Middlesbrough
moving forward

Legal and Governance

HEALTH SCRUTINY PANEL

Date: Tuesday 13th September, 2022
Time: 4.00 pm
Venue: Mandela Committee Room

AGENDA

1. Apologies for Absence

2. Declarations of Interest

3. Minutes - Health Scrutiny Panel - 19 July 2022

   To Follow

4. {my} Dentist - Proposed Cleveland Retail Park Scheme - Consultation — 3 - 20

   Representatives from {my} Dentist will be in attendance to discuss a proposal to merge its 3 current practices in Middlesbrough to create a new practice on Cleveland Retail Park.

5. Integrated and Urgent Care in Middlesbrough and Redcar and Cleveland — 21 - 22

   The Director at North East & North Cumbria Integrated Care Board (NENC ICB) will be in attendance to update Members on the current consultation exercise and high level feedback received to date.

6. Department of Health & Social Care Guidance - Health overview and scrutiny committee principles — 23 - 30

7. Next Steps in Increasing Capacity and Operational Resilience — 31 - 40

in Urgent and Emergency Care Ahead of Winter - NHS England

8. Chair's OSB Update

9. Any other urgent items which in the opinion of the Chair, may be considered.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesbrough
Monday 5 September 2022

MEMBERSHIP

Councillors D Jones (Chair), C McIntyre (Vice-Chair), A Bell, D Davison, A Hellaoui, T Mawston, D Rooney, P Storey and M Storey

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Caroline Breheny, 01642 729752, caroline_breheny@middlesbrough.gov.uk

Europa House, Europa Trading Estate
Stoneclough Road, Kearsley, Manchester M26 1GG
T: 01204 799799 www.mydentist.co.uk

Project Name: *Merge & Relocate – Middlesbrough*

Existing site: *Martonside/Newlands/Ormesby*

Proposed site: *Cleveland Retail Park*

Document summary	
Page 1	*Project Details*
Page 2	*Project information & overview*
Page 5	*Decision & signature*

Section 1: Project information & overview

Overview of investment:

We're proposing to invest a total of £1.5m into NHS dentistry. We are very excited about this investment into a brand-new state of the art dental practice that will enable us to increase patient access in Middlesbrough. {my}dentist is committed to providing the highest quality of care in the best environments possible.

Purpose:

Under section 13Q of the NHS Act, NHS England has a statutory duty to 'make arrangements' to involve the public in the commissioning services for NHS patients. As part of our business case to the NHS Cumbria and North East regional commissioning team we are undertaking both the patient and wider stakeholder engagement to ensure the relevant parts relating to the Act are met. Therefore, the intended use of this document will be to support the NHS Commissioners in their approvals process.

Background and rationale:

The changes to the way dental services are now delivered, is requiring a radical re-think from dental providers on how best they can provide viable services going forward. Recruitment of workforce is becoming increasingly challenging as more dentists are either leaving the NHS or choosing private. Where dentists are remaining in the NHS, dentist working patterns have changed, through working part time hours over several practices, which means additional surgeries and staff are required to achieve our NHS contract targets.

We have provided NHS dental services across three sites in Middlesbrough since 2009, as such our premises now require significant investment in terms of modernisation (buildings & equipment) and re-development to create the additional capacity needed to deliver our NHS targets. We know from ongoing conversations with stakeholders, as well as news coverage that there is high patient demand for dental services in the Middlesbrough area. Therefore, our intention is to relocate our three existing practices listed below into a single large practice located on the Cleveland Retail Park.

1. Cargo Fleet Lane, Ormesby
2. Marton Road, Newlands
3. Martonside Way, Middlesbrough

This type of initiative is not unique to {my}dentist, we have now successfully delivered 7 projects across the UK this year alone, working with NHS commissioners to realise the significant investment and benefits associated with these developments. Our experience to date shows that the new facilities help with the recruitment of dentists, who like to work alongside their colleagues in modern facilities. As an example, set out below is the impact associated with NHS workforce recruitment both pre and post these developments:

1. **Coalville relocation**
   a. 6-weeks prior to build: 50% vs total hours target
   b. 6-weeks after build: 100% vs total hours target

2. **Blackburn merger**
   a. 12-weeks prior to build: Capacity hindered NHS access as insufficient surgeries
   b. 6-weeks after build: Has the relevant number of surgeries and is providing improved access

3. **Halifax merger**
   a. 6-weeks prior to build: Capacity hindered NHS access as insufficient surgeries
   b. 2-years after build: Building additional surgeries to meet clinician demand

4. **Wootton Bassett expansion**
   a. 6-weeks prior to build: Capacity hindered NHS access as insufficient surgeries
   b. 12-months after build: Working through patient list and reducing NHS waiting times for an appointment

Benefits to patients:

The main benefit arising from this proposal is to create patient access though the creation of additional capacity. This capacity will enable more patients to access services that addresses their oral health needs. Some of the key benefits for relocating these practices include, but not limited to:

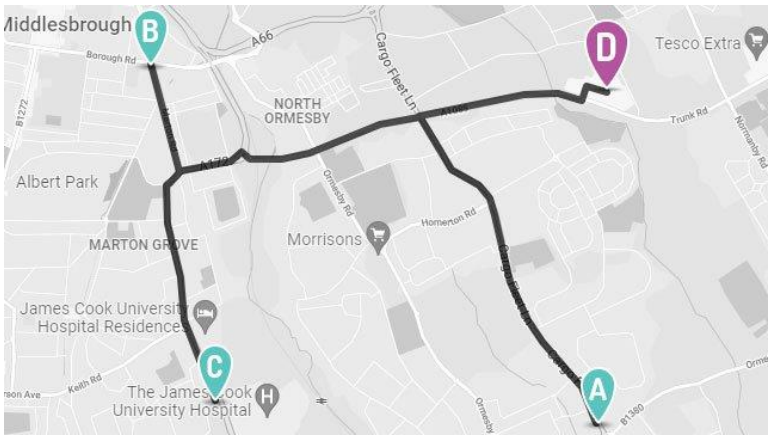
- Provides a “single entry point for all dental requirements”.
- Very accessible to all patients.
- Extended practice opening hours allowing patients to access the practice early mornings, evenings along with weekend appointments.
- Parking and accessibility: Free parking in the retail park and bus stops located nearby.
- Access to a wide range of NHS and private treatments.
- Improved access for more patients which is not possible in the existing premises as we are at capacity in our current buildings.
- New surgeries with state-of-the-art equipment.
- Wheelchair and disabled access.
- All surgeries on ground floor level.
- Improved waiting area and facilities.
- Our existing clinicians would also be moving to the new dental practice.

