Notice of meeting of

Health Overview & Scrutiny Committee

To: Councillors Funnell (Chair), Wiseman (Vice-Chair), Boyce, Cuthbertson, Doughty, Douglas (to be replaced by Cllr Fitzpatrick at Council on 30 June 2011) and Hodgson

Date: Wednesday, 6 July 2011

Time: 5.00 pm

Venue: The Guildhall, York

A G E N D A

1. **Declarations of Interest** (Pages 3 - 4)
   At this point Members are asked to declare any personal or prejudicial interests they may have in the business on this agenda. A list of general personal interests previously declared are attached.

2. **Public Participation**
   At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **5:00 pm** on **Tuesday 5 July 2011.**

3. **Report of the Cabinet Member for Health, Housing and Adult Social Services** (Pages 5 - 8)
   Councillor Simpson-Laing, Cabinet Member for Health, Housing and Adult Social Services will be in attendance to report on the year ahead.

   [An extract from the Cabinet Members written report to Council on 30 June 2011 is attached for information.]

4. Update from York Hospitals Foundation Trust and NHS North Yorkshire and York in relation to Transforming Community Services

The Chief Nurse from York Teaching Hospital NHS Trust and the Associate Director of Public Health and Locality Director from NHS North Yorkshire and York will be in attendance at the meeting to give an update to the Committee.

5. Progress Report - NHS Reforms and the work of the Transition Board (Pages 9 - 26)

To receive a report which outlines national and local developments in relation to progress on the NHS reforms and the work of the Transition Board.

6. Work Plan 2011/2012 (Pages 27 - 28)

To consider the Committee's work plan for 2011/2012.

7. Urgent Business

Any other business which the Chair considers urgent under the Local Government Act 1972

Democracy Officer:

Name: Jill Pickering
Contact Details:

- Telephone – (01904) 552061

Email – jill.pickering@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above

Agenda Annex

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If you would, you will need to:

- register by contacting the Democracy Officer (whose name and contact details can be found on the agenda for the meeting) **no later than** 5.00 pm on the last working day before the meeting;
- ensure that what you want to say speak relates to an item of business on the agenda or an issue which the committee has power to consider (speak to the Democracy Officer for advice on this);
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Further information about what's being discussed at this meeting
All the reports which Members will be considering are available for viewing online on the Council's website. Alternatively, copies of individual reports or the full agenda are available from Democratic Services. Contact the Democracy Officer whose name and contact details are given on the agenda for the meeting. **Please note a small charge may be made for full copies of the agenda requested to cover administration costs.**

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Holding the Cabinet to Account

The majority of councillors are not appointed to the Cabinet (39 out of 47). Any 3 non-Cabinet councillors can 'call-in' an item of business from a published Cabinet (or Cabinet Member Decision Session) agenda. The Cabinet will still discuss the 'called in' business on the published date and will set out its views for consideration by a specially convened Scrutiny Management Committee (SMC). That SMC meeting will then make its recommendations to the next scheduled Cabinet meeting in the following week, where a final decision on the 'called-in' business will be made.

Scrutiny Committees

The purpose of all scrutiny and ad-hoc scrutiny committees appointed by the Council is to:

- Monitor the performance and effectiveness of services;
- Review existing policies and assist in the development of new ones, as necessary; and
- Monitor best value continuous service improvement plans

Who Gets Agenda and Reports for our Meetings?

- Councillors get copies of all agenda and reports for the committees to which they are appointed by the Council;
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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Agenda item I: Declarations of interest.

Please state any amendments you have to your declarations of interest:

Councillor Boyce	Employed by the Alzheimer's Society, York Trustee of York Carers' Centre Mother in receipt of Carers' Services
Councillor Doughty	Volunteers for Our Celebration and partner also works for this charity.
Councillor Funnell	Member of the General Pharmaceutical Council Trustee of York CVS
Councillor Hodgson	Previously worked at York Hospital
Councillor Wiseman	Public Member of York Hospitals NHS Foundation Trust Member of the Adoption Panel and Consultation Meetings with looked after children "Show Me That I Matter"

