ITEM NO: 69.00

TITLE	**Update on site visit and Centre for Public Scrutiny Health Scrutiny networking event**
FOR CONSIDERATION BY	Health Overview and Scrutiny Committee on 24 March 2014
WARD	None Specific
DIRECTOR	Andrew Moulton, Head of Governance and Improvement Services

OUTCOME / BENEFITS TO THE COMMUNITY

To help inform members of the public of site visit undertaken by members of the Committee and steps taken to work with other Health Overview and Scrutiny Committees in the area.

RECOMMENDATION

That the Health Overview and Scrutiny Committee notes the update regarding the site visit to Beeches Manor, Wokingham, extra care housing for those with dementia, in January 2014 and the report produced by the Centre for Public Scrutiny following the South of England Health Scrutiny Network meetings held in February 2014.

SUMMARY OF REPORT

On 16 January 2014 Councillors Houldsworth, Richards and Hayward and the Principal Democratic Services Officer visited Beeches Manor, Wokingham, which is a facility providing extra care housing for those with dementia.

On 7 February 2014, the Principal Democratic Services Officer attended the Centre for Public Scrutiny Thames Valley Health Scrutiny Network meeting.

Background

The Health Overview and Scrutiny Committee have noted that a key priority of the Wokingham Borough Council Health and Wellbeing Strategy 2013-14 was '*Aim for the care of people with dementia to be the best in England.*'

At its meeting held on 20 January 2014, the Committee agreed that a small group of Members would visit Beeches Manor, a facility providing extra care housing for those with dementia. It was felt that this would provide a picture of some of the facilities available in the Borough, to those with dementia.

On 16 January 2014 Councillors Houldsworth, Richards and Hayward and the Principal Democratic Services Officer visited Beeches Manor. A brief summary is attached at Appendix A.

On 7 February 2014, the Principal Democratic Services Officer attended the Centre for Public Scrutiny Thames Valley Health Scrutiny Network meeting.

Topics discussed included:

- Working with new health scrutiny regulations and guidance.
- How Health Scrutiny is engaging with and undertaking forward planning with:

  - Public Health in your local authority
  - Public Health England
  - your Health and Wellbeing Board
  - your Clinical Commissioning Group(s)
  - your NHS England Area Team; specialised commissioning; Quality Surveillance Group
  - the local Healthwatch
  - Care Quality Commission

- Health scrutiny following the Francis Inquiry and the Keogh Review.

A report produced by the Centre for Public Scrutiny following the South of England networking events, is attached at Appendix B.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION

The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?
Current Financial Year (Year 1)	N/A	N/A	N/A
Next Financial Year (Year 2)	N/A	N/A	N/A

Following Financial Year (Year 3)	N/A	N/A	N/A

Other financial information relevant to the Recommendation/Decision
N/A

Cross-Council Implications
N/A

Reasons for considering the report in Part 2
N/A

List of Background Papers
N/A

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Appendix A

Beeches Manor:

- Three members of the Health Overview and Scrutiny Committee and its substitutes and the Principal Democratic Services Officer visited Beeches Manor, Reading Road, Wokingham, on 16 January 2014.
- Beeches Manor is extra care housing specifically for those with dementia and has 18 ground floor flats. The care provider is Housing 21 who are also the care providers for Alexandra Place, extra care housing in Woodley. There also are 8 flats for people with a Learning Disability situated on the first floor. Housing 21 is not the service provider for those living in the first floor flats.
- Extra Care Housing is housing designed to meet the needs of older people and offers varying levels of care and support that is available on-site 24 hours a day, seven days a week.
- Members viewed the hobby room, activities room, communal area and lounge, the assisted bathing facility and an empty flat. There is also a garden area which residents can use. Social activities include bingo, crafts, and cookery which are organised by support staff.
- Residents have tenancy agreements and pay rent. The flats are self-contained homes and residents are able to come and go as they wish. New residents are accepted from 55 years of age.
- Prospective residents are nominated and the Council manages the nomination process. Residents are not accepted privately. Housing 21 hold a fortnightly panel meeting with the Council to review nominations.
- Liaison takes place with the Council and the Care Quality Commission.
- If a residents needs became such that Beeches Manor was no longer the most suitable place to live a multi-disciplinary process is put in place.
- Staff meet quarterly with residents' families and invite them to complete satisfaction surveys.
- Care is recharged through the Council. Each resident has a domiciliary care package in place and the care provided varies from individual e.g. assistance with washing and dressing or support with laundry. Residents can commission care from other providers if they wish. Residents provide their own food but if a resident is unable to prepare food this can be commissioned.

