Notice of a public meeting of

Health Overview & Scrutiny Committee

To: Councillors Funnell (Chair), Doughty (Vice-Chair), Riches, Hodgson, Fraser, Richardson and Cuthbertson

Date: Wednesday, 12 September 2012

Time: 5.00 pm

Venue: The Guildhall, York

A G E N D A

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

2. **Minutes** (Pages 5 - 26)
   To approve and sign the minutes of the meeting held on 23 July and 6 August 2012.

3. **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 **Tuesday 11 September 2012** at **5:00 pm**.

4. **Local HealthWatch York: Progress Update** (Pages 27 - 32)
This report updates the Health OSC on the progression from LINks (Local Involvement Networks) to Local HealthWatch by April 2013.

5. **Introduction from the new Director of Public Health (DPH) - Challenges and Priorities for the DPH**
The Director of Public Health will be in attendance at the meeting to give a verbal report on the challenges and priorities in his role.

6. **Progress Briefing on the Major Trauma Network** (Pages 33 - 36)
This briefing note provides Members with information on the Major Trauma Network arrangements for Major Trauma events in York (and surrounding areas), the implementation plan in place, progress to date and next steps in the process.

7. **Proposal to Redesign Older People's Mental Health Services and Enhance Provision of Community Care and Support** (Pages 37 - 50)
This report presents Members with a report from Leeds and York Partnership NHS Foundation Trust on proposals to redesign older people's mental health services and enhance the provision of community care and support. Their report is at **Annex A** to this report. Members are asked to consider whether the proposed redesign is a substantial variation to service.

8. **2012-13 First Quarter Financial & Performance Monitoring Report for Adult Social Services** (Pages 51 - 60)
This report analyses the latest performance for 2012/13 and forecasts the outturn position by reference to the service plan and budgets for all of the relevant services falling under the responsibility of the Director of Adults, Children & Education.

9. Consultation on Local Authority Health Scrutiny (Pages 61 - 94)

This report asks Members to consider and comment upon the consultation document at **Annex A** to this report and the draft proposed response at **Annex B** to this report.

10. Consultation on the Mandate to the NHS Commissioning Board (Pages 95 - 128)

This report asks Members to consider and comment upon the consultation document at **Annex A** to this report and the draft proposed response at **Annex B** to this report.

11. Work Plan for 2012-13 (Pages 129 - 132)

Members are asked to consider the Committee's updated work plan for the municipal year 2012/13.

12. Urgent Business

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

Democracy Officer:

Name: Judith Betts

Contact details:

- Telephone- (01904) 551078
- E-mail- judith.betts@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

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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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If you have any further access requirements such as parking close-by or a sign language interpreter then please let us know. Contact the Democracy Officer whose name and contact details are given on the order of business for the meeting.

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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 Corporate Scrutiny Management Committee (CSMC). That CSMC 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

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Agenda Item 1

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Agenda item 1: Declarations of interest.

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

Councillor Doughty	Volunteers for York and District Mind and partner also works for this charity. Member of York NHS Foundation Teaching Trust.
Councillor Funnell	Member of the General Pharmaceutical Council Trustee of York CVS
Councillor Hodgson	Previously worked at York Hospital
Councillor Richardson	Frequent user of Yorkshire Ambulance Service due to ongoing treatment at Leeds Pain Management Unit. Member of Haxby Medical Centre Niece works as a staff district nurse for NHS North Yorkshire and York.
Councillor Riches	Council appointee to the governing body of York Hospital Member of UNITE

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City of York Council Committee Minutes

MEETING	HEALTH OVERVIEW & SCRUTINY COMMITTEE
DATE	23 JULY 2012
PRESENT	COUNCILLORS FUNNELL (CHAIR), RICHES, HODGSON, JEFFRIES (SUBSTITUTE FOR COUNCILLOR BOYCE), DOUGHTY (VICE-CHAIR), RICHARDSON AND CUTHBERTSON
APOLOGIES	COUNCILLOR BOYCE
IN ATTENDANCE	COUNCILLOR STEWARD
	JOHN BURGESS (YORK MENTAL HEALTH FORUM)
	JOHN YATES (YORK OLDER PEOPLE'S ASSEMBLY)
	JANE PERGER (YORK LOCAL INVOLVEMENT NETWORKS (LINKS))
	JACKIE CHAPMAN (YORK LINKS)
	CAROL PACK (YORK LINKS-NORTH BANK FORUM)
	LESLEY PRATT (YORK LINKS)
	MICHELE MORAN (LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST)
	ALAN ROSE (YORK TEACHING HOSPITAL NHS FOUNDATION TRUST)
	SALLY HUTCHINSON (AGE UK, YORK)
	DIANE ROWORTH (YORK BLIND AND PARTIALLY SIGHTED SOCIETY)

ANGELA PORTZ (YORK COUNCIL FOR VOLUNTARY SERVICE)

DAVID SMITH (YORK MIND)

SALLY BURNS (CITY OF YORK COUNCIL)

ADAM GRAY (CITY OF YORK COUNCIL)

PAUL MURPHY (CITY OF YORK COUNCIL)

EOIN RUSH (CITY OF YORK COUNCIL)

RICHARD TASSELL (CITY OF YORK COUNCIL)

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10. DECLARATIONS OF INTEREST

Members were invited to declare at this point in the meeting any personal, prejudicial or disclosable pecuniary interests, other than those listed on the standing declarations attached to the agenda, that they might have had.

Councillor Doughty declared his standing personal interest that his partner worked for York and District Mind.

Councillor Hodgson declared his standing personal interest that he had previously worked at York Hospital. He also declared a further personal interest in the remit of the Committee as a member of UNISON.

Councillor Jeffries also declared a personal interest in the general remit of the Committee as the Co-Chair of York Independent Living Network.

Councillor Riches declared personal interests in the general remit of the Committee as the Council appointee on the governing body of York Hospital and a member of UNITE.

Councillor Richardson also declared personal interests in the general remit of the Committee as a frequent user of York Ambulance Service and as a member of Haxby Medical Centre.

He also declared that his niece worked as a staff district nurse for NHS North Yorkshire and York. He requested that these interests be added as standing interests.

No other interests were declared.

11. MINUTES

RESOLVED: That the minutes of the meeting of the Health Overview and Scrutiny Committee held on 26 June 2012 be approved and signed by the Chair as a correct record subject to the following amendment;

- Minute Item 3 (Public Participation) "Both the Health and Wellbeing Board *and Health Watch* would be integral in sharing information about this process".

12. PUBLIC PARTICIPATION

It was reported that there had been three registrations to speak under the Council's Public Participation Scheme.

David Smith from York District Mind spoke regarding Agenda Item 7 (Presentation on the Health and Wellbeing Strategy) about the proposed membership and structure of the York Health and Wellbeing Board. He expressed concerns on the process used for establishing the Health and Wellbeing Board's strategy groups, and felt that voluntary sector groups in mental health had not been consulted properly.

Jackie Chapman from York LINks spoke about the introduction of a passport for those with neurological conditions. She informed the Committee of how the passport would be kept within the patient's medical notes, and it could be transferred to travel with the patient wherever they were treated. A copy of the passport was circulated at the meeting and was attached to the agenda post-meeting.

John Yates from York Older People's Assembly spoke regarding Agenda Item 9 (Work Plan 2012-13 and Briefing Notes on Scrutiny Topics Proposed at the Scrutiny Work Planning Event).

In relation to Community Mental Health Services in Care of Adolescents (particularly boys) he stated that although the briefing note referenced harm to and from young people, it did not mention self harm. He added that some young people with mental health problems had a tendency to self harm, and felt that this should be explored particularly given York's large student population. Finally he sought clarification on whether those who self harmed were referred to Mental Health Services from the Hospital and Ambulance Service.

He also spoke about the Access to Talking Therapies briefing note and felt that the significance of good mental health to wellbeing was often underestimated or not understood by the general public. He urged the Committee to investigate this topic further.

13. ATTENDANCE OF THE CABINET MEMBER FOR HEALTH, HOUSING & ADULT SOCIAL SERVICES

The Cabinet Member for Health, Housing & Adult Social Services, attended the meeting and presented her annual report to the Committee.

Questions from Members to the Cabinet Member focused on the following issues;

- The Council's Day Services for those with Learning Disabilities, in particular the move towards personal budgets and representation on the Project Board which would review the Council's day services.

- The new criteria and approaches to funding community care services through Fair Access to Care Services (FACS) framework.

- Living accommodation for York residents with Learning Disabilities.

In relation to Learning Disability representation on the Project Board for the review of Council's Day Services, it was reported that although the Board's membership included Care Managers, that service users did not sit on the Board but that there was an option to have this in the future. The Chair asked for the Cabinet Member to supply further information on service user representation on the Project Board to Members of the Committee.

Discussion on the funding of FACS took place, and Members asked if an appeals process would be put in place for those whose needs had been assessed at a lower level than before. Some Members pointed out that recently a large number of residents had been assessed wrongly and that serious concerns and confusion over the new system had been expressed by those who used the funding to pay for their care needs.

The Cabinet Member admitted that an administrative error had taken place which had led to the production of incorrect assessment letters. However, the Cabinet Member stated that lower levels of funding for social care services meant that there was not enough money to maintain funding for all of those residents who had previously been eligible for support.

In relation to accommodation for those with Learning Disabilities the Cabinet Member reported that 48% of residents with Learning Disabilities in York were not living within families but were either living in Council Housing or Social Housing schemes. Members asked for figures on how many of these people had made that choice personally, or whether it was determined by their carers.

The Cabinet Member informed the Committee about how she felt that social care services in the city should move towards a more preventative model, to ensure that residents within the system did not have to be reliant on care.

The Chair of the Committee thanked the Cabinet Member for her attendance at the meeting.

14. LOCAL HEALTHWATCH YORK: PROGRESS UPDATE

Members received a report which updated them on the progression from LINks (Local Involvement Networks) to Local HealthWatch by April 2013.

Members asked Officers questions about the following;

- Lay representation in the procurement process
- The cost of the 'signposting' element of PCT Patient Advice and Liaison Services (PALS) teams
- Government guidance in relation to the structure of Local Health Watch

It was reported that a Job Description had been produced in order to recruit a lay member to be involved in the HealthWatch procurement process. In relation to costs of the signposting element of PALS, Members were told that a very small percentage of the current PALS budget was used for this function.

It was underlined that funding for HealthWatch would not be ringfenced, and that officers felt that government guidance in relation to the day to day running of HealthWatch would not be highly prescriptive.

RESOLVED: That the report be noted.

REASON: To oversee the transition from LINks to HealthWatch is identified as a priority in the Health Overview and Scrutiny Work Plan.

15. 2011-12 YEAR END FINANCIAL & PERFORMANCE MONITORING REPORT FOR ADULT SOCIAL SERVICES

Members received a report which analysed the outturn performance for 2011/12 and the financial outturn position by reference to the service plan and budgets for all of the relevant services falling under the responsibility of the Director of Adults, Children & Education.

In relation to the report, Members raised the following concerns;

- That unobtainable targets should not be placed on timeliness of social care assessments.
- That users of Mental Health Services who were receiving Self Directed Support were not being included in the performance analysis figures.

Officers informed Members that the method of social care assessments had been changed, in that longer assessments were being conducted, as it was felt that a snapshot of a person's needs could not be obtained over a week.

In response to a question from a member of the public, they added that they recognised that issues of non availability of Mental Health Services had arisen, but that they were not aware of instances where there had not been sufficient funding for it.

RESOLVED: That the report be noted.

REASON: To update the Committee on the latest financial and performance position for 2011/12.

16. PRESENTATION ON THE HEALTH AND WELLBEING STRATEGY

Members received a presentation from the Director of Communities and Neighbourhoods about the Health and Wellbeing Strategy.

The Committee were informed about a number of updates to the presentation including;

- That a new Director of Public Health had been appointed, Paul Edmondson-Jones, who would join the Council in August.
- That an officer had been seconded into a team to look at cases that had arisen from the Marmot Review.
- That the Association for Public Service Excellence (APSE) had commissioned the Council to conduct a study into how to get people involved in Public Health.

It was hoped that the APSE work would look at issues of health inequalities in the city, and would help to facilitate debate on issues of Public Health across York.

Members underlined that it was crucial to have relevant people involved on the Shadow Health and Wellbeing Board, rather than identifying which groups should be represented.

Some Members questioned why some groups had not been consulted in getting involved on the Board. It was commented that half of those involved in the Shadow Health and Wellbeing Board at their last meeting in July were from the Council. Officers admitted that a greater balance needed to be made, and felt that a representative from Local HealthWatch should be involved in the Board.

A comment that sub groups of the Shadow Health and Wellbeing Board should be properly resourced, was made. This would mean the sub groups would have be able to have their own terms of reference and secretariat, which would ensure that their views and work was examined by the Board.

Members were informed that it was hoped that the Draft Health and Wellbeing Strategy would be completed by November, and then signed off in December. It was noted that community consultation on the strategy would take place in September. For reference, a copy of the presentation was attached to the agenda post-meeting.

RESOLVED: That the report be noted.

REASON: To update the Health Overview and Scrutiny Committee on developments in the production of York's Health and Wellbeing Strategy.

17. VERBAL UPDATE ON CHILDREN'S CARDIAC SURGERY- DECISION OF THE JOINT COMMITTEE OF PRIMARY CARE TRUSTS

The Chair gave a verbal update to the Committee on recent developments that had taken place in relation to children's cardiac surgery and informed the Committee of the decision of the Joint Committee of Primary Care Trusts (JCPCT) in relation

to which centres would continue to provide cardiac surgery in the future.

It was reported that the decision of the JCPCT was to close a centre in Leeds, and to move children's cardiac surgery provision to a centre in Newcastle.

It was also reported that the Joint Health Overview and Scrutiny Committee, which was composed of representatives from all Local Authorities across the Yorkshire and Humber area, would examine the decision and the implications of this. The Chair informed the Committee that the Joint Health OSC was due to meet to discuss the implications of the decisions. She informed Members that she would keep Members up to date with progress.

Members were asked to agree to the continuing appointment of the Chair (with the Vice Chair acting as substitute) to the Joint Health Overview and Scrutiny Committee.

The Scrutiny Officer informed the Committee that she would bring a written progress report on the work of the Joint Health Overview and Scrutiny Committee to the October meeting, this would also include information on a forthcoming consultation on adult cardiology services and the likely continuation of the Joint Committee to respond to this.

RESOLVED: (i) That the verbal update be noted.

(ii) That the continuing appointment of the Chair (with Vice-Chair acting as Substitute) to the Regional Joint Health Overview and Scrutiny Committee be agreed.

(iii) That a future report on the work of the Joint Health Overview and Scrutiny Committee regarding Children's Cardiac Surgery be brought to the October meeting of this Committee (to also include information on a national consultation about adult cardiology services).