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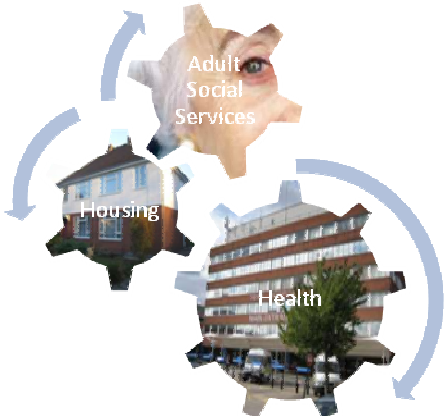
Extract from the Cabinet Member Report: Health, Housing & Adult Social Services _presented to Council 30th June 2011_

Since 9th May I have undertaken numerous briefing sessions with Directors, Assistant Directors and lead officers across the many areas in my portfolio.

Officers have been open and honest and have welcomed being able to work on pledges in our manifesto and on those policies we have been supporting for a number of years.

I have recently attended:

- Centre for Women's Democracy, Leeds - for their project on female Councillors
- Local Government Yorkshire & Humber – Health & Wellbeing Member Group
- Self Direct Support Forum
- National Housing Conference in Harrogate
- Safeguarding Adults Board
- Healthy City Board



Over the coming weeks and months I am due attend:

- Link York as a speaker
- Older Citizens Advocacy York AGM
- Full of Life Event
- Valuing People Board
- York People First
- Ageing Well Event
- Supporting People Board
- Leeds City Region HRA Board
- Local Government Information Unit Local Health Network
- The Rethink Forum (formally the National Schizophrenic Society) – guest speaker

I will also be meeting with:

Mike Proctor – York Hospital NHS Trust
Bill McCarthy – Yorkshire and Humber Strategic Health Authority

Rachael Johns – York and North Yorkshire PCT

Dr David Hayes – GP Commissioning Consortium Chair

Health

Primary Care Trust (PCT) - Good progress has been made in the Council's liaison with the PCT and other health partners and an agreement has been reached on the transferring of funding. This will see increased investments over the next year including in the Council's Reablement Service – which helps people to gain the skills they need to remain at home, its Assessment Service for care packages and our Locality Home Care Service which provides almost 5000 hours care per week to 640 residents across the city.

These changing ways of working will leave the Council better placed than previously to meet the city's changing demographics and respond to the challenge of integrated support services being provided speedily, to keep people in their own homes and facilitate returns home after hospital admissions.

Whilst the changes to the NHS have been subject to a "listening exercise", local preparatory work has continued. A Transition Board co-chaired by the Chief Executives of City of York Council and the PCT has continued to meet covering key workstreams on commissioning, public health transfer, establishing a Health and Wellbeing Board and Healthwatch - a report to Cabinet in early October will make summary recommendations on all four workstreams. To aid this transition, I have agreed to the Council becoming part of an information and best practice sharing group at a Yorkshire and Humber Regional level through the LGYH Health & Wellbeing Group. I have also started to look at regional best practice on Public Health, which will help with shaping the city's health agenda as we move forward.

Adult Social Care

Celebrating York's Older Residents - Changing demographics have and are often perceived and described as "a problem". Here in York I am keen that we reverse this impression and celebrate the contribution that an increasingly ageing population can bring to the city. As part of this process, a photographic competition has taken place celebrating, through images, the roles of older people in society and resulted in a presentation at the Mansion House on the 27th June. I hope that this event can be built upon, working with individuals, families and support groups across the city.

Home Cooking- Residents, families and our own staff have praised the return to home cooked food to our Elderly Peoples Homes which has brought considerable benefits, including a better experience with more flexible mealtimes, greater individual choice and the welcoming smells of

home cooking. On my recent visit to Windsor House the cook had baked buns for tea time and I was told that these small changes were greatly welcomed.

Finance - Due to recent year on year budget cuts, and a reduction in Government funding, extensive work has been undertaken by service managers to remodel staffing deployment in our Elderly Persons Homes which has led to achieved savings in the region of £700k, but importantly still retaining the same levels of care as before. Work has also been done to review the tendering of procurement of goods and is delivering a total of £768k savings in 2011-12. I would like to thank the staff for their help in this work.

Budgetary savings, amounting to around £200k, have also been made from service mergers and management restructuring in Learning Disability provider services. Again, these have been undertaken without impacting on service delivery and continue to receive very positive inspection findings. I would like to thank all who contributed to this work.

