

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

Conferral of health scrutiny function on full council

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

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

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

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

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

Delegation of health scrutiny function by full council

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

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

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

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

Joint health scrutiny arrangements

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

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

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

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

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

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

Reporting and making recommendations

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

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

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

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

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

Conflicts of interest

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

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

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

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

Councils operating a committee system

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

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

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

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

The role of district councils

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

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

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

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

3.2 Powers and duties – changes for the NHS

Extension of scope of health scrutiny

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

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

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

Required provision of information to health scrutiny

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

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

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

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

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

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

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

Required attendance before health scrutiny

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

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

Responding to scrutiny reports and recommendations

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

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

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

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

3.3 Powers and duties – referral by local Healthwatch

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

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

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

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

4.Consultation

4.1 The context of consultation

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

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

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

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

4.2 When to consult

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

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

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

4.3 Who consults

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

4.4 Timescales for consultation

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

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

4.5 When consultation is not required

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

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

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

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

4.6 Responses to consultation

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

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

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

4.7 Referrals to the Secretary of State

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

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

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

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

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

Circumstances for referral

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

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

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

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

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

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

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

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

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

Who makes the referral?

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

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

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

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

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

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

Information and evidence to be sent to Secretary of State

[19] See Regulation 29.

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

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

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

5. References and useful links

5.1 Relevant legislation and policy

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

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

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

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

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

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

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

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

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

5.2 Useful reading

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

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

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

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

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

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

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

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

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

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

INDEPENDENT RECONFIGURATION PANEL

HOW WE ADVISE THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

Who we are

The IRP is the independent expert on NHS service change. We offer advice to the Secretary of State on proposals for health service change in England that are being contested. The Panel's terms of reference can be found in the accompanying document *IRP: general terms of reference*.

The IRP is made up of clinical, managerial and lay members offering wide-ranging experience in clinical healthcare, NHS management and public and patient involvement. Biographies of the chairman and members can be found in the accompanying document *IRP: membership*. The focus of our work is the patient and quality of care within the context of safe, sustainable and accessible services for local people. Depending on the nature of the proposals we are asked to advise on, these three aspects may incorporate issues such as workforce, estate, use of technology or finance.

Why the need for change?

The NHS is constantly evolving. The changing needs of the population and medical advances that lead to new treatments require the NHS to think about and plan how it can provide the best service possible in the appropriate place, with the right staff and within the money available. Patients and the public more widely are part of this planning process alongside clinicians and managers. Various duties apply to the NHS in involving users in the development of services[1].

Who refers proposals to the Secretary of State and why

In addition, *The Local Authority (Public Health, Health and Wellbeing Boards and health Scrutiny) Regulations 2013* require NHS organisations to consult local authorities on any proposals under consideration for substantial developments or variations to local health services. If the authority is not satisfied that:

- consultation has been adequate in relation to content or time allowed
- the reasons given for not carrying out consultation are adequate
- the proposal would be in the interests of the health service in its area

[1] s.14Z2 NHS Act 2006 for CCGs, s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England, s.242 NHS Act 2006 for NHS trusts and foundation trusts

it may refer the matter to the Secretary of State for Health[2]. The Secretary of State may seek advice from the IRP before deciding on the matter.

Are all contentious proposals referred to the Secretary of State?

Wherever possible, decisions about how the NHS is run should be made locally by those directly involved. Only proposals where the organisations involved have satisfied themselves that all other options for local resolution have been fully explored should be referred to the Secretary of State.

Do all referrals to the Secretary of State come to the IRP?

The 2013 Regulations do not define what constitutes a substantial development or variation to health services. This is a matter for local agreement. Similarly, the Regulations do not specify a time period within which a referral must be made. The Regulations do require NHS bodies and local authorities to fulfil certain conditions before a report to the Secretary of State may be made. The IRP provides its advice on the basis that the Department of Health and Social Care is satisfied the referral meets the requirements of the Regulations.

The IRP and the Department of Health and Social Care have agreed a protocol for handling contested proposals, attached at Annex A.

How the Panel determines its advice

The following documentation is required for the Panel to undertake an assessment:

- the *referral letter and all supporting documentation* from the referring body
- a completed *IRP assessment template* providing relevant background information completed by NHS England

Assessment may be undertaken by the full Panel or by a sub-group appointed by the Chairman representing the clinical, managerial and lay membership. Members will have access to all documentation supplied and will discuss the evidence in detail before agreeing on the advice to be provided. Any additional relevant information that is provided to the IRP, from whatever source, will be taken into account in the Panel's deliberations.

The IRP will offer advice to the Secretary of State on what further action should be taken, usually within 20 working days. The Secretary of State will consider the Panel's advice – and may seek further advice elsewhere if desired – and subsequently announce his decision and the future action required.

[2] Now the Secretary of State for Health and Social Care

Most referrals are appropriately handled in this way. The Panel is mindful that referral to the Secretary of State is a last resort and that it is always better to resolve issues locally wherever possible.

Exceptionally, we may advise that further evidence is required before reporting back. This may, for example, be because we need to understand local services and circumstances better and/or wish to take evidence directly from stakeholders. More information is provided in the accompanying document *IRP: When we need to seek further evidence*.

What powers does the IRP have?

We offer advice only. The Secretary of State makes the final decision on any contested proposals.

What happens after we have submitted our advice?

We publish our advice on the IRP website so that the public can see the information we have taken into account, our conclusions and how we reached them. We co-ordinate publication with the announcement of the Secretary of State's decision.

Once our advice has been published, our role is complete. The IRP has no responsibility for the implementation or monitoring of the implementation of the Secretary of State's decision.

