Tuesday, 25 September 2012

HEALTH SCRUTINY BOARD

A meeting of **Health Scrutiny Board** will be held on

Thursday, 19 July 2012

commencing at **4.00 pm**

The meeting will be held in the Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Members of the Committee

Councillor Barnby (Chairwoman)

Councillor Bent
Councillor Davies (Vice-Chair)
Councillor Doggett
Councillor McPhail
Councillor Parrott
Councillor Mills
Councillor Thomas (J)

Working for a healthy, prosperous and happy Bay

For information relating to this meeting or to request a copy in another format or language please contact:

Kate Spencer, Town Hall, Castle Circus, Torquay, TQ1 3DR
01803 207014
Email: scrutiny@torbay.gov.uk

HEALTH SCRUTINY BOARD
AGENDA

1. Apologies

To receive apologies for absence, including notifications of any changes to the committee membership.

2. Minutes (Pages 1 - 2)

To confirm as a correct record the minutes of the meetings of the Board held on 14 May 2012.

3. Declarations of interests

(a) To receive declarations of personal interests in respect of items on this agenda.

For reference: Having declared their personal interest members and officers may remain in the meeting and speak (and, in the case of Members, vote on the matter in question). If the Member's interest only arises because they have been appointed to an outside body by the Council (or if the interest is as a member of another public body) then the interest need only be declared if the Member wishes to speak and/or vote on the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(b) To receive declarations of personal prejudicial interests in respect of items on this agenda.

For reference: A Member with a personal interest also has a prejudicial interest in that matter if a member of the public (with knowledge of the relevant facts) would reasonably regard the interest as so significant that it is likely to influence their judgement of the public interest. Where a Member has a personal prejudicial interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Democratic Services or Legal Services prior to the meeting.)

4. Urgent items (Pages 3 - 32)

To consider any other items that the Chairman decides are urgent.

4(a) Briefing Report (Pages 33 - 39)

To consider the attached report explaining the role of community hospitals (including the range of clinical work undertaken in each hospital, how this links to the role of the acute Trust and also the Zones in Torbay).

4(b) Community Hospitals

To discuss with the League of Friends of the Community Hospitals their role, how they are funded and what their future role could/should be in terms of reducing resource bases.

5. **Learning Disabilities Service Update** (Pages 40 - 42)

To consider an update report on the current position in relation to the Learning Disabilities Service.

6. **Health Scrutiny Work Programme** (Pages 43 - 51)

To agree the Work Programme for the Health Scrutiny Board for 2012/2013.

7. **Cost Improvement Plan** (Pages 52 - 54)

To consider a report on the above.

Minutes of the Health Scrutiny Board

14 May 2012

-: Present :-

Councillor Barnby (Chairman)

Councillors Bent, Davies (Vice-Chair), McPhail, Parrott and Thomas (J)

(Also in attendance: Councillors Cowell, Ellery and Morey)

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670. Apologies

Apologies for absence were received from Councillors Doggett and James.

671. Minutes

The minutes of the meeting of the Board held on 16 March 2012 were confirmed as a correct record and signed by the Chairman.

672. Quality Account 2011/2012 - South Western Ambulance Service NHS Foundation Trust

The Board considered the draft Quality Account of South Western Ambulance Service NHS Foundation Trust. The Chairman of the Trust's Board and the Operations Manager for Torbay attended the meeting to present their report and to answer the Board's questions.

Consideration was given to the work that was ongoing in relation to reducing the numbers of falls, raising awareness of the identification and reporting of pressure sores, increasing the availability of major trauma specialist care in the South West and reducing the re-contact rate with the Ambulance Service.

The Board also highlighted the continued need for the local authority and all health trusts to work together on the wider public health agenda and within the framework of the emerging Health and Wellbeing Board.

> **Resolved:** that, subject to the inclusion of wording in relation to public health, the draft statement from the Health Scrutiny Board on South Western Ambulance Service NHS Foundation Trust's Quality Account 2011/2012 as set out in the report be agreed.

673. Quality Account 2011/2012 - Torbay and Southern Devon Health and Care NHS Trust

The Board considered the draft Quality Account for Torbay and South Devon Health and Care NHS Trust. The Trust's Assistant Director of Professional

Practice attended the meeting to present the draft Account and to answer the Board's questions.

Consideration was given to the priorities in relation to enhancing adult and children's safeguarding, the development and introduction of a quality and safety monitoring tool for independent health care providers and improving access to obesity services.

The previous discussions which the Board had had with the Trust on the production of its Quality Account was noted and it was requested that the Board be involved in discussions about future priorities at an early stage next year.

Resolved: that, subject to the inclusion of wording in relation to public health, the draft statement from the Health Scrutiny Board on Torbay and Southern Devon Health and Care NHS Trust's Quality Account 2011/2012 as set out in the report be agreed.

674. Quality Account 2011/2012 - South Devon Healthcare NHS Foundation Trust

The Board considered the draft Quality Account for South Devon Healthcare NHS Foundation Trust. The Trust's Director of Nursing and Quality and Deputy Chief Executive attended the meeting to present the draft Account and to answer the Board's questions.

The Board asked questions in relation to "intentional rounding", "productive ward" and "enhance recovery" and how these processes benefited patients. Consideration was also given to improving the quality of end of life care and to safeguarding issues which had been highlighted in previous audits.

The Board praised the jargon-free nature of the Quality Account and the easy to read format of the document.

Resolved: that, subject to the inclusion of wording in relation to public health, the draft statement from the Health Scrutiny Board on South Devon Healthcare NHS Foundation Trust's Quality Account 2011/2012 as set out in the report be agreed.

675. Quality Account 2011/2012 - Devon Partnership NHS Trust

The Board considered the draft Quality Account for Devon Partnership NHS Trust.

Resolved: that, subject to the inclusion of wording in relation to public health and a reference that the Quality Account considered by the Board was not as detailed as was expected, the draft statement from the Health Scrutiny Board on South Devon Healthcare NHS Foundation Trust's Quality Account 2011/2012 as set out in the report be agreed.

Chairman

Title: **Consultation on Future of Health Scrutiny**

Department of Health

To: **Health Scrutiny Board** On: **19th July, 2012**

Contact Officer **Bernard Page**

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1. Key points and Summary

1.1 Proposals to update local accountability have been put forward as part of a consultation launched by the Department of Health on 12 July on regulations governing local authority health scrutiny

1.2 The changes proposed in this consultation aim to update the arrangements and regulations for local authority health scrutiny 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.

1.3 The Consultation runs to 3 September 2012

1.4 Any decisions to take further policy action on health scrutiny will be taken only after full consideration is given to consultation responses, evidence and other relevant information. Responses to the consultation, evidence submitted and other relevant information will inform the development of new regulations for local authority health scrutiny. It is intended to bring these new regulations into effect from April 2013

2. Proposals

2.1 Requirement for local authorities and the NHS to agree and publish clear timescales for making a decision on whether a proposal should be referred;

- 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.

- 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
- 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.

2.2 Requirement for local authorities to take account of the financial sustainability of services when considering a referral, in addition to issues of safety, effectiveness and the patient experience

- 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. This will be addressed in further guidance
- 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.

2.3 New intermediate referral stage to the NHS Commissioning Board for some service reconfigurations

- 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.
    - 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.
    - 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.
- 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.
    - 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.

2.4 Requirement for health scrutiny to obtain the agreement of the full council before a referral can be made.

- Given the enhanced leadership role for local authorities in health and social care, propose 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.
- Aimed at enhancing 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.
- 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.

2.5 Joint Overview and Scrutiny

- There are occasions when scrutiny functions from more than one local authority area will need to work together to ensure an effective scrutiny process. 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.

- Propose to make further provision within the regulations on this issue 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 thoseHOSCs 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.

Recommendation

Members consider the consultation document and arrangements for feeding back a response to the consultation

Contact

Bernard Page
Tel 01803 207021

Link to consultation document

http://www.dh.gov.uk/health/files/2012/07/Local-Authority-Health-Scrutiny-Consultation.pdf

Department of Health

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	17747
Title	Local Authority Health Review and Scrutiny: proposals for consultation
Author	Department of Health
Publication Date	**12 July 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Adult SSs
Circulation List	PCT Cluster Chairs, NHS Trust Board Chairs
Description	This consultation document sets out a number of proposed changes to the regulations governing health overview and scrutiny. A small number of focused questions seek respondents views on these proposed changes
Cross Ref	The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002
Superseded Docs	
Action Required	N/A
Timing	**The consultation will close on 7 September 2012**
Contact Details	Scrutiny Consultation Patient and Public Engagement and Experience Room 5E62, Quarry House Quarry Hill, Leeds LS2 7UE
For Recipient's Use	

Local Authority Health Scrutiny

Proposals for consultation

Prepared by the Patient and Public Engagement and Experience Team

Contents

Introduction

1. This document sets out the Government's intentions to strengthen and streamline the regulations on local authority health scrutiny, following amendments to the National Health Service Act 2006[1] ("NHS Act 2006") by the Health and Social Care Act 2012[2] ("the 2012 Act"). These enable regulations to be made in relation to health scrutiny by local authorities.