Telecare - Telecare in York is the fastest growing Telecare service in the region. Referral rates are up by 60%, with over 500 customers now benefiting from the independence and reassurance offered by their Telecare equipment, helping them stay independent in their homes for as long as possible. This scheme will be further funded and expanded thanks to the Labour Council's commitment to increase Telecare by £250k per year.

Personalisation Agenda and Direct Payments - The rollout of the Personalisation Agenda and Direct Payments has continued in York and now all those who require services, irrespective of their customer group, are able to access self directed support. This means that every person who receives support, whether provided by statutory services or funded personally, will have choice and control over the shape of that support in all care settings through Direct Payments and Individual Budgets.

Adult Social Services has worked to increase efficiency and provide choice and control for residents who use the Council's services. Occupational Therapy and Community Equipment Services have been at the forefront of delivering these changes in 2010-11 and have launched an 'Online Self Assessment and Equipment Solution' to meet the pressures of changing demographics and needs of current and future users alongside service re-design to maximise the benefits of these new approaches.

Staffing Issues – The Council's staff are critically important to achieving high level quality services. The Adults Provision and Modernisation

Service has continued to make improvements in the areas of supervision and appraisals of staff having achieved a 100% rate of appraisals in 2011-12 for its 730 staff. The implementation of the staff training and development pathway aimed at ensuring all see the opportunities and career benefits of continued professional development throughout the business area has shown great progress over 2010-11. We have also been successful in the embedding of Equalities Impact Assessments, with equality training and awareness undertaken within teams and included in training and team plans.

Monitoring – Finally, positive Care Quality Commission (CQC) inspections have been achieved under the new CQC regime for Care Service, Reablement Service and Sheltered with Extra Care Schemes. The final Self Assessment for CQC managed and produced by Adults performance teams showed progress in 3 of the 7 Outcome areas for Adults, with all being rated as good, and receiving a first excellent judgement in respect of “Making a Positive Contribution”.

I know that all staff involved in these services worked hard to ensure we met the expected levels and they should be congratulated for their excellent work.

Councillor Tracey Simpson-Laing
Cabinet Member for Health, Housing and Adult Social Services
19th June, 2011

Briefing Paper on the Transition Board and NHS Reforms
prepared by Kathy Clark, Corporate Strategy Manager,
City of York Council

National developments

The Future Forum reported back to Government on 13 June, following the 'Pause' in the progress of the Health and Social Care Bill. The Forum looked at four themes:

- Choice and competition
- Clinical advice and leadership
- Patient involvement and public accountability
- Education and training

The Government responded to the recommendations on the four themes the Forum considered on 14 June. The response is attached at Annex 1.

Some of the changes accepted by the Government will require changes to the Health and Social Care Bill.

The changes proposed will need further consideration locally. One specific issue locally emerges as a result of the expectation that consortium boundaries will normally be co- terminous with local authority boundaries, unless there is good reason. The current boundaries for the commissioning consortium covers City of York, part of North Yorkshire and East Riding. If these boundaries are to be preserved the agreement of the National Commissioning Board will be required, and the views of the local Health and Well Being Board will be taken into account

Local developments

The York Transition Board is meeting regularly and is chaired jointly by the Council's Chief Executive and the Primary Care Trust's Chief Executive.

Membership includes the Chair of the GP Commissioning Consortium for the Vale of York, The Primary Care Trust Locality Director, The Associate Director for Public Health, the Council's Directors for Adults, Children and Education, and for Communities

and Neighbourhoods and Communities, The Chair of York LINK, The Chief Executive of York CVS and the Chief Executive of York Hospital Foundation Trust

Four work streams have been established, each with a project plan, a project sponsor and project lead:

- Establishing a Health and Wellbeing Board
- Transfer of some Public Health functions to the local authority
- Establishing a York HealthWatch service
- Development of Joint Commissioning arrangements

Progress is good on all four work streams, but any key decisions on new arrangements will be made within current governance structures. A paper will be represented to Council Cabinet in September with formal proposals, for example, on the establishment of a Shadow Health and Wellbeing Board in October.