How to contact the IRP

You can get in touch with us by:

- email: irpinfo@dh.gsi.gov.uk
- voice message: 020-7389-8046
- write to: IRP, 6th floor, 157-197 Buckingham Palace Road, London, SW1W 9SP

You can view our website at:

https://www.gov.uk/government/organisations/independent-reconfiguration-panel

ANNEX A

Handling plan for referral of contested reconfiguration proposals to IRP

DHSC/IRP PROTOCOL FOR HANDLING REFERRALS TO THE IRP	
INDEPENDENT RECONFIGURATION PANEL	**DEPARTMENT OF HEALTH AND SOCIAL CARE**
	DHSC monitors potentially contentious referrals. Advises IRP when a proposal has been referred to SofS by a local authority.
	Upon receipt of a referral to SofS, DHSC checks that it meets the requirements of the 2013 Regulations and contacts NHS England to request additional information required. NHS England/NHS consulting body returns information within two weeks of request.
	SofS writes to IRP requesting advice on the contested proposal and providing supporting documentation from local authority and NHS.
Panel Members carry out assessment. IRP provides advice to SofS on what further action should be taken, usually within 20 working days of request.	
Advice published on IRP website. or:	SofS replies to local authority, copied to NHS England, advising of decision and future action required.
Exceptionally, the Panel advises that further evidence is required before reporting back, normally including: • Invitations to submit evidence • Site visits • Oral evidence-taking from key stakeholders and interested parties SofS agreement is sought.	SofS considers IRP proposal to seek further evidence and if agrees:
IRP / DHSC discuss specific terms of reference and timetable for providing advice to the Secretary of State.	
	SofS writes to IRP confirming agreed terms of reference and deadline.
Panel Members gather further evidence. IRP provides advice to SofS on what further action should be taken, usually within 60 working days of request.	
Advice published on IRP website.	SofS replies to local authority, copied to NHS England, advising of decision and future action required.

IRP

157 – 197 Buckingham Palace Road
London
SW1W 9SP

The Rt Hon Jeremy Hunt MP
Secretary of State for Health and Social Care
39 Victoria Street
London SW1H 0EU

18 June 2018

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE
South Tyneside and Sunderland Healthcare Group – The Path to Excellence public consultation
South Tyneside and Sunderland Joint Health Scrutiny Committee

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Rob Dix (South Tyneside Council) and Cllr Norma Wright (Sunderland City Council), Joint Chairs, South Tyneside and Sunderland Joint Health Scrutiny Committee (JHSC). Confirmation of the documentary evidence submitted by the JHSC was received on 21 May 2018. NHS England North provided assessment information. A list of all the documents received is at Appendix One. The IRP has undertaken an assessment in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services that specifies that advice will be provided within 20 working days of the date of receipt of all required information.

In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State may be made. The IRP provides the advice below on the basis that the Department of Health and Social Care is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that:

- **Consolidation of all inpatient stroke services at Sunderland Royal Hospital (Option 1) is in the interests of local health services.**
- **Consolidation of all obstetrics, inpatient gynaecology and special care for babies at Sunderland Royal Hospital with a free-standing midwife-led unit at South Tyneside Hospital (Option 1) is in the interests of local health services.**
- **Further work is required on long term options for paediatric emergency care as part of considering the future of the whole urgent and emergency care system for the area. In the meantime, consolidation of emergency paediatric care overnight at Sunderland Royal Hospital (Option 1) will mitigate the current risks to quality and continuity of care.**

Background

The South Tyneside and Sunderland Healthcare Group (STSHG) formed in May 2016 as an alliance between City Hospitals Sunderland NHS Foundation Trust (CHSFT) and South Tyneside NHS Foundation Trust (STFT). The two trusts have formally committed to collaborating to transform services to ensure that the local communities they both serve will continue to receive high quality, safe and sustainable hospital and community health services in the future. To this end, in July 2016, whilst retaining separate statutory boards, they agreed to operate with a joint management structure under a single chief executive.

Currently, CHSFT provides a full range of hospital services, mostly from Sunderland Royal Hospital (SRH), to the population of Sunderland and some more specialist services to a larger catchment area including South Tyneside and parts of north Durham. STFT provides general hospital services to the population of South Tyneside from South Tyneside District Hospital (STDH) and community services across Gateshead, South Tyneside and Sunderland. Both organisations are in financial deficit – together some £26.5m which is about five per cent of their combined annual turnover.

Ambulance services across South Tyneside and Sunderland are delivered by the North East Ambulance Service which also provides the NHS 111 single point of access to urgent care service. Mental health services are delivered across both areas by Northumberland, Tyne and Wear Mental Health and Learning Disabilities NHS Foundation Trust.

Most of the healthcare services for the 149,000 population of South Tyneside and 277,000 population of Sunderland are commissioned by NHS South Tyneside Clinical Commissioning Group (CCG) and NHS Sunderland CCG respectively. More specialised services for both populations, including some affected by these proposals, are commissioned by NHS England (NHSE). Deprivation among the population is worse than the England average and health needs greater, with particular issues around cancers, respiratory and cardiovascular disease.

In August 2016, STSHG, working in partnership with the two CCGs, started to review and plan hospital services as part of a strategic transformation programme known as *The Path to Excellence*. Reviews of individual services by clinical teams and patient engagement started with Phase 1 of the programme covering stroke, trauma and orthopaedics, obstetrics and gynaecology, paediatrics and increasing elective work at STDH.

On 19 September 2016, the early work was presented to a Joint Meeting of South Tyneside Council: Overview and Scrutiny Co-ordinating and Call-in Committee and People Select Committee and Sunderland Council: Health and Well-being Scrutiny Committee and Scrutiny Co-ordinating Committee. At the meeting, the NHS advised that staffing issues and concerns about outcomes in stroke services had led them to consider the need to concentrate all inpatient stroke care on one site at SRH. This was supported by the Joint Meeting on the basis this move would be a temporary solution pending a full consultation about future options.

The temporary arrangement for inpatient stroke care was implemented at the start of December 2016 and remains today.

On 8 November 2016, the scrutiny members convened to receive an update from the NHS which included sharing a draft document describing the *Path to Excellence* programme. The document was subsequently published as an *Issues Document* describing the major challenges facing the NHS and how clinical staff, patients, carers, the public and other stakeholders could get involved in generating ideas and shaping solutions. Between November 2016 and January 2017, NHS leaders attended 21 meetings across Sunderland and South Tyneside to raise awareness and get feedback to inform the clinical services review programme. In the event, it was decided that, given the significant workforce pressures creating urgent problems with continuity and quality of service provision, proposals for stroke, obstetrics and gynaecology, and paediatric emergency care should take priority in a Phase 1a of the *Path to Excellence* programme.

Proposals for change came from discussions in service specific clinical review groups. Each group developed a long list of potential scenarios, including the 'do nothing' configuration. These were assessed against a set of hurdle criteria reflecting the *Path to Excellence* aims of delivering sustainable, high quality, safe and affordable services within one to two years. Only scenarios that satisfied the hurdle criteria to a reasonable extent were developed further and evaluated in terms of clinical quality and sustainability; accessibility and choice; deliverability and capacity; and affordability and financial sustainability. Alongside the process for development of clinical options, two independent impact assessments (integrated equality, health and health inequalities and travel and transport) were commissioned.