REASON: In order to keep the Committee informed of circumstances and current issues surrounding the provision of children's cardiac surgery.

18. WORK PLAN 2012-13 AND BRIEFING NOTES ON SCRUTINY TOPICS PROPOSED AT THE SCRUTINY WORK PLANNING EVENT HELD ON 2 MAY 2012

Members considered a report which outlined the Committee's work plan for 2012-13 and a set of briefing notes on scrutiny topics that were proposed at the Scrutiny Work Planning Event which was held on 2 May 2012.

Proposed briefing notes were considered which looked at the following areas;

- Personalisation
- Community Mental Health Services in Care of Adolescents (particularly boys)
- Access to talking therapies
- Mental Health Day Services for Older People

In relation to the Briefing Note on Personalisation, Some Members felt that a review needed to be conducted because they felt that the process for accessing Council services was too prescriptive, and that the process needed to reflect the experiences of service users.

Members decided that work on a review should be undertaken by a Task Group made up of Councillors Jeffries, Cuthbertson and a nominee from the Conservative group. It was suggested that due to a full work plan, that scoping work to identify a focus for the review could take place later this year with the actual review commencing early in 2013 (or earlier if the ongoing End of Life Care Review has been completed).

Regarding the topic on Community Mental Health Services in Care of Adolescents, some Members felt that a review should focus on the issue of self harm. It was agreed that some initial scoping work should take place to establish the best focus for a fairly short scrutiny review that would be likely to commence in the New Year.

The Scrutiny Officer agreed to e-mail the Committee for volunteers to sit on a Task Group to undertake both the scoping work and the review.

In response to the Briefing Note on Access to Talking Therapies, Members questioned whether service users and service user groups would be involved in future work on reducing waiting times.
A representative from Leeds and York Partnership NHS Foundation Trust confirmed that service user groups would be involved in future work, as their expertise would be welcomed.

A representative from York Mental Health Forum stated that as funding for Improving Access to Psychological Therapy Services (IAPT) still remained low and demand continued to be high, that an item on IAPT be added to the Committee's work plan. Members agreed that a regular report be presented on issues around IAPT, but suggested that it be scheduled in at a later date due to the heavy workload for the Committee. Members decided not to progress this topic to review but agreed to exercise their overview role and have regular update reports in relation to this.

A representative from Age UK spoke regarding the proposed topic on Mental Health Day Services for Older People. She felt that it was crucial for the topic to be examined by the Committee due to continuing cuts and an increased demand for the services offered by them. She also felt that the topic was particularly relevant for future generations. On consideration of this topic Members decided not to progress it to review at the moment due to their already heavy workload.

Discussions between Members and Officers took place in regards to future reports for consideration and when these could be timetabled in the work plan. The Scrutiny Officer highlighted two current national consultations namely;

- National Consultation on Local Authority Health Scrutiny
- National Consultation on the National Mandate on NHS Commissioning

The Committee agreed to schedule these into the Committee's work plan for September in order to meet the deadlines for comments.

It was suggested that the new Director of Public Health be invited to attend the Committee's September meeting to introduce himself and discuss his forthcoming challenges and priorities.

Further to this it was agreed that the attendance of NHS North Yorkshire and York and the Vale of York Clinical Commissioning Group and the update report on changes to the Urgent Care Unit at York Hospital be moved to the Committee's October meeting.

RESOLVED:

(i) That the work plan and briefing notes be noted.

(ii) That a Task Group composed of Councillors Cuthbertson, Jeffries and a nominee from the Conservative group be formed to undertake the work on the agreed review around Personalisation.

(iii) That a Task Group be formed (membership to be confirmed) to undertake the work on the agreed review around Community Mental Health Services in Care of Adolescents (particularly boys).

(iv) That two items be added to the Committee's work plan (dates to be confirmed) to consider the scoping work and potential remits suggested by the two Task Groups above

(v) That the following items be added to the Committee's work plan;

- September 2012 - A report on the National Consultation on Local Authority Health Scrutiny.

- September 2012 - A report on the National Consultation on the National Mandate on NHS Commissioning.

- October 2012 - An update report on the work of the regional Joint Health Overview and Scrutiny in relation to the provision of children's cardiac surgery and adult cardiology services.

- October 2012 - The attendance of the new Director of Public Health

- October 2012 - The attendance of NHS North Yorkshire and York and the Vale of York Clinical Commissioning Group (moved from September 2012)

- October 2012 – An update report on the changes to the Urgent Care Unit at York Hospital (moved from September 2012).

- Date to be confirmed - An update report on issues around Improving Access to Talking Therapies.

REASON: In order to keep the Committee's work plan up to date.[1]

Action Required

1. To update the Committee's Work Plan TW

Councillor C Funnell, Chair

[The meeting started at 5.00 pm and finished at 7.45 pm].

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City of York Council Committee Minutes

MEETING	HEALTH OVERVIEW & SCRUTINY COMMITTEE
DATE	6 AUGUST 2012
PRESENT	COUNCILLORS FUNNELL (CHAIR), RICHES, HODGSON, RICHARDSON, WISEMAN (SUBSTITUTE), CUTHBERTSON AND FRASER
IN ATTENDANCE	PHIL BAINBRIDGE (YORKSHIRE AMBULANCE SERVICE) JANET PAWELEC (YORKSHIRE AMBULANCE SERVICE) JOHN BURGESS (YORK MENTAL HEALTH FORUM) LESLEY PRATT (YORK LOCAL INVOLVEMENT NETWORK (LINK)) EMMA JOHNSON (ST LEONARD'S HOSPICE) KEITH KOCINSKI (NHS NORTH YORKSHIRE AND YORK) LIBBY MCMANUS (YORK TEACHING HOSPITAL NHS FOUNDATION TRUST) DOCTOR ALASTAIR TURNBULL (YORK TEACHING HOSPITAL NHS FOUNDATION TRUST) DOCTOR ANNE GARRY (YORK TEACHING HOSPITAL NHS FOUNDATION TRUST) DOCTOR MIKE HOLMES (HARROGATE AND DISTRICT FOUNDATION TRUST) JANET PROBERT (HARROGATE AND DISTRICT FOUNDATION TRUST)

	CHRIS BUTLER (LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST) STACEY MCCANN (VALE OF YORK CLINICAL COMMISSIONING GROUP) GWEN VARDIGANS (YORK BRANCH, ROYAL COLLEGE OF NURSING) KEREN WILSON (INDEPENDENT CARE GROUP) KATIE SMITH (YORK CARERS FORUM) IRENE MACE (YORK CARERS FORUM) SIAN BALSOM (YORK COUNCIL FOR VOLUNTARY SERVICE) GEORGE WOOD (YORK OLDER PEOPLE'S ASSEMBLY) JOHN YATES (YORK OLDER PEOPLE'S ASSEMBLY) ALAN HARDACRE (NORTH YORKSHIRE POLICE) KATHY CLARK (CITY OF YORK COUNCIL) BIDDY CHEETHAM (CITY OF YORK COUNCIL) AMANDA GREENSMITH LINDA NICHOLSON ANNE LEONARD
APOLOGIES	COUNCILLOR DOUGHTY

19. DECLARATIONS OF INTEREST

Members were invited to declare at this point in the meeting any personal, prejudicial or disclosable pecuniary interests, other than those listed on the standing declarations attached to the agenda, that they might have had.
Councillor Cuthbertson declared a personal interest in the business on the agenda as an ongoing patient at York Hospital.

Councillor Fraser declared a personal interest in the business on the agenda as a Council appointee to the York Hospital Board of Governors. He also declared a personal interest in the general remit of the Committee as a retired member of UNISON and Unite (TGWU/ACTS sections).

Councillor Hodgson declared personal interests in the general remit of the Committee as a member of the York Co-operative Party and UNISON.

Councillor Wiseman declared personal interests in the business on the agenda as a Public Governor of York Teaching Hospital NHS Foundation Trust and as a member of the Shadow Health and Wellbeing Board.

No other interests were declared.

20. PUBLIC PARTICIPATION

It was reported that there had been one registration to speak under the Council's Public Participation Scheme.

George Wood from York Older People's Assembly spoke regarding item Agenda Item 3 (Interim Report-End of Life Care Review 'The Use and Effectiveness of DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) Forms'). He highlighted to Members that patients and close relatives would be at their most vulnerable if they were in a situation when they had to decide whether or not to allow for CPR to be performed.

In reference to the NHS leaflet at Annex G to the report ("What happens if my heart stops?") which was attached at Annex G to the agenda, he felt that the publicity and availability of the leaflet had a high value in that it could prompt discussions between patients and GPs around a very sensitive subject.

21. INTERIM REPORT- END OF LIFE CARE REVIEW 'THE USE & EFFECTIVENESS OF DNACPR FORMS'

Members considered a report which updated them on progress that had been made in relation to their review on End of Life Care. It also asked them to discuss further some of the issues raised to date and to identify the next steps in the review.

The Clinical Director of Unscheduled Care and the Director of Partnerships and Innovation from Harrogate and District Foundation Trust (who had the contract to run the York and Selby Out of Hours Service) presented papers to the Committee, which were attached at Annexes H-H4 to the report.

In addition to the information contained within their report they highlighted the following key points:

- There were concerns about some of the anecdotal evidence that had previously been received as part of this review and the Out of Hours Service were concerned that these comments were taken in context of how their service operated. The Out of Hours Service saw approximately 130, 000 patients a year and provided a range of different services. Much of the time everything ran very smoothly, however when dealing with this many patients then occasionally the service would not get everything right

- Decisions to put a DNACPR order in place lies with the 'in hours' service i.e. with the patient's GP or with the hospital.

- The Out of Hours Service does not have a role in putting DNACPR orders in place as they have little prior knowledge of the patient – it would therefore be deemed inappropriate.

- This was a multi-step process and unfortunately there were some problems with the various different IT systems and how they communicated with each other.

- Varying degrees of access to patients records between hospital, GPs and Out of Hours Service.

- The call handling service for the Out of Hours Service is operated by Yorkshire Ambulance Service; when a patient or their carer/relative phones in distress this can trigger an ambulance response.

- DNACPR does not mean ‘do not treat’ – we have to be clear what we are discussing here – admitting a patient to hospital, even if there is a DNACPR in place, is not always the wrong thing to do.

- Since the provider arm of the Primary Care Trust (PCT) was split the Out of Hours (OOH) service was operated by Harrogate and District Foundation Trust and the District Nurses by York Teaching Hospital NHS Foundation Trust – the two organisations had slightly different agendas and the two were slightly less joined up than when one organisation had responsibility for both.

- Challenges for the OOH with decreasing budget over the past five years but an increase in activity.

- Concerns about what impact the NHS 111 Service will have on OOH – this could increase OOH workload but with no extra resources available.

- If looking for ways of improving – there was a need for a better flow of interagency communication.

Members asked questions around access to medical records, ongoing projects within IT and where the NHS was at with improving continuity and information sharing. In response a representative from Harrogate and District Foundation Trust said that some parts were now standardised but interfaces between different IT systems presented difficulties. There was a national ongoing project around this but there did not appear to be any timescales for completion.

In North Yorkshire there was no ongoing active work around this so it would continue to be a challenge. However, the NHS were committed to working in partnership and trying to improve systems.

Questions were asked around how the new NHS 111 Service would work alongside the OOH Service. In response it was highlighted that there were potential issues around when the NHS 111 Service's software said that a patient needed to see a GP.

There were concerns that the percentage of telephone triage would reduce and the OOH Service would need to see many more patients face to face – this would have a knock on effect on the OOH Service's capacity to respond; especially as there were no plans to provide any extra clinicians. There were currently very few doctors to cover a very large geographical area across York and North Yorkshire. For example there was only one OOH Doctor for the York and Selby area.

Discussion was had around the low number of DNACPR forms in place for people with an expected death. It was felt that more robust policies needed to be put in place with the OOH being made more aware of when a DNACPR order had been put in place. The Medical Director at York Hospital highlighted the importance of sharing information as much as possible and said that most GPs could access hospital records for a patient and vice-versa; however this did not currently stretch to the OOH Service. There was also a need to be mindful of only sharing information about a patient with those who needed it and there were regulations that all were bound by in relation to this.

It was difficult to store DNACPR forms electronically as they were essentially 'live' documents that should be reviewed at frequent intervals. The form should also travel with the patient and not be kept by the GP or the hospital.

However, despite some of these challenges it was felt that information sharing was fairly good but improvements needed to be made to further share information on DNACPR with the OOH Service and make them aware when these were in place.

Discussions widened to 'how can we do something together with the public around the delicate subject of End of Life Care?' It was noted that it was a sensitive issue and that the review only touched on one area of this subject.

A representative from York Carer's Forum felt that community meetings could provide a chance for discussion and input into the successful use of the DNACPR form and believed that people would welcome the opportunity to have an input into this debate.

Further discussion led to it being said that there was a need for increased awareness around having End of Life Care discussions and there was room for a broader public debate on this.

A representative from the Independent Care Group felt that whilst we had come a long way in this area, stronger connections needed to be made between GPs, OOH Service, Yorkshire Ambulance Service and Care Homes. All partners had a responsibility to ensure that a patient's wishes were being carried out. She also spoke about how some patients with neurological problems in care homes had an "advanced decision" document and asked how this would sit alongside a DNACPR order.

Members were informed that an advanced decision document was a legally binding contract, which allowed the patient to refuse treatment. In comparison to a DNACPR, it could also be interpreted differently, for example if an unforeseen circumstance occurred, medical practitioners might resuscitate a patient, against the decision, but this could not happen if an 'advanced decision' document were in place.

Discussion took place on the proposed reform of the DNACPR form in 2013, and further publicity about the form and options for End of Life Care. It was reported that there was an option on the form that would allow for the form to be completed at a patient's request. The Chair suggested that family members and the voluntary sector be involved in the group that would review the form.

Officers at City of York Council spoke about promotion of the form and information sharing and stated that this would be useful within the development of Neighbourhood Care Teams.

Further people spoke about how the focus on End of Life Care needed to be broader, and that more information should be shared at an earlier stage. This would then avoid the sense that it was a subject that was too difficult to talk about.

In addition it was also suggested that the DNACPR form was only one part of the End of Life Care Review, and that it was important that people knew what other options were available to them, such as Living Wills.

Discussions moved to some possible areas where recommendations could be made namely:

- Better press and publicity around End of Life Care issues in general leading to increased public awareness and willingness to have conversations around this subject.
- Improvements to information sharing between the different agencies involved.

- Improvements to IT systems.

- Partnership working between Clinical Commissioning Group and City of York Council (using Neighbourhood Care Teams).

- Reviews of DNACPR forms already in place are done in a systematic way.

- Further work on 'advanced decisions' and DNACPR orders and how these can be used side by side.

RESOLVED: (i) That the report be noted.

(ii) That a draft final report on this review be prepared for a future meeting of the Health Overview and Scrutiny Committee.[1]

REASON: In order to progress the review towards completion.

