PLEASE NOTE TIME OF MEETING

HEALTH SCRUTINY FORUM AGENDA

HARTLEPOOL BOROUGH COUNCIL

23 August 2012

at 9.00 a.m.

in the Council Chamber, Civic Centre, Hartlepool.

MEMBERS: HEALTH SCRUTINY FORUM:

Councillors S Akers-Belcher, Brash, Fisher, Hall, Hargreaves, G Lilley and Wells

All Members of the Council are invited to attend the meeting for the consideration of Agenda item 7.2 'Outpatient Services':-

The Mayor, Stuart Drummond,
Councillors Ainslie, C Akers-Belcher, Beck, Cook, Cranney, Dawkins, Fleet, Gibbon, Griffin, Hill, Jackson, James, Lauderdale, A E Lilley, Loynes, Dr. Morris, Payne, Richardson, Robinson, Shields, Simmons, Sirs, Tempest, Thompson, Turner and Wilcox.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To confirm the Minutes of the meeting of the forum held on 28 June 2012.
   3.2 To receive the minutes of the Shadow Health and Wellbeing Board held on 18 June 2012.

4. **RESPONSES FROM LOCAL NHS BODIES, THE COUNCIL, EXECUTIVE OR COMMITTEES OF THE COUNCIL TO FINAL REPORTS OF THIS FORUM**

   No items.

5. **CONSIDERATION OF REQUEST FOR SCRUTINY REVIEWS REFERRED VIA SCRUTINY CO-ORDINATING COMMITTEE**

   No items.

PLEASE NOTE TIME OF MEETING

6. **CONSIDERATION OF PROGRESS REPORTS / BUDGET AND POLICY FRAMEWORK DOCUMENTS**

6.1 Consultation Process for Health and Wellbeing Strategy - *Director of Public Health*

7. **ITEMS FOR DISCUSSION**

7.1 Request to establish a Joint Health Scrutiny Committee – Covering Report – *Scrutiny Support Officer*

7.2 Outpatient Services:-

(a) Covering Report – *Scrutiny Support Officer*
(b) Presentation – *Representatives from Hartlepool and Stockton-on-Tees Clinical Commissioning Group / NHS Tees*

7.3 Health Scrutiny Forum Work Programme: Referral of Items – *Scrutiny Support Officer*

7.4 Investigation into Sexual Health: Scoping Report – *Scrutiny Support Officer*

7.5 Local Authority Health Scrutiny – Consultation – *Scrutiny Support Officer*

8. **ISSUES IDENTIFIED FROM FORWARD PLAN**

9. **MINUTES FROM RECENT MEETING OF TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE**

9.1 Minutes of the meeting held on 2 July 2012 *(to follow)*

10. **REGIONAL HEALTH SCRUTINY UPDATE**

10.1 Verbal update from the regional meeting held on 9 August 2012 – *Member of Regional Health*

11. **ANY OTHER ITEMS WHICH THE CHAIRMAN CONSIDERS ARE URGENT**

FOR INFORMATION:

Date of Next Meeting – 20 September 2012, 9.00am in Committee Room B at the Civic Centre, Hartlepool.

HEALTH SCRUTINY FORUM

MINUTES

28 June 2012

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Stephen Akers-Belcher (In the Chair)

Councillors: Jonathan Brash, Keith Fisher, Gerard Hall, Geoff Lilley and Ray Wells.

In accordance with Council Procedure Rule 4.2 (ii), Councillor Marjorie James was in attendance as substitute for Councillor Pamela Hargreaves.

Also Present: Councillors Jim Ainslie, Keith Dawkins, Sheila Griffin, Alison Lilley, Brenda Loynes, Carl Richardson and Sylvia Tempest.

Lynn Kirby, Associate Director of Operations, Julie Gillon, Chief Operating Officer / Deputy Chief Executive and Jean McLeod, Clinical Director / Consultant Physician,
Sue Piggott, General Manager, Medicine and Emergency Care, North Tees and Hartlepool Foundation Trust
Ali Wilson, Director of Commissioning and Systems Devlepment, NHS Tees and Interim Chief Officer, NHS Hartlepool and Stockton on Tees CCG
Dr N Timlin, GP and Clinical Commissioning Group
Councillor Paul Stradling, Vice Chair of Scrutiny, Durham County Council
Jonathan Slee, Scrutiny Officer, Durham County Council
Mark Cotton – Assistant Director of Communications and Engagement - North East Ambulance Service

Officers: Louise Wallace, Director of Public Health
Laura Stones, Scrutiny Support Officer
Angela Armstrong, Principal Democratic Services Officer

16. Apologies for Absence

Apologies for absence were received from Councillors Hargreaves along with Fleet, Morris, Payne and Shields.

17. Declarations of Interest by Members

Councillor Jonathan Brash declared a personal interest in minute 22.

Councillor Keith Fisher wished it to be noted that the Council had unanimously passed a resolution of no confidence in the Senior Leadership of the North Tees and Hartlepool Foundation Trust.

18. Minutes of the meeting held on 15 June 2012

Confirmed.

19. Responses from the Council, the Executive or Committees of the Council to Final Reports of this Forum

None.

20. Consideration of request for scrutiny reviews referred via Scrutiny Co-ordinating Committee

None.

21. Consideration of progress reports/budget and policy framework documents

None.

22. Relocation of Outpatient Services from University Hospital of Hartlepool to One Life, Hartlepool (*Scrutiny Support Officer/Representatives from NHS Tees and North Tees and Hartlepool Foundation Trust*)

Members were informed that whilst the relocation of Outpatient Services from the University Hospital of Hartlepool to One Life was on hold, it was considered that inviting discussions at this point would enable Members' and the publics' views and comments on the proposals to be taken on board at the earliest opportunity in the process.

The presentation highlighted the national drivers behind the proposed relocation of outpatient services from University Hospital of Hartlepool to One Life, Hartlepool. It outlined the Nolan principles and listed the expectations from both a professional and patient perspective. It was suggested that the co-location of services alongside services already provided within the One Life Centre would provide a more efficient and effective delivery of those services. A number of other suggested benefits from the changes were noted within the presentation. It was suggested that

further engagement be undertaken to help decide what reasoning to use in service design and how to prioritise the changes through Overview and Scrutiny in August/September this year.

Members were disappointed that the proposal to relocate Outpatients Services from the University Hospital of Hartlepool to One Life had been announced publicly before being brought to the attention of the Health Scrutiny Forum. The Interim Chief Officer for the CCG and NHS Tees accepted that and apologised for this error in communication.

A Member commented that whilst he was not desperately anxious about the relocation of services within Hartlepool, he was very concerned that the more services that were removed from the University Hospital of Hartlepool, the less viable it would be as a working Hospital. Whilst it was acknowledged that the Foundation Trust had to make huge savings and the advantages of co-locating services would bring, a full and frank debate was needed on the future of Hospital provision for the area and any transition arrangements that may be required from the current arrangements to any new or revamped hospital. It was recognised that the future provision of Hospital services was a very important issue that did require further discussion, however, the focus for today was to look at the possible relocation of outpatient services. The representatives from NHS Tees and the North Tees and Hartlepool Foundation Trust confirmed that the proposal to relocate the Outpatient Services had been put on hold pending further consultation. However, it was noted that whilst one of the key drivers for the proposed change was the level of savings required, the main aim was to deliver safe, appropriate and quality care to patients.

A member of the public raised a number of concerns about access to the One Life Centre via the controlled crossings. It was confirmed that there were several disabled parking bays within the One Life Centre car park and the building was designed to accommodate full disabled access throughout the building. It was noted that the car parking on the site had been limited due to planning constraints and the fact that there was a public car park across the road. In relation to the operation of the controlled crossings, it was noted that this was a local authority responsibility and would be reported to the Traffic and Transportation Team.

In response to a number of concerns from a Member on the level of consultation to be undertaken, a representation from North Tees and Hartlepool NHS Foundation Trust confirmed that the importance of engaging with the public, Members and staff had been recognised to help shape future services to provide the kind of health care required in this area. Members were informed that hospital clinicians were happy to deliver services within the community, as long the clinic was well ran and provided an appropriate service for the patient which ultimately made an improvement to their life. It was confirmed that the proposed changes were a continuation of the Momentum – Pathways to Healthcare Programme which aimed to develop a single site hospital and bring care provision into the local community.

