Divisions Affected – All

CABINET

27 February 2024

Support for People Leaving Hospital; the Oxfordshire Way

Report of the Oxfordshire Joint Health Overview and Scrutiny Committee

RECOMMENDATION

1. The Cabinet is **RECOMMENDED** to **—**

   a) Agree to (delegate to the responsible person to) respond to the recommendations contained within this report within 28 days.

   b) Agree that relevant officers will provide an additional progress update on these recommendations to Oxfordshire Joint Health Overview and Scrutiny Committee in 6 months' time.

REQUIREMENT TO RESPOND

2. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation, and that person must **respond in writing within 28 days of the request.**

INTRODUCTION AND OVERVIEW

3. The Joint Health and Overview Scrutiny Committee considered a report by the Director of Adult Social Care (Karen Fuller) and the Lead Commissioner for Age Well (Ian Bottomley); on the Oxfordshire Way and the support provided to people leaving hospital.

4. The Committee would like to thank the Leader of the Council (Cllr Liz Leffman); the Director of Adult Social Care (Karen Fuller); the Deputy Director for Adult Social Care (Victoria Baran); the Lead Commissioner for Age Well (Ian Bottomley); the Deputy Director for Joint Commissioning for Health, Education and Social Care (Pippa Corner); and the BOB Integrated Care Board Place Director for Oxfordshire (Daniel Leveson) for attending and answering questions in relation to the report.

5. The Committee would like to express that it recognises the ongoing work being invested into developing ways in which to support people who leave hospital as part of the Oxfordshire way.

6. This report was scrutinised by Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) given that it has a constitutional remit over all aspects of health as a whole; and this includes initiatives by the Council and its partners (including the NHS) to provide support for patients who are discharged from hospital. When commissioning this report on the support for people leaving hospital, some of the insights that the Committee sought to receive were as follows:

- Details around the national target of 95% of people being discharged home, what this looks like for Oxfordshire, and how system working has been changing to achieve this.

- Details on the discharge pathways, and on what has been done differently through the Transfer of Care (TOC) team, Discharge to Assess (D2A), as well as the impact all of this has had to date.

- The system work that has been undertaken thus far in relation to urgent care and associated pathways.

- How resources are being used in Oxfordshire, including through community hospital beds/hub beds, including some insights into cost comparison data relating to pathways and different costs.

- The degree to which there has been any learning to date from changes that have been made, including the impact for all communities.

- Details around the nature of hubs bed, and where these sit from a legal perspective.

- Details on the reasons behind the closure of short stay hub beds in Henley.

- The extent to which there has been any stakeholder/public engagement around the closure of hub beds as part of the broader initiatives to support people in their own homes.

- The degree to which there are sufficient resources available to support people leaving hospital and to provide care in peoples' homes.

SUMMARY

7. The Chair highlighted that the purpose of this item was to receive an update on the support for people leaving hospital and the Oxfordshire Way. It was emphasised that upon commissioning the paper for this item, the Committee sought an outline as to the kind of support that residents could receive upon being discharged from hospital, and to look at this in the context of the

Discharge to Assess (D2A) Process and the Oxfordshire Way. It was also specified that key attention should be placed on the rationale behind prioritising care at home, and any national directives and nationally set targets around this; and that it was also important for the Committee to understand how effectively the D2A process was working, and how it met people's healthcare needs.

8. The Lead Commissioner for Age-Well informed the Committee that Oxfordshire was on a journey to improve how the system helped people leaving hospital. Oxfordshire needed to ensure that 95% of people leaving hospital returned to their usual place of residence. Oxfordshire was focused on getting people home and had rolled out a Home First D2A to achieve this. It was more possible to move to this approach due to operational and commissioning improvements that had been made, and the Home First D2A was better for Oxfordshire's residents.

9. The Committee was informed that Oxfordshire also utilised short-term bed options each winter to increase flow out of hospital and to keep A&E moving, leading to the short stay hub model. Short-term beds created a further step in the onward journey, and they needed social work, therapy and medical cover to each bed. Most of the people in those beds eventually went home (over 70% of people in short stay hub beds). Oxfordshire was required to get 95% of people directly home from hospital; however, the current achievement was 91-92%. There had been an improvement to the flow home through reablement, where 78% of people were now discharged without requiring any further care. In order to reach the 95% target, there was a need to support 15-20 people to move from bed-based to home-based pathways. The learning from the discharge to assess pilots indicated that only 33% of people waiting in beds for long-term care actually required that care. Getting people home first was therefore in line with national policy; the right thing to do for residents in line with the Oxfordshire Way; and was now possible because of changes that had been made in the Oxfordshire system.

