

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 through 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 through 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 Finnermore 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:

ADULT SOCIAL CARE SCRUTINY COMMITTEE
Minutes of the Adult Social Care Scrutiny Committee held on Tuesday, 17th
April 2012 at 2.30 p.m. in the Civic Offices, Telford, Shropshire.

PRESENT: Councillors C. Turley (Chairman), F. Bould, J. Greenaway, J. Loveridge, C. Mason, J. Seymour; Co-optee Maurice Viney.

Also Present: Cllr. L. Clare, Cabinet Member Adult & Social Care; Cllr. V. Fletcher; J. Gulliver, Scrutiny Co-optee; Deb Holland, Compliance Central Region, Care Quality Commission; Karen Kalinowski, Assistant Director Care & Support; Chris Harrison, Care & Support Commissioning Manager; Stephanie Jones, Scrutiny Group Specialist.

ASCSC-24 MINUTES

RESOLVED - that the minutes of the meeting of the Adult Social Care Scrutiny Committee held on 2nd February 2012 be confirmed and signed by the Chairman.

Regarding the action points from the previous meeting, the Chairman informed members that:

- The Senior Citizens' Forum had been contacted about setting up an awareness-raising session. There were no available slots at a Forum meeting until April 2013, but an article would be published in the mid-June edition of the newsletter to coincide with World Elderly Abuse Awareness Day on 15th June.
- Information about the SSSFT thematic review had been downloaded from the website and e-mailed to Members. Theresa Moyes, Director of Quality & Clinical Performance at SSSFT, had offered to present the report at a future meeting of the Committee, and to discuss how SSSFT include safeguarding during unannounced visits to services to check on compliance with CQC essential standards of quality and safety. Members agreed this could be done to coincide with a report on the next Annual Report.
- Information regarding training for CSOs had been requested and was awaited.
- The Members' request that the number of staff trained in each organisation should be shown as a percentage of the overall relevant workforce in the next Annual Report had been fed-back.
- Additionally, a survey on training of staff in GP surgeries was being planned with a view to including the results in the next Annual Report.
- The VASB Annual Report 2011/12 had been added to the Committee's work programme. If the new scrutiny committee structure was put in place for next year, the new Health & Adult Care Scrutiny Committee would agree the work programme and this would go forward as a suggestion.

ASCSC-25 APOLOGIES FOR ABSENCE

None

ACSSC-26 DECLARATIONS OF INTEREST

None

ASCSC-27 CARE QUALITY COMMISSION: INSPECTION REGIME FOR CARE HOMES

Deb Holland, Compliance Manager Central Region, Care Quality Commission (CQC) gave a verbal report on the work of the CQC addressing a number of questions submitted prior to the meeting.

The CQC was formed 3 years ago from the merger of three former inspection regimes. The Health & Social Care Act had for the first time brought inspection under one regulatory framework across the whole health economy from acute to domiciliary care. The CQC was responsible for the registration and inspection of all health and adult social care providers including NHS Trusts, ambulances, care homes, domiciliary care and dentists. GP practices would be required to register with the CQC from next year. The Government sets the regulations and standards and the CQC inspects against the regulations and standards.

There were nine managers in the West Midlands each managing 10 inspectors. A restructure was being carried out to create bigger regional structures.

Essential standards included: treating people with dignity and respect, making sure food and drink meets people's needs, making sure that the environment is clean and safe and managing and staffing services. Additional standards are applied for particular settings. Standards are not monitored in isolation, but also in terms of the impact on, and outcomes for, patients. Inspections focus on six key areas:

- The involvement of people in the design of care
- How care has been designed around the needs of the person from assessments to delivery of care plans
- Safeguarding and safety to ensure protection from abuse and equipment
- Staffing – recruitment, checks, induction, training and appraisal processes
- Management arrangements
- Suitability of managers - managers are registered separately from providers.

The work programme is developed based on three types of inspection:

- Routine or planned inspections. This includes an annual inspection of care

homes and agencies, and risk based inspections triggered by a pattern of information or complaints which suggest a problem.

- Responsive inspections where a serious complaint or safeguarding issue has been raised, or in response to a government directive.
- Themed inspections to look at specific standards, sectors or types of care e.g. a thematic review of dignity and nutrition standards in hospitals had recently been extended as a result of mixed results from the initial 100 ward inspections.

Intelligence is used to determine which standards will be inspected so that checks are focussed on problem areas e.g. if there have been complaints about infections, the CQC could inspect hygiene and infection control standards. Five outcomes are usually looked at for a planned visit to gain a balanced view.

Most inspections are unannounced, except where the type of service or location make this impractical e.g. for dentists or remote locations. Staff sometimes arrive early in the morning or late in the evening depending on the service. Inspectors observe what is happening and talk to staff, patients, visitors and relatives, with follow up on the telephone where required. Sensitivity is used according to the circumstances and setting.

Reports document the findings of the inspection and any remedial action required. All reports are published on the CQC website. Easy to read provider profiles show where the provider is compliant or non compliant against inspected standards and where action has been required. Repeat inspections are made to check progress against required actions. In serious or extreme cases, the CQC may limit or stop the operations of a provider under civil or criminal enforcement powers.

With regard to Telford and Wrekin, the priorities for the work programme were being decided. A detailed thematic review of domiciliary care agencies would be carried out starting in April to look at care standards, safeguarding, QA systems, staff training etc. and would include visits to offices and home visits where consent had been given. Members were invited to contact the CQC about any issues they were aware of to feed into this work. The CQC and Council have regular formal and informal communication to share information and ensure work programmes are not duplicated.

The following information was then provided by Deb Holland, Karen Kalinowski and Chris Harrison in response to members' comments and questions:

- Cllr. Seymour wanted to know whether CQC inspections of domiciliary care look at the length of care visits as there had been national reports of visits only taking 15 minutes. Where care is funded by social services, the commissioner specifies the provision and an agency's performance can only be measured against the constraints set by the authority. The key checks are: is the provider clear about the commissioner's expectations, does the person have a clear care plan and does the agency have a clear contingency and communication plan to maintain a

reliable service. From speaking to service users, their key concerns were with the reliability and consistency of the service. There are challenges with the length of care visits when people require services at the same time, and this is particularly acute in rural areas.

The Assistant Director emphasised that Telford & Wrekin care contracts do not ordinarily specify 15 minute visits, unless they are required in accordance with the care & support plan e.g. a pop in visit, and the majority of service calls would be a minimum of 30-60 minutes. This was important because for some people the care worker may be their only social contact. Social care was being looked at to find the best way of providing it across different budgets, and taking these social needs into account. Options for electronic homecare monitoring were being considered, but this would not replace personal care and contact. The domiciliary care commissioning framework was being reviewed to see how providers could be better held to account on cost and quality, with a move away from time limited tasks to needs led and outcome focused.

- Cllr. Seymour raised the issue of hospital patients being discharged in the middle of the night and wanted to know whether the CQC would be looking into this. It was thought that the issues highlighted in the national media may trigger some work nationally. The CQC outcome 6 “working with other partners” could be used to monitor hospital performance from the care or nursing homes’ point of view. Members raised a local issue of hospital patients being moved between wards in the middle of the night. Deb Holland thanked the members for bringing this to her attention. The CQC does not handle individual complaints, but where a pattern of complaints is established, the issue is reported to the provider so they have a chance to address the issue before an inspection.
- Cllr. Seymour drew attention to a recent survey which showed that fewer non-English speaking health professionals and carers were being asked to undergo language training, and that this was causing a communication problem for some patients and service users. Cllr. Greenaway felt that this problem was worse for people with dementia. Cllr. Seymour would forward details of the survey to Deb Holland.
- Cllr. Greenaway asked whether care homes sign-post people to the CQC or to the local authority as well as their internal complaints process. Care homes do not tend to sign-post to the CQC as it is not a complaints body. Complaints received by the local authority from people receiving Council funded care are linked back to the provider to address, and the Council will investigate complaints that are not addressed. Information about risk is passed to the CQC. Self-funders may make complaints to the health ombudsman.
- Staffing levels at the CQC had been increased to deal with the additional responsibilities placed on it and the forthcoming inclusion of GP practices within its

remit.

The Assistant Director welcomed Deb Holland back to Telford and Wrekin and welcomed the news that all care homes and agencies would be inspected at least once a year. The reports would enable people to find out whether providers were compliant or non-compliant with standards.

Members thanked Deb for attending the meeting and providing useful information. Contact details for the CQC would be circulated to members.

ASCSC-22 REHABILITATION AND REABLEMENT STRATEGY UPDATE

The Care & Support Commissioning Manager presented the Implementation Plan for the Telford & Wrekin Rehabilitation and Re-ablement Strategy and the Enablement Plan – Section 256.

The Strategy had been approved in June 2011 by the Council, the Health & Wellbeing Board and the PCT. The Strategy was built on evidence that providing up-front rehabilitation resulted in better outcomes for people. The Strategy would be delivered through a single point of contact, shared resources and a common approach across health and social care partners. The Implementation Plan was the overarching action plan for delivery of the Strategy which was monitored by a Steering Group comprising of health, social care and other key stakeholders. The Council's restructure had been completed with all staff in post and the re-ablement service had gone "live" on 16th April. The aim was to build up the service from 30% of people receiving support to a universal service.

The Action Plan covered actions in 5 key areas:

1. Work in relation to combining appropriate resources (service reconfiguration).
2. Cost-modelling for shifts in community resources, including mapping resources and gaps, working with acute partners to shift resources to the community to help prevent hospital admissions.
3. Rehabilitation and re-ablement care pathways, building on work carried out in a number of work shops.
4. Developing third sector to deliver low level preventative support. More work needed to be done with a range of stakeholders.
5. Development of rapid response and multi-disciplinary teams, including the enhancement of stroke services with the Rehabilitation and Enablement Team.

The Enablement Plan - Section 256 showed how funding transferred from the PCT to the Council under a Section 256 agreement had been allocated. This was reported to the Strategic Health Authority. Funding had been allocated to:

- Additional Occupational Therapy, Physiotherapy and nurse posts to support the Rehabilitation and Enablement Team. Previously known as the Intermediate Care

team. The post holders would work with the Council's Enablement Team but would be employed by the Community Trust to ensure robust clinical governance and supervision.

- Intermediate Care beds. 10 beds were contracted last year and a further tender exercise is being undertaken to seek market interest.
- Investment in telecare equipment to support discharge. A contract had been awarded for an integrated community alarm and telecare service. Further consideration was being given to assisted technologies to complement personal care such as memo pads and sensors.
- Funding to support voluntary sector reablement support.
- Additional practitioner posts in social care to support increased patient numbers.
- Spot purchase of additional care capacity in the community in residential, care and domiciliary settings.

The following information was then provided in response to Members' comments and questions:

- Members raised the issue of how the Home from Hospital team support patients discharged during the night: nationally 1.8% of patients were discharged between 11.00pm and 6.00am. Members were informed that the Home from Hospital team did not work 24/7 but had changed shift patterns to cover more hours. A pro-active approach had been taken with team members being allocated to designated wards, and the team buddied-up with hospital staff to join ward rounds. It was hoped that this fundamental change in the way of working would eventually eliminate the need for Notification 2 notes, issued by wards when patients were ready to be discharged. The team worked in A&E so that people not admitted could be picked up, and admissions could be monitored. The Section 256 money had supported the involvement of the Red Cross to help people who need some low level support on discharge to return home. Mr. Mason commented that night time discharge may be necessary to free up beds for emergency admissions and that it was better to discharge a patient safely out of hours than to block beds needed for emergencies. It was agreed that this would continue to be an issue while hospitals were running at full bed capacity and not the optimum 85%. Bed block concerns should be addressed to SaTH and it was suggested members may want to look at the Unscheduled Care Strategy.
- There was a database to help identify the level of risk associated with a condition which had resulted in a person being admitted to hospital, for example with a stroke. There had been discussions with Dr. Mike Innes, Chair of the Clinical Commissioning Group (CCG), about the risk stratification. There was an issue with separate databases and the CCG wanted to look at a combined database; best practice in other authorities was being looked at.
- More work was being done with the Stroke Network, Shropshire Partners in Care and the PCT on supportive discharge for stroke patients as this had been

recognised an area for further development. Preventative work was being done with the domiciliary and care home sector; a pilot had been run in 2 homes whereby indicators of stroke such as irregular pulse rates were being monitored so preventative and immediate assistance could be put in place.