2. The proposed changes to health scrutiny by local government will strengthen local democratic legitimacy in NHS and public health services, helping to ensure that the interests of patients and the public are at the heart of the planning, delivery, and reconfiguration of health services, as part of wider Government strategy to create a patient-centred NHS.

3. In this document, we will build on proposals set out in *Equity and Excellence: Liberating the NHS*[3], which set out a vision of increased accountability, and *Local Democratic legitimacy in health: a consultation on proposals*[4], which posed a number of questions around health overview and scrutiny in particular.

4. The Government recognises that health scrutiny has been an effective means in recent years of improving both the quality of services, as well as the experiences of people who use them. There is much that is good within the existing system on which to build.

5. Our aim is to strengthen and streamline health scrutiny, and enable it to be conducted effectively, as part of local government's wider responsibility in relation to health improvement and reducing health inequalities for their area and its inhabitants.

6. We are aware from engagement to date that there are a range of related matters on which the NHS and local authorities would welcome further clarification and advice that cannot be provided within regulations. We therefore intend to produce statutory guidance to accompany the new regulations that will address some of these issues.

7. Your views on the proposed revisions to health scrutiny are critical. Your participation in this consultation will help us to ensure that the new regulations and any associated guidance will be successfully implemented.

[1] http://www.legislation.gov.uk/ukpga/2006/41/contents
[2] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm
[3] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
[4] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586

8. The proposals in this document are being consulted on until 7th September 2012. The comments received will be analysed and will inform the development of new regulations for local authority health scrutiny.

9. We would welcome your comments on the proposals outlined in this document, your suggestions as to how to improve them, together with any general points you wish to make. The document sets out a number of questions on which we would particularly like your views. These are repeated as a single list at Annex A. Details of how to respond and have your say are set out on page 22.

10. Once we have considered your views, a summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm. It is our intention to bring the new Regulations into effect from April 2013.

11. The rationale for changes to the scrutiny regulations is set out in the impact assessment published alongside *Local Democratic Legitimacy in Health: a consultation on proposals*. This consultation document is published alongside an Equalities Screening that considers the impact on equalities. The Department welcomes any information or evidence that will help further analyse the impact of the proposals contained in this document.

Increasing Local Democratic Legitimacy in Health

12. *Equity and Excellence: Liberating the NHS* set out the Government's ambition to achieve significant improvements in health outcomes and the quality of patient care. These ambitions will be delivered through a new clinically-led commissioning system and a more autonomous provider sector. Underpinning the White Paper reforms is a commitment to increasing accountability by ensuring a strong local voice for patients and local communities and putting their views and experiences at the heart of care.

13. Strengthening health scrutiny is one of the mechanisms proposed to increase accountability and enhance public voice in health. In addition, health and wellbeing boards are being established within local authorities. Through health and wellbeing boards, local authorities, the NHS and local communities will work together to improve health and care services, joining them up around the needs of local people and improving the health and wellbeing of local people. By including elected representatives and patient representatives, health and wellbeing boards will significantly strengthen the local democratic legitimacy of local commissioning and will provide a forum for the involvement of local people. Overview and scrutiny committees of the local authority will be able to scrutinise the decisions and actions of the health and wellbeing board, and make reports and recommendations to the authority or its executive.

14. Health and wellbeing boards will consist of elected representatives, representatives from clinical commissioning groups (CCGs), local authority commissioners and patient and public representatives. A primary responsibility of health and wellbeing boards is to develop a comprehensive analysis of the current and future health and social care needs of local communities through Joint Strategic Needs Assessments (JSNAs). These will be translated into action through Joint Health and Wellbeing Strategies (JHWSs) as well as through CCGs' own commissioning plans for health, public health and social care, based on the priorities agreed in JHWSs. The involvement of local communities will be critical to this process and to the work of the health and wellbeing board. It will provide on-going dialogue with local people and communities, ensuring that their needs are understood, are reflected in JSNAs and JHWSs, and that priorities reflect what matters most to them as far as possible.

15. From April 2013, local authorities will also commission local Healthwatch organisations – the new consumer champion for local health and social care services. Local Healthwatch will help to ensure that the voice of local people is heard and has influence in the setting of health priorities through its statutory seat on the health and wellbeing board.

16. *Local Democratic legitimacy in health,* a joint consultation between the Department of Health and the Department of Communities and Local Government, proposed an

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

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

Aim of Health Overview and Scrutiny

18. This consultation document deals exclusively with health scrutiny. This is an essential mechanism to ensure that health services remain effective and are held to account. The main aims of health scrutiny are to identify whether:

- the planning and delivery of healthcare reflects the views and aspirations of local communities;
- all sections of a local community have equal access to health services;
- all sections of a local community have an equal chance of a successful outcome from health services; and
- proposals for substantial service change are in the best interests of local health services

The History of Health Scrutiny

19. The Local Government Act 2000[6] established the basis for the arrangements that are still in place today, where there are two groups of councillors in most local authorities;

- The Executive (sometimes called the Cabinet), responsible for implementing council policy; and

[5] http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624
[6] http://www.legislation.gov.uk/ukpga/2000/22/contents

- The Overview and Scrutiny Committees (sometimes called Panels or Select Committees), responsible for holding the Executive to account and scrutinising matters that affect the local area.

20. This Act established that, for the first time, democratically-elected community leaders were able to voice the views of their local constituents, and require local NHS bodies to respond, as part of the council's wider responsibilities to reduce health inequalities and support health improvement.

21. The Health and Social Care Act 2001[7] subsequently amended the Local Government Act, to require local authorities to ensure that their overview and scrutiny committee or committees (OSC) had the power to scrutinise matters relating to health service. The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002[8] ("the 2002 Regulations") required NHS bodies to consult formally with the HOSC on any proposals for substantial variations or developments to local services.

22. The 2002 Regulations also set out the health scrutiny functions of such committees and the other duties placed on NHS bodies. These regulations are still in force today. They:

    a. enable HOSCs to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area;

    b. require NHS bodies to provide information to and attend (through officers) before meetings of the committee;

    c. enable HOSCs to make reports and recommendations to local NHS bodies and to the local authority on any health matters that it scrutinises;

    d. to require NHS bodies to respond within a fixed timescale to the HOSC's reports or recommendations, where the HOSC requests a response;

    e. require NHS bodies to consult HOSCs on proposals for substantial developments or variations to the local health service; and

    f. enable local authorities to appoint joint HOSCs;

    g. enable HOSCs to refer proposals for substantial developments or variations to the Secretary of State where they have not been adequately consulted, or believe that the proposals are not in the best interests of the local health service.

[7] http://www.legislation.gov.uk/ukpga/2001/15/contents
[8] http://www.legislation.gov.uk/uksi/2002/3048/contents/made

Benefits

23. The current health scrutiny functions support the accountability and transparency of public services. They provide a means for councillors to engage with commissioners, providers and local people across primary, secondary and tertiary care.

24. HOSCs set their own priorities for scrutiny to reflect the interests of the people they serve. Councillors on HOSCs have a unique democratic mandate to act across the whole health economy, using pathways of care to hear views from across the system and examining priorities and funding decisions across an area to help tackle inequalities and identify opportunities for integrating services.

25. By creating a relationship with NHS commissioners, health scrutiny can provide valuable insight into the experiences of patients and service users, and help to monitor the quality and outcomes of commissioned services. It can also provide important insight that will contribute to the process of developing JSNAs and JHWSs, on which future commissioning plans will be based.

26. Where relationships between the NHS and HOSCs are mature, health scrutiny adds value by building local support for service changes. Some HOSCs also advise the NHS on appropriate forms of public engagement, including alternatives to full public consultation, thus saving NHS resources. These effective relationships are usually a result of early engagement between the NHS and the HOSC, where there is co-operation on proposals for consultation and potential areas of dispute are surfaced and solutions agreed as part of wider consultation.

Proposals for Consultation

Why are we looking at this?

27. The current reform programme is underpinned by a commitment to increasing local democratic legitimacy in health. Strengthening health scrutiny is one element of this.

28. These important reforms are taking place against a backdrop of a very challenging financial environment for public services. The need to deliver improved quality and outcomes in this economic context will be a significant challenge for both NHS commissioners and local authorities. Commissioners will need to focus on achieving the very best outcomes for every pound of health spend, meaning that complex decisions over the current and future shape of services are likely to be required. In a tax-funded system, it is important that such decisions are grounded with effective local accountability and discussed across local health economies. The role and importance of effective health scrutiny will therefore become more prominent.