Appendix 5

Report of the discussions in the South West, Thames Valley and Wessex areas on 5, 6 and 7 February 2014

Background

In anticipation of the publication by the Department of Health of guidance around health scrutiny subsequent upon the introduction of measures in the Health and Social Care Act 2012, the Centre for Public Scrutiny supported events across the country for health scrutiny chairs and/or vice-chairs or their substitute and their officers.

Three special events were held in the South of England – for councils in the three area team areas in the South West, for councils in the Thames Valley area team and for councils in the Wessex area team.

We are grateful to Bristol City Council, Hampshire County Council and Oxfordshire County Council for each hosting an event.

The purpose was to enable the chairs and/or vice-chairs and the officers supporting health scrutiny to be briefed by the Deputy Executive Director or Health scrutiny Advisor of the CfPS about the guidance and to share experience and challenges with each other. Although the guidance had not been published, it was an opportunity to remind participants of the regulations that had been published in February 2013, to consider the recommendations affecting health scrutiny out of the Francis Inquiry one year on, and to exchange experience regarding changes effected to health scrutiny, new structures and emerging relationships with continuing organisations such as the Care Quality Commission and NHS Trusts and new organisations such as the Clinical Commissioning Groups, the Health and Wellbeing Board and NHS England area teams.

We are grateful to our partners in health and social care who participated in the discussions or provided briefings – from CQC, NHS England area teams and Public Health England centres.

We also were able to enquire whether such health scrutiny networks would be useful in future. All participants agreed that they benefit from exchanging information, experience and challenges with each other, meeting with health and social care partners and receiving briefings from the CfPS and case studies from other councils. There was an appetite to meet from time to time in the networks that were used for these events, and a willingness to share the hosting of the meetings. Evaluation forms provided to CfPS were positive about the opportunity and the events.

Briefing

The CfPS staff explained that the briefing and discussion would focus on practice, outcome and context – reflections on council health scrutiny in 2013, council health scrutiny in 2014 and beyond, and the local context. Although social care is relevant and part of the work of health scrutiny, because the regulations and guidance are about health services, the discussions tended to focus on healthcare. The starting point was CfPS's response to the White Paper of October 2010 'Equity and excellence', which preceded the drafting of the Health and Social Care Act 2012. Our focus was on the redefined relationships between professionals, patients and carers; commissioners and providers; commissioners, providers and communities; and commissioners, providers and councillors.

The question was posed: who has the greatest challenge? That provided by the outgoing head of NHS England, Sir David Nicholson to achieve an efficient service that works for patients, that provided by the late Sir Derek Wanless to engage patients in their own health care and to provide resources sufficient for developing health and social care needs and demand; that provided by Michael Marmot to treat the causes not just the effect of ill-health and to address the wider determinants of health; and that provided by Tim Kelsey, Director of Patients and Information at NHS England, to increase transparency and participation by service users, patients and the wider public. A discussion was facilitated on the challenge presented to health scrutiny in changing times.

The Department of Health has asked, through CfPS, the views of health scrutiny about the support that is needed to effect the changes and provide scrutiny in the new structures and health and social care environment. A reminder was given of the regulations of February 2013 that covered revised structures for health scrutiny with the council now having statutory responsibility rather than the health scrutiny committee or panel (although this power could be delegated); the new procedures for handling referrals; and the revised provisions for local referral on substantial variations. Questions were posed about how the participating councils had adapted their health scrutiny arrangements, if at all. Recognition was made that councils and the health and social care commissioners and providers are having to do more with less, and are having to reassess their priorities. The questions were posed as to whether health scrutiny was focusing on health services, tackling health inequalities or something else; whether they were scrutinising their in-house public health team, policies and plans; and whether they were taking into account the Marmot theme of wider determinants of health and their added value.

A major focus was on exploring what each health scrutiny's relationships were like with health and social care partners, given the reorganisation consequent upon the Health and Social Care Act 2012. Consideration was given to the prospect for increasing joint health scrutiny. Questions were asked of health scrutiny's level of engagement on Strategies including NHS England's five year plan; their awareness of the local CCGs' budget allocations; and the impact of the findings of the Francis Inquiry and the Keogh Review on their work.