Action Required

1. To add to the Work Plan TW

Councillor C Funnell, Chair
[The meeting started at 5.05 pm and finished at 6.15 pm].

Health Overview and Scrutiny Committee **12th September 2012**

Report of the Head of Neighbourhood Management

Local HealthWatch York: Progress Update

Summary

1. To update the Health OSC on the progression from LINks (Local Involvement Networks) to Local HealthWatch by April 2013.

Background

2. Subject to parliamentary approval, Local HealthWatch will be the local consumer champion for patients, service users and the public. It will have an important role in championing the local consumer voice, not least through its seat on the Health and Wellbeing board.

3. On 4th January 2012 the Department of Health (DoH) announced that Local Authorities are now not required to provide Local HealthWatch functions until 1st April 2013, 6 months later than had originally been anticipated.

4. The new date for establishing Local HealthWatch in April 2013 will support the need to align this more closely to the establishment of other new local bodies such as Health and Well Being Boards (HWBs). The extension will also support preparations for the implementation of HealthWatch England (which will still be established in October 2012) to provide the leadership and support to Local HealthWatch organisations.

Commissioning Process – Proposed Timescales

5. Although the new deadline gives an additional six months before the launch of Local HealthWatch it is recommended that the procurement process should begin in time to allow a managed handover. The tender process for HealthWatch will be launched by mid September 2012, with a contract award of late November 2012. The successor body will have time to work alongside the current LINk in order to manage the handover process, secure premises, recruit / train staff and undertake marketing and promotional activity.

6. There will be two separate contract lots as part of the same tender process - one for Local HealthWatch and one for a local NHS Complaints Advocacy service.

7. At the Shadow Health and Wellbeing Board (SHWB) meeting in December 2011 it was suggested that a draft HealthWatch Service specification was produced by February 2012. Given the extended timescales, a revised timetable is suggested as follows.

July:	HealthWatch Supplier Event held
	Draft Service Specifications finalised
Aug:	CYC Portfolio holder to agree final service specifications.
	Announcement of intent to tender – to stimulate the market and encourage collaborative approaches
Sept:	Issue of tender documentation
Oct:	Closing date for responses
Nov:	Contract Award (The full contract will commence April 2013, but the provider will initiate some transitional work beforehand to ensure a smooth handover)

Further Points to Note

8. In order to stimulate the market City of York Council hosted a Local HealthWatch Supplier Day on 4th July, which was well attended by both local, regional and national suppliers.

9. It has been agreed by the Health and Wellbeing Board that two lots are procured - Local HealthWatch and NHS Complaints Advocacy. This may result in two separate providers or may allow a single provider to compete for, and hold both contracts. Alternatively, the delivery of NHS Complaints Advocacy services could be more closely connected to the wider advocacy provision in the City through this approach.

10. In respect of Complaints Advocacy, detailed discussions were held with other Councils in Yorkshire and the Humber to consider a joint procurement exercise. Rather than this approach it has been agreed to ensure regional co-ordination by developing similar specifications / timescales to ensure regional synergy (rather than a combined regional contract).

11. Further guidance is due to be issued imminently by the DoH around the structure / constitution of Local HealthWatches, and the types of delivery models that are permissable. In lieu of this guidance being issued CYC officers are working towards the production of a service specification / tender process which will allow a variety of delivery models to be brought forward.

12. The overarching outcomes and objectives within the service specification will closely align with those contained within York's forthcoming Health and Wellbeing Strategy and the wider community engagement processes of CYC.

13. HealthWatch Tenders will be assessed by a panel of CYC Adult Social Care Commissioners and senior Neighbourhood Management staff. To ensure impartiality and a fresh perspective an independent lay person has also been appointed to the Tender Evaluation Panel. The lay person was appointed as a result of meeting all the requirements contained within a detailed person specification - openly advertised across local and regional networks.

Several expressions of interest were received from LINk and other lay person representatives in neighbouring authorities but a decision was taken to appoint a local resident who possessed the requisite skills and knowledge, and was not in any way associated or aligned to prospective suppliers.

Options

14. This report is for information only report, there are no specific options for members to decide upon.

Analysis

15. Please see above.

Council Plan 2011/2015

16. The establishment of Local HealthWatch in York will make a direct contribution to the following specific outcomes listed in the draft City of York Council Plan:
    - Improved volunteering infrastructure in place to support increasing numbers of residents to give up their time for the benefit of the community
    - Increased participation of the voluntary sector, mutuals and not-for-profit organisations in the delivery of service provision

Implications

17. **Financial -** Local HealthWatch will be financed through three separate strands of funding as follows:

    - Existing government funding to Local Authorities to support the current LINks function will be rolled forward into HealthWatch.
    - Monies provided for the current 'signposting element' of PCT PALS teams will be transferred across to local authority budgets from April 2013.
    - Monies for NHS Complaints Advocacy will be transferred to local authorities in April 2013.

18. It should be noted that while an indicative sum of money will be provided to City of York Council under each of the above headings, none of these monies will be ringfenced i.e. they will be paid to City of York Council as part of various Adult Social Care formula grants. The definitive amount of monies transferring from NHS PALS and Complaints Advocacy budgets to local authorities has yet to be confirmed, although 'indicative' amounts have now been provided by the Department of Health.

19. City of York Council has the discretion allocate all these monies to Local HealthWatch, or allocate some of the funding to other health and social care priorities.

20. **Human Resources (HR)** - There are no human resource implications

21. **Equalities** - Establishing a successful Local HealthWatch in York will enable the targeting of support towards activities which contribute towards all the equality outcomes set out in the draft Council Plan. It will be a requirement of the successful organisation(s) delivering Local HealthWatch to demonstrate and evidence their commitment to equal opportunities in the work of their organisations, in line with the Equalities Act 2010

22. **Legal** - There are no legal implications

23. **Crime and Disorder -** There are no crime and disorder implications

24. **Information Technology (IT) -** There are no information technology implications

25. **Property -** There are no property implications

26. **Other** -There are no other implications

Risk Management

27. There are risks of challenge to the validity of City of York Council's procurement and commissioning process if a HealthWatch contract is let without full and proper consultation with City wide partners. The thorough consultation processes that will be followed through the HealthWatch Pathfinder process will mitigate this risk.

Recommendations

28. Members are asked to note the report and the latest progress towards establishing HealthWatch. A further update will be provided at the next Health OSC meeting.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Adam Gray Senior Partnership Support Officer (VCS) Office of the Chief Executive Tel. 551053	**Kate Bowers** Head of Neighbourhood Management
Report Approved ✓	**Date** 27.08.2012

Specialist Implications Officer(s) n/a

Wards Affected: **All** X

For further information please contact the author of the report

CITY OF YORK COUNCIL

Progress Briefing for the HEALTH OVERVIEW and SCRUTINY COMMITTEE

12th September 2012

Improving the Management and Treatment of Major Trauma across Yorkshire and the Humber

1. Background

1.1. Each region is mandated by the *Department of Health* to establish a major trauma network (MTN). NHS *North of England Specialised Commissioning Group* are leading this work.

1.2. The network system will involve changes to established patient flows. Patients will now be transported direct to a Major Trauma Centre (MTC) instead of first to local A&E, then on to a MTC as is currently commissioned. Service changes do not represent a service configuration or a significant variation to service delivery, but the formalisation, coordination and better use of existing services currently in place.

1.3. Regional major trauma systems will improve the safety, quality and consistency of major trauma treatment and care with specified minimum standards of care for all levels of service. Every hospital has a role in the network with patients receiving follow up care and rehabilitation as close to home as possible.

1.4. The incidence rate of major trauma across the Yorkshire and the Humber region numbers approximately three per day.

1.5. Across Yorkshire and the Humber, it is estimated that these improvements will save in excess of 100 lives a year while more people experiencing major trauma will be able to return to non-dependent life and work, rather than facing a life of long-term disability and unemployment.

2. Timescales

2.1. There are three phases to the pathway development for the adult trauma implementation plan. The work programme is currently in Phase 1 (2012/13).

2.2. This first operational year will use actual network activity to compare against capacity and financial predictive planning models.
Information gathering and gap analysis work will also inform service improvements in 2013-14.

2.3. Adult major trauma will be commissioned across the Yorkshire and Humber region from April 1st 2013 (Phase 2) against standards set out in a revised national service specification. Particular regional networks may well shadow some aspects of the delivery model that are expected to still be in a developmental phase (e.g. the tariff model payment for Recovery, Rehabilitation and Re-ablement).

3. Recent Developments

3.1. The proposal for three sub-regional MTNs for adult trauma serving the region's population was approved. MTCs are located at Hull, Leeds and Sheffield hospitals.

3.2. *York Teaching Hospital NHS Foundation Trust* (YTHFT) is part of the **North & East Yorkshire and Northern Lincolnshire** (NEYNL) sub-regional MTN linking to the MTC service delivered by the *Hull and East Yorkshire Hospitals NHS Trust* at the Hull Royal Infirmary site. People experiencing a major trauma incident within (and around) the City of York Council boundaries will be transported to this MTN.

3.3. YTHFT has interim designation as a Trauma Unit (TU). This was subject to the submission of a self-assessment against network standards and a plan on how the Trust would achieve core standards to which they were not yet compliant. The self-assessment process emphasised a regional need to focus on rehabilitation in 2012/13. The process to award full designation for MTCs and TUs will take place in 2013/14.

3.4. Once patients treated at MTCs are at a point in their care and recovery when they can be safely repatriated, they will be transferred to their local general hospital TU. Patients will receive follow up care and rehabilitation at YTHFT and as close to home as possible.

3.5. Depending on the location of the trauma incident and the distance to Hull (as well as any capacity constraints on the day), patients might alternatively be transported to the MTC in Leeds delivered by the *Leeds Teaching Hospitals NHS Trust* and part of the **West Yorkshire** sub-regional MTN.

3.6. Children's major trauma would be based on a two centre model at Leeds and Sheffield with a phased approach to implementation. (It had been confirmed that Hull would not be a major centre.)

3.7. Best Practice Tariff for major trauma has been introduced.

4. Phase I (2012/13)

- All patients assessed at the roadside using a standard national approach.
- Paramedic in the ambulance control room co-ordinating the decision making on admissions and transfers based on both the capacity at MTCs and clinical priority.
- All secondary transfers from a trauma unit to an MTC to be achieved within 48 hours. (If there is any dispute around the timing of referral and arrival at the MTC this will be subject to local resolution.)
- All transfers out of the MTC for repatriation/rehabilitation to be achieved within 48 hours.
- Robust Trauma Audit and Research Network (TARN) data will be submitted by all Units within 40 days of discharge.
- Rehabilitation prescriptions to be completed and recorded on TARN for all major trauma patients who would be provided with a copy. (In Phase 1, the documentation will be labelled as a 'Rehabilitation *Advice Note'* rather than a rehabilitation prescription.)
- Sub regional networks to be fully established with clear governance arrangements.
- Data and information collection and reporting systems will be established

  To inform the future development of the network. This will include a major trauma patient tracking system that will be managed by Yorkshire Ambulance Service.

5. **Phase 2 (2013/14)**

5.1. With the transition to the new health and social care system, the responsibility for the commissioning of major trauma will be with both the *National Commissioning Board* (commissioning of major trauma as a specialised service and complex rehabilitation (level 1 and 2); and the *Clinical Commissioning Groups* (commissioning of trauma unit services, trauma rehabilitation and ambulance services). Co-commissioning arrangements will be in place to coordinate the commissioning care across the patient pathway.

The commissioning principles upon which Phase 2 of the development of the major trauma network will be commissioned are:

5.2. As a minimum it is expected that MTN providers will achieve the standards set out in the service specification. The national service specification sets out standards required by MTCs, TUs and Ambulance Services while it is likely that there will be local additions to these standards. (The service specification is currently being revised.

5.3. The funding of major trauma will be solely via Payment by Result.

5.4. It is expected that NHS Trusts will provide commissioners with service development plans that set out the plans for the change required to deliver the standards and level of activity required. These plans will not just focus on major trauma service provision but will be set in the context of whole system development of services in the Trust. For instance improving major trauma care is likely to have a positive impact in orthopaedic, vascular, neurosurgical services.

5.5. There will be a Complex Rehabilitation new tariff (Level 1 and 2).

Author: Jim Khambatta
Snr Commissioning Manager
NHS North Yorkshire and York Cluster
Date: September 3rd 2012

Health Overview and Scrutiny Committee **12th September 2012**

Report of the Assistant Director Governance and ICT

Cover Report - Proposal to Redesign Older People's Mental Health Services and Enhance Provision of Community Care and Support

Summary

1. This report presents Members with a report from Leeds and York Partnership NHS Foundation Trust on proposals to redesign older people's mental health services and enhance the provision of community care and support. Their report is at **Annex A** to this report. Members are asked to consider whether the proposed redesign is a substantial variation to service.

Background

2. The background and further information in relation to the proposals is set out within the paper produced by Leeds and York Partnership NHS Foundation Trust and is at **Annex A** to this report.

Consultation

3. **Annex A** seeks agreement from this Committee for Leeds and York Partnership NHS Foundation Trust to proceed on the basis of a one month formal consultation period during September and October. Their rationale for a one month consultation period is that they believe that:

   '...this is not major service change; it is a reconfiguration of existing services and no service elements will be discontinued.'

4. Consultation with patients and the public will take place as set out within **Annex A** unless this Committee believes these proposals constitute a substantial variation.

Guidance on Substantial Variation

5. Health Scrutiny powers around service reconfiguration are focused on the impact of any proposed change/development and the robustness of any associated consultation arrangements.

6. The Department of Health Guidance on Health Scrutiny (published in July 2003) provides assistance to Health Overview and Scrutiny Committees by setting out some guiding principles when considering the nature of proposed service changes and/or developments.

7. The guidance states that, in considering whether proposals are substantial consideration should be given to the general impact of any change on patients, carers and the public who use or have the potential to use a service. Specifically, it is suggested that the following should be taken into account:

   - **Changes in accessibility of services** – both reductions and increases on a particular site

   - **Impact of proposal on the wider community** – including the economic impact and other issues, such as transport and regeneration.

   - **Patients affected** – changes may affect the whole population or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years.

   - **Methods of service delivery** – altering the way a service is delivered may be a substantial change.

Options

8. Members have the following options:

   Option 1 Agree this is not a substantial variation of service and the consultation proposals set out in Annex A to this report are acceptable

   Option 2 Agree the proposed redesign of this service does constitute a substantial variation to service and the full 12 week consultation period should be implemented

Analysis

9. The Associate Director, York and North Yorkshire Services from Leeds and York Partnership NHS Foundation Trust will be in attendance at the meeting to present the report and answer any questions that Members may have.