It was noted that the Governing Body of the Clinical Commissioning Group was seeking two lay members with skills around audit and finance and patient engagement/involvement and applications from local people were welcomed.

Concerns were raised around the public transport provision to other hospitals in the region, for example the James Cook Hospital. The Interim Chief Officer for the CCG commented that whilst the importance of providing as much care in the local community as possible was reiterated, it was acknowledged that sometimes people did have to travel to access specialist care as it was not always feasible to provide this safely and effectively locally. In response to claims that it was difficult to recruit appropriately trained staff, it was noted that a number of specialist staff had recently been recruited across several specialist areas to cover the Hartlepool, Stockton and Easington area.

A Member highlighted that mis-communication had played a huge part in the negative public perception of the future provision of health services and better, clearer publicity of the future provision of services and the funding arrangements involved was required to resolve this issue. It was confirmed that alternatives to Public Finance Initiative (PFI) funding had been explored and any new hospital development would now be funded through pension fund borrowing which had much lower interest rates than PFI.

It was highlighted that there was confusion with the west approaching junction to the One Life Centre with cars having to turn left away from the Centre to then turn back gain access to the site. Whilst it was recognised that this was a highways issue, this should be re-examined and would be forwarded to the Traffic and Transportation Team.

Whilst it was acknowledged that some services had been relocated from the University Hospital of Hartlepool to alternative sites, the footprint of the hospital was being utilised to ensure that the building did function as effectively as possible.

In response to a question from a Member, it was confirmed that the North Tees and Hartlepool Foundation Trust was funding running costs associated with the University Hospitals of North Tees and Hartlepool.

The representative from Overview and Scrutiny at Durham County Council sought clarification on when the South East Durham area would become involved in the community engagement as residents in the area felt that they had been forgotten about. The Interim Chief Officer for the CCG confirmed that NHS Durham and Durham's Clinical Commissioning Group were responsible for consultation and engagement with residents and Members of the South East Durham area and the fact that this question had been raised would be forwarded to them directly. The Chair reiterated the importance of involving residents and elected Members from the South Durham area as they were very important partners in the process and it was hoped that the streams of communication could be widened.

A member of the public commented that she had documentary evidence that the North Tees and Hartlepool Foundation Trust took ownership of the University Hospital of Hartlepool in 1999.

A Member referred to the fact that it had been stated previously that it was difficult to recruit doctors to keep the Accident and Emergency Service running effectively and efficiently at the University Hospital of Hartlepool and that had been part of the reasoning for relocating the service to the University Hospital of North Tees. A representative from the North Tees and Hartlepool Foundation Trust confirmed that it had been difficult to recruit and retain junior doctors in the Accident and Emergency Department as they needed to move around different specialist services in order to gain the required experience. It was noted that the recruitment of Accident and Emergency doctors was proving a nationwide problem. Whilst there had been difficulties and different pressures in this area, there were no such difficulties in recruiting within some specialist areas of the medicine department.

A Member questioned the reasoning behind moving services from University Hospital of Hartlepool to the University Hospital of North Tees which was an older building. A representative from the North Tees and Hartlepool Foundation Trust indicated that the move to centralise services was driven by standards and data not by the actual buildings. The evidence had shown that centralising services was the most effective way of providing health services that could not be provided within the local community. In response to concerns about the distance to be travelled to the Accident and Emergency Department at the University Hospital of North Tees, the representative confirmed that treatment commenced as soon as the patient was in the ambulance due to the fully trained paramedics on board.

A member of the public questioned the capacity of the One Life Centre, especially in view of the proposed relocation of further services. The Director of Commissioning and Systems Development at NHS Tees confirmed that prior to developing the proposals, detailed investigation work had been undertaken to ascertain the capacity of the building including estimated footfall of people visiting the building and whether it could accommodate the services to be included within the proposals.

The Interim Chief Officer for the CCG confirmed that a full consultation exercise was undertaken during the development of the One Life Centre and this would carry on throughout the continuous efforts to improve the standard and quality of care for patients within the area. Whilst it was acknowledge that there were some difficult questions to answer and conversations to have, the continuous involvement and feedback from scrutiny and members of the public was welcomed.

The Chair thanked everyone in attendance for their contribution and for some interesting questions. In conclusion, it was noted that Members do not want to see more services moved away from the University Hospital of Hartlepool and the NHS Tees, Foundation Trust and Clinical Commissioning Group representatives were challenged to respond to this request.

Recommended

(i) The presentation and question and answer session was noted.
(ii) That a further meeting be scheduled August/September to re-examine the proposals after further consultation had been undertaken.
(iii) That the Council's Traffic and Transport Team be requested to examine the junction on Park Road with the One Life Centre taking into account the concerns raised above and report back to Members.

The Chair had to leave the meeting, Councillor Hall in the Chair.

It was noted that the meeting was inquorate.

23. Changes to Ambulance Locations (*Scrutiny Support Officer/Representative from the North East Ambulance Service*)

The Assistant Director of Communications and Engagement from the North East Ambulance Service (NEAS) was in attendance and provided Members with a comprehensive and detailed presentation which looked at the review of the Accident and Emergency service provision from within NEAS.

The Chair returned to the meeting – Cllr S Akers Belcher in the Chair.

The meeting was quorate.

An overview of demand and the performance against that demand was included within the presentation. As a result of the review, a number of changes were proposed including:

- Location of vehicles
- Mix of vehicles at each station
- The location of staff
- Example rotas

It was noted that there had been a small increase in overall staffing numbers and an increase in vehicle numbers. The existing support role to paramedics on front line A&E Ambulances was to be retained and this was reflected in the new staffing model which also identified where all resources were required. It was noted that the consultation process on the proposed changes had commenced with a proposed implementation date of April 2013, although some changes may be in place in October 2012.

A member of the public sought clarification on the average waiting time for an ambulance if requested by a District Nurse. The Assistant Director of Communications and Engagement indicated that the timeframe would be provided by the District Nurse as any clinicians on site were best placed to estimate the required timeframe necessary.

It was highlighted that there was a formal complaints procedure and any

feedback was welcomed as this helped shape the future of the service.

A member of the public referred to the increase in 999 calls and the Assistant Director indicated that this did not necessary point to an increase in patients, but could possibly by where patients were confused as to where they needed to attend for treatment.

In response to a question from a Member, the Assistant Director confirmed that the planning of what type of vehicles to place where was based on historical records of demand. A triage system was operated which had been developed by GPs and Accident and Emergency Consultants and this provided simple questions to ascertain whether a call was life threatening or not within 30 seconds.

The Chair requested an update be provided to the Forum on the flow of services and access routes to the Emergency Assessment Unit at Hartlepool Hospital; the One Life Centre; and North Tees Hospital and how people are accessing the services, for example, by ambulance referral, GP referral etc.

Cllr S Akers-Belcher had to leave the meeting. Cllr Hall in the Chair.

It was noted that the meeting was in quorate.

In relation to the demand for the service, the Assistant Director indicated that there was no definitive reason behind the increase, but lots of little reasons, such as accessibility of services, people living longer and developing more chronic conditions along with societal change where up to 30 mobile telephone calls were received for every accident reported. However, the increase in demand was not out of sync with other areas.

A number of concerns were raised by member of the public and the Chair indicated that the most effective way to have these specific issues examined would be to report them through the incidents or complaints procedure of NEAS.

Members were informed that the '111' service currently operating in Durham was to be rolled out across the remaining north east region during 2013. The intention of this service was to identify where patients needed to go for the most appropriate help. It was noted that this would be subject to further discussion at a future meeting of the Scrutiny Forum.

In relation to the funding of the NEAS, the Assistant Director confirmed that the service provision was based upon quality of care and not just against cost. It was noted that the patient transport service was open to competition and had been for a number of years and this posed a significant risk as it could result in a substantial reduction in income for the service should another organisation take over the service. In addition to the above, the NEAS also received income from the provision of training courses and paramedic cover for outside events and activities as long as they did not impact on core services.