During the summer activities will include:

- A workshop for stakeholders who currently have an interest in the planned function of Health Watch to help shape how York Health Watch will be commissioned.
- Consultation on the draft Terms of Reference for the Health and Wellbeing Board
- Discussion with colleagues in North Yorkshire and East Riding to explore how joint commissioning might be able to work across the current proposed boundaries for the new Commissioning Consortium

<u>Roles for Health Scrutiny and Overview Committee</u>

The Government's response to the Future Forum proposals makes it clear that:
'Health and WellBeing Boards will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority executive functions. The existing statutory powers of local authority overview and scrutiny functions will continue to apply. In line with the principles of the Localism Bill, local authorities will have greater discretion over how to exercise these powers.

Local authorities will still be able to challenge any proposals for the substantial reconfiguration of services, and we will retain the Government's four tests for assessing service reconfigurations.'

Health Overview and Scrutiny will have the opportunity to comment on the draft terms of reference for the Health and Well being Board in the next months.

The Chair and Vice Chair of the Scrutiny Committee have been invited to attend the workshop to help shape HealthWatch on 11 July.

Further updates on the progress of the work of the Transition Board will be provided to the Scrutiny Committee, on a regular basis and on specific issues as required or requested.

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ANNEX 1

GOVERNMENT CHANGES IN RESPONSE TO THE NHS FUTURE FORUM

The following list summarises the key changes that we intend to make, largely structured around the four workstream themes considered by the NHS Future Forum. Some, but not all, of these changes require amendments to the Health and Social Care Bill.

Overall NHS accountability

NHS Constitution

- We will take further steps to embed the NHS Constitution, and the principles and values it contains, in the way the NHS works. The NHS Commissioning Board and commissioning consortia will be required to take active steps to promote the Constitution. The Board, Monitor and the Care Quality Commission will say in their annual reports how they have met their existing duty to have regard to the Constitution.
- We will uphold all of the patient rights in the NHS Constitution. Where necessary we will adapt the way these rights are given legal force, to ensure they have the same legal force under the new legislation. This includes the right to drugs and treatments recommended by NICE, which we will retain after the introduction of value-based pricing for new drugs from January 2014.
- We will make clearer that NHS care must be free at the point of use and that charges for patient services could only be introduced by legislation; and we commit not to introduce any new charges during this Parliament.

The role of the Secretary of State

- The policy is that the Secretary of State will be responsible – as now – for promoting a comprehensive health service. The wording of section 1(1) of the 2006 NHS Act will remain unchanged in legislation, as it has since the founding NHS Act of 1946. This will be underpinned by the new duties that the Bill already places on the Secretary of State, around promoting quality improvement and reducing inequalities.

- We will also make clear that the Secretary of State will also retain ultimate accountability for securing the provision of services, though rather than securing services directly, the Secretary of State will be exercising his duty in future through his relationship with the NHS bodies to be established through the Bill, e.g. the NHS Commissioning Board by way of the "mandate".
- We will make clear that Ministers are responsible, not for direct operational management, but for overseeing and holding to account the national bodies – in particular, the NHS Commissioning Board and the regulators – backed by extensive powers of intervention in the event of significant failure. The Bill will give Secretary of State explicit powers to report on the performance of all of the national NHS bodies, as part of the Department of Health's annual report on the health service.

Clinical commissioning

Clinical commissioning groups

- Commissioning consortia will continue to be groups of GP practices, but we will make a number of changes to provide greater assurance that commissioning will involve patients, carers and the public and a wide range of doctors, nurses and other health and care professionals. To reflect this stronger emphasis on wider professional involvement in commissioning decisions, we intend to use the term "clinical commissioning group" to describe these local NHS organisations.
- Clinical commissioning groups will have a duty to promote integrated health and social care around the needs of users. We accept the recommendation of the Future Forum that their boundaries should not normally cross those of local authorities, with any departure needing to be clearly justified.
- Clinical commissioning groups seeking establishment on the basis of boundaries that would cross local authority boundaries, will be expected to demonstrate to the NHS Commissioning Board a clear rationale in terms of benefit to patients – for example, to reflect local patient flows, or to enable groups to take on practices where, overall, this would secure a better

service for patients – and provide a clear account of how they would expect better integration between health and social care services to be achieved. The NHS Commissioning Board will need to agree proposed boundaries as part of the establishment process. Before establishing any clinical commissioning group, the Board will be required to seek the views of emerging Health and Wellbeing Boards. HWBs may choose to object. The Board will always have to satisfy itself that any such objections have been taken properly into account.