The outline programmes and questions for discussions are attached as appendices.

There were frank and open discussions, and helpful briefings from partners from NHS England area teams; Public Health England local centres; and the Care Quality Commission, and a willingness to sustain this engagement and information sharing.

Findings from the discussions

There are substantial public expectations of health care, which need to be managed. There also has been constant change at significant cost. There are now so many different bodies with which to engage and a lot of relationships to nurture. It is extremely complex. Yet resources are fewer.

Related to this, there is a need to obtain contact details for new partners and to develop an understanding of each other's roles and the importance of sharing information. Relationship building depends upon connections made, capacity, prioritisation and an openness to share work programmes, data and reports. At the moment, it feels like there is a lack of guidance from legislation. Open agenda setting that involves health scrutiny members and consultation with appropriate partners helps, so that the health scrutiny is informed by other work and plans that are relevant to our function and tasks.

Health scrutiny needs to look at the whole picture, not just the NHS, and address the wider determinants of health. There are complex issues with which to work and to understand in respect of health and social care, and NHS data. Pre-meetings are invaluable for this, and it is important to develop questioning skills and confidence in undertaking health scrutiny in a complex area.

It remains challenging to undertake scrutiny of primary care and it continues to be ad hoc, despite the changes to commissioning models and new partners for health scrutiny.

There are resource and capacity issues in fulfilling the health scrutiny role, which requires smarter working and clarity about priorities. It is more difficult to have capacity to undertake in-depth reviews into local issues. There also is a vast agenda of organisations, issues and outcomes that could be scrutinised, as well as the routine quality accounts and the significant substantial variations.

Challenges for health scrutiny include holding the health and wellbeing board to account when there is not yet clarity of the respective roles, and some participants in the new structure do not have a clear understanding of the work of health scrutiny and their relationship to it. It is clear that the HWB has responsibility for the Joint Strategic Needs Assessment and its refresh, for the Joint Health and Wellbeing Strategy, for driving integration of health and social care, and for testing whether commissioning budgets reflect the Strategy. That said there are tensions around the boundary between the work of the HWB and health scrutiny, and indeed varying degrees of openness to health scrutiny by different HWBs.

In some local authorities, the same officer services the HWB and health scrutiny, but in others it has been decided that they should be different officers to avoid any potential conflict of interest. In some authorities, chairs of health scrutiny attend the HWB as an observer, and the HWB chair attends the health scrutiny. The important thing is that there is an open sharing of information and work programmes, and a willingness to be scrutinised and to provide the evidence base for reports and recommendations to the HWB.

The transfer of public health to the local authority has been welcome, but not without challenge. There has been a culture clash in some cases because of the experience of the DPHs in the health service and the adjustments required to working in local government. The DPH and her/his team and particularly Public Health England local centres are an excellent resource for evidence, and important in terms of focusing on a preventative agenda. They have information, can provide evidence, and offer expertise.

Some health scrutiny representatives cited informal meetings with the chair of the CCG as useful. There are issues around the number of CCGs with which to relate in some areas, and challenges around the lack of co-terminocity of boundaries. In some cases there is continuity of personnel as staff transferred from the Primary Care Trust and already had relationships with health scrutiny, but in other cases there has been change.

There is a need for more information about budget allocations, and the scope to challenge them. Health scrutiny should engage with local area teams and CCGs about the resources available for commissioning by CCGs to check that CCGs are using resources to best effect to meet the priorities that have been identified in strategic health and wellbeing strategies. But it is challenging for health scrutiny to have enough capacity to explore where the money is going and to test the relevance of the Strategy.

There is a danger that there is a duplication of responsibilities and consultation, and maybe a need to redefine the role of health scrutiny in the light of the new structures. One of the recurrent issues in the three discussions was around role clarity and the respective terms of reference, and awareness of the different organisations of their respective roles and appropriate ways of working together.