A member of the public questioned the governance arrangements of NEAS and the Assistant Director confirmed that it was a similar structure to the local hospital trust as the NEAS service was funded through the 12 primary care trusts in the region. Other services, such as the patient transport services were governed through contractual arrangements.

In response to a question by a Member the Assistant Director confirmed that the NEAS operated an extremely good and up to date mapping system produced by ordnance survey. However, should the paramedics realise any anomalies within the mapping system, they were immediately updated manually. It was noted that the local knowledge of the paramedics was vital to the quick and effective delivery of the service.

Members were of the view that the Health Scrutiny Forum should continue to monitor the proposals and asked for a progress update to be brought back to the Forum.

The Assistant Director extended an invitation to all Members to visit the 999 control room located within the Headquarters of NEAS at some point in the future through a prior arrangement.

The Assistant Director was thanked for his informative presentation and for answering a number of questions.

Recommended

The presentation and discussion that followed were noted.

24. Issues identified from the Forward Plan

The Chair highlighted that a decision was to be taken by Cabinet in the next couple of months in relation to the review of community involvement and engagement and composition of the Health and Well Being Board. It was noted that it was important that all local Elected Members were fully represented on that body as it was an opportunity to work together to improve public health and well being.

Recommended

Noted.

25. Feedback From Recent Meetings of Tees Valley Health Scrutiny Joint Committee

None.

26. Any Other Items which the Chairman Considers are Urgent

None.

The meeting concluded at 2.09 pm

CHAIR

SHADOW HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

18th June 2012

The meeting commenced at 10.00 am in the Cleveland Fire Authority Headquarters, Hartlepool

Present:

The Mayor, Stuart Drummond - In the Chair

Statutory Members

Councillors: Cath Hill (Deputy Mayor) (Children's and Community Services Portfolio Holder)
John Lauderdale (Adult and Public Health Services Portfolio Holder).
Paul Thompson (Finance and Corporate Services Portfolio Holder)

Christopher Akers-Belcher, Hartlepool LINK Co-ordinator
Nicola Bailey, Acting Chief Executive
Dr Paul Pagni, Clinical Commissioning Group
Louise Wallace, Director of Public Health
Margaret Wrenn, Hartlepool LINK Chair

Non Statutory Members: -
Keith Bayley, HVDA
Nichola Fairless, Associate Director of Strategy, Contracting and Performance, North East Ambulance Service
Alan Foster, Chief Exec, North Tees and Hartlepool NHS Foundation Trust
Dave Stubbs, Director of Regeneration and Neighbourhoods
David Turton, District Manager, Cleveland Fire Authority

Also Present:
Sarah Bowman, Acting Consultant in Public Health (NHS Tees)
Ali Wilson, Interim Chief Officer, Hartlepool and Stockton Clinical Commissioning Group/Director of Commissioning, NHS Tees
Catherine Frank, Performance and Partnerships Manager
Amanda Whitaker, Democratic Services Team Manager

Prior to the commencement of the meeting, the Chair congratulated Louise Wallace on her appointment to the post of Director of Public Health for Hartlepool.

60. Apologies for Absence

Jill Harrison, Assistant Director, Adult Social Care, Sally Robinson, Assistant Director, Prevention, Safeguarding and Specialist Services Chris Willis, Chief Executive, North Tees and Hartlepool NHS Foundation Trust, Martin Barkley, Chief Executive, Tees and Esk Valley NHS Trust

61. Declarations of interest by Members

None

62. Minutes of the meeting held on 23 April 2012

Confirmed.

63. Matters arising from Minutes

Update on Troubled Families – In terms of participation in the development and implementation of the Troubled Families Programme, the Director of Public Health reported that a representative had been identified by the Tees Esk and Wear Valley NHS Trust, details of which had been forwarded to the Assistant Director, Neighbourhood Services.

64. Joint Strategic Needs Assessment

The Director of Public Health provided the Board with a verbal update on progress of the web based Joint Strategic Needs Assessment. The website was continuing to be uploaded and it was intended to submit a report to the September meeting of this Board.

65. Public Health Policy Round Up

The Director of Public Health provided a verbal update on Public Health. It was noted that Public Health England had appointed its Chief Executive and appointment of senior officers would follow. It was expected that Public Health Intelligence would be provided together with information in support of establishment of Clinical Commissioning Groups. In terms of secondary legislation on Health and Wellbeing Boards, initial information had been received. It was agreed that information would be circulated to Board Members which could be considered further at the next meeting of the Board.

The Council's Acting Chief Executive informed the Board that consultation on the new funding formula for Public Health had been received recently from the Department of Health and which included information on indicative public health budgets for each Local Authority area. It was agreed to circulate that information to Board Members when further consideration had been given to the information which had been provided. It was intended also to include as an agenda item to a future Tees Valley Chief Executive's meeting.

The Chief Executive of North Tees and Hartlepool NHS Foundation Trust, Alan Foster, advised that he had also received a copy of the document

referred to by Nic Bailey. He added that there could be a funding issue arising as a result of public health expenditure in the North of England currently being higher than in other parts of the country and questioned if the budget could be ring fenced. In response, Board Members were advised that the new funding formula was based on age, rather than health factors. Board Members discussed the implications, and expressed concerns, if the formula was to be based on age considerations. It was agreed that the concerns should be highlighted whenever possible including any network agendas and that MPs should also be made aware of the issue.

Decision

The update was noted.

66. Clinical Commissioning Group – Update on Authorisation

The Shadow Board received an update from Ali Wilson, Interim Chief Officer, Hartlepool and Stockton Clinical Commissioning Group/Director of Commissioning, NHS Tees, which provided Board Members with an update on Clinical Commissioning Group (CCG) authorisation. The presentation covered the background and process for establishment of CCGs, the criteria for authorisation, the authorisation method and details of documents which were required for submission. The CCG Vision was reiterated together with how the Clear and Credible Plan would achieve that Vision and the positive implications on local people.

Ali Wilson responded to questions arising from the presentation in terms of involvement in the authorisation process and clarified involvement of stakeholders in 360 degree survey.

Decision

The update was noted.

67. Partnership Arrangements for the Shadow Health and Wellbeing Board (*Director of Public Health*)

Further to minute 58 of the meeting held on 23 April 2012, the Director of Public Health reported that the new partnership arrangements needed to allow flexibility so that the structure could be responsive to emerging areas of concern. Rather than identify a static range of groups that fall under the Health and Wellbeing Board, it was proposed that a more fluid approach be taken. In order to reflect the role of wider determinants within the Health and Wellbeing Board it was proposed that all groups be clustered under the 6 Marmot policy areas.
It was proposed that owners be identified for each of the policy areas from the Shadow Health and Wellbeing Board Members. They would be the key

contact for all groups under that policy area and would provide the link into the Shadow Board. It was recognised also that the other theme groups would have key roles in the delivery of the policy areas and in some areas would take the lead. In addition to reflect the commissioning and performance role of the Board, it was proposed that a Performance and Commissioning Group be established, the remit of which was set out in the report.

The proposed structure, reflecting the cross cutting nature of the Public Health Outcomes Framework, was appended to the report. Also appended to the report was an initial draft setting out the existing groups and strategies for each of the Marmot policy areas.

In terms of the policy area 'ensure healthy standard of living for all', it was highlighted that only the Child Poverty Strategy had been identified. It was suggested that perhaps other Groups and Strategies should be included. Board Members recognised that almost everything fitted under this overarching policy area. In terms of the current groups which had been identified in the appendix, it was proposed that a Board Member be identified to overview each of the Groups.
Whilst seeking volunteers to lead on policy areas, the reduction in management capacity was recognised together with the need to reduce the duplication in both the representation on groups and the work undertaken by those groups.

Decision

i. The proposed Performance and Commissioning Group was agreed.
ii. The principles of the partnership arrangements that sit underneath the Shadow Health and Wellbeing Board and how they will feed in and support the work of the Board, were agreed.
iii. The following Lead Board Members were identified and it was agreed that the outcome of considerations would be reported to the September meeting of the Shadow Board:-
    - Create and develop healthy and sustainable places and communities – Mayor, Chair of Board
    - Enable all children, young people and adults to maximise their capabilities and have control over their lives – Joint Clinical Commissioning Group and Child and Adult Department representatives
    - Strengthen the role and impact of ill health prevention – Director of Public Health
    - Create fair employment and good work for all - Director of Regeneration and Neighbourhoods
    - Give every child the best start in life – Child and Adult Department representative
    - Ensure healthy standard of living for all – in order to avoid potential duplication a lead was not considered applicable as it was agreed as an overarching policy area with all Board Members having responsibility to deliver.