In light of the emerging proposals and potential consultation, the two local authorities affected by the proposals decided to form a joint health scrutiny committee (JHSC) and the inaugural meeting took place on 30 January 2017. The methods for public engagement to be used in the planned public consultation were presented and discussed. A subsequent update was given in the JHSC meeting on 7 March 2017 and a *Patient Insight Report* from the listening phase of the programme was published on 31 March 2107.

Three options emerged for stroke services:

- **Option 1:** provide all inpatient stroke care from the SRH stroke unit (ward E58) and close the stroke beds (Ward 8) at STDH. Patients from South Tyneside and Sunderland would have their acute stroke care at SRH before being discharged to community stroke rehabilitation teams in their respective local communities.
- **Option 2:** provide all inpatient and the majority of acute care from the SRH stroke unit (ward E58) with repatriation of South Tyneside patients to STDH for rehabilitation after seven days for those patients requiring longer stays and who are medically stable for transfer.

- **Option 3:** provide all hyper-acute stroke care from the SRH stroke unit (ward E58) with repatriation of South Tyneside patients to STDH for further acute care and rehabilitation after 72 hours for those patients requiring longer stays and who are medically stable for transfer.

For obstetrics and gynaecology, two options emerged:

- **Option 1**: develop a free-standing midwife-led unit (MLU) at STDH to deliver low risk care with all high-risk intrapartum care and an alongside MLU at SRH.
- **Option 2**: develop a single medically-led obstetric unit and alongside MLU at SRH.

As a consequence, under both options, emergency and inpatient gynaecology care would be provided at SRH, as would the single special care baby unit (SCBU), integrated with the existing neonatal intensive care unit (NICU).

For paediatric emergency care, two options emerged:

- **Option 1:** provision of 12-hour day-time paediatric emergency department service at STDH with 24/7 paediatric emergency department at SRH. The service would operate at STDH from 08.00 to 22.00 (doors closing at 20.00 to allow children to be treated and discharged). The service would continue with full medical support.
- **Option 2:** development of a nurse-led paediatric minor injury/illness service between 08.00 and 22.00 at STDH with 24/7 acute paediatric services at SRH.

Outpatient and community based paediatric services would continue to be provided within and from both hospital sites. With both the proposed options, the adult emergency department service at both STDH and SRH would remain unchanged.

As part of preparing for NHSE assurance and to meet the four tests for service change, proposed options were subject to a variety of external review and advice, including from the Northern England maternity, neonatal and child health clinical networks.

On 19 April 2017, NHSE completed its Stage 2 pre-consultation assurance, agreeing a partially assured position for the Phase 1a proposals and supporting the planned move to enter into public consultation with a number of caveats, some to be satisfied prior to consultation and others to be satisfied post-consultation and prior to any final decision being made.

With the general election purdah period intervening, the final version of the pre-consultation business case was produced on 28 June 2017 before public consultation began on 5 July 2017. The JHSC received a formal presentation of the options under consideration in the public consultation on 17 July 2017 and convened on four further occasions during the period of public consultation to take evidence. It submitted an interim response to the consultation before it closed on 15 October 2017 indicating that it would continue its scrutiny and submit a final statement before the NHS made its final decision.

Following the consultation, all of the public feedback was independently analysed and published in a draft report in December 2017. The findings were presented and discussed at

the JHSC on 12 December 2017. Further dialogue was held with the public to consider whether this report was a fair reflection of the issues and views expressed during consultation following which a final, amended, version was published in January 2018. General themes included understanding of the relative benefits of the options and preferences expressed for Option 1 in each of the three services. However, concerns about getting to services further away, the associated costs and the risks of emergency inter hospital transfers were manifest. There was also a clear view that loss of services at STDH was unfair and the future of the hospital in doubt. Concerns about the capacity of SRH to cope were also raised.

The two independent impact assessments (integrated equality, health and health inequalities and travel and transport assessments) were updated after consultation to inform the final decision. A further external review of options for paediatric emergency services was commissioned from the Northern England Clinical Senate at the end of November 2017. The JHSC provided its final response in January 2018, reflecting many of the concerns raised during the consultation and captured in the associated independent report.

NHSE provided their final assurance on 19 February 2018 before, on 21 February 2018, the two CCGs convened a meeting in common to make final decisions about the options for the three services in Phase 1a of the *Path to Excellence* programme. They approved Option 1 for stroke services, Option 1 for obstetrics and gynaecology and Option 2 for paediatric services but with Option 1 as a transitionary step with opening hours extended in the evening from 20.00 to 22.00.

On 28 February 2018, the NHS wrote collectively to the JHSC to provide information to be considered prior to a potential recommendation for referral to the Secretary of State concerning the *Path to Excellence* programme Phase 1a consultation decisions. The letter covered consultation issues, concerns about the risks of delay and their understanding of the relevant regulations.

On 9 March 2018, the JHSC resolved to refer the matter to the Secretary of State.

On 27 March 2018, Save South Tyneside Hospital Campaign Group made the CCGs aware of a pre-action letter for judicial review of the *Path to Excellence* consultation and decision-making process.

The JHSC wrote to the CCGs on 12 April 2018 seeking local resolution by their responding to the concerns raised in the draft referral letter. The CCGs responded in writing on 27 April 2018. The JHSC proceeded with the referral at its meeting on 30 April 2018.

Basis for referral

The JHSC's letter of 1 May 2018 states that:

"The Joint Health Scrutiny Committee can refer decisions to the Secretary of State under certain prescribed criteria outlined in legislation. Based on these criteria the grounds for referral are as follows:

(i) adequacy of the content of the consultation, and
(ii) that the proposals would not be in the interests of the health service in the area

IRP view

With regard to the referral by the South Tyneside and Sunderland Joint Health Scrutiny Committee, the Panel notes that:

Equality issues

- the IRP has been asked to comment on the impact of the proposals with regard to the public sector equality duty and family test.

Consultation issues

- referral on the grounds of inadequate consultation relates to consultation with the relevant scrutiny body rather than wider consultation with patients, the public and stakeholders.
- the consultation focussed on the hospital services with urgent problems of sustainability - genuine concerns have been raised about the future of other hospital services, in particular at STDH.