ASCSC-23 FORWARD PLAN

The Chairman reminded Members about two Scrutiny Committee meetings which may be of interest to members of the Adult Social Care Scrutiny Committee:

- The Health Scrutiny Committee meeting at 5.00pm on 1st May would look at the Health & Wellbeing Board, HealthWatch / LINK arrangements, Public Health Transition. Dr. Mike Innes had been invited to speak about the CCG and confirmation of his attendance was awaited.
- The Budget & Finance Scrutiny Committee would be looking at the finances for Supporting People. A date for the meeting was to be confirmed but would be published on the scrutiny meeting notices.

The Chairman reminded Members about the proposals to merge the Health and Adult Social Care Scrutiny Committees in the next municipal year and that a decision would be taken by the Scrutiny Management Board the following day.

The Chairman said this was the last scheduled meeting of the Committee for the municipal year, but invited members to raise any other immediate issues they might want to look at, and a further meeting could be arranged. There were no further suggestions.

The meeting ended at 4.15 p.m.

Chairman:

Date:

TELFORD & WREKIN COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

7th AUGUST 2012

WORKING WITH THE HEALTH AND WELLBEING BOARD

REPORT OF SCRUTINY GROUP SPECIALIST

1.0 PURPOSE

- 1.1 To update members on the development of the Health and Wellbeing Board priorities and agree an initial 'ways of working' document to avoid unnecessary duplication in the work of the committees and agree to develop a full protocol.

2.0 RECOMMENDATIONS

- 2.1 The Committee receives the update on the developing priorities for the Health and Wellbeing Board. (Appendix 1)
- 2.2 The Committee consider and agree the Principles and Ways of Working Document attached as Appendix 2 and recommend that this is considered by the Health and Wellbeing Board.
- 2.3 The Committee recommend to the Health and Wellbeing Board that work is undertaken to develop a full protocol.

3.0 PREVIOUS MINUTES

- 3.1 HSC – 1 May 2012

4.0 BACKGROUND INFORMATION

- 4.1 The Health and Social Care Act 2012 requires Local Authorities to establish a Health and Wellbeing Board and develop a Health and Wellbeing Strategy. The broad role of the Health Scrutiny Committee is retained under the Act and the Department of Health is undertaking a consultation in the specific changes to Health Scrutiny. The legislation sets out one of the mechanisms for holding the Health and Wellbeing

Board to account is through the Scrutiny Committees (this is recognised in the Board's Terms of Reference). A copy of the consultation document on the Health and Wellbeing Board priorities is attached for information as Appendix 1.

5.0 HOW THE SCRUTINY COMMITTEE AND BOARD WILL WORK TO ADDRESS LOCAL ISSUES

- 5.1 The Health and Wellbeing Board in Telford and Wrekin is operating in shadow form until April 2013 and this provides an opportunity to establish the relationship and way of working between the two committees. An initial practical step will be to co-ordinate the work programmes of the Health and Adult Social Care Scrutiny Committee and the Health and Wellbeing Board and the partners that will be responsible for the Joint Strategic Needs Assessment priorities to avoid unnecessary duplication.
- 5.2 The LGA advise that a protocol or Memorandum of Understanding (MoU) is developed between the health and wellbeing board and the council body designated with health scrutiny powers, indicating how each will carry out their functions in relation to health, public health and integrated health and social care services. An initial 'Draft Ways of Working' document is attached as Appendix 2. It is proposed that the Scrutiny Committee agree this subject to consideration by relevant Cabinet Members and the Health and Wellbeing Board. It is also proposed that the Committee agree to work with the Health and Wellbeing Board to develop a full protocol.

6.0 EQUAL OPPORTUNITIES

- 6.1 There are no specific equal opportunity impacts arising from this report. Equal Opportunity issues will be considered as part of any scrutiny work.

7.0 ENVIRONMENTAL IMPACT

- 7.1 There are no environmental implications resulting from this report. Environmental impacts will be considered as appropriate to the topics in the work programme.

8.0. LEGAL COMMENT

- 8.1 The proposals accord with the provisions in section 244 National Health

Service Act 2006 as amended by section 190 Health and Social Care Act 2012.

9.0 LINKS WITH CORPORATE PRIORITIES

- 9.1 Developing a protocol between the Health and Wellbeing Board and Scrutiny Committee will assist to ensure that these Committee work effectively to meet corporate priorities in a transparent and accountable manner.

10. OPPORTUNITIES AND RISKS

- 10.1 The proposals contained in this report are in accordance with the Scrutiny Handbook and the Council's Constitution.

11. FINANCIAL IMPLICATIONS

- 11.1 There are no specific financial implications from this report. An effective working relationship between these committees will ensure an more efficient use of resources.

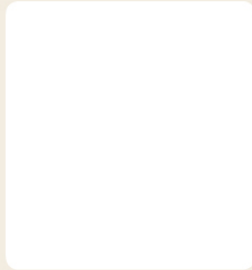
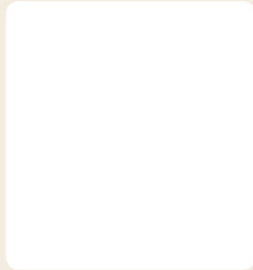
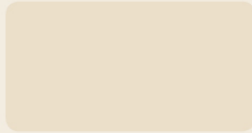
12. WARD IMPLICATIONS

- 12.1 There are no specific ward implications arising from this report.

13. BACKGROUND PAPERS

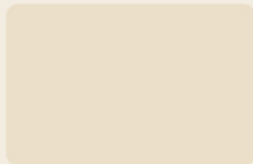
- 13.1 None.

Report prepared by Fiona Bottrill, Scrutiny Group Specialist 01952 383113



Telford and Wrekin

Health and Wellbeing Priorities



Consultation Document
May 2012



Foreword

This document sets out the proposed priorities for a new Health and Wellbeing Strategy. This strategy will describe how we will work to improve the health and wellbeing of people living in the Borough of Telford and Wrekin.

The strategy is being developed by the Telford and Wrekin Health and Wellbeing Board. The Board includes representatives within the NHS and Telford & Wrekin Council with responsibility for health, social care and public health services, together with elected Councillors and service user and patient representatives. The Board's role is to consider local needs and plan the right services for our community.

It is our belief that everyone in the borough has a right to good health. We will work together to provide the support and opportunities to enable this to happen.

The proposed priorities have been identified by the Board members with a commitment to work better, more effectively together to improve the health and wellbeing of people living in Telford and Wrekin. The strategy will then set out where and how we will target our resources over the coming years, both building on our successes and improving our joint working where we need to.

We are now seeking the views of our partners, service providers, service users and residents on these proposed priorities. Please take this opportunity to have your say. Section 5 (page 13) sets out how you can have your say on these priorities.



Councillor Richard Overton

Chair of Telford and Wrekin Health and Wellbeing Board

Cabinet Member responsible for Health

Deputy Leader Telford and Wrekin Council

1. Telford and Wrekin Health and Wellbeing Strategy

The 2012 Health and Social Care Act requires local authorities to establish a Health and Wellbeing Board. The purpose of the Board is to identify and address the health and wellbeing priorities in Telford and Wrekin. It will do this by producing a Health and Wellbeing Strategy, which will be published by April 2013.

The Telford and Wrekin Health and Wellbeing Board has been in development since March 2011. Its current members include representation from:

- Local Authority Elected Cabinet Members
- Clinical Commissioning Group
- Local Authority Officers
- Public Health (currently NHS but will transfer to local authority by April 2013)
- LINK – representative of patient and service users
- NHS T&W/NHS Commissioning Board

The Health & Wellbeing Board is one of a number of ways in which we work in partnership to deliver the right services to shape and improve the quality of life in Telford and Wrekin.

This consultation document sets out the proposed priorities which the Board will address. The priorities have been identified through the development of the 'Joint Strategic Needs Assessment (JSNA)'.

The JSNA uses data, performance information and intelligence to help us identify health and wellbeing needs in Telford and Wrekin. Our JSNA can be found at www.telford.gov.uk/factsandfigures

From all of this work, a long-list of local health and wellbeing priorities have been identified (see Appendix 1), based on:

- Where the borough was shown to be in a worse than the national position
- Existing local priorities
- National priorities
- Areas where we know we need to make financial savings

Using this information the Health and Wellbeing Board identified the proposed priorities, set out in section 3 (page 5).

2. Health and Wellbeing in Telford and Wrekin

Over the past 20 years, the health and wellbeing of the Borough has improved significantly with people living longer and staying healthier than ever before. However, there are some real health challenges and differences across the borough which need to be overcome if this improvement is to continue. Too many people in the Borough, particularly men still die early from cancer, heart disease and stroke and rates of teenage pregnancy, maternal smoking, breastfeeding and childhood obesity are all worse than the England average.

A key health challenge in Telford and Wrekin is that the health of residents is not consistent across the Borough, as shown in the map below. People in our more deprived areas are more likely to die earlier and are more likely to have poor physical and mental health.

Whilst people are living longer, many are spending more years at the end of their life in declining health. This places significant demand on health and social care services and highlights the importance of healthy lifestyles. Many of the causes of poor health are largely preventable, as are the costly consequences. Reflecting this, a number of the proposed priorities focus on the prevention of ill health starting from childhood.

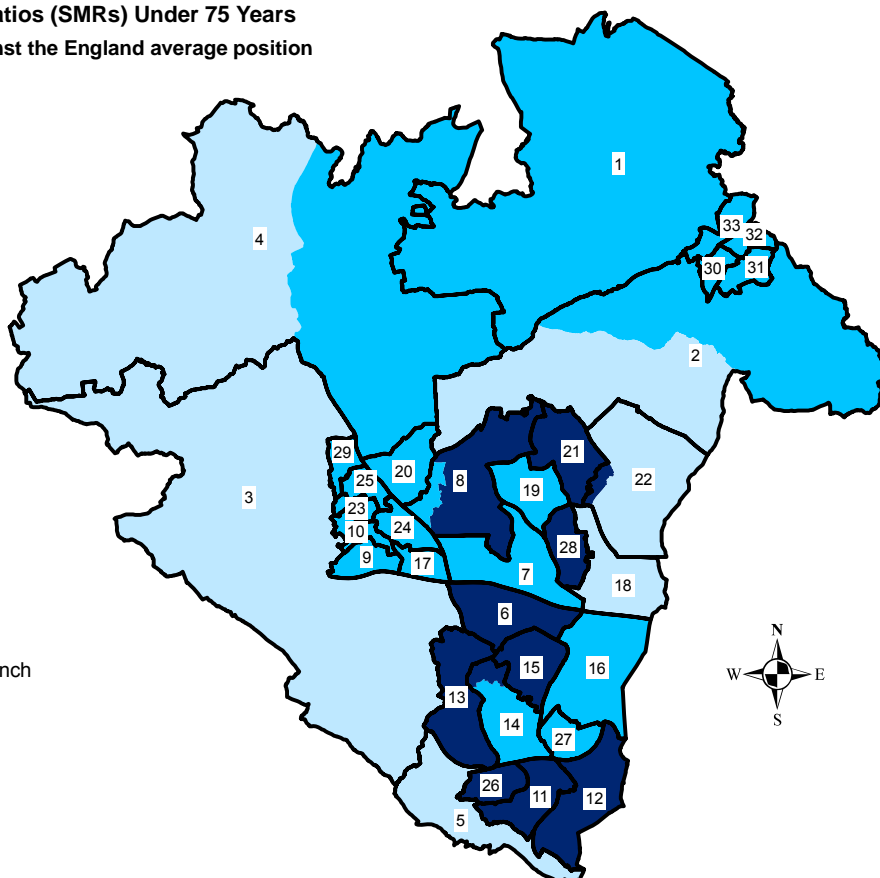
Premature Mortality in Telford and Wrekin

Standardised Mortality Ratios (SMRs) Under 75 Years
Statistical comparison against the England average position