68. Consultation Process – Health and Wellbeing Strategy

Further to discussion at previous meetings of the Board, Members received a further update on the development of the Health and Wellbeing Strategy with particular reference to consultation timescales and the rationale for determination of the following 2 stages:-

- Decisions on strategic aims and objectives
- Prioritising objectives

With regard to the first stage in the process, it was intended to consult a wide range of organisations and a web based survey would be available. It was proposed to submit a framework to this Board for approval which would then be used to facilitate consultation. The final draft strategy would then be circulated.

The importance of avoiding duplication with the Joint Strategic Needs Assessment (JSNA) was acknowledged. Board Members were advised that the Resource Pack would include key elements of the JSNA. Discussion followed on the format of the Health and Wellbeing Face the Public Event which had been arranged for 17th July. The draft format had been circulated to Board Members. It was agreed that the format be realigned on the basis of discussions held earlier in the meeting when project leads had been identified (minute 67 refers).

Decision

The update was noted and the format of the Health and Wellbeing Face the Public event was agreed.

69. Developing a Communication and Engagement Strategy for the Shadow Board *(Director of Public Health)*

The Director of Public Health highlighted that as the Shadow Health and Wellbeing Board developed into the statutory Board, there would be a need to communicate and engage with the public, key partners and the Voluntary and Community Sector (VCS). It was proposed, therefore, that a small sub group be established to prepare the Communication and Engagement Strategy. In order to assist in the preparation of the Strategy it was also proposed that all partners provide details of their current communication and engagement mechanisms so that, where possible, existing mechanisms are utilised and duplication is avoided. In order to implement the Strategy, an action plan would also be prepared.

Decision

(i) It was agreed that a Communication and Engagement Strategy be prepared and a draft Strategy and Action Plan be prepared to submission to the September meeting of the Board

(ii) It was agreed that the sub group comprise the following:-

- Representative of Hartlepool Borough Council's Press and Public Relations Team (representing also Cleveland Fire Authority)
- Representative of North Tees and Hartlepool NHS Foundation Trust's Communications Team
- Hartlepool LINK Co-ordinator
- Representative of NHS Tees Communications Team
- Representative of Tees, Esk and Wear Valley Communications Team.

70. Transport and Health – Presentation by Director of Public Health and Director of Regeneration and Neighbourhoods

The Board received a joint presentation by the Director of Public Health and the Director of Regeneration and Neighbourhoods. The presentation addressed issues including implications of carbon dioxide emissions, road traffic injuries, physical inactivity and outdoor air and noise pollution. Those issues needed to be considered in context of requirement for transport in terms of enabling access to work, education, economies and social networks. Improvements in public health could be achieved by promoting sustainable and active travel creating health environments and reducing non-communicable disease. Public Health improvements would also be achieved by reducing risk of road injuries, increasing numbers of children walking to school (a cycle training grant had been received to deliver training to 10000 school children) and improvements to cycling infrastructure. A non-recurring grant had been received to deliver childhood injury prevention schemes which would be achieved through partnership working with Children and Adults Department to deliver schemes across communities. The Director of Public Health acknowledged that the transport and health link was a complex issue but considered that it was an issue which this Shadow Board needed to consider.

Following the presentation, the Associate Director of Strategy, Contracting and Performance, provided an update on patient transport services provided by the North East Ambulance Service. Board Members acknowledged opportunities to consider more integrated options to improve effectiveness and efficiency of the provision of transport.

The Hartlepool LINK Co-ordinator, referred to the need to review the Tees Valley criteria relating to the eligibility for free transport to hospital service in light of a number of complaints which had been received by LINK. It was noted that this issue would be considered further by the Clinical Commissioning Group representatives.

It was highlighted also that a number of patients did not attend medical appointments for financial reasons and that although financial assistance was available from the North Tees and Hartlepool NHS Foundation Trust, it was not well advertised to patients. In response, the Chief Executive North Tees and Hartlepool NHS Foundation Trust agreed to consider the possibility of including reference, to the financial assistance which was available towards transport costs, in appointment letters sent out by the Trust.

Board Members acknowledged social inclusion issues associated with provision transport. It was highlighted that the Joint Strategic Needs Assessment included reference to transport. It was agreed to circulate the relevant extract of the JSNA, to the Shadow Board when completed, to ensure up to date information had been captured. It was agreed also that it would be appropriate for the Performance and Commissioning Group to consider this issue and report back to the Board.

Decision

The presentation was noted.

71. Work Programme

The Shadow Board's Work Programme 2012/13 had been circulated. Board Members were requested to notify the Director of Public Health of any additional items for inclusion in the Work Programme.

Decision

The Work Programme 2012/13 was noted.

The meeting concluded at 11.45 a.m.

CHAIR

HEALTH SCRUTINY FORUM

23 August 2012

Report of: Director of Public Health

Subject: CONSULTATION PROCESS FOR HEALTH AND WELLBEING STRATEGY

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to outline to the Health Scrutiny Forum the proposed consultation process for the draft joint Health and Wellbeing Strategy (JHWS).

1.2 It is anticipated that the consultation process will allow for consultation with stakeholders on the strategic aims and objectives to be set out in the strategy and also, to prioritise the strategic objectives to deliver the strategic aims for health and wellbeing in Hartlepool.

2. BACKGROUND

2.1 The NHS reform requires the Local Authority with partners agencies including the NHS to develop a joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment (JSNA). The final draft of the strategy must be completed by April 2013. The strategy should focus on not only protecting the health of the population but improving it through a range of evidence based interventions.

3. CONSULTATION PROCESS

3.1 The aims of the consultation process are:

1. To consult stakeholders on the strategic aims and objectives to be set in the JHWS for Hartlepool;

2. To prioritise the strategic objectives to deliver the strategic aims for health and wellbeing in Hartlepool.

3.2 The purpose of consultation is as follows:

- Understand stakeholder views
- Incorporate into Strategy where possible and appropriate
- Fulfill democratic mandate of Local Authority

- Ascertain strategic objectives
- Prioritise objectives
- Inform work programme
- Inform stakeholders of current position
- Manage expectations of stakeholders
- Build platform for ongoing feedback and meaningful stakeholder engagement

3.3 The desired outcomes of consultation are:

Outcome for aim 1:

A set of strategic aims for the Health and Wellbeing Strategy for Hartlepool; and strategic objectives that describe how the Health and Wellbeing Board and its partners will address the aims.

Outcome for aim 2:

A set of strategic objectives that have been prioritised according to agreed criteria.

3.4 The following principles will be adopted during the consultation process:

- Fit with and maximise existing consultation processes
- Add to the existing process as needed
- Be 'fit-for-purpose' for the new world
- Clear process for consultation, with clear definitions e.g. definitions of different types of evidence and different types of need
- Consult a wide range of 'appropriate' stakeholders
- Clear aims and outcomes
- Build on existing work where appropriate
- Encourage innovative and creative working
- Clear expectations about the process and outcomes of consultation
- Clear communication and feedback processes from the consultation

3.5 The consultation process will be carried out in three stages. The stages may not be mutually exclusive; however staging the process encourages a focused approach on specific outcomes throughout a potentially complex process. Different methods will be used for each stage.

Stage 1: Consultation on the strategic aims and objectives for the JHWS

This will enable wide stakeholder engagement on a range of topics and will encourage creative thinking, discussion about what is already done and about where the gaps might be. Stage 1 consultation will be carried out through the 'Face the Public' event and consultation with existing key stakeholder forums:

- Strategic Partners' Group
- Four theme groups:

  - Shadow Health and Wellbeing Board
  - Safer Hartlepool Partnership
  - Housing Partnership
  - Economic Regeneration Forum

- Neighbourhood fora
- Clinical Commissioning Group

It will be important to ensure the most vulnerable groups (who are the most likely to suffer poor health and wellbeing outcomes) are consulted through the above groups.