Stroke

- the future of inpatient stroke services is informed by evidence from elsewhere and the temporary arrangements in place locally since December 2016.

Maternity

- no options for retaining obstetrics at STDH were put forward before or during consultation – implementation of Option 1 involves significant change.

Paediatrics

- options for retaining paediatric emergency care at STDH were put forward and considered – questions remain about their relative merits and implementation.

Advice

The Panel considers each referral on its merits and concludes that:

- **Consolidation of all inpatient stroke services at Sunderland Royal Hospital (Option 1) is in the interests of local health services.**
- **Consolidation of all obstetrics, inpatient gynaecology and special care for babies at Sunderland Royal Hospital with a free-standing midwife-led unit at South Tyneside Hospital (Option 1) is in the interests of local health services.**
- **Further work is required on long term options for paediatric emergency care as part of considering the future of the whole urgent and emergency care system for the area. In the meantime, consolidation of emergency paediatric care overnight at Sunderland Royal Hospital (Option 1) will mitigate the current risks to quality and continuity of care.**

Equality issues

In his commissioning letter for this advice, the Secretary of State asked the IRP to comment on *"the impact of these proposals on different groups, specifically families, and in relation to the public sector equality duty"*. Reference is also made to the requirements of the family test. The Panel understands that the family test relates to guidance for government departments in the process of policy formulation and does not apply to the NHS in the planning or delivering of services. The Panel has therefore commented on the impact of proposals on families only in the general terms that apply to all patients and carers.

The latest NHSE guidance[1] is clear about the need to consider the impact of any proposals on different groups and health inequalities, stating that *"Commissioners should also pay due regard to the duties placed on them under the Equality Act 2010 regarding the public sector equality duty ('PSED') and the duty to reduce health inequalities, and duties under the NHS Act 2006 (as amended by the HSCA 2012)"*. Annex 4 of the guidance (Stage 2 Assurance[2] Checkpoint sample questions) poses the question *"Has an equality impact assessment taken place?"* Similar requirements were included in the previous version of the guidance that was in place at the time of the matters under consideration here.

The NHS commissioned an independent equality, health and health inequalities integrated impact assessment (IIA) in parallel with the clinical service reviews to inform the evaluation of emerging options and approach to consultation. Although using a common methodology, the impacts of proposals for stroke, maternity and paediatrics were each considered separately to reflect differences in specific groups most affected. The IIA was available to support the consultation and feedback incorporated into the final version. It identified a significant overall positive impact for each of the proposals with improved health outcomes outweighing some increased inequalities. It also identified actions to enhance benefits and mitigate drawbacks related to issues such as access, travel, continuity of care and performance of services. The final IIA was an integral part of the decision making process, informing the final decisions made about the options for services[3].

Consultation issues

The JHSC has referred this matter to the Secretary of State on two grounds – the adequacy of the consultation undertaken and that the proposals would not be in the interests of the health service in its area. In considering issues of inadequate consultation, the 2013 Regulations relate to consultation with the scrutinising body rather than wider consultation with patients, the public and stakeholders. The Panel noted that the JHSC offered no evidence about the adequacy or otherwise of consultation with itself but instead "*believes*

[1] Planning, assuring and delivering service change for patients, NHS England, updated March 2018 available at https://www.gov.uk/government/organisations/independent-reconfiguration-panel/about

[2] *"Takes place in advance of any wider public involvement or public consultation process or a decision to proceed with a particular option."* Planning, assuring and delivering service change for patients, NHS England.

[3] South Tyneside CCG & Sunderland CCG Governing bodies meeting in common, 21 February 2018, Phase 1 Path to Excellence Decision Making Report, Sections 4.5, 5.5, 6.5, Appendices 2 and 3

that the consultation process did not comply with the Gunning Principles"[4]. This advice is offered on the understanding that matters of legality or otherwise are for the courts to determine, not the IRP. The concerns expressed by the JHSC about the wider consultation process with interested parties are addressed in this advice on the basis of their not being in the interests of the health service generally.

Faced with the commitment to consult about the permanent future of inpatient stroke services and the inability to get the medical staff needed to provide some services safely, the NHS decided to phase consultation for the *Path to Excellence* programme. In the Panel's view, this was a balanced decision with predictable effects on the consultation process and decisions that followed. First, options that did not address current shortages of key staff were ruled out. Second, because SRH is much the larger of the two hospitals serving the area, with a wider range of services, it is the likely location for consolidation of inpatient acute hospital services if required. Finally, consulting on selected inpatient services exacerbated concerns about knock-on effects and future intentions towards other local hospital services and the viability of STDH.

In this context, the Panel considers that more could have been done by the NHS from the outset to explain clearly the wider strategic context and be explicit about the viability of potential options or otherwise. However, given the time and effort invested on all sides and the myriad opportunities to have addressed these gaps, before, during and after the consultation period, it is disappointing that the process appears to have ended without a shared understanding on these matters between the NHS and JHSC. It appears to the Panel that there was a marked change in the period after the CCGs' decision which was quickly followed by the JHSC decision to refer. Whether this is down to a lack of trust, a breakdown in communication or some other reason, there needs to be a clear commitment to renewed engagement about the big picture for local services and shaping their future through the *Path to Excellence* programme.

The issues described above played out differently for the services included in the consultation and each was considered on its own merits before decisions were made.

Stroke

The JHSC acknowledges that the case for centralisation of hyper-acute stroke services is in line with national policy. The clinical case and the CCG's decision is supported by external clinical assurance and the SRH is the only logical location in the area given the scale of the service and the presence of related services such as vascular surgery.

The consultation's scope covered inpatient stroke services and having considered all the evidence, the Panel concludes that centralising these at SRH is in the interests of local health services. The Panel agrees with the JHSC that the NHS must ensure the rest of

[4] Further information about Gunning principles (R v London Borough of Brent ex parte Gunning) can be found at: http://www.nhsinvolvement.co.uk/connect-and-create/consultations/the-gunning-principles

the stroke pathway outside hospital, both prevention and after care, is functioning to its full potential for the whole population, engaging primary care and community rehabilitation services particularly.

Maternity

The two options for maternity services are driven by the need to consolidate consultant-led services on one site to secure safe and sustainable medical staffing. The one site proposed is SRH, primarily because it is much the larger unit currently and has neonatal intensive care on site. External clinical assurance supported this option and highlighted the potential benefits of more hours of consultant presence for births, the larger combined neonatal and special care baby unit, and the reduction of transfers between sites for babies moving in and out of intensive care. The Panel agrees that consolidation is necessary to address workforce risks to the safety and quality of services and that SRH is the logical location.