Benefits to the Practice Team:

- Brand new future proofed working environment, moving away from the traditional sub scale dental practice environment.

- Fully digital working environment including intra oral scanner technology.
- Multi-skilled team allowing for growth and development in their roles.
- Treatment Care Coordinator to support patients with their decision making.
- Choice of NHS or Private or both to support with clinician professional development.

Distances between existing & new site:



A: Cargo Fleet Lane, Ormesby TS3 0LW (2.3 miles by car)

B: Marton Road, Newlands, TS4 2EN (2.3 miles by car)

C: Martonside Way, Middlesbrough, TS4 3BU (3 miles by car)

D: Cleveland Retail Park, Middlesbrough, TS6 6UX

Current Practices

A: Cargo Fleet Lane, Ormesby

B: Marton Road

C: Martonside Way

Case Study:

We understand it may be difficult to visualise what we are hoping to achieve. In brief, our intention is to invest c £1.5m into a brand-new state of the art facility, which will increase both patient access and enhance the patient experience. To provide context below is a link to one of our recent investments into Killingworth, North Tyneside. Hopefully this will provide you with a view of how our new practice in Middlesbrough will look if we are successful in obtaining NHS approval.

https://3dshowcases.co.uk/mydentist-Killingworth

Section 2: Decision & signature:

Do you support the proposed move? Yes / No (delete as appropriate)

Decision & signature		
Job title	***Signature (print name)***	***Date***

Improving access to NHS dentistry in Middlesbrough

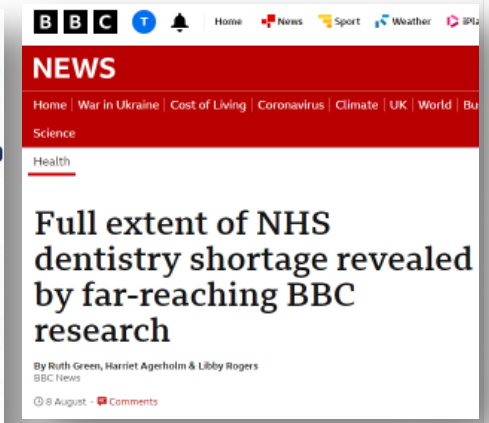
Investment in a new practice with better facilities and accessibility

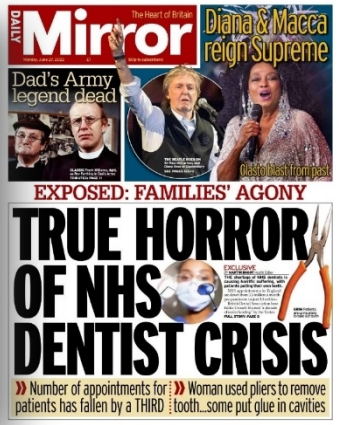
Summary

1. Improving access to NHS dentistry
2. Recent example: Killingworth, North Tyneside
3. The Middlesbrough project

There is a growing crisis in access to NHS dentistry


Hot pots
Celebrities get fired up making ceramics
A new start after 60
I became a ski instructor
The Guardian
For 200 years
Millions without NHS dental care as practices close or turn private
'Bad appl... claim fu... parliame... sexism row
Evacuation of Mariupol steelworks begins


BBC
Home | News | Sport | Weather
NEWS
Home | War in Ukraine | Cost of Living | Coronavirus | Climate | UK | World | Science
Health
Full extent of NHS dentistry shortage revealed by far-reaching BBC research
By Ruth Green, Harriet Agerholm & Libby Rogers
BBC News
8 August · Comments


Daily Mirror
Diana & Macca reign Supreme
Dad's Army legend dead
EXPOSED: FAMILIES' AGONY
TRUE HORROR OF NHS DENTIST CRISIS
Number of appointments for patients has fallen by a THIRD
Woman used pliers to remove tooth...some put glue in cavities


TRIPLE NECTAR POINTS
Daily Mail
As their viral video is sold as 'digital art'...
British boys who bit off a £500k payday
Some NHS patients forced to wait till 2024 for appointment
THE DENTIST WILL SEE YOU... IN THREE YEARS
Boris and Carrie name the big day (but it's not until 2022)


Mail Online
4million people in England left without an NHS dentist after 2,000 quit in just a year leaving health service with smallest workforce in a decade


The Telegraph
The entire county where you cannot get an NHS dentist appointment
Patients reduced to tears after 2,000 dentists quit the health service, forcing people to spend thousands going private


The Guardian
The Guardian view on the dentist shortage: a gap that needs filling
Editorial


Struggle to get a dentist in Devon is revealed
One person needed wheelchair access but there were no NHS dentists that were wheelchair accessible and had to travel 15 miles away and had to go via public transport


Thousands of Wigan children have not seen an NHS dentist all year


NHS dental patients 'face 90-mile trip', union claims

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The crisis is the result of an acute workforce shortage

- **3,000 dentists have left the profession since 2020.** New data shows that since 2020-21, the number of dentists delivering some NHS care has fallen by more than 3,000 (13%), the largest fall on record.

- **75% of dental practices are now struggling to fill vacancies.** This rises to 93% among practices with the highest NHS commitments. In addition, 29% of practices with vacancies say these have been empty for at least 12 months.

- **Half of NHS dentists have reduced their NHS commitment since the pandemic.** In addition, in a survey with the BDA, 75% of dentists said they were likely to reduce their NHS commitment over the next 12 months, with 45% planning to go fully private.

- **UK dentistry is heavily reliant on overseas dentists, which is under particular pressure.** In 2019, 28.3% of dentists who registered with the GDC qualified outside the UK. In 2020 (the last year for which figures are available) the number of overseas dentists on the GDC register had fallen to 2,937, a reduction of 43% in a year. More than 15% of dentists leaving the profession in 2020-2021 were from the EEA.

We are pressing for policy changes to improve access nationally

Simple cost-neutral solutions could have a huge impact in improving the workforce crisis and improving access to NHS dentistry across the country.

1. Reform the NHS contract to make it more attractive to dentists and improve morale
2. Increase the number of dental University places and Foundation Training Places available
3. Better use skill mix to take advantage of dental therapists who are able to deliver c80% of Band 2 treatments
4. Use existing flexible commissioning powers to increase funding for training and prevention
5. Remove obstacles to recruitment of high-quality overseas dentists by:
   - Passing the Section 60 Order quickly to give the GDC discretion over qualifications
   - Maintaining mutual recognition of qualifications with the EU

In the meantime, we are investing in practices to improve recruitment

- More than 80% of {my}dentist clinicians say that their **practice environment makes the biggest difference to their working life**

- By 2025, we are **investing more than £70 million into our practices** to ensure we can offer the best facilities and equipment to patients and clinicians

- And we are **modernising our network to ensure our practices are in good locations** that are more desirable for clinicians and practice teams to work – this creates a more stable environment, with a larger clinical team to offer better support

- We have **completed more than 11 of these projects** now with clear feedback that clinicians and patients prefer them, and that accessibility is improved. We have seen:
    - Improved recruitment and retention following investment
    - Longer practice opening hours
    - More patients supported.