Wards Key

- 1 Edgmond
- 2 Church Aston and Lilleshall
- 3 Wrockwardine
- 4 Ercall Magna
- 5 Ironbridge Gorge
- 6 Lawley and Overdale
- 7 Ketley and Oakengates
- 8 Hadley and Leegomery
- 9 Ercall
- 10 Haygate
- 11 Madeley
- 12 Cuckoo Oak
- 13 Horsehay and Lightmoor
- 14 Dawley Magna
- 15 Malinslee
- 16 The Nedge
- 17 Arleston
- 18 Priorslee
- 19 Wrockwardine Wood and Trench
- 20 Apley Castle
- 21 Donnington
- 22 Muxton
- 23 Park
- 24 College
- 25 Dothill
- 26 Woodside
- 27 Brookside
- 28 St. Georges
- 29 Shawbirch
- 30 Newport West
- 31 Newport South
- 32 Newport East
- 33 Newport North



Source: Association of Public Health Observatories:
<http://www.apho.org.uk/resource/item.aspx?RID=97049>

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3. Telford and Wrekin Priorities

Our Vision “All children and adults living safe, healthy and independent lives through access to timely, appropriate health and social care services”

	Priorities	Outcome Measures
C H I L D R E N A D U L T S	Reduce excess weight in children	<ul style="list-style-type: none"> Excess weight in 4-5 year olds Breastfeeding initiation and prevalence
	Reduce teenage pregnancy	<ul style="list-style-type: none"> Under 18 conception rates Reduction in risk taking behaviour
	Improve emotional health and wellbeing	<ul style="list-style-type: none"> Hospital admission rates from self-harm Further measures to be developed and linked to the strategy
	Support people with autism	<ul style="list-style-type: none"> Measures to be developed and linked to the strategy
	Reduce the number of people who smoke	<ul style="list-style-type: none"> Smoking related deaths Smoking attributable hospital admissions Smoking in pregnancy Low birth weight babies
	Ensure people have a positive experience of health and care services	<ul style="list-style-type: none"> Overall patient experience measures People treated with Dignity and Respect Overall satisfaction with care and support Overall satisfaction of carers with social services
	Improve carers' health and wellbeing	<ul style="list-style-type: none"> Carer-reported quality of life Carers who feel they have been included in discussions about the person they care for Further measures to be developed and linked to the strategy
	Support people to live independently	<ul style="list-style-type: none"> Social care self-directed support Older people who were still at home 91 days after discharge from hospital into reablement services People receiving reablement services who need ongoing support Delayed transfers of care from hospital
	Improve life expectancy and reduce health inequalities	<ul style="list-style-type: none"> Male life expectancy Premature death from CVD Premature death from cancer National cancer screening programme uptake Management and treatment of long term conditions
	Support people with dementia	<ul style="list-style-type: none"> Increase the number of dementia services available

CROSS-CUTTING PRINCIPLES

EQUITY – ACCESSIBILITY – INTEGRATION – QUALITY – ENGAGEMENT
 FINANCIAL SUSTAINABILITY – EARLY INTERVENTION and PREVENTION -
 SAFEGUARDING

Priority 1 - Reduce Excess Weight in Children

Why is it important?

Being overweight or obese is one of the most widespread threats to health and wellbeing in the country. Obesity reduces life expectancy by on average 11 years. Obese children and adolescents are more likely to become obese adults and therefore are at higher risk of future health problems such as type 2 diabetes, cancer and heart disease. Obesity is notoriously difficult to treat, so prevention and early intervention are very important.

Breastfeeding has many clear health benefits for both mothers and babies. Breastfed babies are less likely to suffer from a range of infections (including chest and stomach infections), insulin dependent diabetes and they are also less likely to become obese. Mothers who breastfeed reduce their risk of ovarian and breast cancer and breastfeeding helps women with weight loss after pregnancy.

What is the situation in Telford and Wrekin?

- Obesity amongst 4-5 year olds has decreased during the past five years from 12.5% in 2006/07 to 10.4% in 2010/11. 'Excess weight' in 4-5 year olds (24.9%) remains worse than the average for England (22.6%).
- Amongst 10-11 year olds 252 were overweight and 318 were obese in 2010/11.
- More boys than girls are obese in both the 4-5 and 10-11 year age groups
- Breastfeeding at birth has improved in recent years increasing to 65% in 2010/11 from 58% in 2003/04. However, levels of breastfeeding remained significantly worse than the national average in 2010/11 with:
 - 65% of infants breastfed at birth, compared to 74% in England and;
 - 33% of infants breastfed at 6-8 weeks, compared to 46% in England
- Breastfeeding rates are significantly lower amongst:
 - Younger mothers with 42% of teenage mothers breastfeeding at birth, compared to 72% of mothers aged 35 years and over
 - Deprived communities with: 51% of infants are breastfed at birth in the most deprived areas, compared to 81% in the most affluent areas

Priority 2 - Reduce Teenage Pregnancy Rates

Why is it important?

For some younger people, becoming a parent is a positive choice. However, teenage pregnancy is often associated with poor health and social outcomes for both the mother and child. Young mothers are more likely to suffer postnatal depression and less likely to complete their education, more likely to live in poverty and more likely to become teenage parents themselves. Raising young people's aspirations and building their resilience can help them make informed decisions enabling them to fulfil their potential. This in turn can reduce risk taking behaviours such as drug and alcohol misuse which can undermine young people's life chances, and potentially prevent involvement in crime and anti-social behaviour.

What is the situation in Telford and Wrekin?

- There were 155 conceptions amongst under 18 year olds in 2010
- There has been a decrease in teenage pregnancy rates during the past decade
- However, the under 18 conception rate in 2010 (47.5 per 1,000 females aged 15-17 years) remained statistically significantly worse than the national average for England (35.4 per 1,000)
- Just over half, 55% of pregnant teenagers (under 18 years) opt to continue with their pregnancy, and 45% choose to terminate the pregnancy
- Smoking in pregnancy is highest amongst teenage mothers and breastfeeding rates are exceptionally low
- The electoral wards with the highest teenage pregnancy rates are also amongst the most deprived wards

Priority 3 - Improve Emotional Health and Wellbeing

Why is it important?

Promoting good emotional and physical health and intervening early, particularly in the crucial childhood and teenage years, can prevent mental illness. Improved emotional health and wellbeing is associated with a range of better outcomes for people including: improved physical health and life expectancy, better educational achievement, increased skills, reduced risk of mental health problems and suicide, improved employment rates, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation.

What is the situation in Telford and Wrekin?

- It is estimated that in 2010 around 17,200 people in Telford and Wrekin suffered from a common mental disorder such as depression, anxiety and obsessive compulsive disorder, with around 60% of these estimated to be women.
- One in ten children aged between 5 and 16 years suffers with a mental health problem, and many continue into adulthood. At least one in four adults experience mental health problems at some point during their life.
- There are on average 15 suicides every year. The largest proportion of suicides is amongst men aged 21 to 39 years
- In 2009/10 there were 371 hospital stays for self-harm, 39 of those admitted for self-harm were under 18. The hospital admission rate for self-harm in 2009/10 was significantly higher than the national average

Priority 4 - Support People with Autism

Why is it important?

Autistic Spectrum Condition (ASC) is a lifelong condition that affects how a person communicates with and relates to other people. It also affects how a person makes sense of the world around them. Autistic Spectrum Condition is a lifelong developmental disability, affecting social interaction, communication, social relationships and making sense of the world.

During the last few years there has been a strong message from Government that there is a need for local services to meet the needs of adults and young people with autistic spectrum conditions.

What is the situation in Telford and Wrekin?

- Estimated that 1 in every 100 adults will be on the autistic spectrum, which equates to approximately 1,700 people in Telford and Wrekin.
- More detailed work on the prevalence of autism in Telford and Wrekin is required in the JSNA.
- Historically, services have developed disparately across the local health economy, leading to inconsistencies in the services that users might expect and physical surroundings which are not fit for purpose

Priority 5 - Reduce the Number of People who Smoke

Why is it important?

Smoking is the single biggest preventable cause of early death and illness in the country, causing over 80,000 deaths per year. The overall economic burden of tobacco use to society is estimated at £13.74 billion a year. Smoking cessation is the most cost-effective life saving intervention offered by the NHS. Smoking is more common in deprived communities and low income families and households. Children with parents who smoke are more likely to become smokers and the earlier children start to smoke the more likely they are to continue to smoke as adults. Smoking in pregnancy causes low birth weight and contributes to infant mortality.

What is the situation in Telford and Wrekin?

- 23% of adults are estimated to be smokers (circa 32,000 people aged 16+ years)
- During the past five years smoking quit rates have been amongst the highest in the country, with over 3,900 quitters during 2010/11
- However, mortality rates due to smoking-related deaths and hospital admissions rates attributable to smoking remain statistically significantly worse than the national average
- Levels of smoking in pregnancy are persistently, significantly worse than the national average. 23.6% of mothers smoked during pregnancy in 2010/11 (515 women), compared to 13.5% in England as a whole
- There are clear inequalities with:
 - 41% of teenage mothers smoking in pregnancy compared to 14% of 35+ year olds

- 35% of mothers from the most deprived communities smoked throughout pregnancy, compared to 6% of mothers from the most affluent communities

Priority 6 - Ensure People have a Positive Experience of Health and Care Services

Why is it important?

People can come into contact with health and care services at any point in their lives, sometimes unexpectedly due to illness or crisis and sometimes regularly to support long term conditions. It is important that all people who use our services have a positive experience and that we listen to what they are telling us about the experiences they have.

What is the situation in Telford and Wrekin?

- 83% of patients report that they are satisfied with their GP, and 71% are satisfied with their practice nurse in 2010/11
- 77% of patients report that they are able to see a GP fairly quickly
- 90% of respondents to the 2010/11 Adult Social Care User survey reported that they were satisfied with their care and support services, with 61% extremely or very satisfied, the same as the national rate.
- 95% of people assessed by Adult Social Care were satisfied that they had been treated with dignity and respect during the assessment process, with less than 1% being dissatisfied.

Priority 7 – Improve Carers’ Health and Wellbeing

Why is it important?

It is suggested that at some point in our lives most of us will look after an elderly relative, sick partner or a disabled family member. Caring can take its toll on your finances, your health, your social life, and on your other family and work commitments. However, given a reasonable level of support and understanding, carers are prepared and able to go to very great lengths to care for their loved ones for as long as possible in their own home environments.

Without unpaid carers the country would face a care bill it cannot afford. Well-supported carers also contribute directly to reduced care packages and reduced care-home placements.

What is the situation in Telford and Wrekin?

- Estimated 16,200 people over 18 providing unpaid care. Over 4,000 of these people are providing substantial and intense care
- 193 young carers are known to us though there are an estimated 600 young people in the Borough with caring responsibilities
- Carers are more likely to be female and the largest proportion are aged 35-64

- Carers aged 18-45 are less likely to receive support services than those who are older
- People who care for someone over 65 get fewer carers' services than the national average
- The reported health of carers is below national average. Carers' health is poorer than that of non-carers, and the more hours spent caring, the poorer the reported health of carers.
- There is a predicted decline in the proportion of people able to care for family, friends or neighbours in the borough as the ratio of adults to older people decreases.

Priority 8 – Support People to Live Independently

Why is it important?

Maximising people's independence is shown to prevent or delay the deterioration of wellbeing resulting from ageing, illness or disability and delay the need for more costly and intensive services.

The Government's aim is for people to live independently for as long as possible, ensuring that people who need care and support have as much choice, control and freedom over decisions and services as they want.

What is the situation in Telford and Wrekin?

- 48% of people who completed a period of reablement in 2010/11 did not require any ongoing social care support.
- There are pockets of good practice but these services are not joined up, are complex to navigate and patchy, leading to inequity in access
- Where investment has taken place, there is evidence of reduced on going costs
- Only approx. 30% of people who would benefit from reablement are currently accessing the service

Priority 9 – Improve Life Expectancy and Reduce Health Inequalities

Why is it important?

Cancer and cardiovascular diseases (heart disease and stroke) are the most typical reasons people die early (before the age of 75). People living in the most deprived communities, men and people from Black and Minority Ethnic Groups have a lower life expectancy are more likely to die before the age of 75. It is estimated that at least 80% of all early deaths from heart disease and over 40% of deaths from cancers could be prevented through a healthy diet, regular exercise and by not smoking. Screening programmes, early detection for disease through raising awareness of symptoms and prompt effective treatment can dramatically reduce premature deaths.

What is the situation in Telford and Wrekin?

