

SCRUTINY COMMISSION 3
HEALTH AND CARE

Minutes of a meeting of Scrutiny Commission 3 held on Wednesday,
4 June 2008 at 6.00 p.m. at the Civic Offices, Telford

PRESENT - Councillors D.R.W. White (Chairman), V.A. Fletcher, G.P. Hossell, C.N. Mason, H. Williams and D. Wright

Ms D. Davis and Mrs V. Lindley (Co-optees).

Also Present – Councillor R.E. Groom (for SC3-4)
Mr. C. Cornell (Implementation Consultant, National Institute for Clinical Excellence)

Officers - P. Taylor (Head of Housing Needs & Community Care), N. Brookes (Business Manager – Housing Quality & Renewal), F. Carron (Business Manager – Prevention & Intermediate Care), Paul Smith (Agency Services Manager – Home Improvement Agency), B. Walker (Team Manager – Occupational Therapy), A. Smith (Scrutiny Manager) and P. Smith (Senior Democratic Services Officer)

SC3-1 **MINUTES**

RESOLVED – that the minutes of the meeting of the Commission held on 16 April 2008 be confirmed and signed by the Chairman.

SC3-2 **APOLOGIES FOR ABSENCE**

Councillors J.A. Dixon and A. McClements and Mr D. Saunders (Co-optee)

SC3-3 **DECLARATIONS OF INTEREST/PARTY WHIP**

Councillor C.N. Mason declared a personal interest in agenda item 5 – Adaptations to the Home for Disabled People.

SC3-4 **NATIONAL INSTITUTE FOR HEALTH & CLINICAL EXCELLENCE (NICE)**

The Chairman welcomed Chris Connell (Implementation Consultant, NICE), who made a presentation to Members on the work of the National Institute for Health & Clinical Excellence and its relevance to local authorities in terms of public health.

NICE was established in 1999 as an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. It was originally an NHS specific body, but its role was changing rapidly to involve a much wider audience. Guidance was produced in three areas:

- Public health – guidance on the promotion of good health and prevention of ill health for those working in the NHS, local authorities and wider public and voluntary sector.

- Health technologies – guidance on the use of new and existing medicines, treatments and procedures within the NHS.
- Clinical practice – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

All the guidance was produced following a rigorous, evidence-based process that took into account evidence from specialist research; from patients and clients on their experience; and from professionals/experts in that field. In relation to the guidance produced on new drugs, examples of their positive impact could be seen in the benefits to cancer patients, and in the uptake of drugs to tackle obesity.

Examples were given of the public health issues for which guidance had recently issued, including physical activity in the workplace, school based interventions on alcohol and interventions to prevent sexually transmitted infections. Recent clinical guidelines covered topics such as obesity, dementia, depression and falls. NICE provided considerable support to help organisations implement the guidance, including six implementation consultants based around the country (Chris Connell was consultant for the “West” region), implementation support tools, education initiatives and the sharing of examples of how organisations had worked together to implement guidance.

NICE was keen to broaden its work beyond the NHS and it was seen as being of increasing relevance to local authorities in terms of the public health and care agenda. It was emphasised that the more recent guidance could help Health Scrutiny Committees to carry out their work, in that they provided strong evidence-based recommendations that sought to maximise health benefits and the use of public monies. NICE was also keen to hear from people and organisations from outside the NHS about the sort of topics that should be selected for examination.

Following the presentation, Members asked a variety of questions, including:

- given that the pharmaceuticals is a global industry, is there a body that co-ordinates the licensing of drugs between different countries?

Response: Mr Connell stated that there was a European Medicines Agency to which companies could apply for a Europe-wide licence. NICE had close links with similar organisations in other countries, and had helped in setting some of these up.

- Who is responsible for issuing the licences in the UK, and at what stage does NICE get involved in the development of drugs?

Response: In the UK, the Medical & Health Care Products Regulation Agency licensed the products once they had been developed. NICE then looked at the clinical and cost effectiveness of the products. This process could be quite lengthy, so NICE was looking to get information about a potential drug/medicine earlier in the process via the manufacturers’ trials. However, it was important that this did not compromise NICE’s independence.

- re: recent high profile NICE guidelines on drugs for dementia treatment – how were the views of patients/carers assessed in relation to the views of clinicians/doctors, particularly if they conflicted?

Response – there was a tremendous response from the public about this issue. Anecdotal evidence did have limited value, and “hard” demonstrable evidence would outweigh it. In the end, NICE had to make a judgement, and its conclusions were that these drugs were not cost or clinically effective in the early stages of dementia.

- re: obesity in children – does NICE also look at making sure that children are well nourished?

Response – the guidelines on childhood obesity and child nutrition were probably the most comprehensive in the UK so far. The report looked at a whole range of issues, and included specific guidance for schools.

– does anybody audit or monitor the performance and ethics of NICE, and is there a government representative on NICE’s governing body?

Response – NICE had been scrutinised by the House of Commons Health Select Committee, and had been looked at twice by the World Health Organisation. Decisions or guidelines of NICE could be appealed by the public or drugs companies, and could also be subject to judicial review. There was a government minister who was responsible for NICE, but the Minister did not sit on any of NICE’s internal management bodies. However, the government did have the final say on which topics were selected for examination.

- does NICE intervene if something goes wrong with a drug once it is licensed and approved (eg appearance of side-effects)?