29. Since the scrutiny provisions were implemented in 2003, NHS organisations, health services and local authorities have changed substantially. The 2012 Act will bring about further structural reforms with the introduction of the NHS Commissioning Board, CCGs, health and wellbeing boards and Healthwatch.

30. The Government recognises that the current arrangements for health scrutiny need to be updated to ensure the scrutiny provisions reflect the new structure and are appropriate to the new system. It is important that the new NHS bodies are made subject to effective scrutiny and held to account.

31. In updating the scrutiny regulations, we propose to retain the best of the existing system but take this opportunity to address some of the challenges that have been experienced by both local authorities and NHS bodies since 2003.

32. The 2012 Act has made changes to the regulation-making powers in the 2006 Act around health scrutiny. In future, regulations will:

    a. confer health scrutiny functions on the local authority itself, rather than on an overview and scrutiny committee specifically. This will give local authorities greater flexibility and freedom over the way they exercise these functions in future, in line with the localism agenda. Local authorities will no longer be obliged to have an overview and scrutiny committee through which to discharge their health scrutiny functions, but will be able to discharge these functions in different ways through suitable alternative arrangements, including through overview and scrutiny committees. It will be for the full council of each local authority to determine which arrangement is adopted;

b. extend the scope of health scrutiny to "relevant NHS bodies" and "relevant health service providers". This includes the NHS Commissioning Board, CCGs and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and the local authority, including independent sector providers.

33. These important changes to health scrutiny regulations were consulted upon widely through the White Paper, *Liberating the NHS,* and throughout the passage of the 2012 Act in Parliament. This document does not consult further upon the merits of these changes.

34. The Government recognises that the existing health scrutiny regulations have, on the whole, served the system well. Some elements of the regulations, for example around the provision of information and attendance at scrutiny meetings, are fundamental to the effective operation of health scrutiny, and will need to be retained. We propose therefore to preserve those provisions which:

a. enable health scrutiny functions to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area;

b. require NHS bodies to provide information to and attend (through officers) before meetings of the committee to answer questions necessary for the discharge of health scrutiny functions;

c. enable health scrutiny functions to make reports and recommendations to local NHS bodies and to the local authority on any health matters that they scrutinise;

d. require NHS bodies to respond within a fixed timescale to the HOSC's reports or recommendations;

e. require NHS bodies to consult health scrutiny on proposals for substantial developments or variations to the local health service;

35. The provisions will be modified in accordance with amendments to the 2006 Act by the 2012 Act so, for example, they will apply in relation to the NHS Commissioning Board, CCGs and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and local authorities, in line with paragraph 32 b) above.

36. The Health Act 2009[9] introduced the Unsustainable Providers Regime for NHS trusts and NHS foundation trusts. The purpose of this regime is to deliver a swift resolution in the unlikely event that an NHS provider is unsustainable, to ensure patients are not put at risk. Parliament accepted the principle that under these exceptional circumstances, public consultation and local authority scrutiny should be restricted to a truncated 30-working day consultation period. Therefore, the provisions in the 2002 Regulations on

[9] http://www.legislation.gov.uk/ukpga/2009/21/contents

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

37. The 2012 Act introduced a framework to secure continued access to NHS services, which included a modified and improved version of the 2009 Act failure regime for NHS foundation trusts. We intend to retain the exemption from the need to consult local authority scrutiny functions on proposals contained in a Trust Special Administrator's report and the other exceptions mentioned above. In line with paragraph 32 b) above, we also intend to extend this exemption to Health Special Administration[10] proposals, which will provide equivalent continuity of service protection to patients receiving NHS care from corporate providers in the unlikely event that one such provider becomes insolvent.

Proposals under consultation

The current position on service reconfiguration and referrals

38. Throughout its history, the NHS has changed to meet new health challenges, take advantage of new technologies and new medicines, improve safety, and modernise facilities. The redesign and reconfiguration of services is an important way of delivering improvements in the quality, safety and effectiveness of healthcare.

39. The Government's policy is that service reconfigurations should be locally-led, clinically driven and with decisions made in the best interest of patients. The spirit of 'no decision about me, without me' should apply, with patients and local communities having a genuine opportunity to participate in the decision-making process.

40. Reconfigurations should also demonstrate robust evidence against the Secretary of State's four tests for major service change[11]. This means all proposals should be able to demonstrate evidence against the following criteria.

- a clear clinical evidence base, which focuses on improved outcomes for patients;
- support for proposals from the commissioners of local services;
- strengthened arrangements for patient and public engagement, including consultation with local authorities; and
- support for the development of patient choice.

41. Effective patient and public engagement is at the heart of any successful reconfiguration. NHS bodies have a legal duty to make arrangements that secure the involvement of patients and the public in the planning of service provision, the development and consideration of proposals for changes in the way services are provided and decisions to be made affecting the operation of those services.

[10] Chapter 5 of Part 3 of the 2012 Act
[11] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_118085.pdf

42. Under the current system, NHS bodies must consult the HOSC on any proposals for "a substantial variation" in the provision of the health service or "a substantial development" of the health service. The existing health scrutiny regulations do not define what constitutes 'substantial'. The Government's view, taking into account previous consultation on this issue, is that this is a matter on which NHS bodies should aim to reach a local understanding or definition with their HOSC.

43. It is normal for local stakeholders and communities to have different views on how best to reorganise and reshape services to best meet patient needs within available resources. In the majority of cases, these differences of opinion are reconciled locally through effective partnership working and engagement.

44. However, there may be occasions where a local authority scrutiny body does not feel able to support a particular set of proposals for service change or feels that consultation has been inadequate. Under the 2002 Regulations, a HOSC or a joint HOSC can refer proposals to the Secretary of State if they:

    a. do not feel that they have been adequately consulted by the NHS body proposing the service change, or

    b. do not believe that the changes being proposed are in the interests of the local health service

45. Upon receiving a referral, the Secretary of State will then usually approach the Independent Reconfiguration Panel (IRP) for advice. The IRP is an independent, advisory non-departmental public body that was established in 2003 to provide Ministers with expert advice on proposed reconfigurations. In providing advice, the IRP will consider whether the proposals will provide safe, sustainable and accessible services for the local population.

Proposed changes

46. The Government is aware through conversations with stakeholders from the NHS, local government and patient groups that existing dispute resolution and referral mechanisms do not always work in the best interests of improving services for patients. Moreover, the current referral process was developed in 2002, which pre-dates considerably the current raft of reforms and structural changes underway across the health and social care system. It is essential that the system changes so that local conversations on service reconfiguration are embedded into commissioning and local accountability mechanisms.

47. More integrated working between clinical commissioners, local authorities and local patient representatives will help to move the focus of discussions about future health services much earlier in the planning process, strengthening local engagement and helping build consensus on the case for any change.

48. The introduction of health and wellbeing boards will significantly improve joint working and planning between local authorities and the NHS across health services, social care and public health. Whilst the 2012 Act is very clear that health scrutiny remains a separate function of the local authority (and cannot be delegated to health and wellbeing boards), health and wellbeing boards provide a forum for local commissioners (NHS and local authority) to explain and discuss how they are involving patients and the public in the design of care pathways and development of their commissioning plans.

49. It is sensible, therefore, that we look further at how a balance can continue to be struck between allowing services to change and providing proportionate democratic challenge that ensures those changes are in the best interests of local people.

50. We are proposing a number of changes around service reconfiguration and referral which are designed to clarify and streamline the process in the future. Our proposals on referrals break down into four main areas:

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

    b. requiring local authorities to take account of financial considerations when considering a referral;

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

    d. requiring the full council of a local authority to discharge the function of making a referral.

Publication of timescales

51. Under the 2002 Regulations, an HOSC can decide to refer a reconfiguration proposal at any point during the planning or development of that proposal. The 2002 Regulations do not specify a time by which an HOSC must make this decision. Most referrals are done at the point where the NHS has concluded its engagement and consultation and decided on the preferred option to deliver the proposal. Where referrals have been made earlier in the process, the IRP have usually advised the Secretary of State against a full review and advised that the NHS and HOSC should maintain an on-going dialogue as options are developed.

52. We are aware from feedback from both the NHS and local authorities, that the absence of clear locally agreed timetables can lead to considerable uncertainty about when key decisions will be taken during the lifetime of a reconfiguration programme. Some have expressed a view that timescales should be specified in regulations but we believe that imposing fixed timescales in this way would be of limited value. Each reconfiguration

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

53. We therefore propose introducing a requirement in regulations that, in relation to proposals on which the local authority scrutiny function must be consulted, the NHS commissioner or provider must publish the date by which it believes it will be in a position to take a decision on the proposal, and notify the local authority accordingly. We propose that on receipt of that notification, local authorities must notify the NHS commissioner or provider of the date by which they intend to make a decision as to whether to refer the proposal.