Option 1 also proposes a free-standing MLU at STDH, providing both closer access and wider choice to local mothers-to-be in line with national policy. Although the model of care is well established in practice and supported by the evidence of a significant national study, the Panel understands the concerns raised by the JHSC about its implementation, particularly with regard to securing ambulance response, and the volume of births needed for economic viability.

However, the free-standing MLU is not a substitute for a consultant-led unit and if it were not to be present then no births would take place at STDH. **In this context, the Panel concludes that Option 1 is in the interests of local health services.** Risks identified around the free-standing MLU and its viability must be addressed in a detailed implementation plan incorporating both the necessary assurance about ambulance response and the practical external advice provided about making the free-standing MLU part of a comprehensive hub, offering the fullest possible range of pre and post-natal services, that will engage its users and give them confidence.

Paediatrics

Nowhere has the commitment of staff to services and patients been more clearly demonstrated than in the debate about paediatric emergency care. The Panel noted that the two options proposed are significantly different. Option 1 is essentially the same service as now but open for 12 hours a day rather than 24, thus easing the requirement for medical cover on site. Option 2 is for a nurse-led paediatric minor injuries and illness service 12 hours a day.

Although it better addresses sustainability of medical staffing, Option 2 came with significant caveats. The Panel noted that after consultation the CCGs commissioned a further external review of the two consultation options and a third option previously ruled out, before effectively deferring implementation of Option 2 to allow more work to be done.

The Panel shares the concerns of others about the need to understand in detail how Option 2 could work, particularly with regard to paediatric minor illness, and how it will fit safely and effectively into the overall urgent and emergency care service for children in the area. A detailed proposition must be developed and considered before a final decision to implement is made. This work should provide the opportunity to renew clinical engagement, strengthen collaboration and address the sustainability of both the medical and nursing workforce. **In the meantime, consolidation of paediatric emergency care overnight at SRH (Option 1) between the hours of 22.00 and 08.00 will mitigate the current risks to quality and continuity of care.**

Conclusion

The Panel understands how the options put forward for consultation must have appeared to the population of South Tyneside and why this has sparked genuine concerns about the future of local services at South Tyneside District Hospital. At the same time the NHS, facing risks to the safety, quality and continuity of some services, needed to act in the interests of patients.

Whatever the strengths and weaknesses of the process so far, the NHS, the JHSC and their stakeholders must step forward decisively on two priorities that will build confidence for the future. First, by addressing concerns related to implementing changes to services, notably ambulance capacity to respond, workforce development and practical mitigations to reduce negative impacts on travel for patients and carers. This requires continuing engagement in the planning, implementing, monitoring and evaluating of the changes to services to ensure they deliver what is intended for the population served. Second, by renewing engagement that will develop better understanding about the bigger picture for health and health care in the area and within it the future of the South Tyneside District Hospital. This includes building on the work done so far, including the vanguards in the area, to explore further opportunities for closer working across hospital and community services.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

APPENDIX ONE

LIST OF DOCUMENTS RECEIVED

South Tyneside and Sunderland Joint Health Scrutiny Committee

1 Referral letter to Secretary of State for Health from Cllr Rob Dix (South Tyneside Council) and Cllr Norma Wright (Sunderland City Council), 1 May 2018.
Attachments:
2 Document – Referral to the Secretary of State for Health

NHS

1 IRP template for providing assessment information
Attachments:
2 NHS response to JHOSC re intention to refer to Secretary of State, 27 April 2018
3 Attachment 1_3_1a NE Maternity Network O&G review comments, January 2017
4 Attachment 1_3_1b NTW Local maternity System response to Path to Excellence
5 Attachment 1_3_1c NTW Local Maternity System Letter to JHOSC
6 Attachment 1_3_1d Letter from North East Neonatal Network, 2017
7 Attachment 1_3_1e Northern Neonatal Transfer Services Response
8 Attachment 1_3_1f Child Health Network response to Path to Excellence, October 2017
9 Attachment 1_3_1g NE Clinical Senate Emergency and Urgent Paediatric Services Report
10 Attachment 1_3_1h Northern England CVD Network Stroke Service Review Report
11 Attachment 1_3_1i Letter from National CD for Stroke, Prof A Rudd, August 2017
12 Attachment 1_3_1j Letter from NEAS to CCGs
13 Attachment 1_3_1k NEAS Impact Assessment
14 Attachment 1_3_2a PCBC Full Pre-Consultation Business Case
15 Attachment 1_3_2b PCBC Appendix 4_1 PCBC Communications and Engagement Strategy
16 Attachment 1_3_2c PCBC Appendix 4_2 communications and engagement group, terms of reference
17 Attachment 1_3_2d PCBC Appendix 4_3 PCBC Joint Overview and Scrutiny Committee rems of reference
18 Attachment 1_3_2e PCBC Appendix 4_4 PCBC Summary of patient insight and experience
19 Attachment 1_3_2f PCBC Appendix 5_1 PCBC Overview of Clinical Design Process
20 Attachment 1_3_2g PCBC Appendix 5_2 Five tests self-assessment
21 Attachment 1_3_2h PCBC Appendix 5_3 PCBC Internal and external assurance arrangement
22 Attachment 1_3_2i PCBC Appendix 6_1 NE CVD Network Stroke Service Review
23 Attachment 1_3_2j PCBC Appendix 6_2 Summary Integrated Impact Assessment Report
24 Attachment 1_3_3a Public Consultation Document
25 Attachment 1_3_3b Public Consultation Document Summary