A recent example: Killingworth in North Tyneside

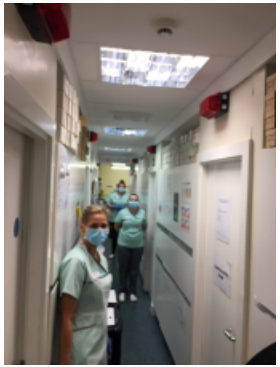
- **£1.1m invested** to relocate a practice into a large, secure shopping centre with **better accessibility** (all surgeries at ground level) and **improved transport links** and parking

- Total **surgery capacity increased by 85%** from 7 chairs to 13 chairs

- Within the first 12 months, **5 new clinicians and 6 new nurses were recruited** to the practice

- A total of **400 new clinical hours per week** have now been recruited allowing us to **extend opening hours** by 26 hours per week (including offering evening and weekend appointments).

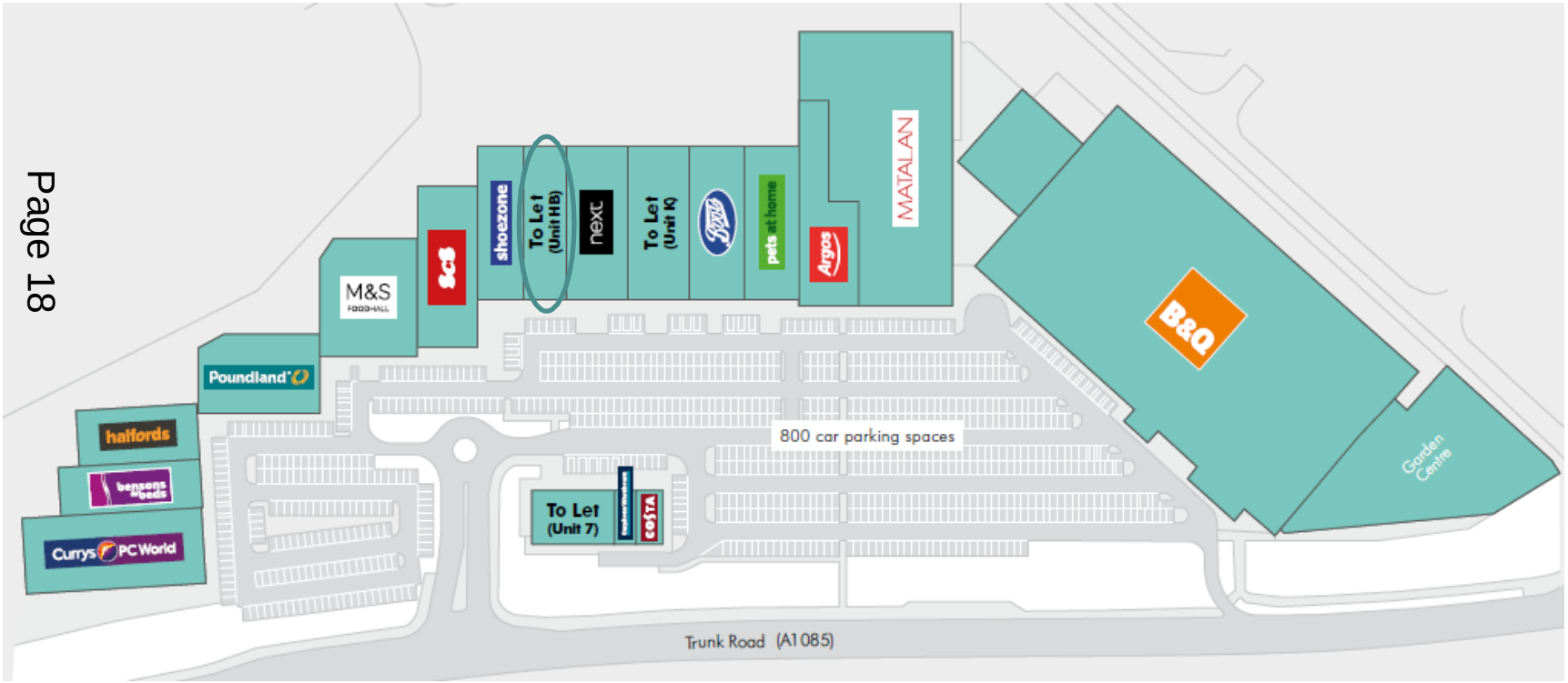
Killingworth: before and after



The proposed project in Middlesbrough

- **£1.5m will be invested** to relocate three local practices into one at Cleveland Retail Park
- **£2.2m committed** in ongoing lease costs, an increase of £70k per annum
- **£40k in payable rates per annum**, an increase of £16k (circa £250k over 15-years)
- Total **surgery capacity will increase** with 12 surgeries being available immediately, with **further options to expand to 14 in the future**, subject to successful recruitment
- The practice will benefit from a **dedicated staff room**, **greater security**, **free parking** and investment in **new digital technology**
- **Opening hours will be 25% larger than at the current practices** (50 hours per week, compared to the current average of 40.25 hours)
- Opportunities will be available to **expand services in future**, subject to support from local commissioners – this could include offering **prevention**, **oral surgery**, as well as **alignment with the nearby University who we currently work with.**

Proposed location of new practice



Proposed look & feel of new site

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North East and North Cumbria

Stakeholder Briefing

Integrated Urgent Care in Middlesbrough and Redcar & Cleveland

A new model of urgent care delivery is being proposed for the populations of Middlesbrough and Redcar & Cleveland which would see the opening of a new Integrated Urgent Treatment Centre (UTC) at The James Cook University Hospital, and increased opening hours at Redcar Primary Care Hospital, providing 24/7 access to urgent care for all residents of South Tees and the wider Tees Valley.

Integrated Urgent Care (IUC) is currently in place across the other boroughs within the Tees Valley, with UTCs at Darlington Memorial Hospital, the University Hospital of North Tees, the University Hospital of Hartlepool and Redcar Primary Care Hospital. The Redcar UTC is currently open from 8am to 9.30pm and under the new proposals this would see access increased to 24/7 opening, 365 days a year.