- Male life expectancy at birth is statistically significantly worse than the national average position (77.5 years compared to 78.6 years)

- Female life expectancy at birth is not statistically significantly different to the national average position (82.1 years compared to 82.6 years)
- Cancers cause 40% of early deaths, with on average 217 cancer deaths under 75 years every year
- The early death rate from cancer is significantly worse than the national average
- CVD causes 25% of early deaths, with on average 140 deaths every year
- Despite a significant decrease the early death rate from CVD remains significantly worse than the national average
- The uptake of cancer screening programmes is below the national average
- Male life expectancy in the most affluent areas is 79.8 years, compared to 74.9 years in the most deprived areas
- Female life expectancy is 82.5 years in the most affluent areas, compared to 80.6 years in the most deprived areas

Priority 10 – Support People with Dementia

Why is it important?

Dementia is becoming more common and the cost of looking after people with dementia is increasing – the Government has identified it as a national priority.

People with dementia will progressively get worse, and as they do will become increasingly dependent on other people to carry out everyday tasks. It mainly affects people over the age of 65, although can affect younger people too.

The Government is committed to improving the care and experience of people with dementia and their carers by transforming dementia services to achieve better awareness, early diagnosis and high quality treatment at every stage and in every setting. Dementia makes the lives of people who have it, and the lives of their families and carers, very difficult, however, there are lots of things that can be done to help people overcome the problems and to improve their quality of life.

What is the situation in Telford and Wrekin?

- In 2010 an estimated 1,600 people aged 65 and over in Telford and Wrekin were suffering from dementia, by 2026 this is estimated to rise to 2,100.
- Increased population and increased longevity of life leading to increased dementia prevalence
- Predicted decline in the number of carers due to social factors
- A need for a greater focus on local delivery of quality outcomes and local accountability for achieving them

4. Cross-cutting Principles

To continually improve health and wellbeing and reduce inequalities in Telford and Wrekin, while making the best use of resources, the strategy will ensure that local services are delivered in partnership, in line with the high level priorities and underpinned by the following cross-cutting principles:

Equity

To tackle inequalities the provision, uptake and outcome of services should be equitable i.e. proportional to need, and proactively targeted towards the areas and groups within the community where they are most needed

Accessibility

Services should be accessible to all, particularly for the nine protected groups identified in the 2010 Equalities Act

Integration

Services should be joined up, with all relevant partners working together to ensure patients, clients, service users and carers experience seamless journeys of support, care and treatment

Quality

Services should be safe and evidence-based, providing value for money i.e. both clinically and cost-effective e.g. based on NICE (National Institute for Health and Clinical Excellence) guidance or other national quality standards

Financial Sustainability

Public sector resources should be used responsibly to deliver and develop services with consideration of financial sustainability and value for money with respect to outcomes

Early Intervention and Prevention

A strong focus on prevention, rather than treatment, to deliver greater overall increases in both life expectancy and quality of life, including an early intervention approach to supporting families, sustained lifestyle behaviour change, awareness raising of symptoms and early detection and treatment of risk factors which cause ill-health

Engagement

Putting the public at the heart of service design

Safeguarding

At the core of our approach to service design and delivery is the protection of vulnerable adults and children. This challenge will be overseen by our Adult and Children's Safeguarding Boards.

5. Your Views Matter

We are seeking the views of our partners, service providers and residents on these proposed priorities for Telford and Wrekin. Please take this opportunity to have your say on what is included, or not included, within this document.

We want to know whether you feel these are the right health and wellbeing priorities or whether you feel there are any important issues missing.

We want to hear your views. We will use this feedback to inform the development of the final strategy. The closing date for this consultation is Friday 20th July 2012.

Online questionnaire: www.telford.gov.uk

Email us at Delivery&Planning@telford.gov.uk

Telephone 01952 380131

Or write to

Delivery and Planning
Telford & Wrekin Council
FREEPOST SY1154
Telford
Shropshire
TF3 4ZZ

Appendix 1: Strategic Priorities Long List

To inform the development of our Health & Wellbeing priorities, our Joint Strategic Needs Assessment (JSNA) was used to develop a long list of local priorities. The following table sets out this long-list together with the reason why each issue was included. Those issues which have been identified as a proposed priorities for the Health And Wellbeing Strategy are highlighted in bold text.

To ensure that all the priorities on the long-list have appropriate focus, those which have not been aligned to the Health & Wellbeing Strategy, have been aligned with another local partnership or partner organisation.

This long-list of priorities has been organised by the Marmot 'life stages'. More information about these can be found in Appendix 2.

	JSNA PRIORITY REASONS							Responsible partner/ partnership board (see key below table)
	Marmot Indicator	Significantly worse than England average	Health (PCT/CCG/PH) Priorities	National Policy / Outcome measure	Financial Pressure	Children, Young People and Families emerging priorities	Adult Social Care emerging priority	
STARTING WELL								
Breastfeeding initiation (@ birth and duration 6-8 weeks)		●	●	●				HWB
Supporting teenage parents			●			●		HWB
Excess weight (overweight and obesity) in 4-5 year olds		●	●	●		●		HWB
Smoking in pregnancy		●	●	●				HWB
Low birth weight babies		●	●	●				CCG
Paediatric hospital admission rates (< 5s)		●						CCG
Children achieving a good level of development at age 5	●	●						CFB
DEVELOPING WELL								
Under 18 conception rates		●	●	●		●		HWB
Disabled Children						●		CFB
Inequalities in educational outcomes						●		CFB or SETF
Children in Care rate	●				●	●		CFB
Care Leavers						●		CFB
Child Protection Plan rate	●					●		CFB
First time entrants to the youth justice system				●				SCCB
Special Educational Needs Rate	●							TWC

	JSNA PRIORITY REASONS							Responsible partner/ partnership board (see key below table)
	Marmot Indicator	Significantly worse than England average	Health (PCT/CCG/PH) Priorities	National Policy / Outcome measure	Financial Pressure	Children, Young People and Families emerging priorities	Adult Social Care emerging priority	
WORKING WELL								
Young people not in employment, education or training (NEET)	●	●		●		●		SETF
Households in receipt of means-tested benefits	●	●			●			SETF & SFTF
Unemployment		●			●			SETF
Workforce skills levels		●						SETF
Average earnings		●						SETF
Inequality in percentage receiving means-tested benefits	●	●						SETF
LIVING WELL								
Emotional Wellbeing						●		HWB
Prevention and maximising independence			●	●	●		●	HWB
Hospital admission rates for self-harm		●		●				HWB
Excess weight in adults		●		●				HWB
Adults not consuming 5-A-DAY fruit and veg		●						PH
Family poverty		●	●	●		●		LSP
Strengthening Families				●		●		SFTF
Homelessness (particularly youth)								HPLTF
Crime attributable to alcohol		●						SCCB
Alcohol-related violent crime		●						SCCB
Anti-social behaviour rates		●						SCCB
Fear of crime								SCCB
People from different backgrounds getting on well together								SCCB
AGEING WELL								
Smoking-related deaths		●	●					HWB
Smoking-attributable hospital admissions		●	●					HWB
Dementia			●	●			●	HWB
Rehabilitation and Re-ablement			●	●	●		●	HWB
Male life expectancy		●	●	●				HWB

	JSNA PRIORITY REASONS							Responsible partner/ partnership board (see key below table)
	Marmot Indicator	Significantly worse than England average	Health (PCT/CCG/PH) Priorities	National Policy / Outcome measure	Financial Pressure	Children, Young People and Families emerging priorities	Adult Social Care emerging priority	
Premature mortality rates from all cancers		●	●	●				HWB
Premature mortality rates from cardiovascular diseases		●	●	●				HWB
Meeting the needs of the ageing population			●		●		●	ALL
Bowel cancer and cervical screening uptake		●		●				CCG / PH
End of life care			●					CCG
Long term conditions management (Respiratory disease and diabetes)								CCG
Management of hypertension in primary care		●	●					CCG
ALL-AGE								
Mental Health			●		●	●		HWB
Young Carers and Carers			●		●	●	●	HWB
Positive experience of health, care and support			●			●	●	HWB
Autism			●	●		●	●	HWB
Early intervention and prevention			●		●	●	●	ALL
Safeguarding - protecting from avoidable harm and caring in a safe environment			●			●	●	LSCB / LSAB

HWB = Health and Wellbeing Board
 CCG = Clinical Commissioning Group
 PH = Public Health
 CFB = Children and Families Board
 LSP = Local Strategic Partnership Executive
 LSCB / LSAB = Local Safeguarding Children and Adults Boards

SCCB = Safer Cohesive Communities Board
 SETF = Skills and Employment Task Force
 SFTF = Supporting Families Task Force
 HPLTF = Homelessness / Private Landlord Task Force
 TWC = Telford and Wrekin Council

Appendix 2: The Life Stage Approach

The national drive to improve the public's health is based on a life stage approach. This is aimed at improving health and wellbeing and reducing inequalities at key stages throughout people's lives. These significant life stages are described below:

Starting well

The health and wellbeing of women before, during and after pregnancy is a critical factor in giving children the healthiest start in life. Evidence indicates that: improving maternal mental health, tackling maternal obesity, decreasing smoking in pregnancy and improving breastfeeding will have the greatest impact. Children's development is crucial and better early years support makes a big difference. Good parent-child relationships help build children's self-esteem and confidence and reduce the risk of children adopting unhealthy lifestyles.

Developing well

Teenage years are a crucial time for health and wellbeing. Teenagers and young people are among the biggest lifestyle risk-takers. Behaviour patterns adopted in childhood and adolescence usually persist into adulthood. The younger people start to smoke the more likely they are to remain smokers and the pattern is the same for overweight and obesity. Half of all mental illness starts by the age of 14.

Living well

The majority of illnesses and early death, before the age of 75, are caused by 'diseases of lifestyle' and therefore could be prevented. It is estimated that a substantial proportion of cancers and deaths from circulatory disease (heart disease and stroke) could be avoided, through a combination of stopping smoking, improving diet, increasing physical activity and sensible alcohol consumption. Improving emotional health and well-being impacts significantly on both people's physical health and their lifestyle behaviour choices.

Working well

The health and wellbeing of people of working age is important to our economy and society. Working is in general good for people's health and being unemployed can negatively impact on both physical and mental health. Taking a preventive approach can impact on musculoskeletal problems, work-related stress, depression and anxiety which in turn will reduce sickness absence from work.

Ageing well

Our population is ageing rapidly, but people are living and staying fitter for longer. Dementia is increasing due to the ageing population, but improving diet and lifestyle earlier in life can significantly reduce the impact for over half of people who suffer with dementia. Intervening early to support the vulnerable elderly, such as those who are frail and isolated in order to prevent falls, depression and unnecessary suffering in cold weather, can make a huge difference.

DRAFT Way of Working Document for Health and Adult Social Care Scrutiny Committee and the Health and Wellbeing Board

The Health and Social Care Act (2012) sets out the roles of these Committees between but it is to be determined locally how the relationship between Committees will work in practice. Public sector organisations are in the process of unprecedented change and financial challenge. This makes it even more important that the roles and responsibilities of the different organisations and structures are clear and their work is co-ordinated.

Roles and Responsibilities

The Health and Wellbeing Board and accompanying Health and Wellbeing Strategy will strengthen democratic legitimacy and ensure that commissioning is joined up across the NHS, Social Care and public health. The Board will also have a lead role in public involvement.

The Local Authorities HOSC will strengthen local democratic legitimacy in NHS and public health services through the scrutiny of the planning, delivery, and reconfiguration of health services , helping to ensure that the interests of patients and the public are at the heart of these services. This will include scrutiny of the Health and Wellbeing Board.