10. The Committee was also informed about the Transfer of Care Hub in the hospital; which allocated patients to the appropriate discharge pathway, anticipated and pre-empted any barriers to discharge, and promoted a discharge to assess approach. In regard to the Home First D2A model, there had been extended reablement through national Additional Discharge Funding to extend the reablement model to include:

    1. Short-term live-in reablement care and/or
    2. Short-term waking nights to support reablement
    3. Discharge to assess pick-ups

11. It was also explained to the Committee that there had been increases in capacity to enable people to be supported at home including:

    1. Short-term additional support from local providers to deliver the Home First D2A model funded from Additional Discharge Funding.

2. Increases in care hours delivered at home under the Live Well at Home framework from 27,888 to 31,095 per week from December 2022 to December 2023, an increase of 7.65%.

12. The Director of Adult Social Care also reiterated that it was important that the support for people leaving hospital is looked at as a system. Historically, Oxfordshire had not performed well with regards to Delayed Transfer of Care, and therefore, something had to be done differently. Oxfordshire was, in comparison to other areas, ahead of the curve in terms of the Transfer of Care Hub. The Adult Social Care Director emphasised that the Transfer of Care Hub was genuinely a multidisciplinary team, with input from Adult Social Care also.

13. The BOB ICB Place Director added that Oxfordshire was working well as a system, and that the NHS and the local authority should be congratulated for this. There was a commitment to continue to work toward building the Partnership between the NHS and the County Council, as well as to support people to live well independently in their homes.

14. In response to a query from the Committee regarding the level of public or stakeholder engagement around prioritising support for people in their homes and the decisions made in this context, the BOB ICB Place Director explained that the engagement could have been better, and that lessons will be learned from the public engagements undertaken in Wantage as part of determining the future of Wantage Community Hospital. The Director of Place outlined that the system needed to find ways of communicating with the public and stakeholders regarding some of the ensuing changes as well as some of the positive developments and activities undertaken by the system; including around the Transfer of Care team, the D2A, the Urgent Community Response, the Virtual Wards, and the Hospital at Home. All the improvements in these aforementioned areas were enabling the system to provide better support for people in their own homes and giving people the independence that they want.

15. The Committee made some enquiries in relation to the withdrawal of Short Stay Hub Beds (SSHBs) in Henley including; who was responsible for commissioning these beds; what engagement had there been around the withdrawal of these beds, and whether there were any potential consequences of delaying the closure of these beds. The Director of Adult Social Care responded that the County Council had commissioned these beds on behalf of the system. SSHBs were initially put in place in Oxfordshire at a time when the system did not have the capacity to enable the flow of patients. It was emphasised to the Committee that these were not statutorily required beds and were established at a point in time to help with system flow. Another important consideration was how the Oxfordshire Pound was maximised to ensure that people received the best benefits from services. Therefore, the system would flex the number of beds up and down as required. The Director of Adult Social Care also explained that 17 SSHBs were already closed in the north of the county, and that the flexing of SSHBs was an indication of business as usual. The Committee was informed that initially, the hub beds were commissioned by Oxford University Hospitals NHS Foundation Trust, and that this had destabilised the market. It was decided

that the County Council was best placed to commission these beds as it had the best relationship with the market.

16. It was also reiterated to the Committee that considerations of how to best maximise the use of the Oxfordshire pound was a factor in determining the closure of the SSHBs in Henley, which had cost £11000 a week to maintain. However, the Director of Adult Social Care emphasised that the withdrawal of the beds was not driven purely by financial considerations but was also a crucial element of supporting people at home and helping them to regain independence. The Director of Adult Social Care also explained that it was difficult to determine what people needed when they were in a hospital bed. Therefore, if people were enabled to go home with the necessary wraparound care, including with Occupational Therapy, Social Workers, as well as Urgent Care at home, this would also make decisions regarding people's long-term care needs much more effective.