- Clinical commissioning groups will be expected to have a name that uses the NHS brand and has a clear link to their locality. We will make it explicit in the Bill that commissioning groups must commission all urgent and emergency care within their boundaries, and are also responsible for any unregistered patients who live in their area. In other words, they will be responsible for their whole population not just their registered patients.
- Clinical commissioning groups will have flexibility to work in partnership when commissioning services, for example with other groups, local authorities and the NHS Commissioning Board. But as public bodies, they will be unable to delegate their statutory responsibility for commissioning decisions to private companies or contractors.
- We will [soon] publish further details on the processes for authorising and assessing clinical commissioning groups and on the accountabilities and relationships between the NHS Commissioning Board, commissioning groups and Health and Wellbeing Boards.

<u>Governance and accountability for commissioning groups</u>

- Every commissioning group will have a governing body with decision-making powers, to ensure that decisions about patient services and use of taxpayers' money are made in an open, transparent and accountable way. There must be at least two lay members, one with a lead role in championing patient and public involvement, the other with a lead role in overseeing key elements of governance such as audit, remuneration and managing conflicts of interest. One of the lay members will

undertake either the role of Deputy Chair or Chair of the governing body. If Deputy Chair, the lay member would take the Chair's role for discussions and decisions involving a conflict of interest for the Chair.

- We do not intend to prescribe in detail the wider professional membership of the governing body, but it will have to include at least one registered nurse and one doctor who is a secondary care specialist. They must have no conflict of interest in relation to the clinical commissioning group's responsibilities, e.g. must not be employed by a local provider.
- To enhance transparency and accountability, governing bodies will be required to meet in public and publish their minutes, and clinical commissioning groups will have to publish details of contracts with health service providers.
- The authorisation process for clinical commissioning groups will ensure that they have robust governance requirements consistent with Nolan principles and are accountable and transparent. This will not be a one-off test: the NHS Commissioning Board will hold commissioning groups to account for this on an ongoing basis.
- We will revise the provisions in the Bill on the quality premium, and we understand the concerns raised. We will make clear that its purpose is to reward clinical commissioning groups that commission effectively and so improve the quality of patient care and the outcomes this leads to, including reducing inequalities in health outcomes. There will, however, be circumstances where it would clearly not be appropriate to award a premium, for instance if a commissioning group has achieved high-quality outcomes by spending more than the money allotted to it and thereby compromising the resources available to other parts of the country. We recognise, however, that great care will be needed to design rules on when a quality payment can be reduced or withheld to reflect factors such as these. We will therefore ensure that any such rules are subject to regulations that have to be approved by Parliament. We will also change the Bill so that regulations can be used to make

provisions for how commissioning groups can use any quality payment awarded to them.

Timetable for establishing the new commissioning system

- Primary Care Trusts will cease to exist in April 2013. However, clinical commissioning groups will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so.
- By April 2013, GP practices will be members of either an authorised clinical commissioning group, or a 'shadow' commissioning group, i.e. one that is legally established but operating only in shadow form, with the NHS Commissioning Board commissioning on its behalf. This is required so that there is clarity about how different clinical commissioning groups cover the whole country without gaps. It will always be clear to patients and the public which GP practices are members of which local group. No individual GP will need to get involved in the work of a commissioning group if they don't want to.
- Clinical commissioning groups that are ready and willing by April 2013 could be authorised to take on full budgetary responsibility. Some will only be authorised in part. Others will only be established in shadow form. This will be determined through a robust process of authorisation, run by the NHS Commissioning Board, with input from emerging Health and Wellbeing Boards and local clinicians.
- Where a clinical commissioning group is not able to take on some or all aspects of commissioning, the local arms of the NHS Commissioning Board will commission on its behalf, and in this role will be subject to the same duties of transparency and engagement. All groups will have the right to take on full responsibility, once they have demonstrated they are ready. The NHS Commissioning Board will work with the GP practices and other stakeholders in these areas to develop fully operational commissioning groups and hand over commissioning responsibility to them as they become ready, so that we move, over time, to avoid a two-tier system of commissioning in the NHS.