The new model will include home visiting, GP Out of Hours, and management of minor injuries and illness, with 24/7 access across all sites. The aim is to provide the right care at the right place, first time, minimising disruption and frustration for patients and improving efficiency and quality of outcomes whilst reducing the time to access Urgent Care services.

Proposals will see a standardised offer, so that wherever a patient lives in Tees Valley, they will have the same access to the same high standard of urgent care around the clock, accessible via NHS111. The proposals would also see the relocation of the GP Out of Hours service from North Ormesby Health Village to The James Cook University Hospital site.

In order to progress plans, the North East and North Cumbria Integrated Care Board (NENC ICB) is carrying out a **10-week period of engagement with patients/carers and stakeholders in Tees Valley, which will run until Sunday 9 October 2022.**

Co-locating GP Out of Hours services as part of an integrated urgent and emergency care service, has been shown to support the delivery of safe and effective care as well as significantly improving patient experience. The integration of primary and secondary care services on acute hospital sites can help to reduce emergency attendances and demand on the system for urgent care services.

The benefits of this proposed new model are:

- Provide consistently high quality and safe care 24/7, 365 days a year
- Provide the right care, at the right time, in the right place by those with the right skills
- Deliver care closer to home where appropriate and safe to do so

- Ensure services are joined up, seamless and co-ordinated with no loss of current services
- Avoid confusion for patients on what to do, who to call and where to go
- Provide services which are safe, responsive and high quality with better continuity of care
- Direct patients to NHS 111 as the initial point of access for advice and triage
- Increase awareness of early detection of illness and options for self-care

Have your say

The NENC ICB is keen to understand what patients, carers and stakeholders think about the current model of care, what works well, what doesn't and what they need to consider with the proposed model.

Complete a survey:

Patients living in Tees Valley are invited to share their feedback by completing a survey before midnight on Sunday 9 October 2022:
https://necs.onlinesurveys.ac.uk/iuc

The survey is being promoted across local print and digital media and through social media, and via posters. Paper copies of the survey and freepost reply envelopes are also available at all Middlesbrough GP practices. Written submissions of feedback can be emailed to necsu.comms@nhs.net**.**

This engagement activity will help to inform the development of proposals to ensure services are developed to best meet the needs of the local population. A full engagement report will be produced at the end of the engagement activity, and this will be used to inform and support next steps.

Seeking the views of the wider community:
In addition to the survey, the NENC ICB will commission voluntary sector partners to conduct facilitated feedback sessions with people from groups with protected characteristics to help us consider the likely impact of any potential changes on local people.

Further information:
Please visit our web page for more information https://nenc-teesvalley.icb.nhs.uk/iuc/

Events:
We are planning a series of local events in September 2022 where patients/carers and stakeholders can also share feedback. Dates for these events will be shared on the web page above in the next few days and promoted across local media.

For more information, please email necsu.comms@nhs.net.

Department of Health & Social Care

Guidance

Health overview and scrutiny committee principles

Published 29 July 2022

Purpose of this document

In advance of the statutory guidance on the Secretary of State's new powers in relation to service reconfigurations, this document sets out the expectations of the Department of Health and Social Care (DHSC), the Local Government Association (LGA) and the Centre for Governance and Scrutiny (CfGS) on how integrated care boards (ICBs), integrated care partnerships (ICPs) and local authority health overview and scrutiny committee (HOSC) arrangements will work together to ensure that new statutory system-level bodies are locally accountable to their communities.

HOSCs, local authorities, ICBs, ICPs and other NHS bodies should use this document to ensure that scrutiny and oversight are a core part of how ICBs and ICPs operate. Leaders from across health and social care should use these principles to understand the importance of oversight and scrutiny in creating better outcomes for patients and service users and ensure that they are accountable to local communities.

Further information on the role of health scrutiny can be found in the Local authority health scrutiny: guidance to support local authorities and their partners to deliver effective health scrutiny.

Integrated care systems

The Health and Care Act 2022 builds on the work of existing non-statutory integrated care systems (ICSs) to encourage more integrated system working, and to improve local population health outcomes through the planning and provision of services.

The act also provides for the creation of new NHS bodies, ICBs, and for each ICB and its partner local authorities to form a joint committee to be known as the ICP.

42 ICBs will be established, and the 106 existing clinical commissioning groups (CCGs) will be abolished. The ICB will take on the commissioning functions of the CCG and have a governance model that reflects the need for integration and collaboration across the system.

Each ICP will have, as a statutory minimum, a representative from the ICB and a representative from each of the partner local authorities. It may decide locally to include a broad range of representatives in its membership – including those from the independent and voluntary, community and social enterprise (VCSE) sector – concerned with improving the care, health and wellbeing of the local population. The ICP will be tasked with developing an integrated care strategy to address the health, social care and public health needs of its system. The ICB and local authorities will have to have regard to that strategy when exercising their functions. It is important to note that ICPs, as a joint committee between the ICB and partner local authorities as well as other members agreed by the ICP locally will be within the scope of HOSCs.

There will be a continuing role for HOSCs, health and wellbeing boards (HWBs) and the local Healthwatch as their roles are protected and preserved in the new system.

HOSCs will continue to play a vital role as the body responsible for scrutinising health services for their local area. They will retain their legal duties to review and scrutinise matters relating to the planning, provision and operation of the health service in the area. As is currently the situation, some local authority areas may have separate scrutiny committees for health and for adult social care. ICBs and ICPs should develop a trusting relationship with HOSCs to enable effective scrutiny.

HWBs will continue to bring together leaders at a place level to develop joint strategic needs assessments and prepare joint local health and wellbeing strategies for their local area. HOSCs should consider these strategies when scrutinising outcomes for their local area.

Local Healthwatch organisations will retain their statutory duty to obtain the views of people about their needs and experience of local health and social care services and will need to continue working with HOSCs to make these views known.

The benefits of scrutiny

Proactive and constructive scrutiny of health, care and public health services, done effectively, can build constructive relationships that deliver better outcomes for local people and communities; the people who represent them, and the commissioners and providers of health and care services. It also has other benefits including:

• providing an opportunity for local people and their elected representatives to contribute to and comment on the local priorities for improving health and care services and outcomes

• giving a voice to local people and communities on the quality, safety, accessibility and effectiveness of local health and care services

• assuring local elected members and the public that health and care services are safe and effective, address local health priorities and reduce health inequalities

• helping health and care providers and commissioners gain insight into the health needs and concerns of particular groups

• enabling health and care providers and commissioners to develop new services and care pathways to address local health priorities more effectively

While the procedures of review and scrutiny are at the discretion of the local authority, we recommend that each individual HOSC develops a framework to help them ensure that their scrutiny work is effective, focused and adds value. While this will be informed by other partners in the system, the assessment of risks, effects and impacts should be the HOSC's own. In particular, we recommend that a framework should consider:

• risks, effects and impacts to individual populations

• risks, effects and impacts to the whole local population

• support and input from local health colleagues

Responsibilities

HOSCs, HWBs, local Healthwatch and NHS bodies collectively have a role to play in good governance and accountability across the health and care system.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 will continue to apply although the formal statutory route for local authorities to report to the Secretary of State will be removed when the new reconfiguration provisions in the Health and Care Act 2022 take effect.