10. As mentioned in **paragraph 3** of this report and in **Annex A** Leeds and York Partnership NHS Foundation Trust do not believe that this is a substantial variation to service and are therefore proposing a one month formal consultation (a 'substantial variation' usually requires a longer consultation period).

11. Members are asked to consider all the information received to date and confirm whether they are happy with the proposals set out in **Annex A** or whether they feel the proposals to redesign this service constitute a substantial variation.

12. In weighing up the situation Members should be aware that a 'substantial variation or development' of health services is not defined in Regulations. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving large number of patients across a wide area. The key feature is that there is a major change to services experienced by patients and future patients. However a useful guide to follow is that set out in **paragraph 7** of this report.

13. Members may wish to ask the representative from the Trust about the changes they intend to make to the service and also about the proposed consultation process i.e. what it will be asking, who it will be asking it of and how the results from the consultation will be used to inform the redesign of this service. This is to enable Members to gain greater clarity on whether they feel the consultation process proposed is commensurate with the proposed changes. If, after this discussion, Members are satisfied that the proposals and the consultation period set out in **Annex A** are suitable then Leeds and York Partnership NHS Foundation Trust will be able to implement their consultation plan attached at **Appendix 1** to this report.

14. However, if Members feel that the service redesign constitutes a substantial variation to service then they should advise Leeds and York Partnership NHS Foundation Trust of this at today's meeting in order that they may consider changing their consultation plan to include a formal 12 week consultation period (the Committee would need to be able to justify its reasoning if they form the view that this is a substantial variation). If it is agreed that a proposal is a substantial variation the Trust must formally consult with the Overview and Scrutiny Committee and other stakeholders, including service users. Cabinet Office guidelines recommend that full consultations should last a minimum of 12 weeks; however it is possible for Health Overview and Scrutiny Committees and Health Trusts to reach agreement about a different timescale for consultation (even if the changes are deemed to be substantial); what is important is the quality of any consultation undertaken

Council Plan 2011-2015

15. The issues discussed within this report are directly associated with the theme of 'Protecting Vulnerable People' as set out in the Council Plan 2011-2015.

16. However the various health organisations working within the city are required to consult with the Health Overview and Scrutiny Committee on some of the more significant service changes.

Implications

17. **Financial** - There are no financial implications for City of York Council associated with the recommendations set out in this report.

18. **Human Resources (HR)** – There are no HR implications for City of York Council associated with the recommendations set out in this report.

19. There are no known other implications associated with the recommendations set out within this report.

Risk Management

20. There are no known risks associated with the recommendations within this report. However, Members should assure themselves that the most appropriate kind of consultation takes place in relation to this redesign of service.

Recommendations

21. Members are asked to consider the information received in the agenda papers and at today's meeting and decide whether they agree with Leeds and York Partnership NHS Foundation Trust that the proposed changes do not constitute a substantial variation of service.

    Reason: To ensure that the most appropriate consultation period is set for the proposed redesign of service.

Contact Details

Author:	**Chief Officer Responsible for the report:**
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Report Approved ✓ **Date** 29.08.2012

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A Report from Leeds and York Partnership NHS Foundation Trust - Proposal to redesign older people's mental health services and enhance provision of community care and support

Appendix 1 Consultation Plan

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Annex A

Leeds and York Partnership NHS
NHS Foundation Trust

Proposal to redesign older people's mental health services and enhance provision of community care and support

Introduction:

Older people's services in York and North Yorkshire have a track record of innovation and improvement over many years. This includes the establishment of a challenging behaviour service for men (Peppermill Court) and two recent projects with The Kings Fund looking at enhancing the healing environment. Leeds and York Partnership Foundation Trust is keen to make further quality improvements and to increase the range of alternatives to hospital care wherever possible.

We would like to enhance community options for older people and their families ensuring that hospital admission only occurs when this is the best option.

This paper sets out a proposal for a dedicated nursing home team and reconfiguration of in patient beds and asks for agreement from the City of York Council Health Overview & Scrutiny Committee to proceed.

Background

The older people's service currently provides the following key elements of a comprehensive specialist service:

- In-patient beds.
- Specialist community mental health teams, including Memory Services.
- Out-patient clinics.
- In-patient respite services.
- Day hospital services.
- Continuing care provision.

The inpatient service is supported by sectorised Community Mental Health Teams (CMHTs), providing assessment and treatment in the community. CMHTs work extended hours up to 8pm. At weekends a reduced service operates, providing support to people already known to the service.

Day services are provided within the three CUE units (Mill Lodge, Worsley Court and Meadowfields).

The current day service provides therapeutic assessment, management and day care support for a significant group of people who have been in receipt of a service for several years; but who in the main require social support and interaction. Respite for carers is also provided.

We are working with North Yorkshire & York commissioners and Local Authority colleagues to review day care across the area.

The York and North Yorkshire locality does not have other community focused teams such as intermediate care or crisis services for older people. Through our transformation programme we will review capacity and demand across all services; and evaluate whether there is a need for intermediate care and crisis services for older people. In the meantime we propose developing a Nursing Home Team which will offer older people enhanced support and will reduce current and future delayed discharges.

Nursing Home Team Model and Proposal:

Estimates of the numbers of older people in residential and nursing homes with mental health problems vary: the proportion of people with dementia in care homes is estimated at between 33% and 66%; and for people with depression (mostly undiagnosed and untreated) it is estimated that the proportion in care homes is about 40% (Audit Commission, 2000). Some will be in specialist homes, but the majority are receiving care in non-specialist care homes for older people. Support from specialist secondary health services have demonstrated prevention of admissions from care homes to hospital and transfer between homes; as well as promoting better practice amongst care home staff and boosting staff confidence and morale.

We propose to improve the way that we provide this support in York and North Yorkshire services through the establishment of a nursing home team. This team will also help to improve the pathway out of NHS inpatient services into residential and nursing homes, helping to prevent delayed discharge.

Success criteria for this service will therefore include:

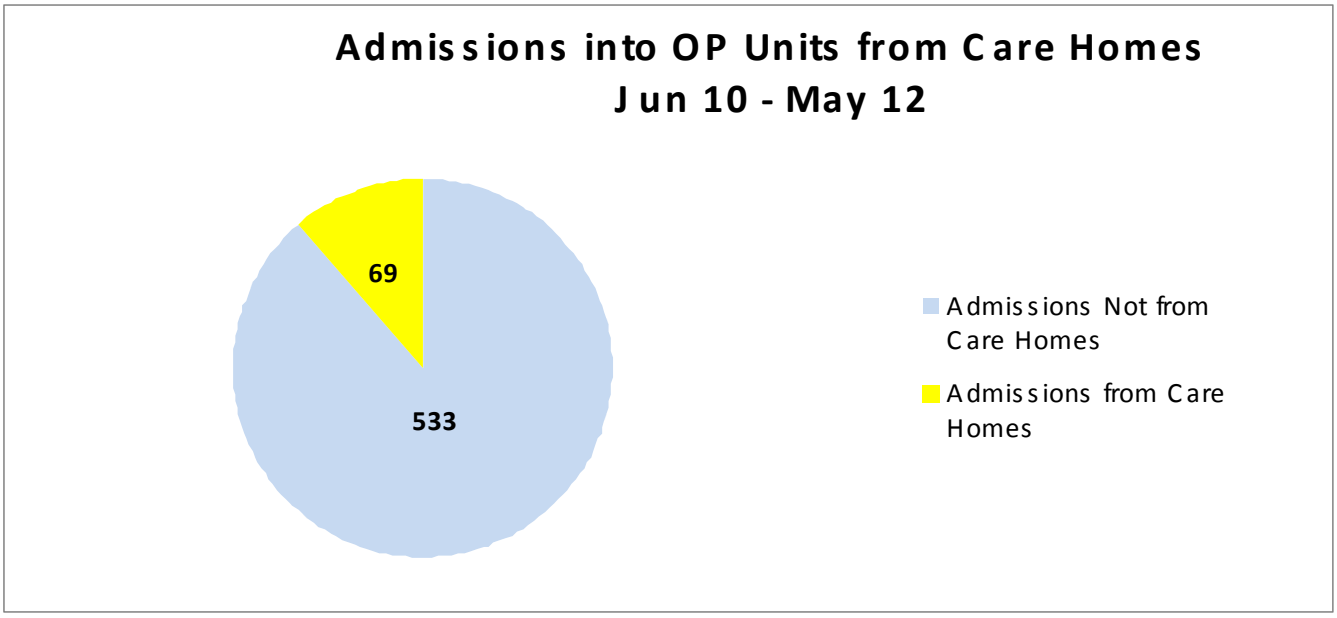
- Improved health outcomes
- Reduction in admissions from nursing homes and care homes
- Reduction in delayed transfers of care from our services
- Reduction in referrals from nursing homes and care homes to Community Mental Health Teams.

Nursing Home Team model:

The Nursing Home Team will work with all homes in the locality to support the care of people in their care with mental health needs. The team will establish regular contact with nursing homes to intervene early. Working closely with social care partners the team will ensure that service users are appropriately discharged to a residence that is able to meet their individual needs, as well as providing necessary discharge support.

The team will provide a discharge liaison service to service users discharged to nursing or residential homes from older people's mental health services. They will work alongside nursing home staff to deliver specialist mental health care. This will help to prevent admission using a step up/step down approach. The team will also provide training to nursing home staff where required and will deliver a flexible service offering support and advice over an extended working day up to 8pm.

Currently our Community Units for the Elderly inpatient services receive over 30 admissions from nursing homes per year. We expect the Nursing Home Team to reduce this by 50% within the first year.



By offering a care homes liaison service we anticipate a reduction in annual referrals to CMHTs from nursing homes of 35% in the first year.

Benefits:

There will be fewer occasions when a vulnerable older person is required to move from their home to hospital, or between homes. This will improve health outcomes for those individuals and reduce their distress and that of their carers.

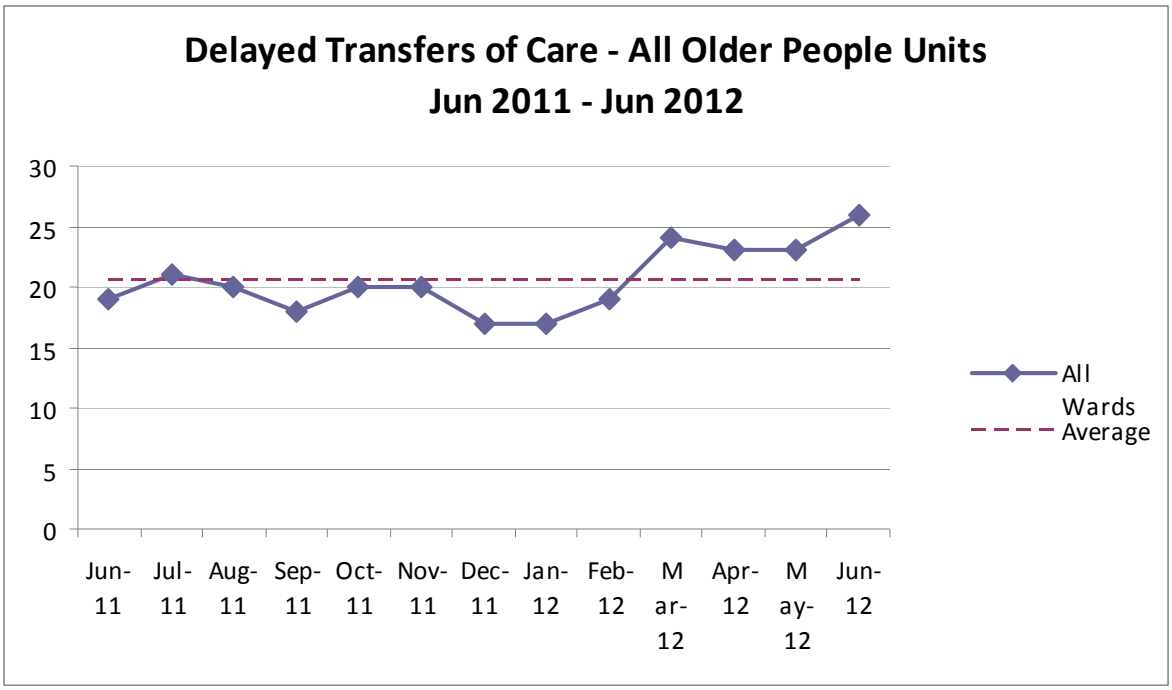
The impact of this proposal will be to release capacity within Community Mental Health Teams to further enhance the support they are able to provide.

The team will be part of the integrated community service and will play an important part in integrated care pathway provision.

Their specialist interventions and advice will help to reduce the need for medication including anti-psychotic drugs.

Care providers in other settings will gain greater understanding of mental health issues, promoting the provision of high quality care.

To resource this service improvement we will need to refocus some further resources from inpatient to community services. The case for this refocus of resources is supported by the current high level of delayed discharges within our inpatient community units; these are service users who no longer require hospital-based health care but who should be discharged to community based or residential care. An analysis of bed use in older people's services over the past year demonstrates an average of more than 20 delayed transfers of care (see table below).



Addressing delays will therefore allow us to release resource currently committed to inpatient facilities and reinvest in community based services, so reducing the need for hospital admission and supporting people to remain in their home. We anticipate that this will also reduce the number of crisis events in the community, which lead to admission to A&E departments and the acute sector.

In order to achieve this service improvement we therefore propose to reconfigure the current inpatient community units. This will allow us to vacate Mill Lodge Community Unit for the Elderly (CUE), therefore inpatient services for older people will be consolidated into the remaining units: Meadowfields, Worsley Court and Peppermill Court.

Staff will either be redeployed to the Nursing Home Team or will be moved into suitable alternative employment within existing vacancies in York and Selby; no staff will be made redundant as a result of this proposal.

It will also provide a potential opportunity to use the vacated Community Unit for the Elderly differently so improving the care environment for service users, supporting plans to address age restrictions within our services and improving the way that we provide single sex accommodation.

The proposal is fully in line with national, regional and local strategy in its aim to reduce reliance on bed-based services, improve preventative services and promote choice. It supports Department of Health objectives to:

- Give people greater control, choice and services that are built around the individual;
- Drive continuous improvement in the quality of services whilst ensuring value for money through the fair and effective use of resources; and
- Promote the commissioning, development and provision of services which allow people to live independently in the community.

Communication and Consultation

An effective communication and consultation plan is being developed to ensure the benefits of these improvements are clearly articulated. We are keen to ensure the longer term benefits of these improvements are clearly explained but that also people currently using the services are fully consulted and any anxieties or concerns they have are understood and addressed. (See Appendix 1)

We have a regular Service Improvement Group in place with membership from LYPFT, NHS North Yorkshire and York (our current health commissioners), the Vale of York Clinical Commissioning Group (our future health commissioners), City of York Council and North Yorkshire County Council. This group is aware of our proposals and will support our public engagement and consultation.

