Herefordshire Council

AGENDA

Overview and Scrutiny Committee

Date: **Tuesday 28 August 2012**

Time: **2.00 pm**

Place: **The Council Chamber, Brockington, 35 Hafod Road, Hereford**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

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Agenda for the Meeting of the Overview and Scrutiny Committee

Membership

Chairman	**Councillor A Seldon**
Vice-Chairman	**Councillor JW Millar**
	Councillor AM Atkinson
	Councillor PL Bettington
	Councillor WLS Bowen
	Councillor MJK Cooper
	Councillor PGH Cutter
	Councillor EPJ Harvey
	Councillor MAF Hubbard
	Councillor RC Hunt
	Councillor TM James
	Councillor Brig P Jones CBE
	Councillor JLV Kenyon
	Councillor JW Millar
	Councillor R Preece
	Councillor SJ Robertson
	Councillor P Rone
	Councillor PJ Watts

Statutory co-optees
Mr P Burbidge - Roman Catholic Church
Miss E Lowenstein – Secondary School Parent Governor
Mr T Plumer – Primary School Parent Governor
Mr P Sell – Church of England

AGENDA

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

To receive details of any Member nominated to attend the meeting in place of a Member of the Committee.

3. DECLARATIONS OF INTEREST

To receive any declarations of interest by Members in respect of items on the Agenda.

4. MINUTES 1 - 8

To approve and sign the Minutes of the meeting held on 4 July 2012.

5. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

To consider suggestions from members of the public on issues the Committee could scrutinise in the future.

(There will be no discussion of the issue at the time when the matter is raised. Consideration will be given to whether it should form part of the Committee's work programme when compared with other competing priorities.)

6. QUESTIONS FROM THE PUBLIC

To note questions received from the public and the items to which they relate.

(Questions are welcomed for consideration at a Scrutiny Committee meeting so long as the question is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it ***no later than two working days before the meeting*** *to the Committee Officer. This will help to ensure that an answer can be provided at the meeting).*

7. NHS MIDLANDS AND EAST STROKE SERVICES REVIEW 9 - 26

To consider the arrangements for a review of stroke services.

8. CONSULTATION ON LOCAL AUTHORITY HEALTH SCRUTINY 27 - 34

To consider a response to a consultation on Local Authority Health Scrutiny.

PUBLIC INFORMATION

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HEREFORDSHIRE COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Overview and Scrutiny Committee held at The Council Chamber, Brockington, 35 Hafod Road, Hereford on Wednesday 4 July 2012 at 10.30 am

Present: **Councillor A Seldon (Chairman)**
Councillor JW Millar (Vice Chairman)

Councillors: AM Atkinson, PGH Cutter, PJ Edwards, EPJ Harvey, JW Hope MBE, MAF Hubbard, TM James, Brig P Jones CBE, JLV Kenyon, R Preece and PJ Watts

In attendance: **Councillors RI Matthews, PM Morgan, NP Nenadich and PD Price**

Officers: **D Taylor (Deputy Chief Executive), Dr S Aitken (Assistant Director of Public Health (Health Improvement)), C Baird (Assistant Director People's Services Commissioning), S Burgess (Head of Transportation and Access), A Carswell (Interim Programme Director: Adult social Care), Y Clowsley (Head of Planning), M Emery (Head of Business Support), Dr D Nicholson (Head of Strategic Planning and Regeneration), P James (Governance Services) and D Penrose (Governance Services).**

9. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors PL Bettington, RC Hunt and SJ Robertson.

10. NAMED SUBSTITUTES

Councillor PJ Edwards for Councillor SJ Robertson and Councillor J Hope for Councillor PL Bettington.

11. DECLARATIONS OF INTEREST

Agenda Item 11. Task and Finish Group Reports - Executive Responses.
Councillor PGH Cutter, Personal, as Chairman of the Planning Committee.

Agenda Item 11. Task and Finish Group Reports - Executive Responses.
Councillor PJ Edwards, Personal, Member of the Management Steering Group for Belmont Country Park.

12. MINUTES

RESOLVED: That the Minutes of the Meeting held on 8 June 2012 be confirmed as a correct record and signed by the Chairman.

13. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

There were no suggestions for future scrutiny.

14. QUESTIONS FROM THE PUBLIC

The Committee noted that a number of questions had been submitted by the public, mainly relating to Agenda Item 9. These were circulated at the meeting together with written answers, where available. It was noted that the full schedule of questions and answers would be forwarded to the members and contributors in due course.

The Chairman thanked the contributors for submitting their questions.

15. OVERVIEW OF HEALTH CARE IN HEREFORDSHIRE

The Committee considered the future of healthcare in Herefordshire as part of a discussion with the Wye Valley NHS Trust, the Herefordshire Clinical Commissioning Group (HCCG) and the West Mercia PCT Cluster. The Chairman welcomed Ms C Gritzner, Chief Operating Officer Designate and Interim Accountable Officer, HCCG, Mr P Maubach, Director of Commissioning Developments West Mercia PCT Cluster and Mr H Oddy, Acting Chief Executive, Wye Valley NHS Trust.

Ms Gritzner provided a presentation, and highlighted the following areas:

- That the Governance structure for the HCCG as outlined for the Committee in the presentation had been agreed, and the organisational structure had been sent out for consultation with staff. A report would be submitted to the Board in August.

- That the HCCG had slipped from Wave 2 into Wave 3 of the authorisation application process, the legal process through which CCGs were approved as the new local statutory NHS commissioning bodies. The application would be submitted in September and assessed by an independent panel from outside the region.

- That the objectives, vision and plan of HCCG had been endorsed by the Health and Wellbeing Board, and the Joint Strategic Needs Assessment had been embedded into the planning process.

Mr Maubach provided a presentation on the structure of the National Commissioning Board (NCB). He said that there would be 8 local area teams within the Midlands and East Cluster, and they would have the same core functions around CCG development, emergency planning, quality and safety and system oversight. All Teams would have responsibility for GP, dental, pharmacy and optical services. Local Authority Directors were currently being recruited. There would be a West Midlands Cluster of 4 PCTs, and transitional risks as the present Cluster was split in two.

- In answer to a question, he said that the NCB would have responsibility for 20% of the commissioning spend, whilst the CCGs would be responsible for a total of 80% of spend. The local Health and Wellbeing Boards and Councils would be expected to assume the bulk of local arrangements.

- In reply to a question regarding the top down nature of the governance structure, he said that it would be necessary to secure resources in order to ensure service delivery, and that the sustainable nature of services would need to be addressed. There would be a more top down approach should the local systems not prove to be sustainable, but the onus was on local determination.

- In response to concerns that the organisational structure was too top heavy and therefore costly, Mr Maubach said that the logistical structure of the NHS Midlands and East Clinical Commissioning Board had been based on the number of CCGs and Health and Wellbeing Boards that would be under its control in

order to provide each region with a consistent number of organisations to work with. The structure had been designed to reduce bureaucracy, and was working with substantially reduced management overheads. Ms Gritzner added that the Commissioning Support Organisation (CSO) that had been appointed by Herefordshire/Shropshire/Telford & Wrekin CCGs had identified Staffordshire as the preferred supplier, and they would work with Hoople and the Council. The decision was not aligned to the Cluster structure, and was specific to those CCGs.

- In reply to concerns over management costs, Mr Maubach said that these figures would be made available to Members.

- In reply to a Member's question regarding how savings would be made by Staffordshire and Hoople, Ms Gritzner said that Herefordshire was leading the country by asking its CSO to work with another organisation. Further savings would be made around prescription service review, and the use of different mechanisms that were in place to achieve the necessary changes.

Mr Oddy provided a presentation on the Wye Valley NHS Trust. He reported that Price Waterhouse Coopers had identified £5.5m of savings within the Trust, but considered it to be a lean organisation. During his presentation, Mr Oddy highlighted the following issues:

- That there was a gap of £15m in the income and expenditure plans for 2012/13.

- Discussions were in hand with the West Mercia PCT cluster and the Strategic Health Authority regarding non-recurrent funding of £9.5m in 2012/13. Financial plans indicated a requirement for further non-recurrent support of £9.2m in 2013/14. Future years planning assumptions required savings of 5% per annum which equated to £8m per annum for the Trust.