Work Programme Planning

Each Committee will determine its own work programme. The Scrutiny Committee's work programme planning cycle is based on the municipal year. The process for putting forward suggestions for issues for the Scrutiny work programme is set out in the Scrutiny Handbook. The Health and Wellbeing Board will have the opportunity to make suggestions and the Scrutiny Management Board will refer this to the relevant Scrutiny Committee to determine if the matter will be included in the work programme. That Scrutiny Handbook also sets out the process to make a Scrutiny Suggestion during the municipal year. The Committee may plan the work programme over a two year cycle. Where an issues is put forward as a suggestion for the Scrutiny Committee to investigate this will cross referenced with the Health and Wellbeing Board priorities and Joint Strategic Needs Assessment Priorities. If the issue is already the responsibility of the Health and Wellbeing Board or another partnership the Scrutiny Committee will consider if there is an overriding reason why this issue should also come to Scrutiny. If there is no overriding reason Members of the Scrutiny Committee may refer specific matters of concern to request the partner / partnership Board to incorporate this in their work on the issue. Scrutiny may in the future hold the Health and Wellbeing Board to account regarding the outcomes of

Appendix 2

this work. Where there is an overriding reason that an issue should also come to the Scrutiny Committee, consideration will be given to the timing of the scrutiny work and the resource implications for all the organisations involved.

TELFORD & WREKIN COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

DATE 7th AUGUST 2012

2012/14 WORK PROGRAMME

REPORT OF SCRUTINY GROUP SPECIALIST

1.0 PURPOSE

- 1.1 To enable the Health and Adult Social Care Scrutiny Committee to consider the suggestions and agree the Committee's work programme for 2012 – 14.

2.0 RECOMMENDATIONS

- 2.1 That the Committee agree the work programme for 2012 – 14.

3.0 PREVIOUS MINUTES

- 3.1 SMB 4 July 2012

4.0 BACKGROUND INFORMATION

- 4.1 The suggestions attached in Appendix 1 were considered by the Scrutiny Management Board on the 4th July and referred to the Health and Adult Care Scrutiny Committee to decide which issues should be included in the Committee's Work Programme. The Management Board also agreed that the work programme will be for a two year period with the opportunity to refresh this at the end of the first year. The work programme will be flexible to allow for important issues which emerge during the 2 year cycle to be scrutinised. However, if a new topic is added to the work programme, an existing item must be removed to avoid the work load becoming unmanageable and losing focus.
- 4.2 Members are asked to be rigorous and focussed in selecting topics for the work programme. It must be recognised that the scrutiny team and Council and partner organisations do not have the capacity to support

scrutiny of all the issues Members may wish to scrutinise. The Scrutiny Management Board agreed that each Scrutiny Committee will 3-5 key topics for the work programme, and other items will be removed. (An exception to this is the Budget & Finance Scrutiny Committee which aligns its work programme to the budget process and proposals.)

5.0 HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE WORK PROGRAMME

5.1 Appendix 1 shows the suggestions put forward for the 2012/14 scrutiny work programme and the items carried over from 2011/12 by lead Scrutiny Committees that have been referred by the Scrutiny Management Board for consideration by the Committee.

5.2 The table also shows:

- Where the item cuts across more than one scrutiny committee and work maybe carried out jointly
- The indicative timetable where known
- Comments made by officers for scrutiny members to consider in their selection of topics and method of scrutiny. This includes topics being reviewed or monitored by other Council committees so that work is not duplicated.
- Any recommendations made by the Scrutiny Chairmen.

5.3 In line with the decision taken by the Scrutiny Management Board Members are asked to agree 3-5 topics that will be included in the 2 year work programme. Each Scrutiny committee has been allocated 6 formal committee meetings during the municipal year. This allocation does not include informal or sub-group meetings which may be held to gather evidence as part of a review, briefing meetings or regional/external scrutiny meetings.

5.4 When agreeing the work programme Members should consider the range of organisations and services that come under the scrutiny remit of this Committee:

- Local Authority Adult Social Care Commissioning and Provision of these services
- Telford and Wrekin Primary Care Trust (Part of the West Mercia PCT Cluster)
- The Developing Clinical Commissioning Group
- National Commissioning Board
- Shrewsbury and Telford Hospital NHS Trust

- Shropshire Community Health NHS Trust
- West Midlands Ambulance Service
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust

5.5 The work of this Committee will need to be co-ordinated with the other Scrutiny Committees as identified in Appendix 1 and also the Joint Health Overview and Scrutiny Committee with Shropshire which has a statutory role.

5.6 Members are also asked to taken into account the forward plan for the Health and Wellbeing Board.

6.0 EQUAL OPPORTUNITIES

6.1 There are no specific equal opportunity impacts arising from this report. Equal Opportunity issues will be considered as part of any scrutiny work.

7.0 ENVIRONMENTAL IMPACT

7.1 There are no specific environmental impacts arising from this report. Environmental impacts will be considered as appropriate to the topics in the work programme.

8.0. LEGAL COMMENT

8.1 The proposals contained in this report are in accordance with the Scrutiny Handbook and the Council's Constitution.

9.0 LINKS WITH CORPORATE PRIORITIES

9.1 Scrutiny members are asked to agree the work programme in the context of the Council's priorities.

10. OPPORTUNITIES AND RISKS

10.1 There is an opportunity to focus the work programme on fewer topics and in more depth in areas of policy development where scrutiny can have a greater impact. There is a risk that too many topics are kept in the work programme so that it loses focus and impact.

11. FINANCIAL IMPLICATIONS

- 11.1 There are no specific financial implications from this report. An effective working relationship between the Scrutiny committees will ensure an more efficient use of resources.
- 11.2 Specific financial implications may arise from the recommendations of the Committee which will need to be considered as part of any future reports on the outcomes of the work programme.

12. WARD IMPLICATIONS

- 12.1 There are no specific ward implications arising from this report.

13. BACKGROUND PAPERS

- 13.1 None

Report prepared by Fiona Bottrill, Scrutiny Group Specialist 01952 383113

Health and Adult Social Care 2012/14 Work Programme Suggestions

Health & Adult Care	The Chairman has made recommendations about the priorities for the work programme.			
Community Trust	Link to other Ctees	Timescale	Consultation planned late summer early Autumn	
South Staffordshire & Shropshire Healthcare NHS Foundation Trust <ul style="list-style-type: none"> • Mental health services – the impact of reduction of mental health workers and benefit changes especially on people with serious mental health problems, and the capacity of the NHS to support. 	C&C		Updates on the implementation of the modernisation of mental health services will be taken to the Joint HOSC The Co-operative and Communities Scrutiny Committee will consider whether to include the impact of welfare reforms in the work programme.	
CAMHS service. <ul style="list-style-type: none"> • Referral processes and waiting times for appointments. • Counselling, anger management psychological services available for ALL children • The move from Telford to Shropshire and how it was dealt with • Prescriptions - not available from doctors, having to phone CAMHS and having them sent in post. 	CYP HWB		CAMHS service delivered by Community Trust. Review of service by commissioners currently underway. Report back to Health & Wellbeing Board in September.	Chairman recommends this is included in the work programme.
Lack of community mental health support for children under 5 within the borough. Children have to go outside the area which costs a lot of money.	CYP		Query whether children under 5 are sent out of borough. Link to CAMHS suggestion above.	

Appointments in walk-in clinics.			Scrutiny currently has no authority to scrutinise GPs or surgeries but the suggestion may be reviewed if legislation brings GPs into scope.	
Local Accounts for social care – annual statement for the public on how the Council is performing in social care. Public can input.	HWB		Possibly set up a sub-group to review. This is on the Health & Wellbeing Board agenda for final sign-off.	
Is it true that hearing impaired people are no longer to be registered as disabled?				
Unscheduled Care Strategy				
Meals on Wheels – review of options for service change			This item was referred from the Budget & Finance Scrutiny Committee to the Adult Social Care Scrutiny Committee.	Chairman recommends this is included in the work programme.
Review the position on Continuing Healthcare funding.	HWB			Chairman recommends this is included in the work programme.
Review of regulations and guidance for health scrutiny in secondary legislation.				
Development of protocols for scrutiny to work with the Health & Wellbeing Board.				
Priorities for the Health and Wellbeing Strategy	HWB		Stakeholder event 3 rd July. Overseen by the Health & Wellbeing Board.	
Development of contract specification for	HWB		Stakeholder event 3 rd July.	

Appendix 1

	Healthwatch			On Health & Wellbeing Board agenda.	
	Development of vision for Public Health and the Transition of Public Health.	HWB		Stakeholder event 3 rd July. Scrutiny of transition relates to Alcohol Strategy below. On Health & Wellbeing Board agenda.	Chairman recommends this item is included in the work programme.
	Alcohol Strategy				Chairman recommends this item is included in the work programme (part of transition of public health).
	CCG authorisation process	HWB		Written updates can be provided. Monitored by Health & Wellbeing Board.	
	Vulnerable Adult Safeguarding Board report, plus report from SSSFT on safeguarding thematic review (adults & children).	HWB	Sept 2012	Also on Health & Wellbeing Board agenda.	Chairman recommends this item is included in the work programme.
	Discharge of patients – findings of Senior Citizens' Forum survey conducted by LINK				
	CQC – update meeting to identify any issues arising from review of domiciliary care or other inspections.				
	Joint Health Overview & Scrutiny Committee (JHOSC) as a sub-group of the Health & Adult Care Scrutiny Committee.			Items in the work plan include: <ul style="list-style-type: none"> • SaTH Foundation Trust application • WMAS • Implementation of reconfiguration: Travel & Transport Plan, Workforce development plans, training for GPs and midwives etc. • 111 service – this is being reviewed by the Health & Wellbeing Board 	The JHOSC will decide its own work programme.

				• Modernising Mental Health Services	
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Have standing Item – Health and Social Care Policy Developments – provide update – report or verbal update at meeting or circulate for information.

Suggestions in bold – new suggestions received 2012

C&C – Co-operative and Communities Scrutiny Committee

CYP – Children and Young People’s Scrutiny Committee

HWB – Health and Wellbeing Board

TELFORD & WREKIN COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

DATE 7th AUGUST 2012

**RESPONSE TO DEPARTMENT OF HEALTH'S CONSULTATION ON
LOCAL AUTHORITY HEALTH SCRUTINY**

REPORT OF SCRUTINY GROUP SPECIALIST

1.0 PURPOSE

- 1.1 To enable the Health and Adult Social Care Scrutiny Committee to consider and agree a response to the Department of Health's consultation for proposals for Local Authority Scrutiny.

2.0 RECOMMENDATIONS

- 2.1 That the Committee consider the Department of Health's consultation document attached as Appendix 1
- 2.2 That the Committee considers the draft response attached as Appendix 2 and agrees a final response.

3.0 PREVIOUS MINUTES

- 3.1 None

4.0 BACKGROUND INFORMATION

- 4.1 Following the Health and Social Care Act the Department of Health has issued an 8 week consultation on the regulations for Health Scrutiny. The consultation recognises that " health scrutiny has been an effective means in recent years of improving both the quality of services, as well as the experience of people who use them. There is much that is good within the existing system on which to build." (p.5) It is recognised that strengthening health scrutiny is one of the mechanisms proposed to increase accountability and enhance public voice in health and that it is important that the new NHS bodies are made subject to effective scrutiny and held to account.

5.0 CONSULTATION QUESTIONS AND DRAFT RESPONSE

- 5.1 The consultation sets out that the aims of health scrutiny are to identify whether:
- The planning and delivery of healthcare reflects the views and aspirations of local communities
 - All sections of a local community have equal access to health services
 - All sections of a local community have an equal chance of a successful outcome from health services
 - Proposals for substantial service change are in the best interests of local health services
- 5.2 The changes to the Health Scrutiny that have already been made under the Health and Social Care Act (2012) are set out in Section 32 in the consultation document attached in Appendix 1. The document sets out that these changes are not subject to further consultation.
- 5.3 The Department of Health is proposing changes around service reconfiguration and referral to the Secretary of State:
- Requiring local authorities to publish a timescale for making a decision on whether a proposal will be referred
 - Requiring local authorities to take account of financial considerations when considering a referral
 - Introducing a new intermediate referral stage for referral to the NHS Commissioning Board for some service reconfigurations
 - Requiring the full council of a local authority to discharge the function of making a referral
- 5.4 The consultation document sets out 11 questions relating to these proposals. A draft response to these questions is set out in Appendix 2.

6.0 EQUAL OPPORTUNITIES

- 6.1 There are no specific equal opportunity impacts arising from this report.

7.0 ENVIRONMENTAL IMPACT

- 7.1 There are no specific environmental impacts arising from this report.

8.0. LEGAL COMMENT

- 8.1 There are no legal implications arising from this report. Any changes necessary as a result of the outcome of the consultation will be reported to future meetings.