Conclusion:

This proposal sets out a new service model to significantly enhance community service provision, ensuring that service users and their families are in receipt of appropriate care and support, delivered in suitable accommodation, whilst minimising delayed transfers of care.

The expansion of community focused services provides support that service users and carers consistently request to help them remain in their home. It also supports other initiatives including the reduction of the prescribing of anti-psychotic medication to older people. It reduces our reliance on bed based services and provides a platform to make further improvements over the coming years, as demand for high quality services which promote personalisation and choice are expected by the public.

This paper seeks agreement to proceed on the basis of a one month formal consultation period during September and October. The rationale for a one month consultation period is that this is not major service change; it is a reconfiguration of existing services and no service elements will be discontinued. It will improve community services, therefore improving choice and home-based care and treatment. The reconfiguration of the inpatient services will not impact on in-patient capacity as it will be achieved by actively addressing delayed transfers of care. At the same time we will develop a new community-based Nursing Home Team, to support people receiving care in their place of residence, reducing admissions to in-patient wards and facilitating discharge. In so doing we will reduce flow into our bed base, thereby creating additional capacity.

Appendix 1: Consultation Plan

	Consultation plan for proposed change to Mill Lodge and development of Nursing Home Team	**Date for event/action**	**Completed on (date)**
1	Production of Consultation plan	Aug 3	Aug 3
2	Produce list of those to be consulted	w/e 17/08	Aug 3
3	Production of a full information document to support consultation	w/e 07/09	
4	Circulation of information including mail out and web site	w/e 07/09	
5	Set dates and hold number of public meetings with invited parties from service users /carers /partners /stakeholders etc	September/ October	
6	Hold staff presentation	September/ October	
7	Collate feedback and produce final recommendation	w/e 18/10	
8	Final report goes to LYFPT Board	30th Oct	
9	Implementation plan	1 November	

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CITY OF YORK COUNCIL

Health Overview & Scrutiny Committee **12 September 2012**

Report of the Director of Adults, Children & Education

2012/13 FIRST QUARTER FINANCIAL & PERFORMANCE MONITORING REPORT – ADULT SOCIAL SERVICES

Summary

1 This report analyses the latest performance for 2012/13 and forecasts the financial outturn position by reference to the service plan and budgets for all of the relevant services falling under the responsibility of the Director of Adults, Children and Education.

Financial Analysis

2 The Adult Social Services budget is reporting early financial pressures of £2,628k (5.6% of the £47,135k net budget) where pressures that have been evident in previous years related to demand for care still remain.

3 Pressure on Adult Social Care budgets is, of course, very much a national and a topical issue. In the last couple of months, one Council (Barnet) has attracted national publicity for publishing a graph that shows that within 10 years, its entire budget will be swallowed up by social care costs. The LGA has conducted a more recent modelling exercise that predicts a 29% shortfall between revenue and spending pressures by the end of the decade.

4 The demographic trends indicate that there has been an increase of over 30% in the number of over 85's between the 2001 and 2011 census data. Further projections indicate a further 9% increase in over 85's by 2015 and 21% by 2020 with a 35% increase in over 90's by 2020. This means not just an increase in the numbers of older people requiring care, but also more people having complex and more costly care needs for longer periods of time.

5 The strategy to address these trends and their incumbent pressures has been to develop early interventions that address needs early and prevent the escalation into more complex care needs and more expensive care packages.

6 There is also a shared ambition across local government and health agencies to see health care delivered closer to home.

This is underlined in York by the need to work as a community to address the budget deficit within the local health care system. The North Yorkshire and York Review highlighted the need for more joined up working and the need to reduce hospital admissions and lengths of stay. This approach does mean that more people will require social care support and this is currently an area of major concern as early discharge from hospital leads to people with complex care needs requiring very expensive care within their community.

7 We have seen increasing numbers referred from the hospital for discharge support over the last two years:

- Average of 125 a month in 2010-11
- Average of 135 a month 2011-12 and this trend is continuing

8 People are leaving hospital on average 7 days earlier this year. This means that they require more social care for longer. This is a positive indicator for delivery of the care closer to home strategy, but progress in one part of the system brings pressures in other parts. We are working together with health colleagues to establish joint care teams that focus on the needs of people with long term health conditions and/or who are most at risk of admission to hospital. This admission avoidance and support to timely discharge will have positive impacts on the health and social care system and costs.

9 Homecare – The Homecare service has been substantially redesigned and we have been successful in signposting customers with low level needs to other forms of provision. This has meant that the number of customers has remained stable despite the growth in the number of potential customers, but it does also mean that the customers receiving the service have more complex needs. This is one reason why, despite unit costs going down following the outsourcing of the service weekly, spend on our home care contracts has increased from £54k a week in July 2011 to £80k a week in July 2012. This results in a forecast financial pressure of some £1,549k.

10 In addition, more people have opted to take direct payments than anticipated and the numbers are likely to increase as personalisation of services is rolled out further. The projected overspend of £297k is despite £500k of growth being allocated to this area in the 2012/13 budget.

11 All high cost packages have to be authorised by a Spend Panel, including The Assistant Director, Group Managers and Commissioning and Contracts Manager to ensure the needs are evidenced and eligible and that the costs are in line with market rates.

12 Residential and Nursing Care - The number of admissions to care homes has remained fairly stable, but as predicted the demographic pressures and the increasing ability to support people at home for longer means people are needing more intensive support as they enter care homes.

This is leading to higher costs in nursing homes, and for some residents additional 1:1 support to keep them safe, leading to a forecast financial pressure of £457k, including reduced income at CYC homes.

13 Demographic pressures are also evident in Adult Transport with a forecast overspend of £264k.

14 With developments in medical science young people with complex needs are living for longer and moving from children's services to adults services where they can need intensive support to keep them safe and able to life a full life. 35 young people have moved from children's to adults' services in the last two years, which is a trend we would not have seen even 5 years ago.

15 Other mitigating actions have also been identified to help compensate for some of these pressures. As well as a number of vacant posts being held whilst the Business Change workstreams continue, and the continuation of a moratorium on non essential expenditure, the directorate is also assessing 2013/14 savings proposals that could be brought forward and reviewing commissioning budgets and new customer/scheme developments with a view to identifying additional one-off savings for 2012/13.

Performance Analysis

16 Of the 24 in year indicators, ten are green, indicating that they have achieved expected target for Q1; six are amber which indicate that although the target for Q1 has been missed, they are within an expected tolerance and 7 are marked as red which indicate that they have missed target and are outside of tolerance. One measure which is still benchmarked nationally is set as monitor only as it has a more relevant local target in place.

Code	Description of PI	11/12		12/13				
			Year End		Qtr 1	Qtr 2	Qtr 3	**Year End**
A&S1C (NPI 130)	Customers & Carers receiving Self Directed Support (Direct Payments and Individual Budgets)	Target	37.0 %	Target	MON	MON	MON	**MON**
		Actual	**32.1 %**	Actual	30.3 %			
A&S1C Part2 (NPI 130)	Customers & Carers receiving Self Directed Support (Direct Payments ONLY)	Target	-	Target	10.0 %	13.5 %	17.5 %	**20.0%**
		Actual	-	Actual	10.6 %	-	-	
A&S1C REGIONAL	Customers & Carers receiving Self Directed Support (Direct Payments and Individual Budgets)	Target	-	Target	70.0 %	73.3 %	76.6 %	**80.0%**
		Actual	65.9 %	Actual	73.6 %	-	-	
A&S1G (NPI 145)	Adults with learning disabilities in settled accommodation	Target	67.0 %	Target	18.5 %	37.0 %	55.5 %	**74.0%**
		Actual	73.1 %	Actual	**8.0%**			

Code	Description of PI	11/12		12/13				
			Year End		Qtr 1	Qtr 2	Qtr 3	**Year End**
A&S1E (NPI 146)	Adults with learning disabilities in employment	Target	5.7 %	Target	2.8%	5.5%	8.3%	**10.0%**
		Actual	10.3 %	Actual	2.7%			
A&S2A	Permanent admissions to residential & nursing care homes per 100,000 population	Target		Target	32.7	65.3	98	**130.6**
		Actual	130.6	Actual	27.5			
PAF C72	Admissions - Permanent (65+) / Per 10,000 pop	Target		Target	15.7	31	47	**62.62**
		Actual	62.62	Actual	12.9			
PAF C73	Admissions - Permanent (18-64) / Per 10,000 pop	Target		Target	0.2	3	7	**0.69**
		Actual	0.69	Actual	0.23	-	-	
Delayed Discharges 1	Average weekly number of CYC Acute delayed discharges	Target	7.98	Target	7.90	7.90	7.90	**7.98%**
		Actual	8.69	Actual	10.46	-	-	
Delayed Discharges 2	Average weekly number of reimbursable delays (people)	Target	4.4	Target	3.8	3.8	3.8	**3.8**
		Actual	4	Actual	5			

Code	Description of PI	11/12		12/13				
			Year End		Qtr 1	Qtr 2	Qtr 3	**Year End**
Delayed Discharges 3	Average weekly number of bed days	Target	41.44	Target	33.3	33.3	33.3	**33.3**
		Actual	41.25	Actual	52.07			
Delayed Discharges 4	Total bed days cost	Target	215.5	Target	40.0	98.0	152.0	**215K**
		Actual	214.5	Actual	67.70			
A&SNPI 132 (Part1)	Timeliness of social care assessment - Commencement of Assessment within 2 weeks.	Target	-	Target	80.0 %	80.0 %	80.0 %	**80.0%**
		Actual	-	Actual	25.0 %			
A&SNPI 132 (Part 2)	Timeliness of social care assessment - Completion of assessment in 6 weeks.	Target	-	Target	80.0 %	80.0 %	80.0 %	**80.0%**
		Actual	-	Actual	42.9 %			

Code	Description of PI	11/12		12/13				
			Year End		Qtr 1	Qtr 2	Qtr 3	**Year End**
A&SNPI 133	Timeliness of social care packages	Target	90.0 %	Target	90.0 %	90.0 %	90.0 %	**90.0%**
		Actual	88.6 %	Actual	89.8 %			
A&S NPI35	Carers receiving needs assessment or review and a specific carer's service, or advice and information	Target	25.6 %	Target	6.3%	12.5 %	18.8 %	**25.0%**
		Actual	24.0 %	Actual	9.2%			
A&S NPI35 a	Joint Assessments that are unlinked on Fwi to Carer - snap shot	Target	-	Target	20	15	10	**0**
		Actual	21	Actual	20			
A&S NPI35 b	Carers Separate Assessment waiting list - snap shot	Target	-	Target	180	150	125	**100**
		Actual	207	Actual	214			
A&SD39	Statement of Needs	Target	96.0 %	Target	97.0 %	97.0 %	97.0 %	**97.0%**
		Actual	96.8 %	Actual	96.3 %			
A&SD40	All services Reviews	Target	90.0 %	Target	22.5 %	45.0 %	67.5 %	**90.0%**

Code	Description of PI	11/12		12/13				
			Year End		Qtr 1	Qtr 2	Qtr 3	**Year End**
		Actual	85.8 %	Actual	36.9 %			
A&SD54	Equipment - 7 days	Target		Target	96.0 %	96.0 %	96.0 %	**96.0%**
		Actual	96.8 %	Actual	97.1 %			
RAP A6	Assessments missing Ethnicity	Target	5.0 %	Target	5.0%	5.0%	5.0%	**less than 5%**
		Actual	2.9 %	Actual	7.1%			
RAP P4	Services missing Ethnicity	Target	5.0 %	Target	5.0%	5.0%	5.0%	**less than 5%**
		Actual	3.8 %	Actual	3.7%			
SGA1	Number of Safeguarding Alerts				<61	<61	<61	**60**
			738 (61 pcm)		54			

17 *Adults with learning disabilities in settled accommodation:* Performance here fell short of expectations for Q1 and has been attributed to the way in which reviews fall due in the year, i.e. there remain a large number of reviews due in Q3 and Q4 which must be completed before they can be counted against this measure. Work is being done to smooth this distribution by bringing forward reviews in year where appropriate.

18 *Average weekly number of CYC Acute delayed discharges / Average weekly number of bed days / Total bed days cost.* The pace and volume of hospital discharges has increased (13% over the last 12 months). In consequence there has, in recent weeks, been a rising trend in terms of delayed discharges.

The measures taken to mitigate this trend have included increasing the capacity of the contracted out re-ablement service, which will continue to increase, and increased planning with hospital colleagues. There are investigations into an 'open referral' systems where early notice is made to the hospital team before a patient is determined medically fit for discharge. This should allow anticipatory planning to take place to ensure prompt discharge.

19 *Timeliness of social care assessment - Commencement of Assessment within 2 weeks./ Timeliness of social care assessment - Completion of assessment in 6 weeks.* These local measures have been introduced to support the original measure of timeliness of assessment which no longer fits the model of delivery which would entail putting a proportion of people through 6 week re-ablement first. These are not performing as expected for 2 identified reasons: There has been a notable fall off in performance of the OT Team which was consistently high in this measure until this year, and the issues with managing duty in the assessment teams which is significantly impacting on their ability to manage assessment work.

20 *Carers Separate Assessment waiting list.* There remain a large number of carers on the waiting list. A trend towards separate assessments in previous years had increased the workload in this area.

The service is now working towards a presumption for a joint client and carer assessment unless there is an identified need to do separate assessments. The backlog is being addressed through telephone assessments. The committee is advised that despite this, the data shows demand for assessments and the waiting lists are still rising in year.

21 In areas of good performance, it should be noted that Eligible Customers & Carers receiving Self Directed Support (Direct Payments and Individual Budgets) has continued to rise since 2011/12 (73.6% against a Q1 target of 70%). This is a local version of the national measure which excludes individuals from the count who would not be eligible for Direct Payments.

22 The Number of Safeguarding Alerts in Q1 has dropped slightly against the 2011/12 figure and is below the expected level.

Council Plan

23 The information included in this report demonstrates progress on achieving the council's corporate priorities for 2011-2015 and in particular, priority 4 'Protect Vulnerable People'

Implications

24 The financial implications are covered within the main body of the report. There are no significant human resources, equalities, legal, information technology, property or crime & disorder implications arising from this report.

Risk Management

25 The overall directorate budget is under significant pressure. This is particularly acute within Adult Social Services budgets. On going work within the directorate may identify some efficiency savings in services that could be used to offset these cost pressures before the end of the financial year. It will also be important to understand the level of investment needed to hit performance targets and meet rising demand for key statutory services. Managing within the approved budget for 2012/13 is therefore going to be extremely difficult and the management team will continue to review expenditure across the directorate.

Recommendations

26 As this report is for information only there are no specific recommendations.

Reason: To update the committee on the latest financial and performance position for 2012/13.