26 Attachment 1_3_3c Public Consultation Easy Read
27 Attachment 1_3_3d Fact Sheet - Stroke
28 Attachment 1_3_3e Fact Sheet - Obstetrics and Gynaecology
29 Attachment 1_3_3f Fact Sheet - Urgent and Emergency Paediatrics
30 Attachment 1_3_3g FAQ Stroke
31 Attachment 1_3_3h FAQ Obstetrics and Gynaecology
32 Attachment 1_3_3i FAQ Urgent and Emergency Paediatrics
33 Attachment 1_3_3j Consulation Communications Plan
34 Attachment 1_3_4a Consultation Analysis Final Report, January 2018
35 Attachment 1_3_4b Consultation Assurance Report
36 Attachment 1_3_4c Consultation Assurance Report Appendices
37 Attachment 1_3_4d CI Best Practice Certificate
38 Attachment 1_3_5a Decision Making Report
39 Attachment 1_3_5b Decision Supporting Information
40 Attachment 1_3_7a Minutes from Decision Making CCG meeting-in-common
41 Attachment 1_3_5c Decision making process and evaluation categories
42 Attachment 1_3_5d Decision Making Process Diagram
43 Attachment 1_3_6a NHS England Stage 2 Assurance Letter, 19 April 2017
44 Attachment 1_3_6b NHS England Final Assurance Letter 19 February 2018
45 Attachment 2_3a Path to Excellence issues booklet
46 Attachment 2_3b A review of patient insight, February 2017
47 Attachment 2_3c Overview of Clinical Design Process
48 Attachment 2_3d Minutes of 19 September 2016 JHOSC meeting
49 Attachment 2_3e Minutes of 08 November 2016 JHOSC meeting
50 Attachment 2_3f Minutes of 30 January 2017 JHOSC meeting
51 Attachment 2_3g Minutes of 07 March 2017 JHSOC meeting
52 Attachment 2_3h Minutes of 17 July 2017 JHSOC meeting
53 Attachment 2_3i Minutes of 01 August 2017 JHSOC meeting
54 Attachment 2_3j Minutes of 04 September 2017 JHSOC meeting
55 Attachment 2_3k Minutes of 21 September 2017 JHSOC meeting
56 Attachment 2_3l Minutes of 10 October 2017 JHSOC meeting
57 Attachment 2_3m Minutes of 12 December 2017 JHSOC meeting
58 Attachment 2_4a Letter to Sunderland and South Tyneside JHOSC, 28 February 2018
59 Attachment 2_4b Minutes of 10 April 2018 JHOSC meeting
60 Attachment 2_4c Letter to CCG - draft Secretary of State referral, 12 April 2018
61 Attachment 2_4d CCG response to JHOSC referral to Secretary of State draft letter 27 April 2018
62 Attachment 2_4e Letter from Mr Bas Sen to support CCG response to JHOSC, 27 April 2018
63 Attachment 2_5a Health Impact Assessment - Stroke
64 Attachment 2_5b Health Impact Assessment - Obstetrics and Gynaecology
65 Attachment 2_5c Health Impact Assessment - Urgent and Emergency Paediatrics
66 Attachment 2_5d Final IIA Post-consultation Summary Report, January 2018

67 Attachment 2_5e Additional information to Integrated Impact Assessment Summary Report
68 Attachment 3_2a South Tyneside Community Health Profile
69 Attachment 3_2b Sunderland Community Health Profile
70 Attachment 3_3aTravel and Transport working group terms of reference
71 Attachment 3_3b Travel and Transport work plan
72 Attachment 3_3c Travel impact assessment scope, September 2016
73 Attachment 3_3d Travel and Transport Impact Baseline Report Executive Summary, January 2017
74 Attachment 3_3e Travel and Transport Impact Baseline Report, January 2017
75 Attachment 3_3f Travel and Transport Impact Assessment Summary Report, June 2017
76 Attachment 3_3g Travel Impact Assessment of service review options, July 2017
77 Attachment 3_3h Travel and transport impact public summary
78 Attachment 3_3i Travel Field Testing Exercise
79 Attachment 3_3j Travel Stakeholders full report, 11 October 2017
80 Attachment 3_3k Travel and transport update report, January 2018
81 Attachment 3_3l Travel and Transport Impact Assessment final, March 2018
82 Attachment 3_3m Wear Transport Report to Secretary of State, July 2012
83 Attachment 3_7a City Hospitals Sunderland CQC Report, January 2015
84 Attachment 3_7b South Tyneside Hospital CQC Report, October 2017
85 Attachment 4_4a Press Release temporary suspension at STDH SCBU 30 November 2017
86 Attachment 4_4b Press Release suspension of births, 03 December 2017
87 Attachment 4_4c Press Release maternity services 15 January 2018
88 Attachment 4_4d Save Tyneside Hospital Campaign Group JR letter, 27 March 2018
89 Attachment 4_4e PTE Response to Save Tyneside Hospital Group JR letter, 10 April 2018
90 NHS JHSC Interim Response
91 NHS JHSC - Final Report, January 2018

Other evidence

1 Letter Before Action issued by Irwin Mitchell solicitors re application for judicial review of acute hospital reconfiguration in South Tyneside and Sunderland, 27 March 2018
2 Correspondence from clinical staff at South Tyneside District Hospital, 6 June 2018

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Stroke services in Mid and South Essex

General comments on the consultation and its stroke specific proposals

The Stroke Association welcomes the opportunity to respond to the stroke specific elements of the Mid and South Essex proposals. We have been actively supporting this consulting process by supporting those affected by stroke to engage at STP events and at dedicated Stroke Association events. We have also been meeting with local MPs in Mid and South Essex to help explain the importance of reorganisation and share evidence.

We have been encouraged by the steps the STP has taken to involve the public in this important decision. It is essential that the views of people affected by stroke are fully considered and taken into account in the process of reshaping stroke services in Mid and South Essex. Recently published evidence has shown the value of involving the patient perspective in a major system change such as an acute stroke service reconfiguration.[1] Engagement and consultation with stroke patients provides the opportunity to 'manage actual or potential resistance or agitation' to plans, to gain verification that plans are supported by patients, and act a reminder of the ultimate importance of reconfiguration, to achieve high quality stroke care for all patients.

The Stroke Association supports the decision to reconfigure acute stroke services in Mid and South Essex. Reconfiguration of services to a more centralised model, as is proposed here, has been proven to save lives, improve recoveries and save the NHS money[2] through improving access to evidence based care.[3]

The available evidence suggests that the proposals outlined in the consultation document will help stroke patients in Mid and South Essex achieve better outcomes after their stroke. The model of diagnosing and treating stroke patients in local hospitals before transporting them to a specialist centre has been shown in other locations to increase overall rates of thrombolysis.[4]

We support the decision to create a specialist stroke unit in Basildon. We recommend that this is developed in line with the Royal College of Physicians (RCP) guideline definition of specialist stroke service, 'all components of a specialist acute stroke service should be based in a hospital which has the requisite facilities to investigate and manage people with acute stroke and the medical and neurological complications.' [5] We've heard anecdotally from hospital staff that the specialist stroke workforce is stretched within Mid and South Essex. Developing a specialist stroke unit in Basildon will provide the opportunity to maximise the use of staff and deliver the best possible stroke care

Reorganisation of acute stroke care is supported by NHS England and by governments and health leaders across the UK. The NHS England's Five Year Forward View refers to the "compelling case for greater concentration of care"[6] and

has also produced guidance to support hospitals, CCGs and Sustainability Transformation Plans (STPs) to reconfigure services[7]. The Royal College of Physicians' guideline on stroke also emphasises the need for greater centralisation[8]. In Northern Ireland the Government has undertaken a pre-consultation on acute stroke reconfiguration across the country. The National Clinical strategy for Scotland acknowledges the need to evaluate the Hyper Acute Stroke Unit (HASU) model in the Scottish context and Wales has also begun research and discussions around reconfiguring acute stroke services.