Response - there was a reporting system within the NHS to pick-up any safety issues. If there was sufficient evidence of a problem, we would review and alter our guidance accordingly.

The Chairman thanked Mr Connell for attending the meeting. The value that NICE guidance could bring to Health Scrutiny work was now better appreciated – for example, in relation to the Commission’s work on alcohol treatment and prevention.

SC3-5 ADAPTATIONS TO THE HOME FOR DISABLED PEOPLE

The Head of Housing Needs & Community Care and his team provided a presentation looking at the Council’s statutory responsibilities to provide adaptations to help people to remain in their homes; the types of adaptation available; the assessment process; the funding streams and budgets; the Council’s performance; and issues and challenges for the service.

The presentation provided details of the role that Occupational Therapy played in carrying out assessments and identifying what options were available to the applicant in order to meet their needs. One of the options was to apply for a Disabled Facilities Grant (DFG), and further information was provided about the Grant. It was delivered via the Home Improvement Agency (HIA), and was a mandatory grant scheme with a limit of £30,000 for individual grants. The grants were means tested, and the HIA organised and planned the identified works for clients. It helped around 175 people a year. The Government had recently made the DFG process more flexible, but there were concerns about the increasing demand for the service, given the increasingly ageing population. For example, it was estimated that there were 14,900 households in the Borough where one or more residents had a disability. In terms of

performance, the average time for Occupational Therapy to make their recommendation following referral was 6 weeks, and Telford & Wrekin was one of the few authorities in the country that did not have a waiting list. Grant applications were determined on average in 19 weeks, which was in the top quartile of national performance.

Following the presentation, Members asked a number of questions including:

Were assessments made for Social Registered Landlords (RSLs), and were tenants informed what the recommendations were?

Response – Occupational Therapy handled all referrals irrespective of where they originated from and tenants of RSLs would be informed. Sometimes an issue arose where a RSL would recommend a tenant move to another property which had already been adapted rather than have their existing dwelling adapted. It was often a balance between maximising the sustainability of properties and the wishes of the tenant about where they wanted to live, and the HIA worked with Wrekin Housing Trust to address any issues.

Mrs Lindley referred to cases she was aware of where applicants for adaptations had not been offered the option to apply for a DFG, and they had been instead steered towards a voluntary organisation - Soldiers, Sailors & Airforce Families Association (SSAFA) - who funded some adaptations.

Response - people were referred to SSAFA if they were ineligible for assistance from the Council (eg: if there was no assessed need). However, if people were eligible, they would be made aware of the availability of DFGs. Any individual cases where this was alleged not to have happened could be looked at outside the meeting.

Was there any budget to commission custom-made adaptations?

Response – most work was undertaken by two technicians, but for very specialist jobs use was made of the expertise of retired engineers.

The Chairman thanked the officers for their attendance, and stated that the issue of adaptations in RSL properties might be something the Commission would want to look at further.

SC3-6 RE-APPOINTMENT OF CO-OPTEEs FOR 2008/09

The Chairman reported that the existing co-optees on the Commission had indicated that they wished to continue in their role. One of the co-optees needed to be nominated by the newly formed Local Involvement Network (LINK) for Telford & Wrekin. Mrs Lindley had been the representative from the former Patient and Public Involvement Forum, and it was hoped that she would be able to continue this role for the LINK. However, this was still to be formalised, and it was therefore proposed that Mrs Lindley be re-appointed on an interim basis.

RESOLVED –

- (a) that Ms D Davis and Mr D Saunders be re-appointed as co-opted members of the Commission for 2008/09.**

- (b) that Mrs V Lindley be re-appointed as a co-opted member of the Commission on an interim basis, pending formal notification from the Local Involvement Network.

SC3-7 NOMINATIONS TO JOINT HEALTH SCRUTINY COMMITTEE

The Chairman reported that the Commission needed to appoint six members to the joint Borough of Telford & Wrekin/Shropshire County Council Health Overview & Scrutiny Committee for 2008/09.

The next meeting of the Joint Committee was likely to be on Friday 11 July 2008 at Shirehall, Shrewsbury.

RESOLVED – that Ms D. Davis (co-optee), Cllr V.A. Fletcher, Mrs V. Lindley (co-optee), Cllr A. McClements, Mr D. Saunders (co-optee) and Cllr D.R.W. White be appointed to the Joint Health Scrutiny Committee for 2008/09.

SC3-8 FORWARD PLAN

The Commission received a report that identified the key decisions to be made by Cabinet relating to the work areas of the Commission, as detailed in the current Forward Plan for the period from June to September 2008.

RESOLVED – that the report be noted.

SC3-9 CHAIRMAN'S UPDATE

a) The Chairman reported that there had been delays in the progress of the NHS Strategy for the Shropshire, Telford & Wrekin Health Economy. Further information was now going to be presented to the Joint Health Scrutiny Committee on 11 July 2008.

b) The Chairman sought Members' views on possible agenda items for the next meeting on 10 September 2008.

RESOLVED – that the two main agenda items should an update on the implementation of the Prevention of Alcohol Misuse & Harm Reduction Strategy, and a presentation from the Director of Public Health on obesity issues in the Borough.

SC3-10 DATE OF NEXT MEETING

The next meeting of the Commission was scheduled for 6.00pm on Wednesday, 10th September 2008.

The meeting closed at 8.00pm

Chairman.....

Date.....