Contact Details

Authors:	**Chief Officer Responsible for the report:**
Richard Hartle Head of Finance *Tel No. 554225*	Peter Dwyer Director of Adults, Children and Education
Mike Richardson Performance & Improvement Manager *Tel No. 554355*	**Report Approved** *Y* **Date** *31 August 2012*

Specialist Implications Officer(s) None

Wards Affected: *List wards or tick box to indicate all* **All** *Y*

For further information please contact the authors of the report

Background Papers
First finance and performance monitor for 2012/13, Cabinet 4 September 2012
Annexes
None

Health Overview and Scrutiny Committee **12th September 2012**

Report of the Assistant Director Governance and ICT

Local Authority Health Scrutiny: Proposals for Consultation

Summary

1. This report asks Members to consider and comment upon the consultation document at **Annex A** to this report and the draft proposed response at **Annex B** to this report.

Background

2. The Heath and Social Care Act 2012 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, Clinical Commissioning Groups (CCGs) and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and the local authority, including independent sector providers.'

3. The above changes were consulted on as the Act was going through its various parliamentary stages. The attached consultation document does not further consult on these changes.

The Consultation Document

4. The document attached at **Annex A** to this report sets out the Government's further proposed changes to health scrutiny in local authorities and asks for comments on a number of proposals around changes to the current position on service reconfiguration and referrals to the Secretary of State, namely:

   i. requiring local authorities to publish a timescale for making a decision on whether a proposal will be referred

   ii. requiring local authorities to take account of financial consideration when considering a referral

   iii. introducing a new intermediate referral stage for referral to the NHS Commissioning Board for some service reconfigurations

   iv. requiring the full council of a local authority to discharge the function of making a referral to the Secretary of State for Health

5. In addition to this the consultation asks:

   '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?'

6. Current regulations enable joint scrutiny arrangements for consultations on substantial developments or variations to health services but do not require them to be formed. Where an NHS body is carrying out a consultation across boundaries, current directions require the local authorities to form a joint HOSC as the body that will undertake the health scrutiny function. The Government is proposing to incorporate this requirement into regulations. It asks whether respondents agree with this proposal and if not, why not.

Consultation

7. This is a national consultation being run by the Department of Health. It is open to all who want to respond and the closing date is 7th September 2012. However, the Health Overview and Scrutiny Committee have been granted an extension until 14th September 2012.

Options

8. There are no direct options associated with this report. Members are asked to consider the draft response at **Annex B** to this report and make any amendments or additions they would like to see prior to this being formally submitted to the Department of Health.

Analysis

9. The draft response is set out at **Annex B** to this report. Members are asked to highlight any amendments/additions to the response that they may wish to make prior to it being formally submitted.

Council Plan 2011-2015

10. This is a national consultation and is not directly linked with the themes that run through the Council Plan.

Implications

11. There are no known implications associated with the recommendations in this report.

Risk Management

12. There are no known risks associated with the recommendations in this report. However, there is a risk that the voice of the Health OSC will not be heard if they do not respond to this consultation.

Recommendations

13. Members are asked to consider the draft response at **Annex B** to this report and highlight any amendments/additions they may wish to make.

    Reason: To respond to the national consultation on Local Authority Health Scrutiny.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Tracy Wallis Scrutiny Officer Scrutiny Services Tel: 01904 551714	Andrew Docherty Assistant Director Governance and ICT Tel: 01904 551004

Report Approved ✓ **Date** 29.08.2012

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A Consultation Document
Annex B Proposed Response

Annex A

Local Authority Health Scrutiny

Proposals for consultation

Annex A

Local Authority Health Scrutiny

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	17747
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

Contents

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 2006[1] ("NHS Act 2006") by the Health and Social Care Act 2012[2] ("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 2000[6] 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 2001[7] 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 2002[8] ("the 2002 Regulations") required NHS bodies to consult formally with the HOSC on any proposals for substantial variations or developments to local services.

22. The 2002 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/2001/15/contents
[8] http://www.legislation.gov.uk/uksi/2002/3048/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 2009[9] 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 Administration[10] 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 change[11]. 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 confidentially 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?

Annex A

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Annex B

Local Authority Health Scrutiny: Proposals for Consultation

Proposed Response to 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?

In response to questions 1 and 2 there are pros and cons. A requirement to publish timescales may be welcome providing those timescales are reasonable and not a moveable feast. If the timetable is too fluid then this could lead to more work and unnecessary correspondence which would not be beneficial to either party.

This may also prove difficult and time consuming for Joint Health Overview and Scrutiny Committees (Joint HOSC) if there was a requirement to get formal agreement for changes to timescales from all Local Authorities forming part of any Joint HOSC prior to timescales being amended.

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

One would presume that this kind of information would be available to Health Overview and Scrutiny Committees as part of their evidence gathering and that they would take into consideration all information and weigh up whether the financial need for change outweighed any other reasons for changing a service.

Any Health Overview and Scrutiny Committee would need to fully understand the situation as a whole and have all the evidence to hand before choosing to make a referral; this would include any financial reasons for a proposed service change.

To require the Health Overview and Scrutiny Committee to have regard to the financial situation before allowing a referral to the Secretary of State places an unreasonable burden on us. Without financial expertise and analytical resource most referrals could be halted by the health provider simply saying service changes are required for financial reasons.

Referrals to the Secretary of State are a last resort for Health Overview and Scrutiny Committees and are not undertaken lightly.

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?

On the surface this appears to just be an extra layer of bureaucracy to navigate. Requiring some referrals to be heard by the NHS Commissioning Board before going to the Secretary of State may simply be an additional hurdle. Further clarification is needed on this aspect

There are also questions still to be asked about how independent the NHS Commissioning Board will be? They will necessarily be supportive of Clinical Commissioning Groups thus not making them a wholly impartial body. Again further clarity is needed.

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.

No, scrutiny should be non-partisan and this would add an overtly political layer.

The requirement for any referral to be made by full council places an additional barrier in the way of the Health Overview and Scrutiny Committee operating effectively. Time at full council meetings is already short, health arguments can often be complex and there is a significant danger that decisions could become party political.

It would add an unwelcome extra layer and the Health Overview and Scrutiny Committee should be trusted to make the judgement on whether something needs to be referred to the Secretary of State or not.

However, if Health Scrutiny is to become a function of the Council (who will no longer necessarily have to have a Health Overview and Scrutiny Committee) then there will need to be a mechanism to make referrals to the Secretary of State – however we are not convinced that full council should be this mechanism due to its political nature.

In addition to this and in the case of Joint HOSCs it would be very time consuming and impractical for all Local Authorities involved if each individual authority sitting on any Joint HOSC had to take a referral back to their own full council meeting. Bearing in mind many Local Authorities only have a full council meeting every 2 months this could directly counteract what is trying to be achieved by the proposals at Questions 1 and 2 in this consultation.

Also in the case of Joint HOSCs what would happen if all of the Local Authorities didn't agree to the referral? Who would have the ultimate decision on whether something should be referred if agreement didn't take place at all full councils?

Both Health Overview and Scrutiny Committees and Joint HOSCs are powerful tools. There is a danger that this proposal would undermine the acquired skills, knowledge and experience that Members of these Committees currently have.

Annex B

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?

Many Health Overview and Scrutiny Committees currently use this mechanism willingly and there are clear directions in place; any further provision in these proposals would simply formalise existing arrangements.

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 proposal we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

May of the proposals put forward in this consultation appear to lead to an erosion of HOSC powers. Despite 26 pages of text, the proposal is essentially laid out in a single paragraph on page 15.

In some places the proposals suggested are just adding further layers of bureaucracy which again mask the fact that they undermine the influence of Health Overview and Scrutiny Committees.

In other places the proposals are akin to a 'sledgehammer to crack a nut' – How many referrals are made to the Secretary of State anyway? Referral is a last resort tool for Health Overview and Scrutiny Committees, not something that they undertake lightly or do on a regular basis.

Health Overview and Scrutiny Committee **12 September 2012**

Report of the Director of Public Health & Well-being

A Consultation on Draft Mandate to the NHS Commissioning Board

Summary

1. This report asks Members to consider and comment upon the consultation document at **Annex A** to this report and the draft proposed response at **Annex B** to this report.

Background

2. The Heath and Social Care Act 2012 set up the NHS Commissioning Board (NHSCB) which will oversee all of the £80 Billion NHS Commissioning budget. While the Board will commission some services directly, most of the budget will be spent by Clinical Commissioning Groups (CCGs).

3. The Mandate to the NHSCB, which will be updated annually, is the means by which the Secretary of State for Health will retain ultimate responsibility for securing the provision of health services by setting clear objectives for the NHSCB.

4. The above changes were consulted on as the Act was going through the various parliamentary stages. The attached consultation document does not further consult on these changes.

Consultation

5**.** The consultation, which runs until 26 September 2012, is seeking responses around six issues:

a. The overall approach to the Mandate

b. The best way of assessing progress against the Mandate

c. The use of objectives based on the NHS Outcomes Framework

d. The principle of “putting patients first”

e. The principle of a “broader contribution from the NHS”

f. The principle of “effective commissioning”

6. The draft Mandate is divided into five core sections based on indicators in the NHS Outcomes Framework. In summary, these are:

a. **Improving our health and our healthcare**. This sets objectives to improve health outcomes, reduce premature deaths and reducing health inequalities.

b. **Putting patients first**. This sets objectives to extend shared decision making and choice, and improve support to carers.

c. **Broader contribution of the NHS**. This sets objectives about how the NHS can work better with other public bodies.

d. **Effective commissioning**. This sets objectives that relate to the new system of commissioning and the transition to that new system.

e. Finance and Financial Management. This will set out the resources available to NHSCB and expectations of increased efficiency.

7. The core purpose of the draft Mandate, and of the NHSCB itself, is to help improve people’s health and the outcomes of healthcare. The main way that it is proposed to do that is to ensure that all the objectives included within the Mandate relate directly to the NHS Outcomes Framework. This is a set of national outcome goals and supporting indicators which patients, the public and Parliament can use to judge the progress of the NHSCB. The Outcomes Framework has already been subject to extensive consultation.

Options

8. There are no direct options associated with this report. Members are asked to consider the draft response at **Annex B** to this report and make any amendments or additions they would like to see prior to this being formally submitted to the Department of Health.

Analysis

9. The draft response is set out at **Annex B** to this report. Members are asked to highlight any amendments/additions to the response that they may wish to make prior to it being formally submitted.

Council Plan

10. This is a national consultation and is not directly linked with the themes that run through the Council Plan. However, members may wish to note that the requirement for the NHSCB to ensure that the NHS works with other partners to help achieve broader social and economic objectives, particularly economic growth, will help support the key Council Plan Objective of "Create Jobs and Grow the Economy"

Implications

11. There are no known immediate or direct implications associated with the recommendations in this report.

Risk Management

12. There are no known risks associated with the recommendations in this report. However, the NHSCB will have an import impact on the overall health and wellbeing of the residents of York in the years ahead and there is a risk that the voice of the Health OSC and the City of York Council will not be heard if they do not respond to this consultation.

Recommendations

13. Members are asked to consider the draft response at **Annex B** to this report and highlight any amendments/additions they may wish to make.

    Reason: To respond to the national consultation on the draft Mandate for the NHS Commissioning Board

Contact Details

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Background Papers:

Our NHS Care Objectives – Draft Mandate to NHS Commissioning Board (published by the DH on 4 July 2012 – Gateway Number 17799)

Annexes

Annex A Consultation Document
Annex B Proposed Response

Department of Health

Developing our NHS care objectives

A consultation on the draft mandate to the NHS Commissioning Board

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/Performance	Clinical Commissioner Development Provider Development Improvement and Efficiency	Estates IM & T Finance Social Care/Partnership Working
Document purpose	Consultation/Discussion	
Gateway reference	17799	
Title	Developing our NHS care objectives: A consultation on the draft mandate to the NHS Commissioning Board	
Author	NHS Commissioning Unit	
Publication date	**4 July 2012**	
Target audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Sector Organisations	
Circulation list		
Description	This document explains and seeks comments on the approach we have taken to developing a draft mandate to the NHS Commissioning Board. This consultation document is published alongside a draft of the first mandate with four annexes, including a draft 'choice framework' illustrating the Government's intended approach to explaining the choices that will be available for people using NHS services in England	
Cross reference	Our NHS care objectives: A draft mandate to the NHS Commissioning Board; Our NHS care objectives: A draft mandate to the NHS Commissioning Board, Annexes; Our NHS care objectives: A draft mandate to the NHS Commissioning Board – Coordinating document for the Impact Assessments and Equality Analysis	
Superseded documents	N/A	
Action required	N/A	
Timing	Views and comments are invited by 26th September 2012	
Contact details	The Mandate Development Team Room 602 Richmond House London SW1A 2NS mandate-team@dh.gsi.gov.uk	
For recipient's use		

Contents

Foreword from the Secretary of State

The Health and Social Care Act, which has recently passed through Parliament, reaffirms the principles of the NHS as a comprehensive health service for everyone, based on clinical need not people's ability to pay.

The Act creates the legislation to support this Government's vision for improving the NHS, in order to:

- put patients and carers at the heart of the health service;
- focus the NHS on improving outcomes and what matters most to patients – high-quality care; and
- hand power to local professionals, and make NHS services more directly accountable to patients and communities.

We now want to work with patients, staff and our partners – including national health charities, think tanks and professional organisations – to put the changes into practice and make them a success.

In line with the new requirements in the Act, we are now consulting on our proposals for the Government's first mandate to the NHS Commissioning Board, and we have published a draft mandate. In future, the mandate will be the main way for the Government to say what it expects the NHS commissioning system to achieve with the money it is given. This is the first time that any government has been required by law to consult on its objectives for the NHS, and brings an unprecedented degree of transparency.

This document explains the approach we have taken to developing the mandate, and tells you how you can get involved and have your say.

Andrew Lansley CBE
Secretary of State for Health

Executive summary

The mandate

The new NHS Commissioning Board[1] will oversee the way that over £80 billion of taxpayers' money is spent to secure NHS services for the people of England.

Under the Health and Social Care Act 2012, the Government must set objectives for the Board in a "mandate", which must be updated every year, following consultation. In order to provide stability for the NHS, the mandate can only be changed mid-year in limited circumstances.

The mandate is one of the most important ways for the Government to set objectives for the Board, but it is just one part of a broader relationship through which the Secretary of State will hold the Board to account for its performance. Ministers will continue to be accountable overall for the health service as a whole.

We have now published:

- a **draft of the first mandate**, informed by what we have heard through previous consultations, debates in Parliament and discussions with stakeholders;
- a draft "**choice framework**", illustrating the Government's intended approach to explaining the choices that will be available for people using NHS services in England; and
- **this consultation document**, which explains the approach we have taken to developing the mandate.

Following consultation, we will publish a final mandate in the autumn, ready to come into force from April 2013.

Meanwhile, we are also publishing the Secretary of State's first report on the effect of the NHS Constitution. The Constitution and the mandate both set out what is expected of the NHS, but they have distinct roles:

- The mandate is a formal accountability document setting objectives for the Board. It is primarily about the Government's ambitions for improving NHS services *in future*. Future mandates will evolve as objectives are achieved and new priorities emerge.

