HEALTH SCRUTINY COMMITTEE

Minutes of the meeting of the Health Scrutiny Committee held on Tuesday, 1st May 2012 at 6.00 p.m. in the Civic Offices, Telford, Shropshire

PRESENT:
Councillors D. White (Chairman), V. Fletcher, J. Loveridge, J. Minor, C. Turley; Co-optees D. Davis, R. Shaw.

Also Present**:** Cllr. Richard Overton, Chairman of the Shadow Health & Wellbeing Board and Deputy Leader with responsibility for public health and wider health issues; Dr. Mike Innes, Chairman of the Telford & Wrekin Clinical Commissioning Group; Paul Taylor, Social Care Specialist; Stephanie Jones, Scrutiny Group Specialist.

HSC-24 MINUTES

RESOLVED - The minutes of the previous meeting held on 14th March 2012 be agreed as an accurate reflection of the meeting and signed by the Chairman.

With regard to the recommendations made at the previous meeting, the Chairman informed Members that:

- the Children & Young People Scrutiny Committee would be meeting on 22nd May to review the Autism Strategy for children, following up on points raised at the meeting on 14th March;
- the other recommendations had been sent to the Assistant Director Care & Support and the Cabinet Member for Adult Social Care requesting a written response to come back to the Committee.

HSC-25 APOLOGIES FOR ABSENCE

Cllr. J. Seymour; J. Gulliver, Co-optee.

HSC-26 DECLARATIONS OF INTEREST

None

HSC-27 CLINICAL COMMISSIONING GROUP

The Chairman welcomed Dr. Mike Innes, Chair of the Telford & Wrekin Clinical

Commissioning Group (CCG) to the meeting and thanked him for his attendance. Dr. Innes welcomed the opportunity to speak to the Committee as part of the CCG's engagement strategy and its commitment to openness and transparency. Critical friend feedback from the Committee would be welcomed.

Dr. Innes gave a presentation on the progress and responsibilities of the CCG covering the following points:

- The timeline in the development of the CCG which showed the massive distance travelled in the last 2 years:
  - Five practice based commissioning groups had joined one Clinical Commissioning Consortia for Telford and Wrekin and had been granted Pathfinder status in January 2011.
  - A GP Forum had been established which represented all GP practices and would both feed into the commissioning process and hold the CCG to account. The CCG differed from the PCT in that it was a membership organisation of clinicians and commissioners: the CCG Board was accountable to its membership as well as to the Department of Health, Health & Wellbeing Board, scrutiny etc.
  - 5 GP s had been elected to the CCG Board in April 2011, with Dr. Innes as Chair. Board duties were equivalent to 1.2 WTE practitioners. There had been concerns about taking this resource out of general practice, especially at a time when GP s were working extended hours within a more complex health economy and, unlike hospital consultants, there had been little expansion of GP s with only 3 new practices established in the last 3 years. Thought would need to be given to how to increase resource in primary care.
  - David Evans had been appointed from Powys as Chief Operating Officer to start in May and would be responsible for overseeing the CCG's development and statutory duties.

- The CCG Vision had been agreed "Every patient experience matters - every clinician is contributing". A key change was that previously accountability had flowed upward from providers to ministers - the CCG would like to see greater accountability to the population served.

- There had been a huge amount of developmental activity including extensive engagement which was challenging with limited resources. The organisational form and function was being developed - five operational and development plans had been developed as part of the authorisation process and could be shared with the Committee. Plans were in place for managing the budget - the CCG had been

responsible for the commissioning budget since October 2011 and had delivered a balanced budget with a surplus of £1m. Mechanisms were in place to ensure commissioning would remain within budget. The healthcare system was being looked at - providers, hospital services, etc. - to look at how the system could be transformed for the future.