17. The Committee urged there to be more effective communication with the public and key stakeholders around the broader context in which the withdrawal of SSHBs was taking place. This would allow for both a greater understanding as to why such withdrawals were occurring as well as a reassurance to residents as to the alternative services that would be provided to them in the absence of these beds.

18. The Committee enquired as to whether there was adequate support for people being discharged from hospital whilst they were at home within the 72 hours. It was queried as to who the assessor would be upon arriving home from hospital, and as to how soon after arriving home the assessment would take place. The Deputy Director of Adult Social Care responded that the Transfer of Care Hub, which operated in the hospital, would review all the referrals that came in when a patient was ready for discharge. As part of this process, a multidisciplinary team in the Hub would determine whether there were concerns with a patient's home environment. If any concerns were identified, such as equipment needing to be provided or furniture needing to be moved, efforts would be made to put things in place in preparation for the patient's return home.

19. The Committee emphasised that some patients who were discharged may require ongoing support in taking their medications appropriately, and queried as to whether this was being taken into account, and the measures that would be taken to provide support in this regard. It was responded that support for patients and their medications is undertaken as part of the original setup with the domiciliary provider, who are certainly experienced in being able to support people with their medication needs. The Home First team was also looking at a range of technologies that could support with medication reminders and in helping people to be able to take charge of their own recovery journey and their ongoing needs when it was appropriate to do so. However, for individuals who had a broader package of care, support with medication was incorporated into their ongoing care plan.

20. The Committee referred to the Live Well at Home providers, and enquired as to how many organisations were being worked with that provided this care, how flexible they were, and whether there was an appropriate level of workforce in this area. The Lead Commissioner for Age Well responded that there was a need for flexibility in their teams, and that things were improving in that regard. A lot of work was undertaken with the providers, and that providers had been expected to be much more sophisticated in their ability to recycle the right staff. Providers had also been encouraged to think about how they organise the right people to the right space so that they could work 7 days a week. There had also been an advantage from the additional discharge funding, which had been used to fund some short-term arrangements with other providers.

21. The Committee enquired as to whether a hierarchy existed for the purposes of monitoring providers, particularly if something were to go wrong in the services that were supposed to be provided. It was also queried as to whether there was a clear and accessible complaints process for discharged patients to be able to access if they were not satisfied with the services they were receiving. The Deputy Director of Adult Social Care explained that it was crucial to take into account that all the relevant teams were working across the board providing many care hours every week. All providers worked to a quality assurance framework that ensured that mechanisms were in place to escalate with health professionals if there were any concerns. Having multiple teams working collaboratively provided the advantage of identifying any issues or challenges with a discharged patient early on. Work was also undertaken with providers to look at incidents and to determine whether the right escalations were made at the right time and whether the right health professional was contacted. It was also highlighted to the Committee that the Adult Social Care team were not medical professionals, although they were competent in being able to recognise the changes in an individual's circumstances and in being able to send up the signal to relevant providers who will help them to resolve such issues.

22. The Committee enquired that given the system's commitment to ongoing learning and evaluation, would the system consider the outcomes and feedback of the recent Public Engagement Exercise held in Wantage around the future of Wantage Community Hospital. The ICB Director of Place responded that the Wantage engagement exercise was discussed at the ICB's executive management committee, and the case of Wantage was being utilised across the BOB footprint as an example.

23. The Committee enquired as to how effective the communication and coordination was between the NHS and care providers. It was explained to the Committee that system meetings were held daily, where points of escalation or concern are raised. Therefore, there were daily escalations within the system that were being heard and addressed.

24. The Committee queried that despite the positive factor of most people having a preference for being at home as opposed to in a bed, were there any potentially

negative consequences if Oxfordshire was not meeting nationally set discharge targets, such as reductions in funding, and whether this might have been a vital context for the closure of beds. It was responded that the system had to demonstrate how effectively the money had been invested to make a difference to the residents of Oxfordshire. The case for having additional discharge funding was dependent on meeting discharge targets, and it would be difficult for Oxfordshire to argue the need for further funding if such targets were not being met. In response to a query by the Chair as to how this would influence the public or stakeholder engagements that took place, the BOB ICB Director of Place explained that at times decisions had to be made in an agile a manner as possible and that some of the system's capacity had to be flexed on some occasions. The Director of Place also specified that the system needed to find ways to have conversations with communities in regard to some of the changes that the system would need to make. But this would require bandwidth, capacity, and immense time and effort on the part of senior officers to be able to reach out and talk to all communities.