Local authorities

Local authorities will retain 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 and overview committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority

• have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals

• have a mechanism in place to deal with referrals made by local Healthwatch organisations or local Healthwatch contractors

• report disputed reconfiguration proposals to the Secretary of State until the new reconfiguration provisions take effect

NHS bodies

NHS bodies will retain the power to:

• provide information about the planning, provision and operation of health services as reasonably required, depending on the subject by local authorities to enable them to carry out health scrutiny

• 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

• 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, local authorities and joint health scrutiny committees or sub-committees

Health and wellbeing boards

HWBs will retain the power to:

• provide assessments of the current and future health and care needs of the local population

• develop joint strategic needs assessments

• develop joint local health and wellbeing strategies at a place level

Local Healthwatch

Local Healthwatch organisations will retain the power to:

• obtain the views of people about their needs and experience of local health and social care services, and to make these views known to those involved in the commissioning and scrutiny of care services

• make reports and make recommendations about how those services could or should be improved

• promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services

The design of new models of integrated care and support that are being introduced through the Health and Care Act 2022 will inevitably lead to changes in how and where services are provided.

HOSCs will have an invaluable role to play during the initial transition and implementation of ICBs and ICPs, and beyond, in scrutinising the impact and effectiveness of integration on health services and outcomes. Under this new structure, there will be a need for scrutiny of health services and outcomes at a local place-based level, as well as more strategic scrutiny of health services and system-level outcomes. Both levels of scrutiny are important; HOSCs should maintain an appropriate balance between the 2, and establish joint health overview and scrutiny committees (JHOSCs) where appropriate and necessary. Individual local authorities hold responsibility for carrying out scrutiny tests.

Scrutiny can play a valuable role in improving the evidence base for decisions about integration and in holding local authorities, NHS bodies, and health service providers to account for the level of local ambition to improve health and integrate services in ways that benefit people who use services and in the interests of taxpayers. It can also help to ensure that the views of people in an area are fully reflected in the consideration of any proposals.

Principles and ways of working

The following 5 principles set out best practice for ways of working between HOSCs, ICBs, ICPs and other local system partners to ensure the benefits of scrutiny are realised and should form the basis of ongoing discussions between these partners about how they will work together.

The 5 principles are:

- outcome focused
- balanced
- inclusive
- collaborative
- evidence informed

1. Outcome focused

Outcome-focused scrutiny can provide a valuable and relevant platform for looking at cross-cutting issues, including:

- general health improvement
- wellbeing
- specific treatment services and care pathways
- patient safety and experience
- overall value for money

Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working and in making recommendations on how it could be improved locally.

By focusing on outcomes, ICPs, ICBs, local political leaders, professionals and communities can explore and consider the complexities of health and wellbeing and help to evaluate the planning, delivery and reconfiguration of health and care services. A strategic approach should be taken to consider how best to apply scrutiny to evaluating key strategies and outcomes of the ICB and ICP, including the integrated care strategy and the ICB joint 5-year forward plan.

Within the wider ICB area, HOSCs will have a valuable role to play in scrutinising and evaluating place-based outcomes at local authority level. HWBs will continue to develop joint strategic needs assessments and establish joint local health and wellbeing strategies; HOSCs will continue to scrutinise place-based health services in relation to these.

However, HOSCs will also play a valuable role in scrutinising the health services of the wider ICB area and should work with other local authority areas, forming JHOSCs where appropriate, to scrutinise outcomes against the joint 5-year forward plan and the integrated care strategy

2. Balanced

Good scrutiny needs to maintain balance between being future focused and responsive. When scrutiny is future focused it can help system partners to understand how local needs are changing, as well as understand the issues that communities face and suggest and test solutions. Future-focused scrutiny can also add value to integration planning and implementation by improving the evidence base for holding local decision makers to account for the level of local ambition to integrate services and improve population health.

ICBs and ICPs should take an inclusive and future-focused approach to agreeing a clear set of arrangements for scrutiny to be built into the whole cycle of planning, commissioning, delivery and evaluation. Leaders from across health and social care should work with openness and candour to establish a clear shared set of priorities and a future work programme to improve health and social care outcomes.

Scrutiny also needs to be reactive and responsive to issues of concern to local communities, including service performance and proposed NHS reconfigurations, local authorities, and other system partners, should ensure that HOSCs have the capacity to respond reactively to public concerns and reconfigurations. ICBs can assist with this by working with HOSCs to shape their forward plans. ICBs should take a proactive approach to sharing at an early stage any proposals on reconfigurations, drawing a distinction between informal discussions and formal consultations. ICBs should also take a proactive approach to involving relevant bodies on any other matters which system partners expect to be contentious, to help navigate complex or politically challenging changes to local services.

With regard to concerns about service performance, ICBs should be open and transparent with HOSCs, bearing in mind that in some cases there may be legal or assurance proceedings. Equally, HOSCs must appreciate the need for regulatory and legal processes to run their course, but ICBs should update HOSCs on the progress of these processes.

3. Inclusive

The primary aims of health scrutiny are to strengthen the voice of local people and provide local accountability. They should ensure that local people's 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. Effective scrutiny allows for more inclusive public conversation than might be delivered as part of a formal consultation exercise. As such, it is important for scrutiny to engage the community, involving the right people at the right time in the right place.

HOSCs are a fundamental way for democratically elected local councillors to voice the views of their constituents, hold the whole system and relevant NHS bodies and relevant health service providers to account and ensure that NHS priorities are focused on the greatest local health concerns and challenges. Flexible and accessible arrangements to scrutinise integration issues provide the best opportunities for councillors to hear from people and groups with whom they may not have previously had much contact, for example primary care practitioners or people who use services. HOSCs, subject to time and resource constraints, may be well placed to engage with members of the public directly.

Systems and NHS bodies should form trusting working relationships with HOSCs, and work together to ensure that this important community intelligence is fed directly into system-wide decision making. Engaging with scrutiny is a way for ICBs and ICPs to add richness to their understanding of local need, and a way to connect strategic planning at system level to the nuances of local pressures and requirements.