9.0 LINKS WITH CORPORATE PRIORITIES

- 9.1 Health Scrutiny relates to a number of Cabinet Priority and service areas. Under the arrangements proposed by the Department of Health the Scrutiny committee with responsibility for Health Scrutiny will retain the power to make reports and recommendations to the local authority in any matter that it scrutinises.

10. OPPORTUNITIES AND RISKS

- 10.1 The consultation by the Department of Health offers an opportunity for The Scrutiny Committee to influence the development of regulation and guidance.

11. FINANCIAL IMPLICATIONS

- 11.1 There are no specific financial implications arising from the recommendations within this report.

12. WARD IMPLICATIONS

- 12.1 There are no specific ward implications arising from this report.

13. BACKGROUND PAPERS

- 13.1 None

Report prepared by Fiona Bottrill, Scrutiny Group Specialist 01952 383113



Local Authority Health Scrutiny

Proposals for consultation

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	17717
Title	Local Authority Health Review and Scrutiny: proposals for consultation
Author	Department of Health
Publication Date	12 July 2012
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Adult SSs
Circulation List	PCT Cluster Chairs, NHS Trust Board Chairs
Description	This consultation document sets out a number of proposed changes to the regulations governing health overview and scrutiny. A small number of focused questions seek respondents views on these proposed changes
Cross Ref	The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002
Superseded Docs	
Action Required	N/A
Timing	The consultation will close on 7 September 2012
Contact Details	Scrutiny Consultation Patient and Public Engagement and Experience Room 5E62, Quarry House Quarry Hill, Leeds LS2 7UE
For Recipient's Use	

Local Authority Health Scrutiny

Proposals for consultation

Prepared by the Patient and Public Engagement and Experience Team

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Introduction

1. This document sets out the Government's intentions to strengthen and streamline the regulations on local authority health scrutiny, following amendments to the National Health Service Act 2006¹ ("NHS Act 2006") by the Health and Social Care Act 2012² ("the 2012 Act"). These enable regulations to be made in relation to health scrutiny by local authorities.
2. The proposed changes to health scrutiny by local government will strengthen local democratic legitimacy in NHS and public health services, helping to ensure that the interests of patients and the public are at the heart of the planning, delivery, and reconfiguration of health services, as part of wider Government strategy to create a patient-centred NHS.
3. In this document, we will build on proposals set out in *Equity and Excellence: Liberating the NHS*³, which set out a vision of increased accountability, and *Local Democratic legitimacy in health: a consultation on proposals*⁴, which posed a number of questions around health overview and scrutiny in particular.
4. The Government recognises that health scrutiny has been an effective means in recent years of improving both the quality of services, as well as the experiences of people who use them. There is much that is good within the existing system on which to build.
5. Our aim is to strengthen and streamline health scrutiny, and enable it to be conducted effectively, as part of local government's wider responsibility in relation to health improvement and reducing health inequalities for their area and its inhabitants.
6. We are aware from engagement to date that there are a range of related matters on which the NHS and local authorities would welcome further clarification and advice that cannot be provided within regulations. We therefore intend to produce statutory guidance to accompany the new regulations that will address some of these issues.
7. Your views on the proposed revisions to health scrutiny are critical. Your participation in this consultation will help us to ensure that the new regulations and any associated guidance will be successfully implemented.

¹ <http://www.legislation.gov.uk/ukpga/2006/41/contents>

² <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm>

³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

⁴ http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586

8. The proposals in this document are being consulted on until 7th September 2012. The comments received will be analysed and will inform the development of new regulations for local authority health scrutiny.
9. We would welcome your comments on the proposals outlined in this document, your suggestions as to how to improve them, together with any general points you wish to make. The document sets out a number of questions on which we would particularly like your views. These are repeated as a single list at Annex A. Details of how to respond and have your say are set out on page 22.
10. Once we have considered your views, a summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at <http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>. It is our intention to bring the new Regulations into effect from April 2013.
11. The rationale for changes to the scrutiny regulations is set out in the impact assessment published alongside *Local Democratic Legitimacy in Health: a consultation on proposals*. This consultation document is published alongside an Equalities Screening that considers the impact on equalities. The Department welcomes any information or evidence that will help further analyse the impact of the proposals contained in this document.

Increasing Local Democratic Legitimacy in Health

12. *Equity and Excellence: Liberating the NHS* set out the Government's ambition to achieve significant improvements in health outcomes and the quality of patient care. These ambitions will be delivered through a new clinically-led commissioning system and a more autonomous provider sector. Underpinning the White Paper reforms is a commitment to increasing accountability by ensuring a strong local voice for patients and local communities and putting their views and experiences at the heart of care.
13. Strengthening health scrutiny is one of the mechanisms proposed to increase accountability and enhance public voice in health. In addition, health and wellbeing boards are being established within local authorities. Through health and wellbeing boards, local authorities, the NHS and local communities will work together to improve health and care services, joining them up around the needs of local people and improving the health and wellbeing of local people. By including elected representatives and patient representatives, health and wellbeing boards will significantly strengthen the local democratic legitimacy of local commissioning and will provide a forum for the involvement of local people. Overview and scrutiny committees of the local authority will be able to scrutinise the decisions and actions of the health and wellbeing board, and make reports and recommendations to the authority or its executive.
14. Health and wellbeing boards will consist of elected representatives, representatives from clinical commissioning groups (CCGs), local authority commissioners and patient and public representatives. A primary responsibility of health and wellbeing boards is to develop a comprehensive analysis of the current and future health and social care needs of local communities through Joint Strategic Needs Assessments (JSNAs). These will be translated into action through Joint Health and Wellbeing Strategies (JHWSs) as well as through CCGs' own commissioning plans for health, public health and social care, based on the priorities agreed in JHWSs. The involvement of local communities will be critical to this process and to the work of the health and wellbeing board. It will provide on-going dialogue with local people and communities, ensuring that their needs are understood, are reflected in JSNAs and JHWSs, and that priorities reflect what matters most to them as far as possible.
15. From April 2013, local authorities will also commission local Healthwatch organisations – the new consumer champion for local health and social care services. Local Healthwatch will help to ensure that the voice of local people is heard and has influence in the setting of health priorities through its statutory seat on the health and wellbeing board.
16. *Local Democratic legitimacy in health*, a joint consultation between the Department of Health and the Department of Communities and Local Government, proposed an

enhanced role for local authorities and asked a number of questions about how the commitment to strengthen public voice in health could be delivered. It aimed to find ways to strengthen partnership working between NHS commissioners and local authorities so that the planning and delivery of services is integrated across health, public health and social care.

17. In the light of responses to that consultation, the Government decided to expand and adapt its proposals for legislation around local democratic legitimacy. *Liberating the NHS: Legislative Framework and Next Steps*⁵ proposed extending the scope of scrutiny to include any private providers of certain NHS and public health services as well as NHS commissioners. It also accepted that its original proposition to confer health scrutiny powers onto health and wellbeing boards was flawed. It instead proposed conferring scrutiny functions on local authorities rather than on Health Overview and Scrutiny Committees (HOSCs) directly, giving them greater freedom and flexibility to discharge their health scrutiny functions in the way they deem to be most suitable. These intentions are encompassed within changes made by the 2012 Act to the health scrutiny provisions in the NHS Act 2006.

Aim of Health Overview and Scrutiny

18. This consultation document deals exclusively with health scrutiny. This is an essential mechanism to ensure that health services remain effective and are held to account. The main aims of health scrutiny are to identify whether:
 - the planning and delivery of healthcare reflects the views and aspirations of local communities;
 - all sections of a local community have equal access to health services;
 - all sections of a local community have an equal chance of a successful outcome from health services; and
 - proposals for substantial service change are in the best interests of local health services

The History of Health Scrutiny

19. The Local Government Act 2000⁶ established the basis for the arrangements that are still in place today, where there are two groups of councillors in most local authorities;
 - The Executive (sometimes called the Cabinet), responsible for implementing council policy; and

⁵ http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624

⁶ <http://www.legislation.gov.uk/ukpga/2000/22/contents>

- The Overview and Scrutiny Committees (sometimes called Panels or Select Committees), responsible for holding the Executive to account and scrutinising matters that affect the local area.
20. This Act established that, for the first time, democratically-elected community leaders were able to voice the views of their local constituents, and require local NHS bodies to respond, as part of the council's wider responsibilities to reduce health inequalities and support health improvement.
 21. The Health and Social Care Act 2011⁷ subsequently amended the Local Government Act, to require local authorities to ensure that their overview and scrutiny committee or committees (OSC) had the power to scrutinise matters relating to health service. The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2012⁸ ("the 2012 Regulations") required NHS bodies to consult formally with the HOSC on any proposals for substantial variations or developments to local services.
 22. The 2012 Regulations also set out the health scrutiny functions of such committees and the other duties placed on NHS bodies. These regulations are still in force today. They:
 - a. enable HOSCs to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area;
 - b. require NHS bodies to provide information to and attend (through officers) before meetings of the committee;
 - c. enable HOSCs to make reports and recommendations to local NHS bodies and to the local authority on any health matters that it scrutinises;
 - d. to require NHS bodies to respond within a fixed timescale to the HOSC's reports or recommendations, where the HOSC requests a response;
 - e. require NHS bodies to consult HOSCs on proposals for substantial developments or variations to the local health service; and
 - f. enable local authorities to appoint joint HOSCs;
 - g. enable HOSCs to refer proposals for substantial developments or variations to the Secretary of State where they have not been adequately consulted, or believe that the proposals are not in the best interests of the local health service.

⁷ <http://www.legislation.gov.uk/ukpga/2011/15/contents>

⁸ <http://www.legislation.gov.uk/uksi/2012/3048/contents/made>

Benefits

23. The current health scrutiny functions support the accountability and transparency of public services. They provide a means for councillors to engage with commissioners, providers and local people across primary, secondary and tertiary care.
24. HOSCs set their own priorities for scrutiny to reflect the interests of the people they serve. Councillors on HOSCs have a unique democratic mandate to act across the whole health economy, using pathways of care to hear views from across the system and examining priorities and funding decisions across an area to help tackle inequalities and identify opportunities for integrating services.
25. By creating a relationship with NHS commissioners, health scrutiny can provide valuable insight into the experiences of patients and service users, and help to monitor the quality and outcomes of commissioned services. It can also provide important insight that will contribute to the process of developing JSNAs and JHWSs, on which future commissioning plans will be based.
26. Where relationships between the NHS and HOSCs are mature, health scrutiny adds value by building local support for service changes. Some HOSCs also advise the NHS on appropriate forms of public engagement, including alternatives to full public consultation, thus saving NHS resources. These effective relationships are usually a result of early engagement between the NHS and the HOSC, where there is co-operation on proposals for consultation and potential areas of dispute are surfaced and solutions agreed as part of wider consultation.

Proposals for Consultation

Why are we looking at this?