- The primary care trust "cluster" arrangements will be reflected in the local arrangements of the NHS Commissioning Board. Those local arrangements will be established before PCTs are abolished.
- The NHS Commissioning Board will be established by October 2012 to start to authorise clinical commissioning groups, but will only take on its full responsibilities from April 2013. The ten Strategic Health Authorities will remain in place as statutory bodies until April 2013, but we will form them into a smaller number of clusters later this year for management purposes, as we have done with PCTs.
- Good management is essential in improving the quality of front-line services and ensuring that money is well spent. We will take steps to boost the quality of management and leadership: for example, by retaining the best talent from PCTs and SHAs in the new system, and through a commitment to the ongoing training and development of managers.

<u>Wider clinical involvement and advice</u>

- We will retain and strengthen the clinical networks of experts, including patient and carer representatives, that exist in areas like cancer care, so that they cover many more areas of specialist care. We will give networks a stronger role in commissioning, in support of the NHS Commissioning Board and local clinical commissioning groups.
- We will enable doctors, nurses and other professionals to come together in "clinical senates" to give expert advice, which we expect clinical commissioning groups to follow, on how to make patient care fit together seamlessly in each area of the country. To support the better integration of services, they should include public health specialists and adult and child social care experts. Clinical senates will have a formal role in the authorisation of clinical commissioning groups. In addition they will have a key role in advising the NHS Commissioning Board on whether commissioning plans are clinically robust and on major service changes.

- Both clinical networks and clinical senates will be hosted by the NHS Commissioning Board; they will not be organisations or new forms of bureaucracy.
- The NHS Commissioning Board will establish close links with the Royal Colleges and other professional bodies so that partnership working across a wide range of experts is firmly entrenched at a national level. It will have a medical director and a chief nursing officer on its board.
- We will strengthen the existing duties on the NHS Commissioning Board and clinical commissioning groups to secure professional advice and ensure this advice is from a full range of health professionals where relevant. For example, commissioners will need to work with public health experts and in line with public health guidance. We will also place Monitor under a new duty to obtain appropriate clinical advice.

Research

- We will create a new duty for the Secretary of State to promote research.
- We will create a new duty for clinical commissioning groups to promote research and innovation and the use of research evidence, in line with the current duty on the NHS Commissioning Board.
- We will ensure that a culture of research and innovation is embedded in the arrangements for both the Board and Public Health England.
- We will also make sure that clinical commissioning groups and the NHS Commissioning Board ensure that treatment costs for patients who are taking part in research funded by Government and Research Charity partner organisations are funded through normal arrangements for commissioning patient care, as set out in existing guidance.

ANNEX 1

Public accountability and patient involvement

Health and Wellbeing Boards and local authorities

- We will give Health and Wellbeing Boards a new duty to involve users and the public.
- The Bill will make clear that HWBs should be involved throughout the process as clinical commissioning groups develop their commissioning plans, and there will be a stronger expectation, set out in statutory guidance, for the plans to be in line with the health and wellbeing strategy. Though they will not have a veto, HWBs will have a clear right to refer plans back to the group or to the NHS Commissioning Board for further consideration.
- HWBs will have a stronger role in promoting joint commissioning and integrated provision between health, public health and social care.
- They will be given a formal role in authorising clinical commissioning groups and the NHS Commissioning Board will have to take HWBs' views into account in their annual assessment of commissioning groups.
- Health and Wellbeing Boards discharge executive functions of local authorities, and should operate as equivalent executive bodies do in local government. It will be for local authorities to determine the precise number of elected members on a Health and Wellbeing Board, and they will be free to insist upon having a majority of elected councillors.
- HWBs will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority executive functions. The existing statutory powers of local authority overview and scrutiny functions will continue to apply. In line with the principles of the Localism Bill, local authorities will have greater discretion over how to exercise these powers.
- Local authorities will still be able to challenge any proposals for the substantial reconfiguration of services, and we will retain the Government's four tests for assessing service reconfigurations.

ANNEX 1

HealthWatch

- There will be a new requirement for the Care Quality Commission to respond to advice from its HealthWatch England subcommittee. The Secretary of State will be required to consult HealthWatch England on the mandate to the NHS Commissioning Board.
- We will add an explicit requirement that local HealthWatch membership is representative of different users, including carers.