4. Collaborative

Work plans that detail the future decisions and issues to be scrutinised by HOSCs should be informed by communities, providers and planners of health and care services to ensure that scrutiny is focused on achieving the most value for its population. Effective health scrutiny requires clarity at a local level about respective roles between the health overview and scrutiny committees, ICBs, ICPs, the NHS, local authorities, HWBs and local Healthwatch.

Service change and integration are typically not challenges that are confined to one local authority's area; these are issues that can straddle one or more local authority population. Under the new system-level structures, health scrutiny may increasingly need to cover issues that cut across local authority boundaries. Therefore, local authorities on ICB boundaries, and neighbouring councils within an ICB area should take a collaborative approach in order to identify any strategic issues that would benefit from joint scrutiny. Under Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities must appoint a joint health overview and scrutiny committee where a relevant NHS body or health service provider consults more than one local authority health scrutiny function about substantial reconfiguration proposals; however local authorities also have the discretion to set up joint committees in other circumstances.

The role of JHOSCs is particularly important in assessing strategic issues that cover 2 or more local authority areas, and will be even more important under the new arrangements as ICB areas will span more than one local authority area in most cases. In particular, JHOSCs will have a strategic role to play in scrutinising the delivery and outcomes of the integrated care strategy.

It is important for ICBs, councils and scrutiny committees to develop joint protocols in advance of the need for any joint scrutiny arrangements, whether these arise under legislation or are optional arrangements. This includes having a clear view about how councils should work together, the structure of joint arrangements, and the time needed to establish these arrangements. JHOSCs will also need to recognise and take into account the potential difficulties of working together, particularly around the political balance between different local areas, as well as resourcing. Developing this shared understanding helps build the foundations for effective joint working. ICBs should have an active role in providing support in these situations and should recognise the complexity and time involved in establishing formal JHOSCs.

5. Evidence informed

Scrutiny informed by evidence can help make the case for better integration of services, better joint working around service improvements and better approaches to major service reconfigurations. Scrutiny adds value to decision making by ensuring that evidence is sound and based on the right insight, so that no voice is unheard or evidence overlooked. The types of evidence that aid effective scrutiny include evidence on quality and safety of services and evidence on population health needs. Qualitative evidence from those with lived experience – including patients, the public and those who

are most likely to be excluded from services – are particularly valuable forms of evidence for aiding scrutiny.

Health scrutiny has a 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 locally and in testing this information by drawing on different sources of intelligence. Local Healthwatch are an important source of evidence and should work with HOSCs to pass on the views of people about their needs and experience of local health and social care services.

HOSCs can request evidence from systems and NHS bodies, and should ensure that their requests for evidence are reasonable, proportionate and relevant.

The health system has a responsibility to provide information needed for health scrutiny. Health and care providers and commissioners should respond positively and constructively to the requests for information from HOSCs. Where an NHS body cannot provide a response to a request for information, it should work with the HOSC to attempt to provide information and support where possible. ICBs should have plans and protocols in place for sharing information for the purpose of scrutiny, as this will avoid the need for continual ad-hoc decision-making when information is requested.

Next steps

The Health and Care Act 2022 introduces a power for the Secretary of State to call in and take decisions on or connected to reconfiguration proposals at any stage in the proposal's process. This does not change local authorities' scrutiny responsibilities for service change. To support this intervention power, the local authority referral power, which is set out in regulations, will be amended to reflect the new process.

DHSC will also issue statutory guidance on the new powers outlining how the Secretary of State proposes to exercise their functions during this new process, including the new Secretary of State call in power. This guidance will also include information for NHS commissioning bodies, NHS trusts and NHS foundation trusts about how they should be exercising their functions under the new reconfigurations process. We expect that these principles will complement the new guidance to help ensure that scrutiny is embedded across the new statutory system-level bodies.

Exact timelines are still to be determined; however, any changes to the reconfiguration process introduced through the Health and Care Act 2022 will not be implemented immediately following Royal Assent. We will work with the system to help prepare for any proposed changes and to develop the new statutory guidance.

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To:
- Integrated Care Board Chief Executives and Chairs
- NHS Foundation Trust and NHS Trust:
  - Chief Executives
  - Chairs

NHS England
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12 August 2022

cc.
- Regional Directors

Dear colleagues

Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter

This week the NHS reached its first key ambition on recovering services, focusing on patients who had been waiting more than 104 weeks. We delivered this important milestone despite having to contend with further waves of COVID-19, including more than a quarter of our COVID-19 inpatients occurring since publishing the Elective Recovery Plan, an unprecedented heatwave, and other significant pressures. It shows once again that when we prioritise, invest, and innovate, the NHS can, acting as a national service, deliver for patients.

Urgent and Emergency Care is currently under significant pressure. Staff have faced one of their busiest summers ever with record numbers of A&E attendances and the most urgent ambulance call outs, all alongside another wave of COVID-19. Thanks to the professionalism and commitment of those staff, the NHS continues to provide care to over 100,000 urgent and emergency care patients each week. Despite their best efforts, these pressures have meant that there have been too many occasions when staff have not been able to provide timely access for our patients in the way they would have wanted.

Our immediate response has been to focus on ambulance performance, and the linked issue of speeding up discharge. We have provided extra funding to ambulance services, offered intensive support to those trusts most challenged by ambulance delays, and rolled out virtual wards across the country, enabling patients who would otherwise be in hospital to receive support at home.

And we have begun planning for the coming winter earlier than usual, recognising pressure on the NHS is likely to be substantial, particularly in UEC, making the most of the opportunity created by the formation of ICBs to maximise the benefits of system working.

In addition to maintaining progress on 2022/23 operational priorities and building on the significant successes in delivering our Elective Recovery plan, with a strong focus on 62 day cancer backlogs and elective long waits, today we are setting out the next steps in our plans to rapidly increase capacity and resilience ahead of winter, building on the operational plans we have worked on together.

Core objectives and key actions for operational resilience

Our collective core objectives and actions are to:

1) **Prepare for variants of COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.
2) **Increase capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
3) **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
4) **Target Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5) **Reduce crowding in A&E departments and target the longest waits in ED**, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
6) **Reduce hospital occupancy**, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7) **Ensure timely discharge**, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the ‘100 day challenge’.
8) **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

This letter and the appendix sets out the important actions, developed in partnership with you, to help deliver these core objectives, as well as how NHS England will support you. Taking these actions should help manage pressure across the pathway, supporting improved flow for patients in emergency departments.

Clearly, expanding capacity is dependent on both sufficient workforce and workforce wellbeing. This is why it is important that the plans have been built from the bottom up, with ICBs responsible for developing plans that are based on realistic assumptions, including how many staff can be recruited and at what speed. We will fully fund the recent pay award nationally, avoiding the need to cut frontline services for winter.