Reconfiguration is even more important because research has shown that the scale of stroke is going to increase. Within two decades the number of strokes will almost double, and the number of stroke survivors will increase by a third.[9] Reorganisation allows for the best use of workforce and specialist infrastructure, it helps to make stroke services more efficient and results in higher quality care. As pressure on the NHS and social care system from the UK's ageing population increases the importance of implement acute stroke reconfigurations will also increase.

Centralisation also helps to address the continued unwanted variation of stroke care across England, including in Mid and South Essex. Patients at Broomfield and Basildon have poorer access to Speech and Language therapy and patients at Southend are not regularly having all of their care delivered in a HASU.[10] Reconfiguration will help ensure equity of access to specialist acute care for all stroke patients within Mid and South Essex.

It is important that post-acute and community rehabilitation services are also put in place to provide evidence based care, and the reorganisation of hospital care is an excellent opportunity to do this. 45% of stroke survivors, in our 2016 survey, have described being abandoned after leaving hospital. They felt there was no support for them to continue their recovery. For stroke survivors to be supported to make their best possible recovery, well-resourced community services must also be put in place in Mid and South Essex. We would like to see the STP develop plans, alongside this reconfiguration, for high quality Early Supported Discharge, 6-month follow-up reviews, community rehabilitation and peer support services across Mid and South Essex, all of which are vitally important to stroke survivors to aid their recovery and are highlighted in NICE and RCP guidelines.

Diagnosis and treatment at local hospital

The recommended treatment for patients with acute ischemic stroke is assessment through brain imaging and, if eligible, administration of thrombolysis.[11] Thrombolysis treatment has been shown to significantly reduce the number of stroke patients who die and also reduce levels of disability following stroke.[12]

We support the decision to transfer suspected stroke patients by ambulance to their local A&E to diagnose and initiate treatment. Research has shown that this model proposed in Mid and South Essex, is safe[13]. Research has also shown that it can

lead to increased number of patients being given access to thrombolysis compared to a local hospital model as is currently set up in Essex.[14]

This model, often referred to as 'drip and ship' provides access to thrombolysis and to the best possible ongoing treatment by being transferred to the specialist stroke unit in Basildon. This ensures patients experience the same access to specialised workforce, who are able to administer the same evidence-based interventions patients would receive in a direct to specialist stroke unit model.[15] Evidence also suggests that there is little difference in patient outcomes between direct transfer and 'drip and ship'.[16]

Data from SSNAP shows that whilst the proportion of eligible patients who receive thrombolysis (97%, Southend 87% Basildon and 94% in Broomfield) is relatively high in all three hospitals, there remains a minority of eligible patients who are missing out on this life saving drug, and we support efforts to improve the situation.[17] By reconfiguring acute stroke services and implementing this 'drip and ship' model, it will allow more patients to receive thrombolysis, leading to more lives saved and more patients avoiding serious disability.

We support the proposal to diagnose and transfer patients with haemorrhagic stroke from their local hospital to Basildon or the higher specialised centre in Cambridge or Romford. Research has shown that centralised stroke care also benefits patients with brain bleeds. [18]

Of course, it is important that any major service reconfiguration is closely monitored and assessed. We appreciate that changes to hospital services can be a scary time for patients and their family and friends. We therefore recommend the STP evaluates this model to understand its effectiveness and its impact on patient's outcomes, as was done in London and Manchester following their reconfigurations. It is important that patient experiences are also monitored to evaluate the impact of the reconfiguration, the Stroke Association can support with this if necessary. It is important that analysis is used to further improve stroke services. In Greater Manchester, the evaluation[19] resulted in a second, more comprehensive, reconfiguration to mirror the pathway used in London and further improve stroke services, with good resulting outcomes for patients.[20]

We know that it can be upsetting and stressful for family and friends to have to travel further to visit their loves ones in hospital. We therefore welcome the decision to fund transport for patient's family and friends between hospitals. We also welcome the decision that this is reviewed to ensure that it is properly supporting families to be able to see their loved ones whilst they are being treated at Basildon hospital.

TIA patients

We would recommend that TIA patients are also explicitly considered in this stroke reconfiguration to ensure they get timely access to treatment and support. There is strong evidence to suggest that treating someone with suspected TIA in an urgent acute setting reduces the likelihood of them going on to have a full or completed stroke within seven days. Giles and Rothwell (2007) showed that the risk of completed stroke was much lower in studies of emergency treatment of TIA in specialist stroke services compared to non-urgent settings (0.9% v 11.0%).[21]

Treating someone with TIA in the same way as someone with full stroke can also present an early opportunity to engage in secondary prevention. For example, fully assessing someone with TIA could uncover previously undiagnosed stroke risk factors such hypertension or atrial fibrillation (AF), allowing clinicians to begin managing these associated conditions.

Specialist Stroke Unit at Basildon

The Stroke Association supports the decision to develop a specialist stroke unit at Basildon hospital. The evidence is clear that stroke patients achieve better outcomes if they spend the majority of their stay in hospital is on a specialist stroke unit, preferably a HASU. Specialist stroke units enable patients to have access to the right skills and equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams.