Patient and public involvement

- Monitor will have a new duty to carry out appropriate public and patient involvement in the exercise of its functions.
- We will further clarify the duties on the NHS Commissioning Board and clinical commissioning groups to involve patients, carers and the public in commissioning decisions and will require commissioning groups to consult on their annual commissioning plans to ensure proper opportunities for public input. They will have to involve the public on any changes that affect patient services, not just those with a “significant” impact.
- We will amend commissioners’ duties to involve patients and carers in their own care to better reflect the principle of “no decision about me without me”.

Protecting confidentiality

- We have heard concerns that the powers in the Bill for the Information Centre in relation to personal information are too broad. We will consider further how to amend the Bill to protect patient confidentiality in a way that supports our plans to drive quality improvement through greater access to information; and to promote high quality research.

Respecting the autonomy of front-line organisations

- We will amend the Bill to set a clear expectation that the Secretary of State’s mandate to the NHS Commissioning Board is a multi-year document, to avoid the impression that a new mandate would be set every year.

Independent public health advice

- Public Health England will be established as an executive agency of the Department of Health, subject to completing the normal government approval processes for establishing new bodies. This will ensure that expert and scientific advice is independent, while at the same time integrating policy and action to allow a more joined-up approach to health protection and emergency planning. We will make further announcements in the government response to the Public Health White Paper.

Choice and competition

Patient choice

- We will amend the Bill to strengthen and emphasise commissioners' duty to promote choice, in line with the right in the NHS Constitution for patients to make choices about their NHS care and to receive information to support those choices. As recommended by the Future Forum, the Secretary of State's mandate to the NHS Commissioning Board will set clear expectations about offering patients choice: a "choice mandate".
- Subject to evidence from the current pilots, the mandate to the Board will also make it a priority to extend personal health budgets, including integrated budgets across health and social care.
- As recommended by the Future Forum's report, HealthWatch England will have the power to establish a citizens' panel, or equivalent arrangement, to look at how choice and competition are working, and inform HealthWatch's annual report to Parliament.
- We will maintain our commitment to extending patients' choice of "Any Qualified Provider", but we will do this in a much more phased way, and will delay starting until April 2012. Choice of Any Qualified Provider will be limited to services covered by national or local tariff pricing, to ensure competition is based on quality. We will focus on the services where patients say they want more choice, for example starting with selected community services, rather than seeking blanket coverage. There will be

some services, such as A&E and critical care, where Any Qualified Provider will never be practicable or in patients' interests.

- Following the Future Forum's recommendation, we will carry out further work on the feasibility of a citizens' 'Right to Challenge' poor quality services and lack of choice.

Competition

- Monitor's core duty will be to protect and promote patients' interests.
- We will remove Monitor's powers to "promote" competition as if it were an end in itself. Monitor will be limited to tackling specific abuses and unjustifiable restrictions that demonstrably act against patients' interests, to ensure a level playing field between providers. Monitor will be required to support the delivery of integrated services for patients where this would improve quality of care for patients or improve efficiency.
- The NHS Commissioning Board, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services, guided by the mandate set by Ministers. This includes guidance on how services should be bundled or integrated.
- We will narrow Monitor's powers over anti-competitive purchasing behaviour so that these are more proportionate and focus on preventing abuses rather than promoting competition.
- We will remove Monitor's powers to open up competition by requiring a provider to allow access to its facilities to another provider.
- We will maintain the existing competition rules for the NHS introduced by the last Government (the Principles and Rules for Co-operation and Competition), and give them a clearer statutory underpinning. The body that applies them, the Co-operation and Competition Panel will transfer to Monitor and retain its distinct identity.
- We will retain our proposals to give Monitor concurrent powers with the Office of Fair Trading, to ensure that competition rules

can be applied by a sector-specific regulator with expertise in healthcare. The Future Forum recommended that this was the best safeguard against competition being applied disproportionately. The Bill does not change EU competition law.