1 The NHS Commissioning Board will be established on 1 October 2012. The NHS Commissioning Board Authority, a Special Health Authority set up to prepare for the establishment of the Board, is being abolished at the same time as the Board is created.

- By contrast, the NHS Constitution is an enduring document, which sets out the principles and values of the NHS and the rights and responsibilities of patients and staff. It describes what everyone can expect from the NHS *now*, and it is about the NHS as a whole – patients, public and staff – not just commissioners.

The structure of the draft mandate

The draft mandate includes objectives under five headings:

1. **Improving our health and our healthcare**: this sets objectives for improving outcomes and reducing inequalities under the NHS Outcomes Framework, rather than setting objectives for individual clinical conditions. It sets ambitions for:

   - preventing people from dying prematurely;
   - enhancing quality of life for people with long-term conditions;
   - helping people to recover from episodes of ill-health or following injury;
   - ensuring that people have a positive experience of care; and
   - treating and caring for people in a safe environment and protecting them from avoidable harm.

2. **Putting patients first:** this sets objectives to extend shared decision-making and choice, improve information, make services more integrated around the needs of individuals, and improve the support the NHS gives to carers.

3. **The broader contribution of the NHS:** this sets objectives about how the NHS can work better with other public services, and how it can contribute to economic growth, including through its support for research and innovation.

4. **Effective commissioning:** this sets objectives about getting the full benefits from the new system of commissioning, while at the same time managing the transition in a way that safeguards service performance and finances.

5. **Finance and financial management:** this will set the Board's resources and expectations of increased efficiency.

Setting ambitions for improving high-level outcomes rather than focusing on processes or individual clinical conditions has many advantages. It focuses attention on the outcomes that really matter: saving and improving lives, reducing harm and enhancing patients' experience. It gives more freedom to local commissioners to decide how best to improve quality and outcomes in the light of the needs of their populations. And it recognises that, as more people are living with multiple long-term conditions, it is more important to take a holistic

approach, looking at quality of life and quality of care as a whole, rather than focusing primarily on the treatment of specific clinical conditions.

However, as Chapter 3 explains, this is a radical shift in approach from the past, and the detailed approach we take will evolve as information about outcomes improves and our methodology develops.

Have your say

We would welcome your views on the objectives in the draft mandate, and on the consultation questions set out there (these are also listed below in Chapter 6). You can find out more and respond to this consultation at: http://mandate.dh.gov.uk. You can contact us via: mandate-team@dh.gsi.gov.uk. Please respond by 26 September.

1. The mandate in context

The Government's NHS reforms

1.1 From April 2013 **clinical commissioning groups** (CCGs) will become responsible for commissioning most healthcare – planning, buying and monitoring services to meet the needs of their local communities. Within CCGs, GPs and other healthcare professionals will be empowered to use their clinical insight and local knowledge to make decisions about NHS services.

1.2 A new national organisation – the **NHS Commissioning Board** – will support CCGs to commission high-quality care for their patients. The Board will also commission some healthcare services directly. The Department of Health will allocate funding to the Board, and set objectives for it in a "mandate".

1.3 CCGs and the Board will commission services from a range of **providers**, offering greater choice to patients. In turn, providers will be regulated on a consistent basis: by the **Care Quality Commission**, as now, to ensure safety and quality; and by **Monitor**, which will focus on promoting value for money in the provision of services, for example by regulating prices and taking action against anti-competitive behaviour that harms the interests of patients.

1.4 **Health Education England** will provide national leadership for professional education, training, and workforce development, to ensure that the health workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and health improvement.

1.5 Meanwhile, new **Health and Wellbeing Boards**, based in local authorities, will bring together NHS commissioners with local government, helping to join up the commissioning of NHS, public health, social care and other local services.

1.6 To strengthen the voice of patients and the public, **HealthWatch England** will be a new independent consumer champion, as a statutory committee within the Care Quality Commission. **Local HealthWatch** organisations will provide advice and information about access to local care services and choices available to patients, and a stronger voice for patients on the local Health and Wellbeing Board.

1.7 The Health and Social Care Act makes clear that, as now, **Ministers** will be accountable overall for the health service. The Department of Health will provide strategic direction and stewardship, and will hold all of the national bodies to account for their performance, to ensure that the different parts of the system work properly.

1.8 The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, is due to be published in the autumn. While many of the themes and objectives in the draft mandate address the issues that emerged from the previous inquiry, it will be for future mandates to reflect any specific recommendations from the final report relating to the new commissioning system.

The mandate

1.9 The mandate will be at the heart of the accountability relationship between the Board and the Department of Health. The Act says that the Secretary of State must publish a mandate setting objectives for the Board, and any supporting requirements, as well as the funding available to the Board. The Board must seek to achieve the objectives and must comply with any requirements.[2]

1.10 The mandate will be:

- a multi-year document, but published annually to ensure it remains up to date. The first mandate will come into force from April 2013, when the Board takes on its full powers;
- based on public consultation and consultation with the Board;
- fixed for the entire year: it can only be changed mid-year by agreement with the Board, or in exceptional circumstances, which Ministers would have to explain to Parliament (it could also be changed after a general election);
- an accountability mechanism for the Board, not for the NHS as a whole. For example, it would not deal with the way that providers are regulated, since this is the responsibility of Monitor and CQC, which have their own, distinct legal responsibilities.

Other requirements on the NHS Commissioning Board

1.11 The mandate will be the document that sets the Government's ambitions for the Board. But it will not be the only influence on the Board, nor will it cover everything that the Board will do. As explained in Chapter 4, the mandate forms part of a broader cycle of accountability.

1.12 Like other arm's-length bodies, the Board will also be bound by:

a) legal requirements

- The **Health and Social Care Act** sets out the Board's core functions, and gives the Board a number of cross-cutting duties, including duties about reducing

2 The Secretary of State considers that at this stage it is not necessary to impose any requirements in relation to any of the objectives.

inequalities, seeking continuous improvement in quality and promoting the NHS Constitution.

- **Regulations** made under the Act will set more detailed legal requirements including, for example, regulations defining exactly what services the Board should commission. "Standing rules" regulations will set legal requirements on the way the Board and CCGs commission services, and will be used to ensure that rights for patients in the NHS Constitution continue, such as the right for patients to access services within maximum waiting times. They will also be used to maintain existing policies, such as the eligibility rules for NHS continuing healthcare.[3]

b) standard government accountability procedures

- As with other arm's-length bodies across government, there will be a **framework agreement** outlining how the Board and the Department of Health will work together. For example, this will include details about financial management and financial reporting, and will describe how the Board will help the Department to respond to questions from Parliament.
- The Department will make a limited number of **financial directions** under the Act to set technical controls on the Board's spending, to ensure it is managed in line with Treasury requirements.

1.13 In addition, there are some public health services which in future will be the legal responsibility of the Secretary of State, but which the Board will commission on the Department's behalf. The details will be set out in a formal **"section 7A" agreement** under the Act, which will be published alongside the final mandate. The services it will cover include immunisation and screening programmes, public health services for young children and for people in custody, and the commissioning of sexual assault referral centres and of child health information systems.

1.14 The mandate is designed as a specific accountability mechanism for the Board, to recognise the scale of the Board's responsibilities and the size of the budget it will oversee. But there is no need for the mandate to duplicate requirements that are made elsewhere.

1.15 Some people have asked how the mandate relates to the NHS Constitution. The key distinction is that the NHS Constitution is about the entire NHS – public, patients and staff – and captures the essence of what people can expect from the NHS *now*. The mandate is a formal accountability document for the Board (therefore, for example, it says relatively little about staff, because the vast majority of staff in the NHS are

3 NHS continuing healthcare is a package of continuing care arranged and funded solely by the health service for a person to meet physical or mental health needs which have arisen as a result of illness.

employed by providers of healthcare services), and deals mainly with the Government's ambitions for improving the NHS *in future*. While the Constitution is an enduring document, the mandate will evolve over time, as objectives are achieved and new priorities emerge.

1.16 We have asked the NHS Future Forum to consider how the NHS Constitution can be strengthened and reinforced for the future. The Forum plans to engage on potential changes over the summer. In light of its advice, we will launch a public consultation on any changes to the Constitution later this year.

2. Our approach to the mandate

2.1 The draft mandate we have published draws on an extensive process of consultation, listening and engagement. For example:

- We have already held full consultations on many of the elements within the draft mandate, including the NHS Outcomes Framework and our plans for extending shared decision-making and patient choice.
- We have had many informal discussions about developing the mandate with stakeholders and representative bodies, and drawn on feedback and recommendations from the work of the NHS Future Forum.
- The mandate was debated extensively in Parliament during the passage of the Health and Social Care Bill.
- We have worked very closely with the NHS Commissioning Board Authority (the preparatory body for the Commissioning Board).

2.2 Because this is the first mandate, and the start of a new system of commissioning, there has been much debate about high-level questions such as: how detailed the mandate should be; whether it should include objectives about the way the Board implements reforms as well as about the ultimate purpose of those reforms; and how to assess the Board's progress against the mandate.

2.3 However, some common themes have emerged. We have heard many people support the ideas that the mandate should be:

- based primarily around **outcomes** and the NHS Outcomes Framework – while at the same time recognising that the Board must be clearly accountable and that there are other important objectives that the Government will want to set;
- **aligned** with other parts of the NHS, and promoting an integrated approach with social care, public health and other public services;
- **affordable**, recognising the sustained financial challenge facing the NHS over the coming years; and
- **focused** on a core set of priorities, in line with the principle of promoting front-line autonomy, to ensure that commissioners have the headroom and flexibility to respond to local needs. Extending ambition in one area can only come at the expense of ambition in other areas. Many people have highlighted the risk that the mandate could turn into a long "shopping list" unless the Government is restrained in selecting its priorities.

2.4 We have reflected these points in the draft mandate.

2.5 Another point where we heard much agreement was that it would be helpful for the Government to consult on a draft version of the mandate, rather than simply on principles or high-level proposals. Many people said that, in order to avoid the consultation becoming abstract or theoretical, it would be easier to engage properly if they had seen an actual document. This is why we have published a draft mandate as the basis for consultation and discussion.

Structure of the draft mandate

2.6 The draft mandate is divided into five core sections:

- **Improving our health and our healthcare**. This section explains how we intend to set ambitions for improving healthcare outcomes and reducing inequalities, while upholding core performance standards such as on waiting times. It also includes an objective for strengthening the priority given by the NHS to preventing illness and supporting people to improve their health.
- **Putting patients first**. A core part of improving the quality of care, especially for the rising numbers of people living with long-term conditions, is to empower patients, families and carers, and support them to manage their health better. This section sets objectives to extend shared decision-making and choice, improve information, make services more integrated around the needs of individuals, and improve the support the NHS gives to carers. We have also published a draft "choice framework" alongside the draft mandate, explaining where and how patients can expect to be able to make choices.
- **The broader role of the NHS**. This section emphasises that the NHS is in a unique position to work with other public services to help achieve broader social and economic objectives. The NHS can, by working well with its partners, go beyond the traditional boundaries of the healthcare system, such as in providing support for children with special educational needs and disabilities, or helping to reduce reoffending. The draft mandate highlights some areas where partnership working between services is particularly important or needs to be improved. This section also includes an objective about the role of NHS commissioners in supporting research and contributing to economic growth through the life sciences industry.
- **Effective commissioning**. This section sets a small number of objectives about the way that the Board introduces the new commissioning system: to help achieve the full benefits of clinically-led commissioning, while at the same time managing the transition in a way that safeguards service performance and finances. There is a specific objective for the Board to be able to account transparently for the quality and value of the services that it commissions directly.

- **Finance and financial management**. This section will set the Board's budget (the figures are not included in this draft mandate but will be published in the final version). It also includes some principles for the Board to allocate resources in a fair and transparent way, and sets the Board an objective to make efficiency savings. However, most of the detailed financial requirements on the Board will be set out elsewhere – in particular in the framework agreement.

2.7 Because setting outcome-based objectives is a radically new approach for the NHS, the next chapter of this document gives some more background on this, and we have published a technical annex on the NHS Outcomes Framework with more detail. But we have not included a section-by-section commentary on the other parts of the draft mandate; instead, we have included some consultation questions in the draft mandate itself (these are listed in Chapter 6 below). We would welcome your views on these questions and on our approach to developing the mandate generally.

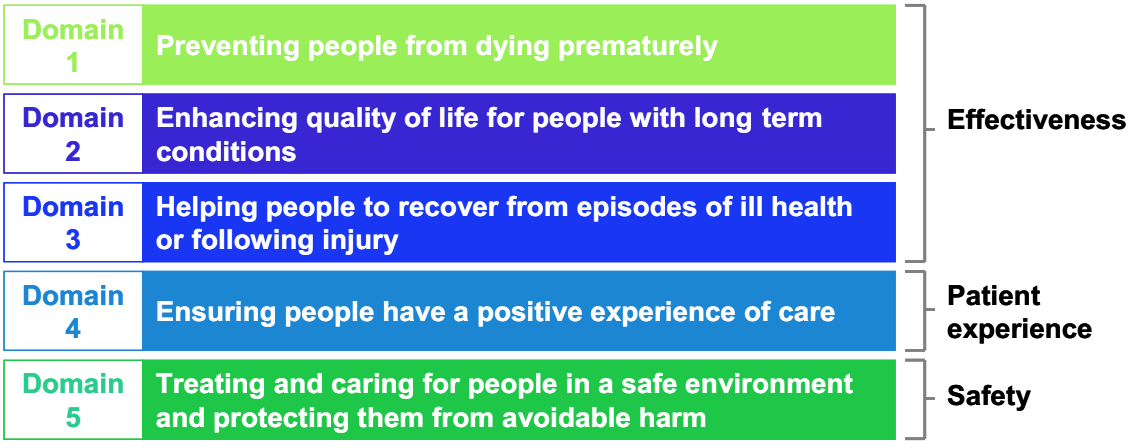
3. Setting outcome-based objectives

3.1 The core purpose of the mandate, and of the NHS Commissioning Board itself, is to help improve people's health and the outcomes of healthcare. The main way we propose to do that through the mandate is by setting objectives for improvement against the NHS Outcomes Framework.

The NHS Outcomes Framework

3.2 The NHS Outcomes Framework is a set of national outcomes goals and supporting indicators which patients, the public and Parliament will be able to use to judge the overall progress of the NHS, and which the Department of Health will be able to use in holding the Board to account.

3.3 The Framework, which has already been subject to extensive consultation, is structured around five "domains", capturing the NHS's role in reducing premature deaths, enhancing quality of life, helping people to recover from ill-health and injury, providing a good experience of care, and providing a safe care environment. The domains were chosen to reflect the three elements of good quality care: effectiveness, patient experience and safety.