Similarly, ICBs have been clear with us that much of the pressure on urgent and emergency care is driven by the current, significant, growing strain in social care. Too many patients are spending longer in hospital than they need to, creating pressure along the entire pathway. We will continue to work with the Government, and national local government partners, to help, as far as possible, address these issues. At a local level, the creation of ICSs offers an opportunity for all partners in a local system to work together to deliver local solutions. This includes making best use of the Better Care Fund, building on the work you are doing locally to map local demand and capacity.

Performance and accountability: A new approach to working together

This plan is underpinned by a new approach to how organisations in the NHS work together – the Health and Care Act 2022 has enshrined Integrated Care Systems in law. Although this winter presents significant challenges, it is an opportunity to show how these new ways of working can make a real difference to patients and join up the entire urgent and emergency care pathway in ways we've been unable to do before. The plan empowers system leaders to do this in a number of critical areas, and where you can go further, please do so.

System working also means a new approach to accountability. ICBs are accountable for ensuring that their system providers and other partners deliver their agreed role in their local plans and work together effectively for the benefit of the populations they serve. ICBs are responsible for initial problem solving and intervention should providers fail, or be unable, to deliver their agreed role. Intervention support can be provided from NHS England regional teams as required, drawing on the expertise of our national level urgent and emergency care team as needed.

That line of accountability does mean that we will want to continue to work with you to stress test your plans and to 'check and challenge' progress in delivering them. We will expect that you work with us to report on local performance and collaboratively, but quickly, tackle problems where they occur.

On performance metrics, the overall objective remains the provision of safe and effective care. Until the adoption of the Clinically-led Review of Standards is agreed with the Government, current standards remain for emergency department performance and flow. Likewise, objectives set out in Planning Guidance, which includes reducing 12 hour waits and increased clinical input in 111, remain. These should continue to be used to understand flow through your emergency departments.

Working with ICBs we have identified the following six specific metrics, key to the provision of safe and effective urgent and emergency care, that NHS England and ICBs will use to monitor performance in each system through the Board Assurance Framework:

- 111 call abandonment.
- Mean 999 call answering times.
- Category 2 ambulance response times.
- Average hours lost to ambulance handover delays per day.
- Adult general and acute type 1 bed occupancy (adjusted for void beds).
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

We will work with you through the Assurance Framework to develop local performance trajectories to sit alongside these measures.

The work on elective care and the 100 day discharge challenge demonstrates the value of using an improvement approach based on data, easy to access best practice guidance, as well as senior clinical and executive peer review in spreading solutions focused on those facing the greatest challenges. We will launch new improvement offers to support ambulance handover and response times in the coming weeks.

To support ICBs, we will provide you with a Board Assurance Framework to monitor progress monthly against the combined System Capacity Plans, Actions and Good Practice basics and improvement priorities developed with colleagues over time. This is aimed at supporting and ensuring trusts continue to implement best practice. Each BAF will be unique to each ICS to reflect the specific capacity gaps that you have identified.

While these plans represent substantial work to increase capacity and improve operational resilience, clearly epidemiological modelling suggests reasonable worst-case scenarios for Covid-19 which would require a more significant set of actions. We will work with you to develop plans for these scenarios.

Thank you to you and your teams across the NHS for your continued hard work. While there is no doubt that we are going to experience challenges over the winter, when the NHS unites as it has over the past two and half years of the pandemic and works closely with wider partners, we know we can best serve patients, support our teams and maintain the momentum of the NHS's recovery from the pandemic.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Julian Kelly
Chief Financial Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Appendix – Actions: Further details on increasing capacity and operational resilience in urgent and emergency care ahead of winter

Each ICB plan has been discussed, and agreed, with the relevant NHS England region and a series of specific actions have been agreed between NHS England and each ICB in the following areas:

1. **New variants of COVID-19 and respiratory challenges**

SPI-M scenarios for COVID-19, combined with scenarios for flu, suggest that even in optimistic scenarios, high numbers of beds may be needed for respiratory patients during winter. Resulting IPC requirements will make bed management complex, especially if bed occupancy remains high. We will do further work with you in the coming months on stress-testing planning for the operational response to realistic worst-case scenarios. We are working with local areas to:

- Deliver an integrated COVID-19 booster and flu vaccination programme to minimise hospital admissions from both viruses.
- Implement UKHSA's IPC guidance in a proportionate way and develop strategies to minimise the impact of 'void' beds.

2. **Demand and capacity**

A lack of capacity across the NHS has an impact on all areas of the system. It is essential that ambulance and NHS 111 services have the necessary capacity in place and that access to primary care, community health services and mental health services for urgent patients is sufficient to ensure patients do not need to present to emergency services. We are working with local areas to:

- Open additional beds across England, to match the additional capacity identified by ICSs to be able to deliver against expected winter demand. This should create the equivalent of 7,000 additional general and acute beds, through a mix of new physical beds, scaling up virtual wards, and improvements in discharge and flow.
- Increase the number of NHS 111 call handlers to 4,800 and the number of NHS 999 call handlers to 2,500.
- Increase provision of High Intensity User services.
- Support good working relationships with the independent sector, building on the success so far, and facilitating patient choice.

In community care:

- Increase two-hour Urgent Community Response provision by maximising referrals from the ambulance service and other providers, aiming to maintain and improve the current standard of responding to 70% of call outs within two hours.
- Increase the number of virtual wards to create an additional 2,500 virtual beds.

In primary care:

- We will maximise recruitment of new staff in primary care across the winter, including care co-ordinators and social prescribing link workers.
- ICBs to actively support and engage with PCNs to work with each other and other providers to develop collaborative models to manage seasonal preparedness and

specific winter pressures (such as oximetry monitoring for COVID-19 patients) alongside the digital development of primary care.

In mental health, cancer, and elective care:

- Share mental health best practice between systems and work with the VCS and LA sector to alleviate capacity constraints.
- Releasing £10m of annual funding to support MH through the winter, in addition to continued planned growth in community and crisis provision.
- Maintain and increase elective capacity to eliminate waits of over 18 months, as per the Elective Recovery Plan, except for patients who choose to wait longer or require alternative plans due to clinical complexity.
- Reduce the number of people waiting more than 62 days from an urgent cancer referral back to pre-pandemic levels by March 2023.
- Ensure the preservation of the standard clinical pathway for CYP elective surgery, critically ill children, and emergency, general and specialist services.