Safeguards against privatisation

- Competition will be on the basis of quality not price. We will create additional safeguards against price competition and "cherry picking".
- So that providers cannot "cherry pick" the profitable, "easy" cases, services will be covered by a system of prices that accurately reflect clinical complexity, except where this is not practical. Commissioners will be required to follow "best value" principles when tendering for non-tariff services, rather than simply choosing the lowest price.
- We will outlaw any policy to increase the market share of any particular sector of provider. This will prevent current or future Ministers, the NHS Commissioning Board or Monitor from having a deliberate policy of encouraging the growth of the private sector over existing state providers – or vice versa. What matters is the quality of care, not the ownership model.
- We will require foundation trusts to produce separate accounts for NHS and private-funded services.

Integration of services

- In addition to revising Monitor's core duty, we will create a new duty for clinical commissioning groups to promote integrated services for patients, both within the NHS and between health, social care and other local services; and we will strengthen the existing duty on the NHS Commissioning Board.
- The NHS Commissioning Board will promote innovative ways of demonstrating how care can be made more integrated for patients: for example, by developing tariffs for integrated pathways of care, and exploring opportunities to move towards single budgets for health and social care. We will work with

organisations such as the King's Fund and the Nuffield Trust to develop these ideas further.

Providers

- We strongly expect that the majority of remaining NHS trusts will be authorised as foundation trusts by April 2014. It will not be an option to stay as an NHS trust, but there will no longer be a blanket deadline in the Bill for abolishing NHS trusts as legal entities. All NHS trusts will be required to become foundation trusts as soon as clinically feasible, with an agreed deadline for every trust. The stringent tests set by Monitor will remain and they will continue to obtain assurance from the Care Quality Commission as part of the authorisation process.
- To enable time for foundation trusts' governors to build capability in holding their boards to account, we will further extend, to 2016, the transitional period where Monitor retains specific oversight powers over foundation trusts.
- We will have an effective failure regime that ends the culture and practice of hidden bailouts and gets the right incentives into the NHS, whilst protecting essential services. But we have heard concerns about the practicality of our current proposals for an up-front system of designating services for additional regulation, and we will be amending the Bill accordingly.
- We will amend the Bill to require foundation trusts to hold their board meetings in public.
- We will introduce a "duty of candour": a new contractual requirement on providers to be open and transparent in admitting mistakes.

Education and training

- We will ensure a safe and robust transition for the education and training system, and will set out further details in the autumn. During the transition, deaneries will continue to oversee the training of junior doctors and dentists, and we will give them a clear home within the NHS family.
- We have set out broad proposals for ensuring all providers contribute to the costs of education and training. However, it is

vital that any changes to the funding of education and training must be introduced in a careful, phased way that does not create instability. We will therefore take the time to develop our proposals, working with our health and care partners and through further consultation, and we will publish more detail this autumn.

- To reinforce its importance, we will introduce an explicit duty for the Secretary of State to maintain a system for professional education and training as part of the comprehensive health service.

Health Overview & Scrutiny Committee Work Plan 2011/2012

Meeting Date	Work Programme
20th June 2011	1. Introduction to the Role & Remit of the Health Overview & Scrutiny Committee 2. Presentation by Lead Officer & Assistant Director on ongoing & future planned work within the Directorate 3. Report on Draft Work Plan for 2011/2012
6th July 2011	1. Report from the Cabinet Member for Health, Housing & Adult Social Services on the year ahead 2. Update from York Hospitals Foundation Trust & NHS North Yorkshire & York in relation to Transforming Community Services 3. Progress Report – NHS Reforms and the work of the Transition Board 4. Work Plan
21st September 2011	1. Six Monthly Update from York Teaching Hospital NHS Foundation Trust 2. Annual Performance Account for Adult Social Care 3. Update on the Implementation of the Recommendations Arising from the Childhood Obesity Scrutiny Review 4. Update on Dementia Strategy Action Plan 5. Quarter 1 Monitoring Report 6. Work Plan
30th November 2011	1. Six Monthly Update from NHS North Yorkshire & York 2. Update on the Implementation of the Recommendations Arising from the Carer's Review 3. Six Monthly Report in Relation to the Indicators being Monitored in Relation to Carers 4. Annual Update Report on the Carer's Strategy for York 5. Quarter 2 Monitoring Report 6. Work Plan
18th January 2012	1. Six –Monthly Update from Yorkshire Ambulance Service 2. Work Plan
14th March 2012	1. Quarter 3 Monitoring Report 2. Work Plan

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