25. The Committee queried whether there were any indications to suggest that the use of D2A had actually resulted in an improvement of hospital flow within Oxfordshire. It was outlined to the Committee that the D2A process was slowing the growth in the demand for hospital services and was also reducing delays to discharging. Additionally, the Committee enquired as to whether there were consistent criteria that were utilised to determine which patients would be more suited to the D2A process. The Deputy Director of Adult Social Care responded that the Transfer of Care team were charged with looking at the initial referrals and making a pathway decision. The system was working hard collectively to make such discussions around a patient's discharging arrangements were as robust as possible. People working in the Transfer of Care team had access to a whole range of health and social care systems to help understand what was most appropriate for each patient.

26. The Committee queried how long the system had tracked outcomes for people discharged home, and how long subsequent trips to hospital were observed. It was responded that the system worked collectively to track individuals who have had made frequent subsequent trips to hospital. Data was also looked at by the system to monitor if a particular individual has had regular trips to hospital after being discharged, and decisions could be made as to how to provide an alternative service to such individuals that may be more suited to their needs.

27. The Committee emphasised that there were existing pressures within primary care, and queried how well-resourced neighbourhood teams were in the context of such pressures, and whether there was further funding for these teams or if it was a case of joining up existing provision. The BOB ICB Director of Place specified that there was some funding that was secured for integrated neighbourhood teams. However, part of this would also include utilising

resources that had already existed in the system, as well as attempts to secure further avenues of funding.

KEY POINTS OF OBSERVATION AND RECOMMENDATIONS:

28. Below are some key points of observation that the Committee has in relation to the support for people leaving hospital. These key points of observation relate to some of the themes of discussion during the meeting on 16 January 2024, and have also been used to shape the recommendations made by the Committee. Beneath each observation point is a specific recommendation being made by the Committee. The Committee understands that given that this work is systemwide in nature, it will be ideal to receive a systemwide response to each of the recommendations below.

29. **Please note:** the Committee had also asked questions relating to D2A in its 08 February 2024 meeting as part of its scrutiny of Oxford University Hospitals NHSFT (OUH) and the CQC improvement journey around the John Radcliffe Hospital. There may be other relevant recommendations that the Committee will be issuing in a separate report directed at OUH.

Process of Learning and Evaluation: The Committee is supportive of the ongoing work being invested into developing ways in which to support people who leave hospital as part of the Oxfordshire Way. This could help to reduce unnecessary length of stay, which would not be ideal for both a patient that is clinically ready to leave hospital on the one hand, and for those who are in need of a hospital bed. Therefore, the ambition to prioritise care in people's homes when it is appropriate to do so is something that should be worked towards. However, it is vital that throughout the process of this transition toward prioritising care in people's homes, important processes of learning and evaluation are adopted. If national directives require Oxfordshire to reach the 95% target, this could result in rapid changes to how residents are discharged from hospital, and there is therefore a need for consistent and routine monitoring and evaluation of how the ambitions and measures taken to reach the aforementioned target are actually playing out.

The experience of patients is crucial in this regard, and service users should be encouraged to share their feedback on how the process of discharging them from hospital into their homes has actually turned out. The Committee firmly believes that if residents and key stakeholders are to be supportive of these initiatives, then it is imperative that they are reassured that routine processes of learning and evaluation will be established. The Committee recommends that the System makes use of and provides opportunities for input from Healthwatch Oxfordshire. As a leading avenue for the patient voice, the input from Healthwatch could help the system regularly monitor, evaluate, and reflect on what is working well and where there may be areas for improvement.

The system therefore needs to work collaboratively, and there is also a point about regular sharing of information for the system to be able to

identify where challenges may exist and how to tackle these. The role of learning and evaluation would not be for the purposes of questioning or altering the overall direction of travel in terms of prioritising care in people's homes, but more for ensuring that the system is pursuing these objectives in a manner that involves the least risk and disadvantage for residents.