3.6 Method for consultation

Consultation at 'Face the Public' events will be through:

- Providing background context and information to delegates
- Setting expectations and outcomes
- Facilitated workshop discussions to generate strategic aims and objectives

Consultation with existing stakeholder groups and fora will be through:

- Circulation of the available draft JHWS as a discussion point
- Facilitated discussion through attendance at group meetings (a framework for discussion will be provided to ensure the group is consulted on the areas and issues required)

3.7 Stage 2: Prioritisation of the strategic objectives.

This will enable prioritisation of the objectives according to a set of agreed criteria to encourage objectivity. The process will use the strategic objectives generated in stage 1 and is likely to be a structured process.

A framework for prioritisation will be selected based on evidence of good practice and discussion with the Shadow Health and Wellbeing Board. The framework will cover a range of criteria e.g. evidence base, service user and public views, economic considerations and political considerations. The framework will be used to facilitate a structured discussion on how the list of objectives generated in stage 1 should be prioritised.

3.8 Stage 3: Consultation on the draft JHWS

The outcomes of stages 1 and 2 will be assimilated to draw conclusions. These will be fed back to the Shadow Health and Wellbeing Board and will be used to draft a draft JHWS document, which will be circulated for consultation and comment with a wide range of stakeholders.

The draft will be circulated to the key stakeholders from stages 1 and 2 of the consultation process plus additional groups and stakeholders, with a brief

questionnaire to encourage a broad and structured response. It will also be made available on the Local Authority website, together with the consultation questionnaire.

The outcomes of the consultation will be used to inform the final draft of the JHWS, which will be presented to the shadow Health and Wellbeing Board. The work programme for delivery on the objectives will be generated from the JHWS.

3.9. What is needed for consultation?

- List of existing groups
- Existing mechanisms
- Gap analysis
- Proposals to consult on the draft Strategy
- Information pack: evidence base, existing services, possibly cost information / info. on financial resources and pressures
- Have a clear process for feeding back to consultees on the outcome of the consultation and resulting actions
- Have a clear process for incorporating the views of stakeholders into plans
- Clear process (and communication of this process) for ongoing feedback to Health and Wellbeing Board on implementation of the Strategy, once official consultation is complete
- Process for engaging and using the media where appropriate
- Process for linking to other groups who relate to the consultation e.g. CCGs, GPs, VCS

4. Process and timescales

4.1 The following timetable is proposed for the key stages in developing the JHWS:

Step 1 – Initial consultation and development. June – October 2012		
Where	**Description**	**Date of Meeting**
Forward Plan	Entry for Forward Plan due by 14th August 2012	N/A
Face the Public Event	Initial workshops based around 6 Marmot Themes	17 July 2012
Cabinet	Initial report on HWB Strategy setting out the consultation process.	23 July 2012
Scrutiny Coordinating Committee	Initial report on HWB Strategy setting out the consultation process.	27 July 2012

Shadow Health & Wellbeing Board	Initial report on HWB Strategy setting out the consultation process.	30 July 2012
Health Scrutiny Forum	Initial report on HWB Strategy setting out the consultation process.	23 August 2012

During this period further consultation opportunities are being explored, including;

- Practitioner Workshop
- A half day CCG / HW Board event
- Young people specific consultation
- Online consultation utilising survey monkey tool

Step 2 – Formal Consultation Period. October 2012 – February 2313 (minimum 8 week requirement)		
Where	**Description**	**Date of Meeting**
Cabinet	Present draft for consultation	15 October 2012
Health Scrutiny Forum	Present draft for consultation	18 October 2012
Scrutiny Coordinating Committee	Present draft for consultation	19 October 2012 (6 weeks required)
Shadow Health & Wellbeing Board	Present draft for consultation	22 October 2012

Step 3 – Final consultation and endorsement. January – February 2012.		
Where	**Description**	**Date of Meeting**
Forward Plan	Entry for Forward Plan due by 13th November 2012	N/A
Scrutiny Coordinating Committee	Second Draft for comment / endorsement	25 January 2013
Shadow Health & Wellbeing Board	Second Draft for comment/ endorsement	28 January 2013
Cabinet	Second Draft for comment / endorsement	4 February 2013
Health Scrutiny Forum	Second Draft for comment / endorsement	7 February 2013

Step 4 - Political Approval for Strategy. March – April 2013.		
Where	**Description**	**Date of Meeting**
Health Scrutiny Forum	Final Strategy for approval	7 March 2013
Scrutiny Coordinating Committee	Final Strategy for approval	8 March 2013
Shadow Health & Wellbeing Board	Final Strategy for approval	11 March 2013
Cabinet	Final Strategy for approval	2 April 2013
Council	Final Strategy for approval	11 April 2013

5. RECOMMENDATIONS

5.1 Scrutiny Co-ordinating Committee is asked to note the process of consultation for the Joint Hartlepool Health and Wellbeing Strategy.

6. APPENDICES AVAILABLE ON REQUEST, IN THE MEMBERS LIBRARY AND ON-LINE

No appendices attached to this report.

7. BACKGROUND PAPERS

None

8. CONTACT OFFICER

Louise Wallace
Director of Public Health
4th Floor Civic Centre
Hartlepool Borough Council

HEALTH SCRUTINY FORUM

23 August 2012

Report of: Scrutiny Support Officer

Subject: REQUEST TO ESTABLISH A JOINT HEALTH SCRUTINY COMMITTEE - COVERING REPORT

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1. PURPOSE OF THE REPORT

1.1 To inform Members that a request from Durham County Council has been received to establish a Joint Health Scrutiny Committee under Section 245 of the NHS Act 2006 to consider service reconfigurations as part of the Momentum project.

2. BACKGROUND INFORMATION

2.1 Following a meeting of this Health Scrutiny Forum on 28 June 2012, where outpatient services were discussed, a request from Durham County Council has been received to establish a Joint Health Scrutiny Committee under Section 245 of the NHS Act 2006 to consider any future service reconfigurations proposed as part of the ongoing Momentum project including those related to community based outpatient services.

2.2 Section 245 of the NHS Act 2006 provides for the establishment of Joint Overview and Scrutiny Committees. Two of more local authorities can appoint a joint committee to discharge health scrutiny functions, if there is a requirement to consult one or more Health Scrutiny Committees.

3. RECOMMENDATION

3.1 That Members consider this request and agree how to proceed.

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523087
Email: laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

(i) NHS Act 2006

HEALTH SCRUTINY FORUM

23 August 2012

Report of: Scrutiny Support Officer

Subject: OUTPATIENT SERVICES - COVERING REPORT

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1. PURPOSE OF THE REPORT

1.1 To introduce representatives from Hartlepool and Stockton-on-Tees Clinical Commissioning Group and NHS Tees who will be present at today's meeting to discuss the proposals on the relocation of outpatient services from University Hospital Hartlepool to One Life Hartlepool.

2. BACKGROUND INFORMATION

2.1 At the meeting of the Health Scrutiny Forum held on 28th June, Members were informed that the relocation of Outpatient Services from the University Hospital of Hartlepool to One Life was on hold pending further consultation and discussion with this Forum.

2.2 Subsequently representatives from Hartlepool and Stockton-on-Tees Clinical Commissioning Group and NHS Tees will be present at today's meeting to discuss the proposals with Members.

3. RECOMMENDATION

3.1 That Members note the content of this report, seeking clarification on any issues from the representatives present at today's meeting.

Contact Officer:- Laura Stones – Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
Tel: 01429 523087
Email: laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

The following background paper was used in the preparation of this report:-

(i) Report of the Scrutiny Support Officer entitled Relocation of Outpatient Services from University Hospital of Hartlepool to One Life Hartlepool – Covering Report

(ii) Minutes of the Health Scrutiny Forum – 28 June 2012

HEALTH SCRUTINY FORUM

23 August 2012

Report of: Scrutiny Support Officer

Subject: HEALTH SCRUTINY FORUM WORK PROGRAMME – REFERRAL OF ITEMS

---

1. PURPOSE OF REPORT

1.1 To inform the Health Scrutiny Forum that items from the Joint Strategic Needs Assessment have been referred to the Health Scrutiny Forum for consideration / inclusion in future work programmes.