- Key opportunities and threats were highlighted.
  - It was felt the enhanced relationship with the local authority would bring huge benefits in terms of links with social care and the potential for joint commissioning and co-location.
  - There were opportunities to build a stronger connection and greater local accountability to the population though LINk, contract negotiations, consumer panels and patient representative groups.
  - Relations between primary care and providers would be shifted from a managerial level to a clinical level as the core interaction.
  - Costs were a huge challenge: the health service was facing its biggest ever cost challenge, with a potential saving of £250m needed in Shropshire and Telford & Wrekin over the next 5 years. The budget for administration of health services would reduce from £35 per head of population received by the PCT now, to £25 per head for the CCG. The CCG had resisted pressure to coalesce with other CCGs as had happened in other parts of the country and remained committed to strong local commissioning to meet the needs of the population of Telford and Wrekin.
  - There was a risk of marketisation leading to the separation and fragmentation of services. There seemed to be a drive nationally for Commissioning Support Organisations (CSOs) supporting CCGs to have a strong centralised model which could increase the likelihood of privatisation at a later date. It had just been announced that the CSO supporting the CCGs in the West Mercia cluster had failed the authorisation process. This was a set back as the CCG could not be authorised without an authorised CSO. Other CSO arrangements would need to be found, possibly looking towards Staffordshire.
  - There was more work to do on engagement. There still a view that GP s are independent practitioners and businesses which was at odds with the need to engage, collaborate and consult. The engagement of providers was not guaranteed - the hospital Trust and Community Trust were intent on getting Foundation Trust (FT) status which would provide greater independence and reduce the impetus to engage with commissioners.
  - Overall, Dr. Innes was optimistic that the CCG would succeed in terms of authorisation, delivery and survivability.

- The statutory roles of the CCG were set out and the COO would be accountable for these. An additional role would be added to promote medical education and workforce development to address the issue with the low number of GP s coming though.

- The steps towards authorisation were outlined. The Chairman, CEO and COO needed to be vetted and approved, and the development plans had been approved by the PCT and SHA. Telford & Wrekin was in the second wave of approvals to receive authorisation in November. Authorisation could be granted without conditions, or with conditions which would need to be discharged and reassessed for unconditional authorisation by April 2013. The key challenge now was the approval of a CSO. There was a risk that the CCG may be challenged on collaboration with Shropshire, but the CCG was committed to retaining its independence. Overall, Dr. Innes rated the likelihood of authorisation as 7/10.

Following the presentation, the following additional information was provided in response to members' questions:

- There was a potential issue with the separation of the commissioning structure between the CCG and CSO - CSO staff would be answerable to CSO managers and not directly to the CCG - and it was important that services for vulnerable people remained seamless. Two safeguarding posts had therefore been included in the CCG structure to ensure this did not happen.

- The £250m saving for Shropshire and Telford & Wrekin was an indicative figure, but helped to emphasise the scale of the problem to providers. Finnamores had been working on predictive modelling for the whole health economy and Dr. Innes felt the early work looked good. The scale of savings required may mean that the way health services are funded will be affected - for example, the NHS may offer a basic health care package with other services being funded through private insurance.

- Telford & Wrekin had been under-costed by 6% for fair shares for health, an equivalent under-funding of £16m. It had been hoped that the funding formula would be changed, but the government had retained allocations based on historical spend. However, Dr. Innes was confident that GP's clinical experience could make a difference for example though the clinician brokered amalgamation of hospital services and the through shrewd contract negotiation.

- Regarding the cost of drugs, Telford and Wrekin only uses generic medicines to as good effect as possible, and although there was pressure from specialist and new

drug treatments, Telford & Wrekin was conservative in the adoption of new drugs. There needed to be a balance of cost against benefit which can be difficult, and engagement of the public was very important in establishing what the priorities should be - for example, funding bariatric surgery was very expensive but has long term benefits; should this be prioritised against IVF treatment or another service?

- With regard to competition in the health sector, Dr. Innes expressed the view that closed markets were a threat in that they can inflate costs in the long run. Furthermore, markets have no concern for failure but a provider going "bust" would cause a problem for the population.

- One of the threats to the CCG was the pressure to operate across a bigger platform, notably with Shropshire. However, the CCG remained committed to Telford and Wrekin. Telford and Wrekin had a different demographic and services needed to be commissioned differently to meet local needs. Within the borough, there was a good level of co-operation between partners creating a good platform to provide excellent local solutions though a joined up approach. The larger the organisation, the less priority there was for local people.

- Members raised a concern about the implementation of the 111 service and the potential threat to Shropdoc. Dr. Innes said that a local contract variation had been negotiated whereby 111 calls flagged as a complex needs would be automatically routed to Shropdoc. He referred to a similar situation when NHS Direct had been launched as a telephone, then internet service, but had not been able to cope with the volume of calls and Shropdoc had provided support. There could be a similar issue with the 111 service.

- Following the failure of the West Mercia cluster CSO to gain authorisation, a meeting would be convened urgently with the other CCGs in the cluster to see whether another model could be developed. The model had not been homogenous, but rather supported local delivery with staff in each location (Shropshire, Telford & Wrekin, Herefordshire, Worcestershire.) The government was looking for homogenous models - possibly with a view to selling them off in future - so the new model would need to be bigger and different. Staffordshire may provide a model as more patients were exported there rather than to Herefordshire or Worcestershire so there were synergies with Telford & Wrekin.