Recommendation 1: *That a process of learning and evaluation is reviewed and developed. It is recommended that input from Healthwatch Oxfordshire and service users is also enabled inasmuch as possible so as to improve the process of learning and evaluation.*

Monitoring Performance and KPIs: The Committee strongly believes in the importance of monitoring the performance of the services being delivered under the D2A and the Oxfordshire Way. The D2A process is an early one, and the Committee understands and recognises that the system is gradually becoming accustomed to this new way of working. However, aside from the process of ensuring that the voices of service users are heard (as per the previous recommendation), it is crucial that the system is able to monitor its performance. Such performance monitoring should not solely include the monitoring of how many patients are discharged straight home in line with nationally set targets, but also the examining of how effective each part of the process of ensuring support for discharged patients has been.

The Committee also urges there to be clear transparency around the process of monitoring and evaluating the performance of these services. This would also help provide reassurances to stakeholders and the wider public and could instil further confidence in the system and its ability to deliver support services effectively for those leaving hospital.

Furthermore, the Committee strongly recommends that the role of lived-experience is also incorporated into the process of evaluating long-term outcomes of the D2A process and the Oxfordshire Way. Lived experience can provide important and valuable contributions to the system's reflections on what has worked well, and on what could be improved moving forward. The Committee welcomed the data collected from residents on D2A in Wantage as part of determining the future of Wantage Community Hospital that could be used for this purpose.

Recommendation 2: *For the establishment of clear KPIs for the purposes of measuring the performance of services delivered under Discharge to Assess and the Oxfordshire Way. It is recommended that there is clear transparency around this, alongside the inclusion of lived experience (including the learnings from the data in the Wantage co-production work) and the evaluation of long-term outcomes.*

Communications and Public Engagement: The committee firmly believes in the importance of raising awareness and understanding amongst the public as to the nature of any changes in system working that are taking place. Some residents may remain uncertain as to the

NHS reforms and the changes to the structures of health and social care that are taking place more broadly. Even more important is for residents to understand and appreciate the changes being made in the nature of the services they would receive from the system. Hence, it is important for there to be clear communication with the public for two reasons:

- For the public to understand how services are changing regarding the support they could expect to receive upon being discharged from hospital.

- For the public to be reassured as to the nature of these changes, and as to how such changes may, as the system is promulgating, work more greatly in their favour as opposed to any older models of discharging and aftercare.

There will be understandable anxieties by some Oxfordshire residents as to how the prioritisation of care in people's homes would work, and whether there is an adequacy of resources for this. It is for this very reason that there may be objections to the closure of short stay hub beds for instance. Therefore, the committee is recommending that there are clear communications and regular engagements with the public and key stakeholders so as to better inform residents of the D2A process and the Oxfordshire way, and what the changes in the pathways would mean for patients leaving hospital.

Furthermore, the importance of engagement is not simply for the purposes of raising awareness of the support available for patients upon being discharged from hospital and for helping residents to understand the Oxfordshire Way but is also for utilising such engagements as an avenue through which to receive feedback from residents or those with lived experience. This could help better inform the system's understanding of how the services for people leaving hospital are actually being received by discharged patients. Feedback may also be a useful means to understand not merely how residents feel about any support mechanisms in place, but also about where residents may have had negative experiences. This could help inform the system's process of evaluation of the support services in place and the extent to which these services are proving effective.

Recommendation 3: *For communications and regular public engagement to be adopted so as to provide reassurances to the public as to the quality of the services they could expect to receive upon being discharged from hospital; and for any additional feedback from the public or stakeholders to be heard.*

Clear Communication with Patients and Relatives: The Committee understands that in many cases, patients who no longer need to be in hospital may actually prefer to have the opportunity to return to their own homes. This often means that it is not only the system that wishes to avert undue delays in discharging, but also the patient themselves. Therefore, it is crucial that patients and their family are abundantly clear

regarding the specific support services they are eligible for, and that they could expect to receive, subsequent to leaving hospital. This is crucial for two reasons. Firstly, patients would prefer to have absolute clarity on the next steps in the process of continuing to receive support or being assessed at home after they are discharged. Secondly, patients would feel a strong sense of reassurance if they were aware of what these next steps are. If patients are uncertain as to what the next steps will be, they could feel anxious about leaving hospital, particularly if they do not have a strong support base at home or in their community, or if they are not aware of how such post-discharge services would operate to begin with. This reassurance factor is also vital in that patients need to be able to understand who would be responsible for their assessment/care, as well as who they are to contact if they have any concerns or potentially complaints regarding the services they have received.