2. BACKGROUND INFORMATION

2.1 The Health Scrutiny Forum confirmed their Work Programme at the meeting held on 15 June 2012 and the Forum choose to investigate Sexual Health as the main topic of investigation for the 2012 / 13 Municipal Year.

2.2 Subsequently, at the work programming meeting of the Scrutiny Co-ordinating Committee held on 15 June 2012, authority was delegated to the Scrutiny Chairs to determine the items to be included in each of their respective Forum's work programme. These items were based on the areas of the Joint Strategic Needs Assessment (JSNA) most appropriate to each Forum.

2.3 In addition to Sexual Health, which forms part of the JSNA, the Scrutiny Chairs identified the following areas of the JSNA which fall within the remit of the Health Scrutiny Forum:-

(a) Circulatory Diseases
(b) Diabetes Mellitus
(c) Diet and Nutrition
(d) Illicit Drug Use
(e) Obesity
(f) Oral Health
(g) Physical Inactivity
(h) Respiratory Diseases

2.4 Members have already identified and agreed an area of investigation for this Municipal Year, which is included within the JSNA. Therefore, it is suggested that one area from the list outlined in 2.3 is added to the Health Scrutiny Forum's rolling programme for consideration as part of next year's work programme.

3. RECOMMENDATIONS

3.1 Members of the Health Scrutiny Forum are asked to identify one area to add to the rolling programme for consideration as part of next year's work programme.

Contact Officer:- Laura Stones– Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
Hartlepool Borough Council
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BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i) Report of the Scrutiny Support Officer entitled 'Determining the Health Scrutiny Forum's Work Programme for 2012/13' presented at the Health Scrutiny Forum meeting of 15 June 2012; and

(ii) Minutes of the meeting of the health Scrutiny Forum held on 15 June 2012.

(i) Minutes of Scrutiny Co-ordinating Committee of 15 June 2012.

HEALTH SCRUTINY FORUM

23 August 2012

HARTLEPOOL BOROUGH COUNCIL

Report of: Scrutiny Support Officer

Subject: SCRUTINY INVESTIGATION INTO SEXUAL HEALTH – SCOPING REPORT

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1. PURPOSE OF REPORT

1.1 To make proposals to Members of the Health Scrutiny Forum for their forthcoming investigation into Sexual Health.

2. BACKGROUND INFORMATION

2.1 The Health Scrutiny Forum met on the 15 June 2012 to consider their Work Programme and agreed that the Forum would in 2012/13 focus on the following JSNA topic:-

Sexual Health - This key health protection issue is a priority within the JSNA as nationally over recent years there has been a rise in sexually transmitted infections. Prevention and education are key to supporting people to make healthy and safe choices. Improving access and increasing provision (particularly in areas of disadvantage) to meet the needs of all ages including young people, over 35s and minority groups. A briefing report is attached as **Appendix 1** as background information.

2.2 Members approved the adoption of the Marmot principles as the overarching framework against which Scrutiny would measure the provision of Council services and allocated each Scrutiny Forum to act as a lead in relation to each principle. The principle allocated to the Health Scrutiny Forum was 'Strengthen the role and impact of ill health prevention'.

2.3 The priority objectives and policy recommendations in relation to this principle being:-

Priority Objectives:-

(1) Prioritise prevention and early detection of those conditions most strongly related to health inequalities.

(2) Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

Policy Recommendations

(1) Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.

(2) Implement an evidence-based programme of ill health preventive interventions that are effective across the social gradient by:

- Increasing and improving the scale and quality of medical drug treatment programmes

- Focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient

- Improving programmes to address the causes of obesity across the social gradient.

(3) Focus core efforts of public health departments on interventions related to the social determinants of health

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION/ENQUIRY

3.1 To strategically evaluate and contribute towards the development of the 'Sexual Health' topic within Hartlepool's Joint Strategic Needs Assessment, whilst reflecting (where possible / appropriate) on the Marmot principle to 'Strengthen the role and impact of ill health prevention'.

4. PROPOSED TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION/ENQUIRY

4.1 The following Terms of Reference for the investigation/review are proposed:-

i) To gather evidence in relation to the following:-

(a) What are the key issues?
(b) Who is at risk and why?
(c) What is the level of need?
(d) What services are currently provided?
(e) What is the projected level of need / service use?
(f) What evidence is there for effective intervention?
(g) What do people say?
(h) What needs might be unmet?
(i) What additional needs assessment is required?
(j) What are the recommendations for commissioning?

(ii) To formulate a view in relation to:-

(a) the needs of Hartlepool residents; and

(b) the current level and quality of service provision to meet those needs.

(iii) To make recommendations to inform the development and delivery of the health & wellbeing and commissioning strategies.

5. POTENTIAL AREAS OF ENQUIRY / SOURCES OF EVIDENCE

5.1 Members of the Forum can request a range of evidential and comparative information throughout the Scrutiny review.

5.2 The Forum can invite a variety of people to attend to assist in the forming of a balanced and focused range of recommendations as follows:-

(a) Member of Parliament for Hartlepool;

(b) Elected Mayor;

(c) Cabinet Member with Portfolio Holder for Adult and Public Health Services;

(d) Ward Councillors

(e) Director of Public Health and Appropriate Officers within the Public Health Team;

(f) Health providers;

(g) Hartlepool and Stockton-on-Tees Clinical Commissioning Group;

(h) Voluntary and Community Groups;

(i) Youth Groups;

(j) Local residents;

(k) Representatives of minority communities of interest or heritage; and

(l) Neighbourhood Forums.

5.3 The Forum may also wish to refer to a variety of documentary / internet sources, key suggestions are as highlighted below:-

(a) Hartlepool JSNA – Available online at http://www.teesjsna.org.uk/hartlepool/

(b) The Marmot Review – Available online at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

6. COMMUNITY ENGAGEMENT / DIVERSITY AND EQUALITY

6.1 Community engagement plays a crucial role in the Scrutiny process and diversity issues have been considered in the background research for this enquiry under the Equality Standards for Local Government. Based upon the research undertaken, paragraph 5.2 includes suggestions as to potential groups which the Forum may wish involve throughout the inquiry (where it is felt appropriate and time allows).

7. REQUEST FOR FUNDING FROM THE DEDICATED OVERVIEW AND SCRUTINY BUDGET

7.1 Consideration has been given, through the background research for this scoping report, to the need to request funding from the dedicated Overview and Scrutiny budget to aid Members in their enquiry. At this stage no additional funding has been identified as being necessary to support Members in their investigation. Members, however, may wish to seek additional funding over the course of the investigation and the pro forma attached at **Appendix A** outlines the criteria on which a request to Scrutiny Co-ordinating Committee will be judged.

8. PROPOSED TIMETABLE OF THE SCRUTINY INVESTIGATION

8.1 Detailed below is the proposed timetable for the review to be undertaken, which may be changed at any stage:-

23 August 2012 – Formal meeting of the Forum:-

(i) To receive the Scoping Report

20 September 2012 – Formal meeting of the Forum to receive the following:-

(i) A 'Setting the Scene' presentation on the key issues; the level of need; and who is at risk and why; and

(ii) Evidence from the MP / Mayor / Portfolio Holder.

3 October 2012 and / or 23 January 2013 – Neighbourhood Forums meet to contribute to the scrutiny process.

18 October 2012 – Formal meeting of the Forum to receive evidence on the following areas:-

(i) The services that are currently provided; and

(ii) The projected level of need / service use.

29 November 2013 – Formal meeting of the Forum to receive evidence on how effective is the current intervention.

10 January 2013 – Formal meeting of the Forum to receive evidence on:-

(i) What needs might be unmet and any additional needs assessment that maybe required; and

(ii) Response from the Neighbourhood Forums and any other relevant stakeholders.

7 February 2013 – Formal meeting of the Forum to:-

(i) Formulate a view in relation to:-

(a) the needs of Hartlepool residents; and

(b) the current level and quality of service provision to meet those needs.

(ii) To make recommendations to inform the development and delivery of the health & wellbeing and commissioning strategies.