27. The current reform programme is underpinned by a commitment to increasing local democratic legitimacy in health. Strengthening health scrutiny is one element of this.
28. These important reforms are taking place against a backdrop of a very challenging financial environment for public services. The need to deliver improved quality and outcomes in this economic context will be a significant challenge for both NHS commissioners and local authorities. Commissioners will need to focus on achieving the very best outcomes for every pound of health spend, meaning that complex decisions over the current and future shape of services are likely to be required. In a tax-funded system, it is important that such decisions are grounded with effective local accountability and discussed across local health economies. The role and importance of effective health scrutiny will therefore become more prominent.
29. Since the scrutiny provisions were implemented in 2003, NHS organisations, health services and local authorities have changed substantially. The 2012 Act will bring about further structural reforms with the introduction of the NHS Commissioning Board, CCGs, health and wellbeing boards and Healthwatch.
30. The Government recognises that the current arrangements for health scrutiny need to be updated to ensure the scrutiny provisions reflect the new structure and are appropriate to the new system. It is important that the new NHS bodies are made subject to effective scrutiny and held to account.
31. In updating the scrutiny regulations, we propose to retain the best of the existing system but take this opportunity to address some of the challenges that have been experienced by both local authorities and NHS bodies since 2003.
32. The 2012 Act has made changes to the regulation-making powers in the 2006 Act around health scrutiny. In future, regulations will:
 - a. confer health scrutiny functions on the local authority itself, rather than on an overview and scrutiny committee specifically. This will give local authorities greater flexibility and freedom over the way they exercise these functions in future, in line with the localism agenda. Local authorities will no longer be obliged to have an overview and scrutiny committee through which to discharge their health scrutiny functions, but will be able to discharge these functions in different ways through suitable alternative arrangements, including through overview and scrutiny committees. It will be for the full council of each local authority to determine which arrangement is adopted;

- b. extend the scope of health scrutiny to “relevant NHS bodies” and “relevant health service providers”. This includes the NHS Commissioning Board, CCGs and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and the local authority, including independent sector providers.
33. These important changes to health scrutiny regulations were consulted upon widely through the *White Paper, Liberating the NHS*, and throughout the passage of the 2012 Act in Parliament. This document does not consult further upon the merits of these changes.
34. The Government recognises that the existing health scrutiny regulations have, on the whole, served the system well. Some elements of the regulations, for example around the provision of information and attendance at scrutiny meetings, are fundamental to the effective operation of health scrutiny, and will need to be retained. We propose therefore to preserve those provisions which:
 - a. enable health scrutiny functions to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority’s area;
 - b. require NHS bodies to provide information to and attend (through officers) before meetings of the committee to answer questions necessary for the discharge of health scrutiny functions;
 - c. enable health scrutiny functions to make reports and recommendations to local NHS bodies and to the local authority on any health matters that they scrutinise;
 - d. require NHS bodies to respond within a fixed timescale to the HOSC’s reports or recommendations;
 - e. require NHS bodies to consult health scrutiny on proposals for substantial developments or variations to the local health service;
35. The provisions will be modified in accordance with amendments to the 2006 Act by the 2012 Act so, for example, they will apply in relation to the NHS Commissioning Board, CCGs and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and local authorities, in line with paragraph 32 b) above.
36. The Health Act 2009⁹ introduced the Unsustainable Providers Regime for NHS trusts and NHS foundation trusts. The purpose of this regime is to deliver a swift resolution in the unlikely event that an NHS provider is unsustainable, to ensure patients are not put at risk. Parliament accepted the principle that under these exceptional circumstances, public consultation and local authority scrutiny should be restricted to a truncated 30-working day consultation period. Therefore, the provisions in the 2002 Regulations on

⁹ <http://www.legislation.gov.uk/ukpga/2009/21/contents>

consultation of HOSC and referrals by them, and on provision of information to them and attendance before them, do not apply in relation to a Trust Special Administrator's report.

37. The 2012 Act introduced a framework to secure continued access to NHS services, which included a modified and improved version of the 2009 Act failure regime for NHS foundation trusts. We intend to retain the exemption from the need to consult local authority scrutiny functions on proposals contained in a Trust Special Administrator's report and the other exceptions mentioned above. In line with paragraph 32 b) above, we also intend to extend this exemption to Health Special Administration¹⁰ proposals, which will provide equivalent continuity of service protection to patients receiving NHS care from corporate providers in the unlikely event that one such provider becomes insolvent.

Proposals under consultation

The current position on service reconfiguration and referrals

38. Throughout its history, the NHS has changed to meet new health challenges, take advantage of new technologies and new medicines, improve safety, and modernise facilities. The redesign and reconfiguration of services is an important way of delivering improvements in the quality, safety and effectiveness of healthcare.
39. The Government's policy is that service reconfigurations should be locally-led, clinically driven and with decisions made in the best interest of patients. The spirit of 'no decision about me, without me' should apply, with patients and local communities having a genuine opportunity to participate in the decision-making process.
40. Reconfigurations should also demonstrate robust evidence against the Secretary of State's four tests for major service change¹¹. This means all proposals should be able to demonstrate evidence against the following criteria.
- a clear clinical evidence base, which focuses on improved outcomes for patients;
 - support for proposals from the commissioners of local services;
 - strengthened arrangements for patient and public engagement, including consultation with local authorities; and
 - support for the development of patient choice.
41. Effective patient and public engagement is at the heart of any successful reconfiguration. NHS bodies have a legal duty to make arrangements that secure the involvement of patients and the public in the planning of service provision, the development and consideration of proposals for changes in the way services are provided and decisions to be made affecting the operation of those services.

¹⁰ Chapter 5 of Part 3 of the 2012 Act

¹¹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_118085.pdf

42. Under the current system, NHS bodies must consult the HOSC on any proposals for “a substantial variation” in the provision of the health service or “a substantial development” of the health service. The existing health scrutiny regulations do not define what constitutes ‘substantial’. The Government’s view, taking into account previous consultation on this issue, is that this is a matter on which NHS bodies should aim to reach a local understanding or definition with their HOSC.
43. It is normal for local stakeholders and communities to have different views on how best to reorganise and reshape services to best meet patient needs within available resources. In the majority of cases, these differences of opinion are reconciled locally through effective partnership working and engagement.
44. However, there may be occasions where a local authority scrutiny body does not feel able to support a particular set of proposals for service change or feels that consultation has been inadequate. Under the 2002 Regulations, a HOSC or a joint HOSC can refer proposals to the Secretary of State if they:
 - a. do not feel that they have been adequately consulted by the NHS body proposing the service change, or
 - b. do not believe that the changes being proposed are in the interests of the local health service
45. Upon receiving a referral, the Secretary of State will then usually approach the Independent Reconfiguration Panel (IRP) for advice. The IRP is an independent, advisory non-departmental public body that was established in 2003 to provide Ministers with expert advice on proposed reconfigurations. In providing advice, the IRP will consider whether the proposals will provide safe, sustainable and accessible services for the local population.

Proposed changes

46. The Government is aware through conversations with stakeholders from the NHS, local government and patient groups that existing dispute resolution and referral mechanisms do not always work in the best interests of improving services for patients. Moreover, the current referral process was developed in 2002, which pre-dates considerably the current raft of reforms and structural changes underway across the health and social care system. It is essential that the system changes so that local conversations on service reconfiguration are embedded into commissioning and local accountability mechanisms.
47. More integrated working between clinical commissioners, local authorities and local patient representatives will help to move the focus of discussions about future health services much earlier in the planning process, strengthening local engagement and helping build consensus on the case for any change.

48. The introduction of health and wellbeing boards will significantly improve joint working and planning between local authorities and the NHS across health services, social care and public health. Whilst the 2012 Act is very clear that health scrutiny remains a separate function of the local authority (and cannot be delegated to health and wellbeing boards), health and wellbeing boards provide a forum for local commissioners (NHS and local authority) to explain and discuss how they are involving patients and the public in the design of care pathways and development of their commissioning plans.
49. It is sensible, therefore, that we look further at how a balance can continue to be struck between allowing services to change and providing proportionate democratic challenge that ensures those changes are in the best interests of local people.
50. We are proposing a number of changes around service reconfiguration and referral which are designed to clarify and streamline the process in the future. Our proposals on referrals break down into four main areas:
 - a. requiring local authorities to publish a timescale for making a decision on whether a proposal will be referred;
 - b. requiring local authorities to take account of financial considerations when considering a referral;
 - c. introducing a new intermediate referral stage for referral to the NHS Commissioning Board for some service reconfigurations;
 - d. requiring the full council of a local authority to discharge the function of making a referral.

Publication of timescales

51. Under the 2002 Regulations, an HOSC can decide to refer a reconfiguration proposal at any point during the planning or development of that proposal. The 2002 Regulations do not specify a time by which an HOSC must make this decision. Most referrals are done at the point where the NHS has concluded its engagement and consultation and decided on the preferred option to deliver the proposal. Where referrals have been made earlier in the process, the IRP have usually advised the Secretary of State against a full review and advised that the NHS and HOSC should maintain an on-going dialogue as options are developed.
52. We are aware from feedback from both the NHS and local authorities, that the absence of clear locally agreed timetables can lead to considerable uncertainty about when key decisions will be taken during the lifetime of a reconfiguration programme. Some have expressed a view that timescales should be specified in regulations but we believe that imposing fixed timescales in this way would be of limited value. Each reconfiguration

scheme is different and it is right to allow local flexibility for the adoption of timetables that are appropriate to the nature and complexity of any change.

53. We therefore propose introducing a requirement in regulations that, in relation to proposals on which the local authority scrutiny function must be consulted, the NHS commissioner or provider must publish the date by which it believes it will be in a position to take a decision on the proposal, and notify the local authority accordingly. We propose that on receipt of that notification, local authorities must notify the NHS commissioner or provider of the date by which they intend to make a decision as to whether to refer the proposal.
54. If the timescales subsequently need to change – for example, where additional complexity emerges as part of the planning process – then it would be for the NHS body proposing the change to notify the local authority of revised dates as may be necessary, and for the local authority to notify the NHS organisation of any consequential change in the date by which it will decide whether to refer the proposal. The regulations will provide that the NHS commissioner or provider should provide a definitive decision point against which the local authority can commence any decisions on referral.

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons

Q2 Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?

Financial sustainability of services

55. Under present regulations, an HOSC can make a referral if it considers the proposal would not be in the best interest of the local health service. The regulations do not define what constitutes ‘best interest’ but evidence from previous referrals indicates that local authorities interpret this in terms of the perceived quality and accessibility of services that will be made available to patients, users and the public under the new proposals.
56. The Government protected the NHS in the Spending Review settlement with health spending rising in real terms. However, this does not mean that the NHS is exempt from delivering efficiency improvements - it will need to play its part alongside the rest of the public services. Delivery of these efficiencies will be essential if the NHS is to deliver improved health outcomes while continuing to meet rapidly rising demands.
57. As local authorities and the NHS will increasingly work together to identify opportunities to improve services, we believe it is right that health scrutiny be asked to consider whether proposals will be financially sustainable, as part of its deliberations on whether to support or refer a proposed service change.

58. It would not be right for a local authority to refer a reconfiguration proposal to the Secretary of State without considering whether the proposal is both clinically and financially sustainable, within the existing resources available locally. We believe health scrutiny would be improved in it was specifically asked to look at the opportunities the change offered to save money for use elsewhere in improving health services.
59. We therefore propose that in considering whether a proposal is in the best interests of the local health service, the local authority has to have regard to financial and resource considerations. Local authorities will need support and information to make this assessment and the regulations will enable them to require relevant information be provided by NHS bodies and relevant service providers. We will address this further in guidance.
60. Where local authorities are not assured that plans are in the best interests of the local health services, and believe that alternative proposals should be considered that are viable within the same financial envelope as available to local commissioners, they should offer alternatives to the NHS. They should also indicate how they have undertaken this engagement to support any subsequent referral. This will be set out in guidance rather than in regulations.

Q3. Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your views.

Referral to the NHS Commissioning Board

61. The 2012 Act ensures the Secretary of State's duty to promote a comprehensive health service remains unchanged in legislation, as it has since the founding NHS Act 1946. The NHS Commissioning Board has a parallel duty. The 2012 Act also makes clear that the Secretary of State remains ultimately accountable for the health service. However, the Secretary of State will no longer have general powers to direct the NHS. Instead, NHS bodies and the Secretary of State will have specific powers that are defined in legislation, enabling proper transparency and accountability. For example, Ministers will be responsible, not for direct operational management, but for overseeing and holding to account the national bodies in the system, backed by extensive powers of intervention in the event of significant failure. The NHS Commissioning Board and CCGs will have direct responsibility for commissioning services. The NHS Commissioning Board will help develop and support CCGs, and hold them to account for improving outcomes for patients and obtaining the best value for money from the public's investment.
62. We believe that where service reconfiguration proposals concern services commissioned by CCGs, the NHS Commissioning Board can play an important role in supporting resolution of any disputes over a proposal between the proposer of the change and the local authority, particularly where the local authority is considering a referral.