The Committee understands that new leaflets are being worked on. Therefore, the Committee recommends that written information is produced which would provide patients with the following:

1. Information on the services they will receive when leaving hospital.

2. Details of key contacts of those responsible for managing or providing their care.

3. An outline of any potential complaints process that may be in place that the patient could invoke in circumstances where they have significant concerns.

Recommendation 4: *For patients to be clearly communicated with in relation to the services they will receive upon being discharged from hospital. It is also recommended that leaflets for patients include an outline of the complaints processes in place.*

Importance of Staff Training: The Committee is pleased to hear that there are a vast array of staff members that would be involved in discharging and supporting patients who leave hospital. It is positive to see that the process of discharging patients and providing support to them after discharge is one that is multidisciplinary in nature. This is certainly one of the strengths of the system and the Committee would like to see a continuation of this. Nonetheless, the Committee feel that it is vital for all staff involved in the entire process of discharging and providing support to patients to be sufficiently trained. It would be ideal for such staff to be trained in both their own relevant areas of work, as well as in being made aware of the role of other relevant teams/support services that they would have to work closely with in order to provide a network of support to patients who leave hospital and who require ongoing support at home.

The Committee also believes that it is pivotal for any such training to include guidance on how to deal with the close network of individuals (be

these relatives or friends) that a discharged patient has. This would help to keep a patient's loved ones well informed of who is responsible for the care of the patient as well as who such loved ones could contact if they noticed anything or had any concerns regarding the patient that they might wish to bring to their support workers' attention.

Furthermore, there is also a point about training being ongoing, particularly in the sense of keeping up to date with any new/additional national developments or best practice guidance. However, training should not only be about "telling" staff members what it is that they should be doing, but could also help staff to reflect on scenarios they have been involved in with patients, and on how they could potentially learn from previous actions they had taken to potentially reflect on how to improve the manner in which they support patients.

Recommendation 5: *To ensure that staff who provide support for discharged patients at home receive adequate and ongoing training.*

Resourcing for Neighbourhood Teams: The Committee is supportive of the role of integrated neighbourhood teams and considers that such teams have the potential to provide an immense network of support for those leaving hospital (particularly those with long-term conditions or vulnerability). Whilst it is crucial that those involved in these teams are sufficiently trained and closely connected in being able to provide support to discharged patients, there is also a point about such teams being adequately resourced for the purposes of being able to meet demand within both urban and rural areas throughout the County. The process of ensuring such teams are adequately resourced would involve the need to assess the demand for services that provide support for those leaving hospital. This is understandably not a simple undertaking, and may require some time, although it is a vital element of the system being able to assess the degree to which neighbourhood teams should be resourced and to seek additional national funding for this work.

The Committee was pleased to hear from the BOB ICB Director of Place that there was some funding that was secured for integrated neighbourhood teams. However, the Committee recommends that further funding is sought (subject to the outcomes of any assessment of demand), and that considerations are given to utilising resources that already exist in the system for the purposes of ensuring adequate resource for the relevant workforce for neighbourhood teams.

Furthermore, it is also vital that neighbourhood teams are geographically spread in a manner that caters for both urban and rural areas. For instance, rural areas tend to have ageing populations that could require long-term care after leaving hospital.

Recommendation 6: *To ensure that integrated neighbourhood teams are sufficiently resourced and geographically spread in as appropriate a way possible so as to meet demand across both rural and urban areas. It is recommended that any available*

resources are maximised to meet demand for support at home, and that further funding is sought to support vital local transformation and prevention work in local communities.

Recommendation 7*: As agreed during the meeting on 16 January, for site visits to be arranged to provide the Committee with insights into how the Discharge-to-Assess process functioned in practice.*

LEGAL IMPLICATIONS

30. Under Part 6.2 (13) (a) of the Constitution Scrutiny has the following power: 'Once a Scrutiny Committee has completed its deliberations on any matter a formal report may be prepared on behalf of the Committee and when agreed by them the Proper Officer will normally refer it to the Cabinet for consideration.

31. Under Part 4.2 of the Constitution, the Cabinet Procedure Rules, s 2 (3) iv) the Cabinet will consider any reports from Scrutiny Committees.

32. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Anita Bradley
Director of Law and Governance

Annex 1 – Scrutiny Response Pro Forma

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