- There would be no immediate impact of mid-Staffordshire Hospital Trust report on the CCG or CSO, but the CCG would be looking carefully at the findings and how to build soft intelligence and patient involvement to build safeguards into the system.

- Members brought up their concerns about the risk of losing 24/7 A&E from PRH, which had been raised with the SaTH Chief Executive at the last Joint Health Scrutiny Committee meeting. Dr. Innes said that he Chairs the A&E work stream within the Unscheduled Care Strategy, and was promoting the view that SaTH should be managing the A&E as one unit over 2 sites with one rota, rather than managing them as separate units.

At the end of the discussion, the members congratulated Dr. Innes moving the CCG this far and welcomed assurances that the CCG was committed to the people of Telford & Wrekin.

HSC-28 SHADOW HEALTH & WELLBEING BOARD

The Chairman welcomed Cllr. Overton who was attending the meeting in his capacity as Chairman of the Shadow Health & Wellbeing Board, and as Cabinet member with responsibility for public health and wider health issues. Paul Taylor, Social Care Specialist, gave a synopsis of the changes to local authority responsibilities brought about by the Health & Social Care Act by way of introduction to the following three agenda items.

The Act placed responsibility on local authorities for health outcomes and making health services more accountable, and work was on-going to ensure the Council was ready to take on the new duties. Duty for the Joint Strategic Needs Assessment (JSNA) which identified the needs of the local population had passed from the PCT to the authority, and the authority would resume responsibility for Public Health.

The authority had a statutory duty to establish a Health & Wellbeing Board by April 2103, and in Shadow form by April 2012. This was in place, and the first public meeting of the Shadow Board had been held in April. The responsibilities of the Board included:

- Oversight of the development and delivery of a Health & Wellbeing Strategy, informed by the needs identified in the JSNA, and including elements delivered by NHS bodies. The draft Priority Outcomes for the Health & Wellbeing Strategy had been discussed at the previous Shadow Health & Wellbeing Board meeting and a consultation programme was being developed. It was agreed that the Health Scrutiny Committee would be consulted on the Priority Outcomes.
- Ensuring that services commissioned by the CCG were in-line with the needs identified in the JSNA and the Health & Wellbeing Strategy
- Oversight of the local delivery of services commissioned nationally by the NHS

Commissioning Board and Public Health England.

The Cabinet report of 29th March on governance arrangements for the Shadow Health & Wellbeing Board had been circulated to the Committee for information. The governance arrangements were important to the authority as part of the accountability framework. A question was raised as to whether there was a conflict of interest with HealthWatch being a member of the Health & Wellbeing Board when the service would be commissioned by the authority. Members were informed that there was a statutory requirement for HealthWatch to sit on the Board and the role was to represent the views of patients and the public and in this capacity was not deemed to be a conflict of interest.

There was a discussion about the role of the Health Scrutiny Committee in the new health arrangements, how scrutiny would work with the Health & Wellbeing Board and other new health bodies, and the levels of accountability. The Scrutiny Group Specialist reminded members that the Health & Social Care Act had amended the provisions of the National Health Service Act 2006 so that scrutiny powers would be exercised by the authority rather than a health overview and scrutiny committee. The draft regulations and guidance for Scrutiny were due to be published for consultation later in the year. The Health Scrutiny Committee had previously supported comments submitted to the Department of Health and the Centre for Public Scrutiny by the West Midlands Regional Health Scrutiny Chair's Network Group to influence the drafting of the regulations and guidance.

It was agreed that there needed to be dialogue between the Health Scrutiny Committee and the Shadow Health & Wellbeing Board to clarify the roles and responsibilities of each body to avoid duplication of work and ensure that there is an effective interrelationship. The Chairman said he would take discussions forward after the meeting.

Members drew Cllr. Overton's attention to a number of concerns which were subject to on-going or future scrutiny, but that the Health & Wellbeing Board might want to be aware of. The issues raised were:

- The performance of Shropshire Community Trust, the balance of services between Shropshire and Telford & Wrekin and concerns about spending on services out of the county.
- The potential risks to the 24 A&E service at PRH
- West Midlands Ambulance Service – development of pathways for patients affected by the reconfiguration proposals, progress on the implementation of the Make Ready system in Telford & Wrekin and Shropshire

- Issues with the transfer of patient records between GPs and hospitals, and between hospitals
- The impact of the West Midlands 111 service
- The fact that the Finnamore report on the future of the health economy had not been available in time to inform the Full Business Case for the hospital reconfiguration.