Public engagement remains a challenge. Healthwatch, which covers both health and social care, is developing at a local level, but appear to be variable in stage of set-up. Some are at an earlier stage of development than others, and at different stages of staff appointments. Many are represented on health scrutiny, similar to the LINks, but others feel they could have a conflict of interest, given their place on the HWB, even if it is a different representative. It is early days for local Healthwatch, and it is important to see the business plan and seek to scrutinise it, both in terms of scrutiny of local Healthwatch and scrutiny of the council as commissioner of local Healthwatch. There is scope for collaboration between health scrutiny and local Healthwatch, and equally a need to avoid duplication of role and activity. Each must add value to the other, and share information and work programmes and collaborate where possible. There is a need to coordinate approaches to the Trusts, for example, to avoid the Trusts having to report to several meetings and organisations on similar matters. There seems to be increasing use of expert co-optees.

Substantial variations have not 'gone away', and indeed there are likely to be more of them because of resource pressures and growing demand for services. However, no local authorities were able yet to share experience of scrutiny of reconfigurations of the new structures, or any developments with the use of local resolution.

There was interest in developing work and sharing information and work programmes with the Care Quality Commission. Whilst the CQC at national level is very keen to develop work and information sharing with health scrutiny, the relationship is dependent upon the local compliance managers and inspectors, and the level of engagement by health scrutiny. The CQC/CfPS regional events in 2013 were helpful, but the commitments made then were not always followed through at a local level. Participants therefore welcomed the development of a new CQC/CfPS project, as long as it led to outcomes. It was reported that HOSC chairs and officers should be receiving the following information from the CQC; if not, email the engagement team: involvement.edhr@cqc.org.uk.

1. Bi-monthly e-bulletin announcing updates - more recently about the new inspections.
2. For hospital inspections - Inspection managers should be writing to local HOSC's around 4 weeks beforehand to advise them of the visit and also seek feedback about the service. This includes the relevant contact details for this.
3. Following inspections each HOSC should be invited to the quality summit, if applicable.
4. CQC press releases about non-compliant services, where appropriate.
5. Should be aware of their local CQC compliance manager who will be keeping in regular contact with the HOSC chair or representative.

New approaches

An issue for health scrutiny is to consider how to hear and understand individual voices and concerns and use the insight appropriately. Health scrutiny is not a complaints process, but we should monitor trends.

Bournemouth devised an action plan post-Francis and had a 360 degrees input into perceptions of NHS providers to test the evidence base.

Healthwatch in Wessex is investigating the possibility of a three authority protocol, and also is considering contract monitoring.

Poole has a post-Francis action plan, and could work with Bournemouth and Dorset more on joint scrutiny.

Southampton has joint working with its Clinical Commissioning Group on quality checks.

Some authorities have introduced a system of leads or champions on particular areas of work, given the breadth of the agenda and its complexity.

Next steps

Regular meetings of the South West, Thames Valley and Wessex health scrutiny chairs/vice-chairs and officers would be welcome, so that participants could continue to share experience and address challenges together, and receive briefings from wider stakeholders in health and social care. The South West network will meet again on 28 March, hosted by Devon County Council, with input from the CQC and possibly specialised commissioning, and a case study from DCC on scrutiny of potential closures of community hospitals. Thames Valley agreed to rotate hosting between the local authorities, and will seek to achieve a shared understanding of legislation and guidance and good practice. Buckinghamshire County Council could host in six months time. Each network would set its own agenda, and draw on case studies from the participating councils, as well as briefings and networking with health and social care partners.

It will be important to exchange work programmes, and for this it would be useful to have email groups.

It would be useful to visit each others' health scrutiny from time to time.

Health scrutiny should develop ways to explore how CCG allocations are being spent locally and consider the impact of spend.

There are likely to be more opportunities for joint scrutiny, which might require revision of existing protocols or introduction of protocols where they are not in place. Not only will health scrutiny need to work cross-LA boundary to reflect the catchment areas of acute trusts, but also because of changes in specialised commissioning and to match the boundaries of partners.

It is important to provide comprehensive induction to new members of health scrutiny that covers changes consequent upon the Health and Social Care Act 2012, the scope of health scrutiny, the network of organisations and their relative responsibilities and roles etc. CCGs need to make primary care more accessible to health scrutiny.

Councils and health partners need to publicise what health scrutiny does best.

Prioritisation and the use of criteria are becoming more important given the scale of the challenge. This should not be a tick box exercise.

Health scrutiny needs to ensure that the JSNA and its activity reflect the Marmot principles of the wider determinants of health. This could include raising public awareness about factors affecting health and wellbeing and social care, and the different services (primary and community, as well as acute) that help to achieve better care, quality, safety and health outcomes.