3. Discharge

While challenges are often seen at the ‘front door’, we know that their root cause is often in the ability to discharge patients from, and flow through, hospitals. There is a significant number of patients spending longer in hospital than they need to, often due to a lack of availability of social care. While the provision of social care falls outside of the NHS’s remit, the health service must ensure patients not requiring onwards care are discharged as soon as they are ready and can access services they may need following a hospital stay. We are working with local areas to:

- Implement the 10 best practice interventions through the 100-day challenge.
- Encourage a shift towards home models of rehab for patients with less severe injuries or conditions.
- Maximise support available from the Seasonal Surge Support Programme, provided by VCS partners.

4. Ambulance service performance

While ensuring there is enough capacity for ambulances to respond to the most urgent calls and take patients to hospital is essential, it is also important to focus on what can be done to reduce avoidable ambulance activity, through treating patients at the scene. We are working with local areas to:

- Implement a digital intelligent routing platform and live analysis of 999 calls.
- Agree and implement good practice principles for the rapid release of queuing ambulances in response to unmet category two demand.
- Work with the most challenged trusts on ambulance handover delays to develop solutions, including expanding post-ED capacity.
- Increase the utilisation of rapid response vehicles, supported by non-paramedic staff, to respond to lower acuity calls.
- Model optimal fleet requirements and implement in line with identified need.
- Implement the ambulance auxiliary service which creates national surge capacity to enhance the response and support for ambulance trusts.

- Deploy mental health professionals in 999 operation centres and clinical assessment services and deliver education and training to the workforce.
- Increase the use of specialist vehicles to support mental health patients.

5. NHS 111 performance

The NHS 111 service can only work if it has sufficient clinical capacity to provide consultations if required and patients are able to be directed to the right service for their needs. We are working with local areas to:

- Improve call handling performance through the implementation of regional call management which will enable better integration between providers and ensure the entire NHS 111 capacity is used effectively.
- Continue pilot of national Paediatric Clinical Assessment Service and build on what we are learning.
- ICBs to update details of the 24/7 urgent mental health helplines for patients experiencing a mental health crisis, and ensure these services are promoted.

6. Preventing avoidable admissions

A full range of urgent care services should be available to ensure patients can access the right care in the right place. The Directory of Services should be used by staff to direct patients to the most appropriate place, while same-day emergency care, frailty and 'hot' outpatient services should also be available for patients requiring urgent specialist treatment but not necessarily via an ED. We are working with local areas to:

- Increase number and breadth of services profiled on the Directory of Services to ensure only patients with an emergency need are directed to A&E.
- Develop and protect capacity for same-day emergency care services so that operational hours are profiled against demand and surgical availability.
- Review non-emergency patient transport services so that patients not requiring an overnight hospital stay can be taken home when ready.
- Improve the provision of the Acute Frailty service, including the delivery of thorough assessments from multidisciplinary teams.
- Implement out of hospital home-based pathways, including virtual wards, to improve flow by reducing hospital attendances. Reduce unnecessary attendances for patients with mild illness through revised NHS @home pathways that incorporate broader acute respiratory infections.

7. Workforce

NHS staff have worked incredibly hard throughout the pandemic and both current and future pressures on the health services mean teams will remain stretched. The health and wellbeing of the workforce is crucial and interventions targeting recruitment and retention will be important in managing additional demand this winter. We are working with local areas to:

- Implement your recruitment and retention plans including staff sharing and bank arrangements.
- Utilise international support for UEC recovery, identifying shortages of key roles and skills and targeting recruitment as such.

- Implement the Wellbeing Practitioners' Pack.
- Develop roles for volunteers that reduce pressure on services and improve patient experience, such as community first responders and support in discharge.

8. Data and performance management

Making the full use of data at a local, regional, and national level will help inform operational decision-making and improve the delivery of services. We are working with local areas to:

- Ensure timely and accurate submission to the Emergency Care Data Set.
- Encourage use of the A&E Forecasting Tool.

9. Communications

We are undertaking the following actions to enable strong communications:

- Implement your winter communications strategy to support the public to minimise pressures on urgent and emergency services.
- Deliver the NHS 111 and GP Access strands of the Help Us Help You campaigns.

HSJ QUALITY AND PERFORMANCE

NHS England reveals six targets for ICSs this winter

By James Illman12 August 2022

- **Winter letter focuses on bed occupancy, ambulance delays and 111 capacity**
- **The NHSE letter sets out six key metrics and eight focal areas**
- **Powis warns of first winter with combined pressures from covid and flu**
- **Increase acute and community 'beds' by equivalent of 7,000**

NHS England today identified six key metrics it will use to monitor the performance of every integrated care system this winter.

The 2022-23 winter letter includes a broad range of measures to boost capacity across the system through a mix of new hospital beds, increased non-acute capacity and virtual wards and a boost in urgent and emergency call handlers.

NHSE medical director Sir Stephen Powis warned that this year would be especially challenging for the service because it would be "the first winter where we are likely to see combined pressures from covid and flu".

The six main new key targets for integrated care systems are:

- 111 call abandonment;
- Mean 999 call answering times;
- Category 2 ambulance response times;
- Average hours lost to ambulance handover delays per day;
- Adult general and acute type 1 bed occupancy (adjusted for void beds); and
- Percentage of beds occupied by patients who no longer meet the criteria to reside

The document, *Next Steps in Increasing Capacity and Operational Resilience in Urgent and Emergency Care Ahead of Winter*, says: "Working with integrated care boards, we have identified the following six specific metrics… that NHSE and ICBs will use to monitor performance in each system through the board assurance framework."

However, the letter from NHSE leadership warns: “Clearly, expanding capacity is dependent on both sufficient workforce and workforce wellbeing.”

Eight core objectives

It sets out eight core pillars, which include an integrated covid-19 and flu vaccination programme and boosting hospital capacity by the equivalent of “at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway”.

It also sets a target to increase the number of call handlers to 4,800 in 111 and 2,500 in 999 and “target category 2 response times (the 18-minute target) and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts”.

The other “core objectives” of the letter are:

- Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
- Reduce crowding in A&E departments and targeting the longest waits in ED through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
- Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the ‘100 day challenge’.
- Provide better support for people at home, including the scaling up of virtual wards and additional support for high intensity users with complex needs.

Health and social care secretary Steve Barclay also said he had “launched a taskforce to drive up the recruitment of international staff into critical roles across the system, while we recruit and retain more doctors and nurses, so we can continue our work of busting the covid backlogs”. However, it remains to be seen how many staff this could add this winter given the lengthy timescale required by the international recruitment process.

Sir Stephen said in a statement: “This is the first winter where we are likely to see combined pressures from covid and flu, so it is right that we prepare as early as we can for the additional demand that we know we will face. “Ahead of the winter, we want to make sure we are doing everything we possibly can to free up capacity so that staff can ensure patients get the care they need – this includes timely discharge, working with social care, and better support in the community with the expansion of virtual wards.”