We support the decision to have the specialist stroke unit as Basildon so that it can have strong links with the existing Essex cardiothoracic centre for heart and lung problems which is also based at Basildon. Evidence from the STP transfer modelling also shows that Basildon is best situated in terms of access and travel times. The modelling shows that 91% of patients will get to the hospital by 45 minutes by blue light transfer compared with 86% for Southend and 85% for Broomfield. [22]

Stroke units with higher patient volumes, like specialist stroke units, have a better quality of care.[23] NHS guidelines state that stroke units need to admit between 600-1500 patients a year for staff to have enough clinical experience and institutional learning to maintain their experience.[24] Data from the SSNAP annual portfolio April 2016 – March 2017 shows that all of the existing hospitals in Mid and South Essex either do not meet or are at the lower end of this range (Broomfield 555, Basildon 620 and Southend 678).[25] Creating one specialist stroke unit for patients in Mid and South Essex will ensure that it has high enough patient volume to maintain the staff experience needed for high quality care.

Effective stroke interventions such as, brain imaging, thrombolysis and thrombectomy require expert knowledge and infrastructure to diagnose patients, safely deliver treatment and monitor for and treat any complications.

Workforce

By creating a specialist stroke unit in Basildon the existing specialist workforce will be able to be used most effectively to provide evidence based interventions that save lives and reduce disabilities. Access to and availability of a specialist stroke workforce continues to be a problem for delivering high quality evidence based stroke care. The British Association of Stroke Physicians has stated 'Clinical developments in UK stroke services have overtaken the specialist resource needed to support them'.[26] In 40% of hospitals there is at least one unfilled stroke consultant post.[27] We know from anecdotal evidence that hospitals in Mid and South Essex are struggling with workforce issues, and these must be resolved in order to maintain a good level of service for those affected by stroke in the area.

Rehabilitation and ongoing care

Centralising acute services is incredibly important, however this must be done in conjunction with high quality post-acute rehabilitation services that can deliver evidence-based care for all stroke survivors. Without this support stroke survivors cannot continue their recoveries.

We support the proposal that the stroke team in Basildon would provide a clear plan to support stroke patients' recoveries including physiotherapy and speech and language therapy. In acute rehabilitation, variation also remains a problem, nationally only 31% of stroke units provide at least two types of therapy to applicable patients 7 days a week.[28] Data from SSNAP shows that within the three hospitals in Mid and South Essex the percentage of eligible patients receiving the equivalent of at least 45 minutes, 5 days a week physiotherapy varies considerably (15% at Southend, 27% at Broomfield and 46% at Basildon).[29]

Stroke patients who need ongoing inpatient rehabilitation should be treated in a specialist stroke rehabilitation unit. In particular the 2016 RCP guidelines state 'patients should accumulate at least 45 minutes of each appropriate therapy every day, at a frequency that enables them to meet their rehabilitation goals, and for as long as they are willing and capable of participating and showing measurable benefit from treatment'.[30] Without this 7 day rehabilitation in acute stroke units in Mid and South Essex patients may miss out on vital rehabilitation assessments and intervention, which can impact on patient outcomes and quality of life.

Early Supported Discharge

Early Supported Discharge (ESD) service is central to a good start to post-acute rehabilitation. Evidence suggests that ESD for people with mild to moderate disability after stroke helps to reduce dependency and admission to institutional care.[31] ESD is also cost-effective and can save money. We recommend that a properly resourced, stroke specific early supported discharge service is in place for all eligible stroke patients in Mid and South Essex.

Community support

Stroke survivors need to have access to services and support in the community to be able to continue their recovery. However a survey carried out by the Stroke Association in 2016 found that 45% of stroke survivors across the country felt 'abandoned' after being discharged from hospital.

Stroke survivors report that they need early and ongoing rehabilitation and support, regular holistic reviews of their progress and information about stroke and sources of support throughout their stroke journey. Without 6 month reviews ongoing issues are not identified and patients can struggle to adapt to life after stroke. Access to support needs to be available into the long term as research has shown that around half of stroke survivors between 1 and 5 years post stroke have at least one unmet need.[32]

In Mid and South Essex stroke patients have told us how they left hospital or finished their ESD rehab without a plan or named contact for ongoing support. We therefore believe it is important that community support for those affected by stroke is also improved alongside this acute reconfiguration of services in Mid and South Essex

Conclusion

The acute service reconfigurations that have taken place across the UK, most notably in London and Greater Manchester, have been successful in improving the overall quality of stroke care for patients in that area. However progress in other areas has been slower, and unfortunately these delays lead to unnecessary variation and deaths and disability from stroke that could have been avoided.

Our latest report, *Current, future and avoidable costs of stroke in the UK*[33], warns that the number of stroke survivors in the UK is expected to rise to over two million over the next 20 years, and each year, 700,000 people will be living with a long-term disability as a result of stroke. There is an urgent need to reshape stroke services to save more lives and reduce disabilities and the Stroke Association welcomes this process as an opportunity to create a world class stroke service for everyone in Mid and South Essex.

However it is vital this process is about reshaping the *whole stroke pathway* – with adequate investment and consideration given to post hospital/long term care as well as lifesaving acute care. Ensuring people affected by stroke have sufficient and timely access to physiotherapy, occupational therapy, speech and language therapy, psychological and emotional support and peer support will help them make the best recovery possible.

[1] Fulop et al (2018) http://onlinelibrary.wiley.com/doi/10.1111/hex.12668/full

[2] . Hunter, RM. (2013). Impact on Clinical and Cost Outcomes of a Centralized Approach to Acute Stroke Care in London: A Comparative Effectiveness Before and After Model. 2013. Available: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0070420
[3] Bray BD, Ayis S, Campbell J, et al. Associations between the organisation of stroke services, process of care, and mortality in England: prospective cohort study
[4] Price et al 2009
[5] Royal College of Physicians (2016) National clinical guideline for stroke. Fifth Edition. P.14 Available: https://www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines Last Accessed 02 March 2018
[6] NHS England (2014) Five Year Forward View. Page 23. Available: https://www.england.nhs.uk/wpcontent/uploads/2014/10/5yfv-web.pdf
[7] NHS England (2016) Stroke services: configuration decision support guide. p.44 Available: http://www.eoescn.nhs.uk/index.php/download_file/force/2069/168/ Last Accessed 02 March 2018
[8] Royal College of Physicians (2016) National clinical guideline for stroke. Fifth Edition. Available: https://www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines
[9] A Patel et al Current, Future and Avoidable costs of stroke costs of stroke in the UK, Executive Summary Part 1: Burden of stroke in the next 20 years and potential returns from increased spending on research. (2017) p.6 Available: https://www.stroke.org.uk/sites/default/files/costs_of_stroke_in_the_uk_report_-_executive_summary_part_1_v2.pdf Last Accessed 02 March 2018
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