54. If the timescales subsequently need to change – for example, where additional complexity emerges as part of the planning process – then it would be for the NHS body proposing the change to notify the local authority of revised dates as may be necessary, and for the local authority to notify the NHS organisation of any consequential change in the date by which it will decide whether to refer the proposal. The regulations will provide that the NHS commissioner or provider should provide a definitive decision point against which the local authority can commence any decisions on referral.

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

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

Financial sustainability of services

55. Under present regulations, an HOSC can make a referral if it considers the proposal would not be in the best interest of the local health service. The regulations do not define what constitutes 'best interest' but evidence from previous referrals indicates that local authorities interpret this in terms of the perceived quality and accessibility of services that will be made available to patients, users and the public under the new proposals.

56. The Government protected the NHS in the Spending Review settlement with health spending rising in real terms. However, this does not mean that the NHS is exempt from delivering efficiency improvements - it will need to play its part alongside the rest of the public services. Delivery of these efficiencies will be essential if the NHS is to deliver improved health outcomes while continuing to meet rapidly rising demands.

57. As local authorities and the NHS will increasingly work together to identify opportunities to improve services, we believe it is right that health scrutiny be asked to consider whether proposals will be financially sustainable, as part of its deliberations on whether to support or refer a proposed service change.

58. It would not be right for a local authority to refer a reconfiguration proposal to the Secretary of State without considering whether the proposal is both clinically and financially sustainable, within the existing resources available locally. We believe health scrutiny would be improved in it was specifically asked to look at the opportunities the change offered to save money for use elsewhere in improving health services.

59. We therefore propose that in considering whether a proposal is in the best interests of the local health service, the local authority has to have regard to financial and resource considerations. Local authorities will need support and information to make this assessment and the regulations will enable them to require relevant information be provided by NHS bodies and relevant service providers. We will address this further in guidance.

60. Where local authorities are not assured that plans are in the best interests of the local health services, and believe that alternative proposals should be considered that are viable within the same financial envelope as available to local commissioners, they should offer alternatives to the NHS. They should also indicate how they have undertaken this engagement to support any subsequent referral. This will be set out in guidance rather than in regulations.

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

Referral to the NHS Commissioning Board

61. The 2012 Act ensures the Secretary of State's duty to promote a comprehensive health service remains unchanged in legislation, as it has since the founding NHS Act 1946. The NHS Commissioning Board has a parallel duty. The 2012 Act also makes clear that the Secretary of State remains ultimately accountable for the health service. However, the Secretary of State will no longer have general powers to direct the NHS. Instead, NHS bodies and the Secretary of State will have specific powers that are defined in legislation, enabling proper transparency and accountability. For example, Ministers will be responsible, not for direct operational management, but for overseeing and holding to account the national bodies in the system, backed by extensive powers of intervention in the event of significant failure. The NHS Commissioning Board and CCGs will have direct responsibility for commissioning services. The NHS Commissioning Board will help develop and support CCGs, and hold them to account for improving outcomes for patients and obtaining the best value for money from the public's investment.

62. We believe that where service reconfiguration proposals concern services commissioned by CCGs, the NHS Commissioning Board can play an important role in supporting resolution of any disputes over a proposal between the proposer of the change and the local authority, particularly where the local authority is considering a referral.

63. We are seeking views on how the NHS Commissioning Board could provide this support and help with dispute resolution. One option is to introduce an intermediate referral stage, where local authorities make an initial referral application to the NHS Commissioning Board. Upon receiving a referral, the NHS Commissioning Board could be required by regulations to take certain steps, which could include working with local commissioners to resolve the concerns raised by the local authority. The NHS Commissioning Board would be required to respond to the local authority setting out its response and any action that it had taken or proposed to take.

64. If the local authority was not content with the response from the NHS Commissioning Board, it would continue to have the option to refer the proposal to the Secretary of State for a decision, setting out in support of its application where the NHS Commissioning Board's response fell short in addressing the concerns of the authority.

65. The exception to this referral intermediate stage would be where the reconfiguration proposals relate to services commissioned directly by the NHS Commissioning Board. In such a case, any referral would be made directly to the Secretary of State.

66. The Government believes this option holds most true to the spirit of a more autonomous clinical commissioning system, strengthening independence from Ministers, and putting further emphasis on local dispute resolution. However, we are aware through testing this option with NHS and local authority groups that it is not without complexities. It may be difficult for the NHS Commissioning Board to both support CCGs with the early development of reconfiguration proposals (where CCGs request this support) and also to be able to act sufficiently independently if asked at a later date by a local authority to review those same plans. Furthermore, this additional stage could lengthen the decision-making timetable for service change, which could delay higher quality services to patients coming on stream.

67. An alternative approach would be for the NHS Commissioning Board to play a more informal role, helping CCGs (and through them, providers) and the local authority to maintain an on-going and constructive dialogue. Local authorities would be able to raise their concerns about a CCG's reconfiguration proposals with the NHS Commissioning Board and seek advice. However, that would be at the local authority's discretion rather than a formal step in advance of referral to the Secretary of State.

68. If a local authority chose to engage the NHS Commissioning Board in this way, the Board would need to determine whether it was able to facilitate further discussion and resolution, and respond to the CCG and local authority accordingly. If following the Board's intervention the local authority's concerns remained, the local authority would continue to have the option as under current regulations to refer the proposal to the Secretary of State for review.

69. The Government does not have a preference between the formal and informal methods set out above, and would welcome comments from interested stakeholders on the

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

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

Q5. Would there be any additional benefits or drawbacks of establishing this intermediate referral?

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?

Full council agreement for referrals

70. Under existing regulations, it is for the HOSC to determine whether to make a referral to the Secretary of State for Health. A referral to the Secretary of State in many ways represents the break down in the dialogue between local authorities and the NHS. It should be regarded as a last resort and the decision itself should be open to debate.

71. Given the enhanced leadership role for local authorities in health and social care, we believe it is right that the full council should support any decision to refer a proposed service change, either to the NHS Commissioning Board or to Secretary of State. We propose that referrals are not something that the full council should be able to delegate to a committee, and that the referral function should be exercised only by the full council.

72. This will enhance the democratic legitimacy of any referral and assure the council that all attempts at local resolution have been exhausted. It is potentially undesirable for one part of the council (the health and wellbeing board) to play a part in providing the over-arching strategic framework for the commissioning of health and social care services and then for another part of the council to have a power to refer to the Secretary of State.

73. This change would mean scrutiny functions would need to assemble a full suite of evidence to support any referral recommendation. It is important that all councillors should be able to contribute their views, to allow them to safeguard the interests of their constituents. This will also bring health oversight and scrutiny functions in line with other local authority scrutiny functions, which also require the agreement of a full council. The Government believes that this additional assurance would help encourage local resolution, and further support closer working and integration across the NHS and local government.

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

Joint Overview and Scrutiny

74. There are many occasions when scrutiny functions from more than one local authority area will need to work together to ensure an effective scrutiny process. Joint scrutiny is an important aspect of existing health scrutiny practice, and has been very successful in a number of places. Some regions have established standing joint OSCs, or robust arrangements for introducing joint OSCs on specific regional issues. Joint scrutiny arrangements are important in that they enable scrutineers to hear the full range of views about a consultation, and not just those of one geographical area.

75. The Government is aware from its engagement with patients and the public, the NHS and with local authorities, that there are differences of opinion as to when a joint scrutiny arrangement should be formed. The current regulations enable the formation of joint scrutiny arrangements, but do not require them to be formed. We propose to make further provision within the regulations on this issue.

76. Under the 2003 Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions)[12] where a local NHS body consults more than one HOSC on any proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such service, local authorities of those HOSCs must appoint a joint HOSC for the purposes of the consultation. Only that joint HOSC may make comments on the proposal, require information from the NHS body, require an officer of that NHS body to attend before the joint HOSC to answer questions and produce a single set of comments in relation to the proposals put before them. This is fundamental to the effective operation of joint scrutiny and we propose that it should be incorporated into the new regulations.

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

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

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

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

Responding to this consultation

79. The Government is proposing a number of measures to strengthen and improve health scrutiny.

80. The Government wants to hear your views on the questions posed in this document, to help inform the development of the health overview and scrutiny regulations. We are also seeking your views on the following questions:

Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

Deadline for comments

81. This document asks for your views on various questions surrounding the issue of local authority health overview and scrutiny.