63. We are seeking views on how the NHS Commissioning Board could provide this support and help with dispute resolution. One option is to introduce an intermediate referral stage, where local authorities make an initial referral application to the NHS Commissioning Board. Upon receiving a referral, the NHS Commissioning Board could be required by regulations to take certain steps, which could include working with local commissioners to resolve the concerns raised by the local authority. The NHS Commissioning Board would be required to respond to the local authority setting out its response and any action that it had taken or proposed to take.
64. If the local authority was not content with the response from the NHS Commissioning Board, it would continue to have the option to refer the proposal to the Secretary of State for a decision, setting out in support of its application where the NHS Commissioning Board's response fell short in addressing the concerns of the authority.
65. The exception to this referral intermediate stage would be where the reconfiguration proposals relate to services commissioned directly by the NHS Commissioning Board. In such a case, any referral would be made directly to the Secretary of State.
66. The Government believes this option holds most true to the spirit of a more autonomous clinical commissioning system, strengthening independence from Ministers, and putting further emphasis on local dispute resolution. However, we are aware through testing this option with NHS and local authority groups that it is not without complexities. It may be difficult for the NHS Commissioning Board to both support CCGs with the early development of reconfiguration proposals (where CCGs request this support) and also to be able to act sufficiently independently if asked at a later date by a local authority to review those same plans. Furthermore, this additional stage could lengthen the decision-making timetable for service change, which could delay higher quality services to patients coming on stream.
67. An alternative approach would be for the NHS Commissioning Board to play a more informal role, helping CCGs (and through them, providers) and the local authority to maintain an on-going and constructive dialogue. Local authorities would be able to raise their concerns about a CCG's reconfiguration proposals with the NHS Commissioning Board and seek advice. However, that would be at the local authority's discretion rather than a formal step in advance of referral to the Secretary of State.
68. If a local authority chose to engage the NHS Commissioning Board in this way, the Board would need to determine whether it was able to facilitate further discussion and resolution, and respond to the CCG and local authority accordingly. If following the Board's intervention the local authority's concerns remained, the local authority would continue to have the option as under current regulations to refer the proposal to the Secretary of State for review.
69. The Government does not have a preference between the formal and informal methods set out above, and would welcome comments from interested stakeholders on the

advantages and disadvantages of both approaches. Irrespective of the referral route any informal dispute resolution process that may be put in place, we do not propose to fundamentally remove a local authority's power of referral to the Secretary of State. This ability to refer to Secretary of State is unique within local authority scrutiny and provides a very strong power for local authorities within the new landscape, where the Secretary of State will have fewer powers to direct NHS commissioners and providers.

- Q4. Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?**
- Q5. Would there be any additional benefits or drawbacks of establishing this intermediate referral?**
- Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?**

Full council agreement for referrals

70. Under existing regulations, it is for the HOSC to determine whether to make a referral to the Secretary of State for Health. A referral to the Secretary of State in many ways represents the break down in the dialogue between local authorities and the NHS. It should be regarded as a last resort and the decision itself should be open to debate.
71. Given the enhanced leadership role for local authorities in health and social care, we believe it is right that the full council should support any decision to refer a proposed service change, either to the NHS Commissioning Board or to Secretary of State. We propose that referrals are not something that the full council should be able to delegate to a committee, and that the referral function should be exercised only by the full council.
72. This will enhance the democratic legitimacy of any referral and assure the council that all attempts at local resolution have been exhausted. It is potentially undesirable for one part of the council (the health and wellbeing board) to play a part in providing the over-arching strategic framework for the commissioning of health and social care services and then for another part of the council to have a power to refer to the Secretary of State.
73. This change would mean scrutiny functions would need to assemble a full suite of evidence to support any referral recommendation. It is important that all councillors should be able to contribute their views, to allow them to safeguard the interests of their constituents. This will also bring health oversight and scrutiny functions in line with other local authority scrutiny functions, which also require the agreement of a full council. The Government believes that this additional assurance would help encourage local resolution, and further support closer working and integration across the NHS and local government.

Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

Joint Overview and Scrutiny

74. There are many occasions when scrutiny functions from more than one local authority area will need to work together to ensure an effective scrutiny process. Joint scrutiny is an important aspect of existing health scrutiny practice, and has been very successful in a number of places. Some regions have established standing joint OSCs, or robust arrangements for introducing joint OSCs on specific regional issues. Joint scrutiny arrangements are important in that they enable scrutineers to hear the full range of views about a consultation, and not just those of one geographical area.
75. The Government is aware from its engagement with patients and the public, the NHS and with local authorities, that there are differences of opinion as to when a joint scrutiny arrangement should be formed. The current regulations enable the formation of joint scrutiny arrangements, but do not require them to be formed. We propose to make further provision within the regulations on this issue.
76. Under the 2003 Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions)¹² where a local NHS body consults more than one HOSC on any proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such service, local authorities of those HOSCs must appoint a joint HOSC for the purposes of the consultation. Only that joint HOSC may make comments on the proposal, require information from the NHS body, require an officer of that NHS body to attend before the joint HOSC to answer questions and produce a single set of comments in relation to the proposals put before them. This is fundamental to the effective operation of joint scrutiny and we propose that it should be incorporated into the new regulations.

Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?

77. The ability of individual local authorities to refer proposals to the Secretary of State for review has been an important enabler of local democratic legitimacy. It is important that this ability to refer is preserved, where a joint health scrutiny arrangement is formed. Should a local authority participating in a joint health scrutiny arrangement wish separately to refer a proposal either to the NHS Commissioning Board or to the Secretary of State, they will still be required to secure the backing of their full council in order to make the referral.

¹² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4006257

78. There are a range of circumstances beyond service variation or development in which two or more local authorities may wish to come together to scrutinise health matters, for example where a CCG or NHS foundation trust spans two local authority boundaries. In such circumstances, the formation of a joint scrutiny arrangement would be discretionary.

Responding to this consultation

79. The Government is proposing a number of measures to strengthen and improve health scrutiny.
80. The Government wants to hear your views on the questions posed in this document, to help inform the development of the health overview and scrutiny regulations. We are also seeking your views on the following questions:
- Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?**
- Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?**
- Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?**

Deadline for comments

81. This document asks for your views on various questions surrounding the issue of local authority health overview and scrutiny.
82. This is an 8 week consultation, running from 12th July 2012 to 7th September 2012 and building on earlier consultation on *Liberating the NHS, Local Democratic Legitimacy in Health*. In order for them to be considered, all comments must be received by 7th September 2012. Your comments may be shared with colleagues in the Department of Health, and/or be published in a summary of responses. Unless you specifically indicate otherwise in your response, we will assume that you consent to this and that your consent overrides any confidentiality notice generated by your organisation's email system.
83. There is a full list of the questions we are asking in this consultation on page 25. You can respond online at http://consultations.dh.gov.uk/public-patient-engagement-experience/http-consultations-dh-gov-uk-ppe-local-authority/consult_view by email to scrutiny.consultation@dh.gsi.gov.uk or by post to:

Scrutiny Consultation
Room 5E62
Quarry House

Quarry Hill
Leeds LS2 7UE

84. When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear whom the organisation represents and, where applicable, how the views of the members were assembled.
85. It will help us to analyse the responses if respondents fill in the questionnaire, but responses that do not follow the structure of the questionnaire will be considered equally. It would also help if responses were sent in Word format, rather than pdf.

Criteria for consultation

86. This consultation follows the Cabinet Office Code of Practice for Consultations. In particular, we aim to:
 - formally consult at a stage where there is scope to influence the policy outcome;
 - follow as closely as possible the recommendation duration of a consultation which is at least 12 weeks (with consideration given to longer timescales where feasible and sensible) but in some instances may be shorter. In this case, it is 8-weeks in light of previous consultation referred to in paragraph 82 above and engagement undertaken by the Department throughout passage of the 2012 Act.
 - be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
 - ensure the consultation exercise is designed to be accessible to, and clearly targeted at those people it is intended to reach;
 - keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' "buy-in" to the process;
 - analyse responses carefully and give clear feedback to participants following the consultation;
 - ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.
87. The full text of the code of practice is on the Better Regulation website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

88. If you have any concerns or comments which you would like to make relating specifically to the consultation process itself, please contact

Consultations Coordinator
Department of Health
Room 3E48
Quarry House

Quarry Hill
Leeds LS2 7UE

Email: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address

Confidentiality of information

89. We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.
90. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).
91. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a Statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.
92. The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

After the consultation

93. Once the consultation period is complete, the Department will consider the comments that it has received, and the response will be published in the Autumn
94. The consultation and public engagement process will help inform Ministers of the public opinion, enabling them to make their final decision on the content of the health scrutiny regulations.
95. A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the consultations website at <http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>

Annex A - Consultation Questions

- Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons
- Q2. Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?
- Q3. Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your view.
- Q4. Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?
- Q5. Would there be any additional benefits and drawbacks of establishing this intermediate referral?
- Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?
- Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.
- Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?
- Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?
- Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?
- Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

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DRAFT Response from the Telford and Wrekin Health and Adult Social Care Scrutiny Committee
to the Department of Health's Consultation on Proposals for Local Authority Health Scrutiny

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons.

Q2. Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?

The consultation document sets out that a HOSC or Joint HOSC may make a referral to the Secretary of State if the HOSC :

Do not feel that they have been adequately consulted by the NHS body proposing the service change
Or

Do not believe that the changes being proposed are in the interests of the local NHS

In either of these situations a referral could be made **during the consultation period (or in the absence of any consultation)** if the Local Authority has such serious concerns regarding the proposal or lack of consultation and sufficient evidence to support these concerns. The timescales for referral would be within the consultation period but no further time restrictions should apply to the referral in these circumstances.

Equally the HOSC or Joint HOSC may make a referral to the Secretary of State **after the consultation has ended (if a consultation has been undertaken) and the Board(s) of the NHS body(s) has decided on the change in service.** It may be helpful under these circumstances for there to be a time scale specified within which a referral should be made on this decision. If this is implemented this should take into account any requirement that may be introduced for a formal referral to be made by Full Council.

If the Local Authority **does not** make a referral following the Trust Board(s) decision this **should not preclude a future referral** if the implementation of the change is not carried out in line with the decision taken by the Trust Board(s) as understood by the Local Authority health Scrutiny body .

Q3. Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your view.

The Local Authority should consider as part of the evidence received that any proposed service change or development is financially sustainable. This will become a much more complex issue to assess as the range of provider organisations expands. Evidence should be received from both the relevant NHS commissioning body(s) on their commissioning intentions and relevant provider organisation(s) on the work force, estate and clinical/technological financial implications. The fact the Local Authority believes that the service change is unsustainable or an alternative proposal provides better value may provide some of the supporting evidence for the referral.

However any requirement to consider the financial implications should not require the Local Authority to make costed alternative proposals in the event of a referral to the Secretary of State.

Q4. Given the new systems landscape and the proposed role for the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?

Q5. Would there be any additional benefits and drawbacks of establishing this intermediate referral?
A first stage referral to the NHS Commissioning Board would introduce an unnecessary stage in the referral process. The Board may also have a conflict of interest if it has been involved in the development of the proposals. The Board could have a role in facilitating discussion to resolve any local dispute regarding proposed service changes.
Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?
The emphasis on local autonomy should support the resolution of disputes at a local level therefore removing the need for referral to the Secretary of State. In order to ensure local negotiation is constructive all bodies involved must be clear about their relevant roles and responsibilities. All CCGs and the Local Offices of the National Commissioning Board should be encouraged to develop a good working relationship with Scrutiny at the earliest opportunity. In Telford and Wrekin the Chair of the CCG has already presented to the HOSC and Joint HOSC.
Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.
Requiring referral by Full Council would add an unnecessary stage to the process.
Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not why not?
Telford and Wrekin has a long established Joint HOSC with Shropshire Council which has a good working relationship with local NHS organisations.
There is also Regional Health Scrutiny Chairs' Forum which is an informal network and has supported a good working relationship across the region. Telford and Wrekin have previously expressed the view that this should be formalised to become a Joint HOSC which would be the consulting body for regional and national services changes.
There is a risk that the rate and scale of service change under the new commissioning arrangements and any requirement to establish additional Joint HOSCs could result in an unrealistic work load.
Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?
Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?
Q 11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?
At a regional meeting for Health Scrutiny Chairs an issue had been raised about referral of service

changes proposed by a Foundation Trust. This issue may have been resolved but it was commented that when the HOSC wanted to make a referral to the Secretary of State they were informed that a referral would have to be made initially to Monitor. No response was received from Monitor following this referral which delayed the referral to the Secretary of State. It would therefore be helpful to include regulations / guidance on the role of Monitor in resolving disputes on service changes provided by Foundation Trusts and time scales in which a response will be made to the Local Authority when a referral is made to Monitor .

Feedback from HOSC that have made a referral to the Secretary of State has said that it would be helpful of regulations/ guidance to include timescales for the decision made by the Secretary of State whether to refer the matter to the Independent reconfiguration panel.