7 March 2013 – Consideration of Draft Final Report by the Health Scrutiny Forum

26 April 2013 – Consideration of Final Report by the Scrutiny Co-ordinating Committee

13 May 2013 – Consideration of Final Report by the Cabinet (tentative date)

9. RECOMMENDATION

9.1 Members are recommended to agree the Health Scrutiny Forum's remit of the Scrutiny investigation as outlined in paragraph 4.1.

Contact Officer: - Laura Stones – Scrutiny Support Officer
Chief Executives Department – Corporate Strategy
Hartlepool Borough Council
Tel: - 01429 523087
Email:- laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i) Report of the Scrutiny Support Officer entitled 'Determining the Health Scrutiny Forum's Work Programme for 2012/13' presented at the Health Scrutiny Forum meeting of 15 June 2012; and

(ii) Minutes of the meeting of the Health Scrutiny Forum held on 15 June 2012.

APPENDIX A
PRO-FORMA TO REQUEST FUNDING TO SUPPORT CURRENT SCRUTINY INVESTIGATION

Title of the Overview and Scrutiny Committee:
Title of the current scrutiny investigation for which funding is requested:
To clearly identify the purpose for which additional support is required:
To outline indicative costs to be incurred as a result of the additional support:
To outline any associated timescale implications:
To outline the 'added value' that may be achieved by utilising the additional support as part of the undertaking of the Scrutiny Investigation:
To outline any requirements / processes to be adhered to in accordance with the Council's Financial Procedure Rules / Standing Orders:
To outline the possible disadvantages of not utilising the additional support during the undertaking of the Scrutiny Investigation:
To outline any possible alternative means of additional support outside of this proposal:

Hartlepool Health Improvement Service

Sexually Transmitted Infections 2011

Briefing Update

More than 600 people in Hartlepool were diagnosed with a new sexually transmitted infection (STI) last year according to figures published by the Health Protection Agency (HPA) on Thursday 31 May 2012.

A total of 611 new cases of STIs were diagnosed in Hartlepool last year compared to 576 in 2010. This suggests that overall cases in the locality have increased by 6%, regionally cases are stabilising and nationally there is a slight increase of 2%.

The five most commonly diagnosed STIs both nationally and locally, continue to be chlamydia, gonorrhoea, syphilis, genital herpes and genital warts.

In Hartlepool the most commonly diagnosed STI continues to be Chlamydia, with 357 new cases, although cases have decreased by 5% from the previous year. This compares well to the North East Region as a whole which had a 3% reduction.

The STI which increased the most in Hartlepool last year was gonorrhoea with cases rising 178% from 9 in 2010 to 25 in 2011. This increase is also being seen nationally and regionally with cases going up by 25% and 28% respectively.

New diagnoses of herpes also increased over the period by 7% although cases of syphilis seem to be stabilising.

New diagnoses of warts are stabilising regionally and nationally however, in Hartlepool, they have continued to rise by 11% from 146 in 2010 to 162 cases in 2011. (1)

Table 1

Hartlepool figures for the five most commonly diagnosed sexually transmitted infections:

STI	2010	2011	Variation
Chlamydia	374	357	-17 (5%)
Gonorrhoea	9	25	+16 (178%)
Herpes	45	48	+3 (7%)
Syphilis	< 5*	< 5*	
Warts	146	162	+16 (11%)
Total	576	611	+35 (6%)

* Number less than 5 therefore data has been suppressed due to confidentiality issues.

Deborah Gibbin
Health Improvement Practitioner
18 June 2012

HIV Prevalence

Teesside has seen a continued rise in HIV diagnosis over the past few years. In 2010-11 the England prevalence dropped by 4.4% but the North East rose by 7%. The diagnosed HIV prevalence is greater in males than females. The diagnosed HIV prevalence in Hartlepool is second lowest in Tees (above Redcar and Cleveland) and fifth lowest in the North East (see table 2). Late diagnosis is known to be an issue so true prevalence will be higher. Particularly in some localities, this may be a 'hidden' problem - the HPA are looking at whether high-risk groups for HIV are currently accessing services. (2)

Table 2

Diagnosed HIV prevalence (per 1000 15 – 59 yr olds) by Local Authority area across Teesside 2010-11

Local Authority	Residents accessing HIV related care (aged 15 – 59)	Diagnosed HIV prevalence per 1,000 (aged 15 - 59
Hartlepool	27	0.50
Stockton	98	0.85
Middlesbrough	118	1.35
Redcar & Cleveland	19	0.24

References

1. *Health Protection Agency (2012), Sexually Transmitted Infections Annual Data Set, North East SHA 2010 – 2011*

2. *Tees Public Health, Joint Strategic Needs Assessment (2012) Sexual Health, Hartlepool*

Deborah Gibbin
Health Improvement Practitioner
18 June 2012

HEALTH SCRUTINY FORUM

23 August 2012

Report of: Scrutiny Support Officer

Subject: LOCAL AUTHORITY HEALTH SCRUTINY – CONSULTATION

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1. PURPOSE OF REPORT

1.1 To:

i) Inform Members that a public consultation on proposed changes to how local authorities exercise health scrutiny functions was launched on 12 July and will run until 7 September 2012; and

ii) To seek views on the questions put as part of the consultation to formulate a response to the Department of Health.

2. BACKGROUND INFORMATION

2.1 The reforms set out in *Equity and excellence: liberating the NHS* are underpinned by a clear commitment to increasing accountability and local democratic legitimacy in health. Strengthening health scrutiny is one element of this. The full consultation is attached as **Appendix 1** to this report.

2.2 The regulations currently in force have, on the whole, served the system well. However, since the health scrutiny powers were introduced in 2003, NHS organisations, health services and local authorities have changed substantially, and the Health and Social Care Act 2012 will bring about further structural reforms. There is a need to bring the arrangements for health scrutiny into line with these changes.

2.3 This consultation sets out a number of proposals to strengthen and streamline the arrangements and regulations for local authority health scrutiny. The consultation does not outline a draft version of the new regulations, but asks for views and comments on what the content of those regulations should be.

2.4 The proposals set out in the consultation document are drawn from a series of engagement, testing and other design processes, which have taken place

since publication of *Equity and excellence: liberating the NHS* (July 2010) and passage through Parliament of the Health and Social Care Act 2012. The results of this public consultation will be summarised into a report from the Department of Health, which will in turn inform the regulations and associated guidance for local authority health scrutiny, ready for their statutory introduction from April 2013.

2.5 The aim is to make sustainable changes that will support the structural reforms, make the NHS more accountable to local people and communities and enable health scrutiny 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.

2.6 The changes proposed in this consultation will strengthen local accountability and help to ensure that the interests of patients and the public are at the heart of the planning, delivery and reconfiguration of health services. In preparing this consultation, the Department has discussed the range of possible options with representatives from the NHS, local authorities and patient and public representative groups. Their involvement has been helpful in developing the proposals.

2.7 The consultation asks for views and comments on the content of the planned regulations on local authority health scrutiny, following amendments to the National Health Service Act 20061 ("NHS Act 2006") by the Health and Social Care Act 20122 ("the 2012 Act"). The questions are as follows:-

2.8 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?

2.9 The Scrutiny Co-ordinating Committee are due to consider this consultation at their meeting on 17 August 2012 and the feedback from the Committee will be available at today's meeting for consideration / inclusion within the consultation response from this Forum.

3. RECOMMENDATIONS

3.1 That Members of the Health Scrutiny Forum provide comments on the proposals outlined in the consultation document, with specific reference to the questions outlined in 2.8 of this report.

Contact Officer:- Laura Stones– Scrutiny Support Officer
Chief Executive's Department - Corporate Strategy
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Email: laura.stones@hartlepool.gov.uk

BACKGROUND PAPERS

The following background papers were used in the preparation of this report:-

(i) Department of Health – Local Authority Health Scrutiny – Proposals for Consultation – 12 July 2012

Local Authority Health Scrutiny

Proposals for consultation

DH INFORMATION READER BOX

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

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

Local Authority Health Scrutiny

Proposals for consultation

Prepared by the Patient and Public Engagement and Experience Team

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?