82. This is an 8 week consultation, running from 12th July 2012 to 7th September 2012 and building on earlier consultation on *Liberating the NHS, Local Democratic Legitimacy in Health*. In order for them to be considered, all comments must be received by 7th September 2012. Your comments may be shared with colleagues in the Department of Health, and/or be published in a summary of responses. Unless you specifically indicate otherwise in your response, we will assume that you consent to this and that your consent overrides any confidentiality notice generated by your organisation's email system.

83. There is a full list of the questions we are asking in this consultation on page 25. You can respond online at http://consultations.dh.gov.uk/public-patient-engagement-experience/http-consultations-dh-gov-uk-ppe-local-authority/consult_view by email to scrutiny.consultation@dh.gsi.gov.uk or by post to:

Scrutiny Consultation
Room 5E62
Quarry House

Quarry Hill
Leeds LS2 7UE

84. When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear whom the organisation represents and, where applicable, how the views of the members were assembled.

85. It will help us to analyse the responses if respondents fill in the questionnaire, but responses that do not follow the structure of the questionnaire will be considered equally. It would also help if responses were sent in Word format, rather than pdf.

Criteria for consultation

86. This consultation follows the Cabinet Office Code of Practice for Consultations. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- follow as closely as possible the recommendation duration of a consultation which is at least 12 weeks (with consideration given to longer timescales where feasible and sensible) but in some instances may be shorter. In this case, it is 8-weeks in light of previous consultation referred to in paragraph 82 above and engagement undertaken by the Department throughout passage of the 2012 Act.
- be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' "buy-in" to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

87. The full text of the code of practice is on the Better Regulation website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

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

Consultations Coordinator
Department of Health
Room 3E48
Quarry House

Quarry Hill
Leeds LS2 7UE

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

Please do not send consultation responses to this address

Confidentiality of information

89. We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

90. Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

91. If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a Statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentially disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

92. The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

After the consultation

93. Once the consultation period is complete, the Department will consider the comments that it has received, and the response will be published in the Autumn

94. The consultation and public engagement process will help inform Ministers of the public opinion, enabling them to make their final decision on the content of the health scrutiny regulations.

95. A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Annex A - Consultation Questions

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

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

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

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

Q5. Would there be any additional benefits and drawbacks of establishing this intermediate referral?

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?

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

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

Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

First published 12 July 2012

Published to DH website, in electronic PDF format only www.dh.gov.uk/publications

Torbay and Southern Devon Health and Care NHS Trust

Community Hospitals – Briefing

Torbay Council Overview and Scrutiny Board

19th July 2012

1. Introduction

1.1 The purpose of this paper is to provide Council members with a briefing as requested outlining the function of the Community Hospitals, the services available and how these align and support transition from acute care to the Zone based model of care. The briefing will also provide an overview of any planned changes for 2012-13.

2. Community Hospitals in Torbay and Southern Devon

2.1 In April 2011 the "Transforming Community Services" reconfiguration led to the integration of health provision in the Southern area of Devon, including nine community hospitals with Torbay Care Trust. The integration of the nine southern community hospitals increased the number of community hospitals managed by Torbay and Southern Devon Health and Care Trust from two to eleven.These eleven community hospitals have 196 beds and primarily provide general medical services and are located in and comprise the following bed numbers:

Community Hospital	Beds
Ashburton	12
Bovey Tracey	10
Brixham	20
Dartmouth	16
Dawlish (PFI Hospital)	18
Kingsbridge	12
Newton Abbot (PFI Hospital)	35 (including 15 stroke)
Paignton	28
Tavistock	15
Teignmouth	12
Totnes	18
Total	**196**

Community Hospitals

2.2 The hospitals are open 24 hours a day, seven days a week. The hospitals admit, treat, rehabilitate and discharge patients.They provide a multi-professional team response that is focused on maximising the return to independence of patients through a short-stay inpatient admission (to either a community hospital or virtual ward); this includes health assessment, diagnosis and delivery of healthcare and support at a level of

quality that meets national and locally agreed standards. Patients are accepted either as a direct admission from a GP/health care professional/secondary care medical triage units, or as an early discharge/transfer from secondary care.

2.3 Newton Abbot Hospital also provides a specialist in-patient Stroke service. This provides rehabilitation for people with stroke and neurological conditions, together with specialist outpatient services and stroke aftercare.Patients are accepted either as a direct referral from a GP/health care professional/consultant or as a transfer from secondary care. Patients may self-refer to the outpatient part of the service.

Minor Injury Units

2.4 The Trust operates 10 Minor Injury Units (MIUs), one in each community hospital with the exception of Bovey Tracey hospital. The MIU service provides clinical assessment, examination, treatment and discharge or referral of adults and children over two years with minor injury and ailment conditions. The larger MIU's located at Newton Abbot and Paignton Hospitals are able to treat a broader range conditions. Patients may be referred by GPs and other health professionals or they may self-refer. In the last final year 55,000 MIU visits occurred during daylight hours.

Theatres

2.5 The Trust operates two theatres - on a staff and facilities-type basis - one at Tavistock and the other at Teignmouth hospital. The services and activity in both of these units is owned and provided by Acute Trusts. These include general surgery, orthopaedics, plastic surgery, dermatology and others.

Outpatients

2.6 All the community hospitals operate a wide range of therapy and outpatient services including in house as well as services provided from Derriford and South Devon Healthcare Trusts.

2.7 In general these services are located close to home to meet and serve the geography of our area. Transport to service is a key issue in most areas of Devon and Torbay, thus these services wherever feasible are located in the heart of communities.

3. Community Hospitals key numbers and performance

Occupancy

3.1 The 196 beds are used as part of the wider Health system in Torbay and Southern Devon to support NHS beds capacity in meeting patient need. Average bed occupancy stands at 88.4%, in a range between 76% and 96% (11-12). Our objective is to keep stays to a minimum and return patients to their home/community environment once they have been treated quickly and safely. In terms of primary diagnosis for patients in Community Hospitals the top five groups relate to minor injuries, problems with

circulation and breathing, cancer, poor renal function and musculoskeletal problems although a wide range of other diagnosis are treated.

Activity

3.2 During 2011-12 in the Community Hospitals 3,871 in-patients seen in the 196 beds across the 11 hospitals, 55,000 MIU patients seen and 125,000 outpatients seen.

3.3 Work has been undertaken recently to establish a daily bed management monitoring system as well as daily patient flow reporting processes and regular performance summaries. These systems which are community hospital orientated have been developed with the local matrons and provide a real sense of local ownership. This system means that services can be managed more effectively and objectives delivered more efficiently. All our resources endeavour to be flexible and remain in a state of readiness to respond to periods of pressure, for example during the winter period.

Cost

3.4 The combined budget of the Community Hospitals is £22.7 million.

Quality and Safety

3.5 Since February 2011 the Care Quality Commission (our external auditors /inspectors) have visited the following Community Hospitals: Ashburton, Bovey Tracey, Brixham, Dawlish, Dartmouth, Kingsbridge, Paignton and Tavistock. The key themes highlighting best practice from the feedback and reports received included:

- very high standards of cleanliness
- good systems in place to identify and manage any infections and to prevent these spreading
- hospitals combine technical excellence with kindness and that makes for first class nursing, Staff are extremely caring, kind and thoughtful, Staff are respectful of people's feelings and patients feel that staff listen to them
- Patients are given tasty and nutritious meals that suit them and which promote their health and well-being, the quality of meals is excellent and people are offered wholesome choices
- There are clear systems in place for people to understand how to complain about their care and treatment, if they wish

3.6 Patient's views are taken into account and they are supported to make choices, the ward environments are calm and well organised and patients feel safe and secure.

3.7 Some common themes have been identified that provide a focus for service improvement activities, these include:

- Safeguarding Adult procedures

- Mental Capacity Act and Deprivation of Liberty – awareness, training and obtaining consent

- Personalised care - planning to be demonstrated in documentation

- Documentation and clinical record keeping

- Clinical Supervision - the need for a consistent approach, purpose and structure

- End of life care - resuscitation and Treatment Escalation Plans

- Discharge planning - systems to ensure patients are discharged in a timely manner

3.8 The themes above are incorporated into Community Hospital CQC action plans. These are developed by matrons in collaboration with the Professional Practice and Operations Team. Matrons have accountability for delivering the service improvements identified in the CQC report.

3.9 Performance in national audits such as the Patient Environment Assessment Team (PEAT) assessments also provide an indication of the quality and safety of services. 7 of the 11 hospitals achieved a rating of excellent in all three PEAT measures, 4 Hospital achieved a mixture of good and excellent in all categories assessed including the environment, food and privacy and dignity.