3.4 Twelve overarching indicators cover the broad aims of these five domains, and 60 indicators in total capture the breadth of NHS activity. The NHS Outcomes Framework sits alongside similar frameworks for public health and adult social care. The distinct frameworks reflect the different delivery systems and accountability models for the NHS, public health and adult social care. But the frameworks are aligned and contain shared indicators to drive collaboration and integration.

Outcome-based objectives

3.5 The draft mandate sets an objective for the Board to ensure continuous improvement across all of the 60 indicators in the NHS Outcomes Framework. This is in line with the Board's legal duty about continuously improving the quality of care. But we do not propose to set specific objectives for individual indicators, or for particular clinical conditions or groups.

3.6 Instead, our intention is to set the Board a stretching ambition to improve against each of the five domains as a whole, based on an aggregate measure of performance for each domain. To reflect the fact that there can be a time-lag in changing outcomes, we plan to set ambitions to achieve within two, five and ten years.

3.7 We think there are several advantages of setting objectives at domain level:

- This focuses attention, in a transparent way, on the **ultimate outcomes of care** that matter to patients and professionals: saving and improving lives, enhancing patients' experience, and reducing harm.
- It provides a "**balanced scorecard**", which gives commissioners freedom to decide how to improve quality and outcomes in ways that are most important for their local populations. Setting prescriptive objectives for individual indicators would reduce local autonomy and risk distorting clinical priorities.
- The biggest healthcare challenge of the future is the rise in the number of people living with long-term conditions. Increasingly, many people have complex needs, with more than one condition at once. Therefore it is better for the mandate to take a **holistic approach** that looks at quality of life and quality of care as a whole, rather than focusing primarily on the treatment of individual clinical conditions.

3.8 As the draft mandate makes clear, there are specific areas of NHS care, such as care for people with cancer, where the Government has already set out ambitions for improvement. Many of these are reflected in the NHS Outcomes Framework, and we intend that they will be captured in the outcomes objectives we set the Board. There is no doubt that these areas will be priorities for the Board and for CCGs. However, we want the mandate to focus on the Board's performance as a whole, across the range of healthcare services.

Setting levels of ambition

3.9 A separate technical annex on the NHS Outcomes Framework describes the detailed methodology for constructing the levels of ambition. In summary, we are looking to create levels of ambition that take into account recent and likely future trends in outcomes (where these are known), and which set an additional challenge to the Board, which is achievable within the current resources available to the NHS.

3.10 More data on outcomes will become available during the consultation period. As the technical annex explains, we currently have a partial assessment of what could be included in a level of ambition for each domain. Our aim is therefore to develop the levels of ambition over the summer before they are published in the final mandate, so that they are as comprehensive as possible. The draft mandate includes suggestions of how these objectives might be phrased. The technical annex includes examples of what these levels of ambition may contain, and invites views.

3.11 We think it is right to use outcomes as the basis for assessing the performance of the health service. But we recognise that this approach is a significant shift from the past, and we are still at the early stages of a journey. It is likely that the ambitions included in the final mandate will still include some gaps – because of lack of evidence or measures. The Department of Health and the Board will need to work together over the coming years to develop and improve the NHS Outcomes Framework and the information and indicators that support it, and we have established an advisory group (the Outcomes Framework Technical Advisory Group – OFTAG) to provide expert input. Views expressed during this consultation will be particularly helpful in informing this longer term work.

3.12 We want the mandate to set a clear sense of direction and challenge to the Board. But some of the detail of the ambitions, especially the 10-year ambitions, is likely to be refined and updated in future mandates in the light of experience and improving information.

Reducing inequalities

3.13 A particular area where there is a need for further work is in measuring outcomes for different groups of people, to assess the impact on equality and inequalities.

3.14 The Health and Social Care Act has, for the first time, created legal duties about tackling inequalities in access to services and the outcomes of healthcare – in line with the Government's aim of improving the health of the poorest fastest. Legal duties about reducing health inequalities build on the existing duties of all public bodies in relation to promoting equality. The focus on localism and clinical leadership within the new NHS commissioning system, together with the creation of local Health and Wellbeing Boards, will produce new opportunities to address health inequalities in every area across the country, by focusing on disadvantaged groups which experience poor health outcomes, including those who are vulnerable or socially excluded.

3.15 Our approach to the NHS Outcomes Framework supports this: by highlighting data across a wide range of indicators, it will shine a light on areas that need to be tackled and expose unjustified variations in outcomes.

3.16 The draft mandate includes a specific objective to reduce inequalities in domain 1 of the NHS Outcomes Framework (preventing people from dying prematurely), where there is sufficient evidence to be able to set a level of ambition. To add more focus on inequalities in the other domains, the draft mandate includes a general objective for the Board to assess and seek to reduce inequalities while achieving the overall outcome objective. Our aim is that, as information and evidence improves and the methodology develops, this will provide a basis for setting more targeted goals in future mandates.

4. Assessing progress

4.1 The mandate is a formal mechanism for the Government to hold the NHS Commissioning Board to account for its performance, on behalf of patients and taxpayers. It is important to be able to judge clearly how well the Board has performed. Therefore, we have published an annex to the draft mandate (Annex B) describing for each objective how we intend to assess the Board's progress. In some cases, there is an obvious measure of performance to use. But for many objectives, there is no existing indicator, and we will be asking the Board to develop and provide evidence of what has been achieved.

4.2 In line with our commitment to transparency, the Government will be interested in evidence that can be objectively measured and, wherever appropriate, independently reported.

The accountability cycle

4.3 The mandate is one part of a wider cycle of accountability for the Board. The Health and Social Care Act makes clear that:

- The Board must publish a **business plan** each year, saying how it intends to carry out its functions and deliver the objectives and requirements in the mandate.
- The Secretary of State must **keep the Board's performance under review**, including how it is performing against the mandate.
- The Board must publish a **report** at the end of each year saying how it has performed.
- The Secretary of State must then publish an **assessment** of the Board's performance.

4.4 Besides these formal requirements, there will be an ongoing sponsorship relationship between the Department of Health and the Board, which will be described in the framework agreement. In particular, the Secretary of State will hold formal accountability meetings with the Chair of the Board, normally every two months, and the minutes of these meetings will be published. These meetings will be an opportunity for Ministers to discuss progress or raise any emerging priorities or concerns. If there were particular concerns about performance, Ministers could, for example, ask the Board to report publicly on what action had been taken, or ask the Chair to write a letter setting out a plan for improvement.

4.5 The Department of Health intends to carry out assessments of all its arm's-length bodies, looking not only at how they have carried out their functions, but also to give assurance about their "organisational health": the strength of their governance and their relationships with other bodies. In the same way as for other arm's-length bodies, we intend to use a range of hard and soft evidence to assess the Board's performance, including feedback from stakeholders such as patients, commissioners, GPs and other clinicians, as part of a balanced scorecard approach. We would be interested in your views about the best way of achieving this.

5. The consultation process

5.1 This consultation will run from 4th July to 26th September 2012.

5.2 You can find out more and respond to this consultation at: http://mandate.dh.gov.uk. You can contact us via: mandate-team@dh.gsi.gov.uk.

Criteria for consultation

5.3 This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation's 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; and
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

5.4 The full text of the code of practice is on the Better Regulation website at:

http://www.bis.gov.uk/policies/bre/consultation-guidance/subscribers-to-code-of-practice

Comments on the consultation process itself

5.5 If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:
Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE
e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

5.6 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter at http://www.dh.gov.uk/en/FreedomOfInformation/DH_088010.

5.7 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).

5.8 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.

5.9 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.

Summary of the consultation

5.10 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

6. Consultation questions

Our approach to the mandate

1. Will the mandate drive a culture which puts patients at the heart of everything the NHS does?

2. Do you agree with the overall approach to the draft mandate and the way the mandate is structured?

3. Are the objectives right? Could they be simplified and/or reduced in number; are there objectives missing? Do they reflect the over-arching goals of NHS commissioning?

Assessing progress

4. What is the best way of assessing progress against the mandate, and how can other people or organisations best contribute to this?

5. Do you have views now about how the mandate should develop in future years?

Improving our health and our healthcare

6. Do you agree that the mandate should be based around the NHS Outcomes Framework, and therefore avoid setting separate objectives for individual clinical conditions?

7. Is this the right way to set objectives for improving outcomes and tackling inequalities?

8. How could this approach develop in future mandates?

Putting patients first

9. Is this the right way for the mandate to support shared decision-making, integrated care and support for carers?

10. Do you support the idea of publishing a "choice framework" for patients alongside the mandate?

The broader contribution of the NHS

11. Does the draft mandate properly reflect the role of the NHS in supporting broader social and economic objectives?

Effective commissioning

12. Should the mandate include objectives about how the Board implements reforms and establishes the new commissioning system?

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Annex B

A Consultation on the Draft Mandate to the NHS Commissioning Board

Proposed Response to Consultation Questions

Section One: Our Approach to the Mandate

Q1 Will the Mandate drive a culture which puts patients at the heart of everything the NHS does?

Q2 Do you agree with the overall approach to the draft mandate and the way in which the mandate is structured?

Q3 Are the objectives right? Could they be simplified and/or reduced in number and are there objectives missing? Do they reflect the overarching goals of NHS commissioning?

While it is possible to comment on general terms on the draft mandate and on the choice of topics for which objectives will be set. However, it is not possible to comment on the detail of any quantifiable objectives as that detail is not yet given and nor is it possible to comment authoritatively on anticipated effectiveness of some of the other proposals until it is clear how the NHSCB interprets the Mandate and how the NHSCB behaves in practice.

We welcome the objective that promotes integrated care including the emphasis on "joint commissioning around individuals, particularly people with dementia and other complex conditions". We also welcome the objective that promotes parity between mental and physical health as well as emphasising the interrelationship between the two. Finally, we welcome the two part objective on improved support for carers.

We would like to see a statutory review of the Mandate in one year's time once the NHSCB has had the Mandate and being working with it in order to ensure that the general objectives are being delivered and that sufficient consultation and co-production is taking place.

Section Two: Assessing progress

Q4 What is the best way of assessing progress against the mandate, and how can other people or organisations best contribute to this?

Annex B

Q5 Do you have views now about how the mandate should develop in future years?

The local Health & Well-being Board must be able play a key role in assessing progress against the objectives and also in developing the Mandate for the future. It is essential the voice of the public is heard at a local level in order that the NHS can be shaped "bottom up" as well as being moulded "top down". If the Health & Well-being Board does not have this influence then the main purpose of the NHS reforms – to make services more clinically led and more responsive to local need – will be lost.

Section Three: Improving our health and our healthcare

Q6 Do you agree that the Mandate should be based around the NHS Outcomes Framework, and therefore avoid setting separate objectives for individual clinical conditions?

Q7 Is this the right way to set objectives for improving outcomes and tackling inequalities?

Q8 How could this approach develop in future mandates?

We suggest that there should be much more mention and attention paid to the Public Health Outcomes Framework and the Social Care Outcomes Framework in the Mandate. Failure to do so will encourage and enable the NHS to work in a silo or vacuum and will not encourage an appropriate effective approach to reducing inequalities.

Section Four: Putting patients first

Q9 Is this the right way for the Mandate to support shared decision-making, integrated care and support for carers?

Q10 Do you support the idea of publishing a "choice" framework for patients alongside the Mandate?

The mandate alone cannot do anything more than set a direction of travel and the key will be how the NHSCB behaves in practice. It is entirely right that there should be greater shared decision making, integrated care and support for carers but these are easy ideals to have and we will want to see that they have an appropriate weight when set against the need for the NHS Commissioning Board to drive efficiencies and service transformation.

Section Five: The broader contribution of the NHS

Q11 Does the draft Mandate properly reflect the role of the NHS in supporting broader social and economic objectives?

Once again, we strongly support the emphasis on the NHS playing a role in supporting broader social and economic objectives. It is not something that the NHS has generally undertaken very well or made much real commitment to. The emphasis on supporting economic growth is really important given the impact that employment and financial well-being have on health outcomes.

Section Six: Effective commissioning

Q12 Should the mandate include objectives about how the Board implements reforms and established the new commissioning system?

In general, the "how" should be left to the Board to determine and not directed "top down" by Government. However, we would like to see more emphasis here on integrated commissioning and integrated care.

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Draft Health Overview & Scrutiny Committee Work Plan 2012/2013

Meeting Date	Work Programme
6 August 2012	1. Interim Report – End of Life Care Review
12 September 2012	1. Health Watch Procurement Monitoring Report 2. Introduction from the new Director of Public Health (DPH) – challenges and priorities for the DPH 3. Progress Report on the Major Trauma Network 4. Proposal to redesign older people's mental health services and enhance provision of community care and support 5. First Quarter CYC Finance & Performance Monitoring Report 6. Consultation on Local Authority Health Scrutiny 7. Consultation on the Mandate to the NHS Commissioning Board 8. Workplan for 2012-13

24th October 2012	1. Attendance of NHS North Yorkshire & York and Vale of York Clinical Commissioning Group – Financial Status and Handover Process 2. Health Watch Procurement Monitoring Report 3. Transition Update 4. Progress Report from Leeds & York Partnership NHS Foundation Trust (Mental Health Services) 5. The Local Account for Adult Social Care 6. Update Report on Proposed Changes to Children's Cardiac Services and Formation of a Joint Health Overview and Scrutiny Committee to respond to A National Consultation on Adult Cardiology Services 7. *Possible Final Report of End of Life Care Review* 8. Update on changes to the Urgent Care Unit at York Hospital 9. Workplan for 2012-13

19th December 2012	1. Health Watch Procurement Monitoring Report 2. Second Quarter CYC Finance & Performance Monitoring Report 3. Update on Implementation of the NHS 111 Service 4. Update on Yorkshire Ambulance Service Patient Transport Services 5. Update on the Recent Review of Services for Homeless Patients at Monkgate Health Centre 6. Safeguarding Assurance report 7. Update Report on the Carer's Strategy 8. Update on the implementation of outstanding recommendations arising from the Carer's Scrutiny Review 9. Scoping Report – Personalisation Review 10. Workplan for 2012-13
16th January 2013	1. Health Watch Procurement Monitoring Report 2. Update on the North Yorkshire Review 3. Update from Leeds & York Partnership NHS Foundation Trust (Access to Talking Therapies/Improving Access to Psychological Therapy(IAPT)) 4. Scoping Report – Review into Community Mental Health Services in Care of Adolescents (particularly boys) 5. Workplan for 2012-13

20th February 2013	1. Health Watch Procurement Monitoring Report 2. Workplan for 2012-13
13th March 2013	1. Health Watch Procurement Monitoring Report 2. Third Quarter CYC Finance & Performance Monitoring Report 3. Workplan for 2012-13
24th April 2013	1. Health Watch Procurement Monitoring Report 2. Workplan for 2012-13