It was suggested that concerns should also be raised with the CCG to feed through the commissioning group.

The Health & Social Care Act also required providers to become Foundation Trusts by April 2014. The requirement applied to two providers in the county: the Shrewsbury and Telford NHS Hospital Trust and the Community Trust. The Council would have representatives on the Boards of the Foundation Trusts and currently had one seat on the South Staffordshire and Shropshire NHS Healthcare Trust. This was currently an officer, but there was a debate about whether Foundation Trust Board membership should be a political role.

RESOLVED

- **That the Chairman would take forward discussions about scrutiny working with the Shadow Health & Wellbeing Board.**
- **That the Committee would be consulted on the draft Priority Outcomes for the Health & Wellbeing Strategy at a future meeting**

HSC-29 HEALTHWATCH / LINK

The Cabinet report of 29th March on HealthWatch and interim LINk arrangements had been circulated to the Committee for information. Staffordshire University had hosted the LINk service in Telford and Wrekin, but had decided not to extend the contract beyond March 2012. There was therefore a need to make alternative arrangements for the LINk until HealthWatch came into being in April 2013, and the staff had been TUPE transferred as direct employees of the Council for this interim period.

The process for commissioning the HealthWatch service was outlined in the Cabinet report, and the involvement of scrutiny in developing the contract specification had been built into the process. It was suggested that members could join the stakeholder workshops which would be set up to develop the specification, and that details of the arrangements would be discussed by the Chairman and officers.

A copy of the Centre for Public Scrutiny's 10 questions to ask about HealthWatch had

been sent to the Committee and officers, but as time was limited, it was agreed that the Social Care Specialist would provide a written response to be circulated to members.

It was also agreed that as part of the discussions about scrutiny's role in the new health arrangements, the relationship with HealthWatch would also need to be considered.

RESOLVED

- **That members of the Committee would be involved in developing the HealthWatch contract specification**
- **That the Social Care Specialist would provide a written response to the questions submitted by scrutiny**

HSC-30 PUBLIC HEALTH TRANSITION

The Social Care Specialist reminded members that responsibility for Public Health would transfer from the PCT to the Council from April 2013.

The Cabinet report of 29th March on the Public Health Transition Plan had been circulated to the Committee for information. A Public Health Steering Group had been set up between the authority and the NHS to oversee the transition. There was still a debate about what monies would transfer from the NHS to the local authority for public health. A shadow budget had been drafted by the PCT, but the amount announced had been based on 2010/11 spend and the Council's view was that budget needed to be based on 2012/13 spend. A decision had been taken late in the passage of the Bill to exclude services such as sexual health from local authority responsibility, but the shadow funding had not been adjusted to take account of the change. The Council had written to the Director of Public Health to express the view that the allocation should be higher.

Members asked about the approach that was being taken to the transition, and whether this would be a transformational change or a "lift and shift" operation. The Social Care Specialist explained that the approach was being considered by the Steering Group and the Council's view was that there was an opportunity to be transformational. A vision for local public health services would be developed, and there was an opportunity for the Scrutiny Committee to be involved in developing the vision. The Department of Health had put out fact sheets on public health including 10 case studies describing the different approaches being taken by other authorities,

some of which were quite radical. It was useful to learn from the national experience, but services would need to meet local needs for Telford and Wrekin.

There were currently 12 dedicated Public Health staff employed in the NHS and TUPE transfer arrangements were being looked at. The NHS had not operated on a local authority boundary basis and there would therefore be some changes in responsibilities, for example emergency planning for health related matters had been led by the Shropshire Public Health Director, whereas Telford & Wrekin would take on this responsibility. Consideration needed to be given to how the new staff would fit into the Council structures and the spans of responsibility across the organisation.

RESOLVED - that the Committee be involved in work developing the vision for public health services.

HSC-31 FORWARD PLAN

Members were reminded that the Children & Young People Scrutiny Committee meeting to look at the Autism Strategy for children would be at 6.00pm on Tuesday, 22nd May and the Health Scrutiny Committee Sub-group meeting to review the Community Trust's Quality Accounts was at 10.00am on Tuesday, 15th May.

No further meetings of the Committee would be held in the 2011/12 municipal year.

The meeting ended at 7.40 p.m.

Chairman: .....

Date: .....