3.10 The current challenges are:

- Patient complexity e.g. the impact of older age, co-morbidities and dementia in patients will require the development of new care pathways to support people in a range of care settings

- Minor Injury Units –There is difficulty in sustaining staff competencies in some of the smaller units where activity levels are very low and the potential need to agree a realignment of the operating hours

- The need to deliver the financial savings targets will require significant redesign of services

- The acute hospital have achieving one of the lowest lengths of stay in the country, we need to be able to support them in ensuring there are no delayed discharges. Managing whole system capacity demand and ensuring the continuity of our day to day business

- The changing needs of patients will require us to review some services in relation to clinical care pathways requirements

- Recruitment and retention of staff especially to services where exposure to certain clinical experiences are limited but will be will be necessary to retain competency levels and registration.

4. Interaction with Community Zone Teams and Acute Hospitals

4.1 The Community Hospitals have a key role in the delivery of the whole integrated approach to Health and Social Care provision for our community.

4.2 This ethos is best summed up in our approach of the “Right care, Right place, Right time” with our client/patient “Mrs Smith” always placed in the centre of the activity, based on her needs and the needs of her family.

4.3 The health system uses a “Clinical Pathway” process (Stroke Care and Falls for example) which takes the patient on a journey from admission to the Acute Hospital when ill and requiring urgent treatment, followed by placement for rehabilitation in a Community Hospital once the patient’s condition is stabilised. When ready for discharge home the Zone Team will arrange community support services such as Domiciliary Care to maintain Mrs Smith’s independence in the Community. If a patient requires other services such as long or short-term residential care or nursing home placements, the Health and Social Care Zone team will assess the client/patient and will arrange such services as may be necessary.

4.4 In all of the above activity the patient’s GP has a key role at all stages and works closely with the Community Hospitals and Zone teams to ensure the patients have good outcomes. Some Community Hospitals are GP led so will be a regular visitor to the wards to assess the patient’s condition and progress. Once discharged from the hospital, the GP’s role continues as they too work closely with the Zone’s Health and Social Care team.

4.5 Our Health system is committed to prevention with an aim to return patients safely to their community setting. The Zone teams approach in Torbay and Southern Devon is to deliver joined-up care in a seamless fashion across all boundaries. The Zone teams have a track record of providing integrated care with a single point of contact for GPs to coordinate care and to work closely with our acute hospital services at the South Devon Healthcare Trust. The teams serve a combined population of 385,000 centred around 11 localities in Torbay and Southern Devon. These teams include Social Workers, GPs, Occupational Therapists, District Nurses and others. Our person-centred approach aims to improve access, provide appropriate responsive care and eliminate Mrs Smith being passed around between different professionals. The various multi-disciplinary teams are well placed to deliver this model of care.

4.6 The impact of this approach has been evidenced as being very successful. We have a much lower bed day usage per 1,000 of the population than average for the South West and thus have very few delayed discharges. We have also reduced long-stay Residential and Nursing home placements.

5. Future challenges

Ageing population

5.1 Planning for the future presents a number of challenges for Community Hospitals. Clearly, we face an ageing population in a context where people rightly expect to be able to make choices about where they receive their care. The population of the Torbay and Southern Devon area is in the region of 375,000. 23 % of the population is over 65 years old, which is a higher percentage than the average for the rest of the country. 8% of the population is also over 75 years old and 4% over 85 years old, again above the national average.

Financial challenges

5.2 Financial resources are finite and the NHS is required to deliver £20 Billion savings targets across its service over the by 2014. There are many examples of care systems that meet the needs of the organisation rather than the needs of the patient. The savings plan is driving a review of all NHS services with critical appraisal of how they benefit the patient. This will lead to changes to care pathways and ensure patients are at the centre of care.

Technology

5.3 Technology is changing the way we deliver services, providing us with great opportunities on how the community interacts with us. Tele-health is a reality that allows patients to be monitored and managed in their own home. There are now examples of where Tele-health has allowed the patient with a long-term condition to remain in their own home but with daily contact with the specialist nurse or GP. This will reduce the need for bed based care.

Workforce

5.4 The workforce profile is also changing with the average age of NHS employee increasing. Staff have a greater range of opportunities than in the past and this leads to increasing competition between employers to recruit and retain staff. The move towards more care provision in the community will require staff to develop new skills and competencies to ensure they are fit for the future.

Increasing complexity

5.5 In the clinical arena, care will become more complex with the increasing age of our patients (80-90's) who have a number of medical conditions e.g. dementia, long-term conditions such as diabetes, strokes, falls and mobility problems. We need to continue to provide safe services in quality environments in order to meet our customers' expectations and especially their privacy and dignity rights. Keeping patients flowing through the system and maximising the use of our resources will remain central to our ability to deliver effective and efficient services.

Increasing community based care

5.6 There is a clear national and local consensus that more services will be delivered in people's own homes with less reliance on hospital or other residential beds. It is anticipated that initiatives such as personalised budgets will drive this change in approach much further. Service/opening hours may need to extend and this in turn will have many operational implications.

5.7 We will need to think through a range of issues linked to rurality, isolation and transport and the quality and location of our estate. The current financial climate and the drive for further cost effectiveness and efficiency will over arch all of the challenges alluded to above.

5.8 Community Hospitals can be and will remain a key component in our provision but they will need to evolve to be an integrated part of care communities delivering services in or closer to Mrs Smith's home.

Summary

5.9 The newly established Torbay and Southern Devon Health and Care NHS Trust is now a provider only organisation following the approval of the Health and Social Care bill. The Trust's area is diverse with both rural and urban dimensions, with a large Older Persons population. As a provider beginning its life in an environment of on-going public spending constraints we have a duty to ensure we balance the quality of our services and value for money so that our Community Hospitals are well regarded by the locality and perceived as efficient in our use of limited resources. The public are familiar with these circumstances given that the general environment of austerity is now a well-established requirement. As referenced above, for some years the direction of travel in National Health and Social Care policy has been to move away from the provision of hospital beds towards the provision of community and preventative services. The Trust has operated an integrated health and social care model in Torbay in partnership with the Local Authority since 2005. This has been recognised nationally as a model of good practice and any future change would indeed retain these stated principles.

5.10 Any changes that may be planned on the provision of services in Community Hospitals in future will be reported at an early stage to the Health and Wellbeing Scrutiny committee as well as including appropriate consultation channels with relevant stakeholders. It should also be noted that in the new arrangements in the NHS currently being implemented that the new Commissioning Bodies (CCG's) will lead any service change and that the implementation will be the duty of the provider of services. However, this will in reality occur in partnership with our commissioners in order to deliver the desired outcomes in the best interest of and in response to changing local needs.

Steve Honeywill, Head of Community Redesign
Pat McDonagh, Assistant Director Community Hospitals June 2012

Title: **Learning Disabilities Services Update**

Wards Affected: **All**

To: **Health Scrutiny Board** On: **19th July 2012**

Contact Officer: **Dr Sonja Manton, Assistant Director of Operations**
Torbay and Southern Devon Health and Care Trust

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1. Key points and Summary

1.1 This paper provides an update of the key developments within the Trust's in-house learning disabilities services. This includes the residential care provided at Occombe House, day services and short breaks.

2. Occombe House

2.1 The Trust is currently working with the families of the Occombe residents to identify an alternative provider for Occombe House, who will work with the families and residents to re-develop the site according to the needs of the individuals, as identified in the best interest process.

2.2 A competitive dialogue procurement process is being followed, which commenced with the issuing of an *Invitation to Negotiate* in April, to which a number of potential providers expressed an interest.

2.3 A series of dialogue meetings have been held potential future providers to explore the potential for re-development of the site according to the needs of the individuals and to assess the suitability of these providers. Families and staff representatives have been involved in all stages of this procurement process.

2.4 It is anticipated that following the issue of a formal *Invitation to Tender* in September and subsequent evaluation of bids, a future provider for Occombe House will be selected in October and the residential unit transferred in November 2012.

2.5 It is expected that the new provider will then work closely with the families of the residents and the local authorities to re-develop the site according to the best interest outcomes into supported living within 12 months of contract transfer.

2.6 There continues to be a risk that re-developing the site into supported living for the seven residents on their own may not be financially viable and all potential providers have considered how this could be overcome by considering what additional services could be provided on the site to attract additional income.

3. Day Services

3.1 In February 2012, the Care Trust Board approved a decision to re-focus the number and types of day opportunities provided by the Trust for people with learning disabilities across two centres (Hollacombe CRC and Torquay CRC) as part of a first phase to changes, with a long term view to re-providing these individually or collectively by alternative providers, following a commissioning-led market assessment.