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TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE
2nd July, 2012

PRESENT -

Representing Darlington Borough Council:
Councillors Newall and J. Taylor.

Representing Hartlepool Borough Council:
Councillors Fisher and Hall.

Representing Redcar and Cleveland Council:
Councillors Carling, Hunt and Mrs Wall.

Representing Stockton-On-Tees Borough Council:
Councillors Javed, Wilburn and Mrs M. Womphrey.

ALSO IN ATTENDANCE – Councillor Todd, Durham County Council and Councillor Skilbeck, Hambleton District Council.

APOLOGIES – Councillor H. Scott (Darlington Borough Council), Councillor S. Akers- Belcher (Hartlepool Borough Council) and Councillor Dryden (Middlesbrough Council).

OFFICERS IN ATTENDANCE – A. Metcalfe (Darlington Borough Council), S. Gwillym (Durham County Council), L. Stones (Hartlepool Borough Council), J. Ord (Middlesbrough Council), M. Ameen (Redcar and Cleveland Council) and P. Mennear (Stockton-On-Tees Borough Council).

EXTERNAL REPRESENTATIVES –
David Brown, Director of Operations – Tees, Tees, Esk and Wear Valleys Foundation Trust. Paul Carter, Contract Manager, North East Primary Care Services Agency (NEPCSA).
Sarah Marsay, Engagement Manager, NHS Tees
John Stamp, Mental Health and Learning Disability Lead, NHS Tees

Due to there not being a representative present from each of the Tees Valley Local Authorities, the meeting was inquorate and an informal meeting was held.

1. APPOINTMENT OF CHAIR – AGREED – That Councillor Newall (Darlington Borough Council) be appointed as Chair of the Tees Valley Health Scrutiny Joint Committee for the Municipal Year 2012/13.

2. APPOINTMENT OF VICE-CHAIR – AGREED –That Councillor Javed (Stockton-on-Tees Borough Council) be appointed as Vice-Chair of the Tees Valley Health Scrutiny Joint Committee for the Municipal Year 2012/13.

3. DECLARATIONS OF INTEREST – Councillor Mrs Wall (Redcar and Cleveland Council) declared a Personal and Non-Prejudicial Interest in respect of any matters arising in relation to the North East Ambulance Service NHS Trust as she is related to a number of employees.

4. MINUTES – Submitted – The Minutes (previously circulated) of the meeting of the Tees Valley Health Scrutiny Joint Committee held on 23rd April 2012.

AGREED – That the Minutes be approved as a correct record.

5. PROTOCOL – TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE – Submitted – The Protocol governing the operation of the Tees Valley Health Scrutiny Joint Committee (previously circulated), which had been updated to take into account the changes within the local NHS and other developments.

AGREED – That, subject to the inclusion of the Shadow Clinical Commissioning Groups, the protocol for the operation of the Tees Valley Health Scrutiny Joint Committee, as submitted, be approved.

6. RE-PROCUREMENT OF THE DENTAL ANXIETY MANAGEMENT AND SEDATION SERVICE FOR NHS TEES AND NHS COUNTY DURHAM AND DARLINGTON – NHS Tees and NHS County Durham and Darlington submitted a report (previously circulated) explaining the current dental anxiety management and sedation services for the populations of Teesside, County Durham and Darlington which were currently provided on a two-tier basis. It was noted that the current contract was due to expire and, as a result, a service review was currently being undertaken. NHS Tees and NHS County Durham and Darlington, had carried out an internal review of the current service which informed the procurement of a new service.

The Contract Manager, NEPCSA, outlined the aim of the procurement process to commission a high quality specialised dental conscious sedation referral service for those patients who met the referral criteria. As part of the proposed commissioning process, it was intended to remodel the service provision by commissioning Tier 1 (simple sedation techniques) and Tier 2 (alternative more complex sedation techniques) separately; reduce waiting times and ensure geographic equity of services. The service would be available for all residents within the locality NHS Tees and NHS County Durham and Darlington and at least one provider of basic conscious sedation techniques (Tier 1) would be located at three locations; North of the Tees, South of the Tees and County Durham and Darlington.. Additionally there would be one provider of advanced techniques (Tier 2) to be commissioned from one centrally located within the Borough of Stockton-On-Tees.

Particular reference was made to the dis-proportionate figures contained within the report which alluded to very high numbers being referred from the Stockton-On-Tees area. Members also discussed how Ward Councillors had been engaged as part of the consultation; how the new service was expected to reduce the current waiting time to 18 weeks; for Tier 1 service unevenness of provision, whether one, tier-two provision across the large area was adequate and whether water being fluoridated had influenced the low numbers of patients accessing from the west side of County Durham..

In response to a question, the Contract Manger outlined the variety of clinical indicators which might indicate the need to use conscious sedation, including the patients age, patients that were anxious or phobic, patients with movement disorder and with physical and/or mental disability (including dementia), to enable a particularly unpleasant and complicated procedure to be carried out without distress to the patient and to avoid the need for general anaesthesia.

AGREED – That the Chair, in conjunction with the Vice-Chair, be authorised to respond to the consultation, taking into account the above comments, on behalf of the Tees Valley Health Scrutiny Joint Committee.

7. REHABILITATION SERVICES – TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST – The Director of Operations for Teesside introduced a power point presentation outlining the Trusts proposals for rehabilitation beds at Lustrum Vale. The Director explained that the Trust's aim was to move towards a more recovery focused model with the approach that people with mental health issues should be able to live a full life with hope and optimism. The Trust wanted to be able to provide an improved environment for patients and support them in community placements and community living. The vision was to increase capacity, services and care within a couple of locations by moving the rehabilitation beds in Middlesbrough to Lustrum Vale. This would also make savings and increase staff at Lustrum Vale and enable the Trust to invest in community provision for patients with complex needs to remain in the community. The Director suggested bringing to the Joint Committee the consultation on the impact of moving the beds to Lustrum Vale and not on separate options.

The Director also briefed the Joint Committee on the current Crisis Review being undertaken. It was noted the crisis teams had changed over the years and that out of hours provision was no longer just about being on call and that there were four crisis teams located across the Tees Valley. The review aimed to enhance liaison services within acute hospitals and change the focus of the crisis teams, although, it was acknowledged, that work in relation to challenging behaviour of older people may influence these proposals. It was reported that the recent saving on moving beds from Lustrum Vale to Roseberry Park had enabled the Trust to allocate more resources on liaison services. Members expressed an interest in being kept informed about the proposals and future consultations.

AGREED – (a) That the presentation be noted.

(b) That the Director of Operations – Tees bring a consultation document to the Joint Committee for comments and queries prior to the consultation process commencing in respect of the reorganisation of rehabilitation beds.

(c) That the Director keeps the Joint Committee informed of any impending changes in respect of the on-going crisis team review.

8. WORK PROGRAMME FOR 2012/13 – The Director of Resources submitted a report (previously circulated) outlining the topics that the Joint Committee may wish to consider during the Municipal Year 2012/13. The Chair guided Members of the Joint Committee through the report and welcomed the Work Programmes of four of the Tees Valley Local Authorities.

Pursuant to the Minutes from the meeting held on 30 January 2012, it was recognised that undertaking a full scrutiny review on Prosthetic Services was not appropriate at this time given the huge agenda and hospitals changes happening this year. Members agreed that this year the Committee would have to be more reactive than proactive, however, it was agreed that an initial item should be brought to the Joint Committee for consideration in respect of Prosthetic Services to ascertain whether further scrutiny work is needed.

AGREED – (a) That the topics contained with the submitted report be agreed and that further consideration be given to the scheduling of those items

(b) That, given the magnitude of the work ahead, the Joint Committee agrees to continue to meet monthly.

(c) That the Work Programmes, submitted by the Tees Valley Local Authorities, be noted.

9. DATES FOR FUTURE MEETINGS – AGREED – That the following dates be agreed and that all meetings commence at 10.00am;

(a) Monday, 10 September 2012
(b) Monday, 8 October 2012
(c) Monday, 5 November 2012
(d) Monday, 3 December 2012
(e) Monday, 7 January 2013
(f) Monday, 4 February 2013
(g) Monday, 11 March 2013
(h) Monday, 15 April 2013