3.2 The organisational context within which in-house day services is being reviewed includes: increased financial pressure and reduction in the overall adult social care budget, and in particular over-expenditure in learning disabilities, implementation of personal budgets set by resource allocation schedules with associated increased choice and control in the way these are spent, avoidance of paying twice by people accessing multiple services to meet the same outcome (e.g. paying for 24 hour residential care and accessing day services), and a focussing of core business provided by a NHS Trust.

3.3 Following this decision, the operational management team compiled a more detailed implementation plan, which has been shared with families, staff and within the Trust.

3.4 The first phase of these changes involves the relocation of services provided at Fairwinds to Hollacombe and Torquay CRC. Minor adaptations to the Hollacombe building are required to care for clients currently supported at Fairwinds, who have different and more complex needs than those currently supported at Hollacombe. The building works commenced on 25th June and will be complete in mid-August, at which time the clients and staff can move to the other two centres. The most disruptive part of the building work is now complete and every effort was made to minimise the impact this would have had on clients.

3.5 Person-centred reviews have commenced to work with clients and their circles of support to understand the impact of changes on their individual care and support plans and identify alternative ways of meeting needs where the change affects them.

3.6 Regular meetings with staff, families and carers are being held to ensure that all stakeholders are kept up to date and there is an opportunity to feedback on progress, air any concerns or issues and resolve these as they arise. Additionally, SPOT have been commissioned to provide support to the clients in understanding these changes and supporting them at this time.

3.7 A thorough market assessment of day opportunities in the bay will be completed later this year to determine the long term future of the remaining two centres.

4. Short Break Service

4.1 Since 1st April 2012, the Trust no longer provides short breaks at Occombe House. The service was de-commissioned as part of the work of the Learning Disabilities Transformation Programme in 2011 and this decision communicated to all stakeholders.

4.2 The employment of none of the staff at Occombe House was affected by this cessation, as there were no employees currently employed specifically for staffing this service.

4.3 Short breaks will continue to be provided at Baytree House and relevant adjustments to the building have been completed.

4.4 All former clients of the short break service at Occombe House now have access to alternatives and are supported by the community learning disabilities team to ensure that their needs continue to be met.

Dr Sonja Manton
Assistant Director of Operations

Title:	**Health Overview and Scrutiny Work Programme 2011/2012**		
Public Agenda Item:	**Yes**		
Wards Affected:	**All**		
To:	**Health Scrutiny Board**	On:	**7 July 2011**
Key Decision:	**No**		
Change to Budget:	**No**	Change to Policy Framework:	**No**

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1. What we are trying to achieve and the impact on our customers

1.1 To ensure that the Health Overview and Scrutiny Work Programme for 2012/13 is robust and realistic but also flexible enough to enable emerging issues of concern to be addressed. This will help ensure that overview and scrutiny is both improving and safeguarding health services for the people of Torbay. A successful scrutiny function would also have a positive impact on our customers as the community would be involved in the work being undertaken and the outcomes of that work would be focused on the community's needs.

2. Recommendation(s) for decision

2.1 **That the Health Scrutiny Work Programme for 2012/13 set out in Appendix 1 to this report be approved.**

3. Key points and reasons for recommendations

3.1 The Constitution requires that, early in the Municipal Year, the Overview and Scrutiny Board will co-ordinate the production of a Work Programme for the function as a whole. At its meeting on 20 June 2012 the Overview and Scrutiny Board was advised that a Health Overview and Scrutiny Work Programme would be agreed at the next meeting of the Health Scrutiny Board.

3.2 In May 2012, a questionnaire was sent to all members of the Council asking them to identify three issues within their wards which they felt should be subject to scrutiny together with three Bay-wide issues. The Mayor, Directors and Executive Heads were also asked for their views on the Bay-wide issues

which should be considered and the Council's health partners were asked to identify issues which may need to be subject to scrutiny. Whilst it was acknowledged that there will not be space within the Work Programme to consider every issue it was hoped that some themes would emerge on the issues which the two scrutiny Boards could investigate to the benefit of the community as a whole.

3.3 The document attached as Appendix 1 has been prepared taking account of the suggestions received from the consultation exercise and subsequent informal discussions with the Health Scrutiny Lead, the Director of Adults Services and Torbay and Southern Devon Health and Care NHS Trust.

For more detailed information on this proposal please refer to the supporting information attached.

Mark Bennett
Executive Head (Business Services)

Supporting information

A1. Introduction and history

A1.1 The Work Programme for the Health Scrutiny Board has been developed around two, inter-linked themes – namely, reducing demand on acute services and services for the elderly. Rather than undertaking in-depth reviews, it is suggested that the Health Scrutiny Board will employ similar methods to the Overview and Scrutiny Board such as site visits, consideration of case studies, attendance at health partner events whilst keeping in mind its key lines of enquiry for the year. Time will also need to be allowed for the consideration of any possible substantial variations in services or referrals from the Torbay LINk. Further, the Health Scrutiny Work Programme will be shared with health scrutiny colleagues in neighbouring authorities to avoid duplication and possibly undertake shared work.

A2. Risk assessment of preferred option

A2.1 **Outline of significant key risks**

A2.1.1 A critical success factor will be members' commitment to the work programme. Members need to be sure that these issues are matters which can help improve and safeguard health services for the people of Torbay. Members need to be willing to commit time and energy into identifying key questions, meeting and discussing issues with other members, officers and consultees, reading and challenging the information presented to them, and drawing conclusions, considering options appraisals and risk assessments, and formulating recommendations.

A2.1.2 Health Scrutiny Board members need to receive information and support from local NHS bodies; however, local NHS bodies are under a statutory duty to provide overview and scrutiny with any information about the planning, provision and operation of health services as it may reasonably require to undertake effective scrutiny.

A2.1.3 The changing national political arena may lead to initiatives and changed priorities during the year and the work programme may need to be amended as a result. Members are reminded that the work programme must have sufficient capacity to respond to requests from the NHS to consider service change proposals.

A2.1.4 If members are not committed to the Health Overview and Scrutiny Work Programme and to making overview and scrutiny a worthwhile mechanism to improve the lives of the community of Torbay (and if they do not receive adequate support from officers or information from local NHS bodies), then there is a risk that positive outcomes cannot be shown to have been achieved by Overview and Scrutiny.

A2.2 **Remaining risks**

A2.2.1 There are none at the time of writing.

A3. Other Options

A3.1 Members may wish to add to, or delete, or change any of the items within the work programme set out in Appendix One.

A4. Summary of resource implications

A4.1 The proposed Work Programme can be delivered within the resources available provided that members are willing to give their time and energy.

A5. What impact will there be on equalities, environmental sustainability and crime and disorder?

A5.1 Each review will take account of these issues.

A6. Consultation and Customer Focus

A6.1 The draft Work Programme has been prepared taking account of the views expressed by the Overview and Scrutiny Co-ordinator, Scrutiny Lead Members, the Mayor and all other Members of the Council, senior Council officers, and health partner organisations.

A6.2 Each review will aim to involve the community through consultation and possible co-option.

A7. Are there any implications for other Business Units?

A7.1 The relevant Executive Heads will be involved in the work of overview and scrutiny especially at the scoping, options appraisal, and risk assessment stages as well as providing information to members as part of each review.

Appendices

Appendix One Health Overview and Scrutiny Work Programme for 2012/2013

Documents available in members' rooms

None

Background Papers:

None

Health Scrutiny Work Programme 2012/2013

1. Background

1.1 All members of the Council, senior officers and representatives from the NHS organisations that work with the Health Scrutiny Board were asked for their views on the topics or issues which should be the subject to review over the course of the year.

1.2 The topics put forward are set out in the Appendix to this report.

1.3 This report makes suggestions for the Work Programme for the Health Scrutiny Board for the forthcoming Municipal Year.

2. Methods of Working

2.1 There are a range of options open to the members of the Health Scrutiny Board to carry out their work:

Health Scrutiny Board
Health Scrutiny Liaison Group
Site Visits
Attendance at NHS Trust/provider/partnership meetings and events
Adults Policy Development Group
Councillor Policy Briefings

2.2 Not all members of the Health Scrutiny Board need to attend every meeting and/or event. However, members will need to provide feedback to other members of the Board so that the information they receive can help inform the work of the Board overall.

3. Themes for the Year

3.1 Members will recall that the theme that ran throughout the Quality Accounts that the Board received at the final meeting of the last Municipal Year was reducing pressure on acute services.

3.2 In looking at the topics which were put forward for consideration during the Work Programme consultation, many fitted into the category of "care for the elderly".

3.3 It is suggested that these two, interlinked issues provide the overarching theme for the work of the Health Scrutiny Board for 2012/2013. Rather than undertaking specific, stand-alone reviews, topics will be considered throughout the year (in the forums listed in 2.1) and the findings and views of the Board will be amalgamated into a report towards the end of the year.

4. Scope, Key Lines of Enquiry and Timetable

4.1 A draft scope (including key lines of enquiry) which will form the basis of the work of the Health Scrutiny Board is attached for discussion. A draft timetable for the year is also attached.

Services for the elderly

Reducing demand on acute services

SCOPE AND KEY LINES OF ENQUIRY

To gain an understanding of the demographics of Torbay and who is responsible for commissioning and delivering services.

- What does the Joint Strategic Needs Assessment tell us about the demographics of Torbay?
    - How skewed is the population towards older people?
    - What are their health and social care needs?
    - How are these needs being met?
    - What will be the needs of the next generation of older people?
- What are the emerging priorities of the Health and Wellbeing Board?
    - How does the Health and Wellbeing Strategy fit with the Community Plan?
    - What consultation will be undertaken?
    - How are all partners ensuring that the priorities for Torbay are articulated coherently within their own plans?
- Where does the responsibility lie for commissioning and providing services for the elderly?

To review the range of work that is underway within Torbay (including within the Third Sector) to reduce the demand on acute services.

- What preventative work is being undertaken to reduce demand on acute services?
    - How are partners working together to reduce demand?
    - What's the evidence of this work having an effect on demand?
    - What work is being undertaken within the Third Sector to reduce demand?
    - What further support is needed in the Third Sector?
    - What's the impact of public sector spending cuts?

To consider a number of case studies in relation to services for the elderly.

- Residential care homes
    - What is the make up of the residential care homes sector in Torbay? How does this compare with other similar authorities?
    - How is care within these homes commissioned?

- What is the relationship between the care homes sector, the Council and Torbay and Southern Devon Health and Care NHS Trust?
- What levels of care should the elderly expect within these homes? How is this monitored? Where does the responsibility lie?
- What methods are used to bring homes up to standard? What is the timescale for this improvement? What happens if they don't improve?
- What is the measurable impact of reducing public sector funding?

- Community Hospitals
  - What role do the community hospitals in Torbay play? How are elderly people rehabilitated after an acute hospital stay?
  - What services are provided?
  - How do they help prevent pressure on acute services? What value can be placed on the role of community hospitals in Torbay? How is this recognised by partners?
  - What is the role of the League of Friends?
  - How sustainable are the community hospitals?
  - What measures are being taken to reduce wastage within the community hospitals (e.g. unused medicines/dressings, missed appointments)?

- Falls Prevention
  - Why is falls prevention an important issue?
  - How are agencies working together to reduce the number of falls?
  - How well are we doing at reducing falls? What impact is this having?

- Dementia Services
  - What is dementia? What are its impacts – on patients? on carers? on the wider community?
  - What services are provided in Torbay for people with dementia?
  - How do we compare – regionally? nationally?
  - How are services linked together? How effectively is this working? The Dementia Challenge
  - How do we create dementia friendly communities?
  - How could health and care for people with dementia and their carers be improved?

	Health Scrutiny Board	Liaison Group	Site Visits/Meetings	Policy Development Group	Policy Briefings	Health and Wellbeing Board
July	19 July 2012 Cost Improvement Plan Learning Disabilities Service Update Community Hospitals Community Hospitals – League of Friends	-	5 July 2012 Chairman to meet CE of St Kilda's 19 July 2012 Right Care Open Day (SWAST) tbc Visit to SWAST Headquarters	17 July 2012		5 July 2012
August	-	-		21 August 2012 Adult Social Care Local Account	Social Care White Paper (timing to be confirmed)	
September	-	4 September 2012 Agenda Planning (October) Longer Term View for Adult Social Care		18 September 2012 Care Home Provision		20 September 2012
October	4 October 2012 Acquisition Process – TSDHCT Public Health Transition Plan Joint Strategic Needs Assessment Adult Social Care Local Account	-	Dementia Services	17 October 2012		
November	-	-		20 November 2012		22 November 2012
December	-	20 December 2012 Agenda Planning (February)		17 December 2012		
January	-	-		21 January 2012		17 January 2013
February	21 February 2012 Falls Prevention	-		18 February 2012		

March	-	-		19 March 2012		21 March 2013
April	-	4 April 2012 Agenda Planning (May)		15 April 2012		
May	8 May 2012 Quality Accounts x 4 Health Scrutiny Board's Report			-		

Topics suggested through consultation process

Drugs
Foundation Trust status
Deprivation
Future services for the elderly – what should they expect/what do they deserve
Care home provision/fees
Priorities of the Health and Wellbeing Board
How to reduce demand for high cost adult social care
Transition of children to adults services
Impact of cost reduction plans
Alcohol and supermarket licensing
Impact of welfare reform > On individuals > On services
Changes to adoption standards
Cost and efficiency of children's and adults services
How to reduce demand for high cost children's services

Title: **Council Cost Savings Programme - Briefing**

To: **Health Scrutiny Board** On: **19th July, 2012**

Contact Officer **Caroline Taylor, Director of Adult Services and Resources**

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- **Key points and Summary**

  - This paper provides an update of the cost improvement programme deployed by Torbay and Southern Devon Health and Care Trust for 2012/13 as commissioned by Torbay Council for adult social care.

- **Overview –** the Trust has identified Adult Social Care (ASC) cost savings programmes totalling £3.2 million in the following areas.

  - In House Learning Disabilities (LD) - Targeted savings of £200,000
  - ASC Independent Sector – Targeted savings of £3.0 million

  The Trust has committed to achieve these savings and has specific programs and a governance process in place to monitor delivery of these savings.

  The Trust has also committed to reduce its internal overheads within its integrated health and social care related schemes (not shown) and specifically a £500,000 efficiencies target. The £500,000 back office savings have been met through staff reductions in the back office.

- **Schemes** – saving schemes are outlined below, these have previously been discussed informally at the Adults Policy Development Group and are reflected in the Annual Strategic Agreement.

Savings Area	Overview / Description of Scheme	Savings £(000)	Start Date	RAG Rating
LD Day Services	Review of Day Services and re-focussing of what is provided by the Care Trust, with a view to reduction of the number of facilities and services provided in-house (from 3 to 2	£200	April start – on track	A

	facilities)			
Savings Area	**Overview / Description of Scheme**	**Savings £(000)**	**Start Date**	**RAG Rating**
Residential & Nursing Homes -- Preserved Rights clients	Running down / attrition of Preserved Rights Clients (Target 12 clients)	£200	April start – on track	G
Renegotiation of Tier 1 & Tier 2 Rates 2012/13	Negotiations complete - rates and timings agreed	£125	Complete	G
Fairer Charging Policy (Dom & Day Care)	Introduce national charging policies. Complete reviews of over-policy clients and reassess in line with latest needs and national guidelines	£50	May start – reviews on track	A
LD high-cost clients	Identify and review higher cost care packages to reassess needs and seek opportunities for most economical solutions	£250	April start – on track	G
LD clients with multiple services	Review clients in receipt of multiple care packages and rationalise in line with needs assessments to avoid multiple provision	£110	Plans delivering £70k	A
LD – Reconfigure services	Reconfiguration of LD services including adherence to the Choice, Cost and Risk Policy	£225	April start – on track	G
Mental Health (MH) - Care homes placements for under 65 years	Mental Health (MH) clients - seek to reduce reliance on care homes placements - transition 6 clients to home based services (delivery through DPT)	£200	Plans not delivering – under review	R
Res.Home Placements	Reduction in residential placements – continue trend to more home based services	£200	April start – on track	G
Nursing Home Placements	Reduction in nursing placements - trend to more home based services	£30	Complete	G
Domiciliary Care clients – care packages reviews	Structured programme of reviews to re-assess service provision including training and seeking opportunities to intensively re-able clients. Targets deployed to zone (operating teams) level.	£1,000	Plans not complete / ramp-up under way.	R
Domiciliary Care – resource allocation system (RAS) compliance	Compliance reviews of over RAS service provision – includes training and ensuring that that clients packages comply fully with RAS and Choice, Cost and Risk Policy. Targets deployed to zone level.	£355	Plans not complete / ramp-up under way.	R

Other Reviews - Respite care programme	Minimisation of respite and short break stays over and above the RAS	£75	April start – on track	G
ASC Target - Fees Offset	Stretch target assigned to Trust to offset known additional Fees increases	£180	To be developed	R

- **Programme Opportunities and Risks**. The Trust has in-place programme management and monitoring controls to oversee the delivery of the schemes and take appropriate contingency actions where underperformance against commitment is identified.

    - Red schemes above are being reviewed, including mitigation actions to ensure the Trust's full year target commitments are met in order to bring the overall expenditure for adult social care in on budget by the year end.

- Additional opportunities for 2012/13 and forward years are being explored through recently introduced joint service reviews between the Council and the Trust.

Caroline Taylor
Director of Adult Services and Resource