- That whilst the Trust could be financially viable by 2014/15, changes to its structure were inevitable.

- In reply to a question from a Member regarding the impact the Trust's financial situation would have on the health and social care transformation programme, Mr Oddy went on to say that the proposed changes would be undertaken more slowly. It was in the interest of both the Trust and the Herefordshire Clinical Commissioning Group to reduce hospital admissions and to increase the role of the Neighbourhood Teams to provide care in the home rather than in high cost facilities. The reduction of patient length of stay was also important in order to reduce the pressure on beds in the hospital.

- In reply to a further question, Mr Oddy went on to say that the Trust was funded by an early example of a Private Finance Initiative, and was working to ensure that as much value as possible was extracted from the contract. A review by KPMG had found that the PFI Contract was not a major factor in the current financial difficulties facing the Trust

RESOLVED:

That:

a) the West Mercia PCT Cluster, the Wye Valley NHS Trust and the Herefordshire Clinical Commissioning Group should be invited to attend the Committee in order to ensure that common issues were debated at the same time and that each would have a chance to respond to matters of concern;

b) an all Members Seminar be arranged to clarify the position in relation to Herefordshire's Healthcare provision and specifically the progress of the Herefordshire Clinical Commissioning Board and the changes to the Midlands and East Strategic Health Authority; and;

c) West Mercia PCT Cluster performance data should be monitored by the Committee on a quarterly basis and that the Committee should regularly assess the impact that changes would have on the population

The Committee adjourned for a 10 minute break at 12.36.

16. TASK & FINISH GROUP REPORT - REVIEW OF WYE VALLEY NHS TRUST (STROKE & TRAUMA SERVICES AND THE DELAYED TRANSFER OF CARE)

The Committee considered the findings arising from the Task & Finish Review into the Wye Valley NHS Trust (Stroke & Trauma Services and delayed transfer of care).

The Vice-Chairman reported that the Group had concluded that the potential benefit of the further integration of the Adaptions Team into the Total Patient Care Pathway should be supported, as this was a logical adjunct to the Integrated Care Pathway.

The Group also recommended that the rationale for the Wye Valley NHS Trust's bid to the West Mercia PCT Cluster for funding from the Strategic Health Authority's Reserve Fund to invest in further work to improve the flow from acute care to home care be supported.

RESOLVED: That the report be noted and referred to the Wye Valley NHS Trust.

17. CONSULTATION IN RESPECT OF THE LOCAL DEVELOPMENT FRAMEWORK AND LOCAL TRANSPORT PLAN

The Committee considered a report outlining how and when it should be consulted in respect of the programmes for adopting the Local Development Framework (LDF) and Local Transport Plan (LTP) as set out in the report to Cabinet of 12 July 2012. It was noted that a number of public questions had been received for this item, and would be submitted to Officers for a written response.

The Head of Transportation and Access and the Head of Strategic Planning and Regeneration presented the report and outlined the respective timetables for consultation on the LTP and LDF. In view of the timetable changes proposed, work should proceed on an LTP covering the period to 2014/15 with key long term linkages between the two strategies being maintained.

During the discussion, the following principal points were raised:

- That whilst the possibility of an Eastern Link Road had been raised to link Holme Lacey Road and Ledbury Road, the feasibility study had yet to be completed

- That whilst there were differences of opinion regarding the summary of results of the Revised Preferred Option consultation undertaken in the Autumn of 2011, the results were a matter of public record as part of the consultation process.

- That the LTP and LDF were of such weight, that a broader discussion was required, perhaps as a series of one off meetings that would allow for a wide ranging discussion of the issues.

- A Member suggested that the Committee should be advised when each area of evidence was nearing completion and should then be briefed on its contents. He asked that non-technical summaries to help explain the evidence base should also be produced as a matter of course in order to help the Committee ensure that the evidence base was adequate. The evidence base should include a refreshed Community Strategy, as the LDF was required to have this as part of the National Planning Policy Framework (NPFF).

- He went on to say that under the NPFF, paragraph 49 of the report would allow any developers to put forward plans for development on greenfield rather than brownfield sites. He suggested that identified brownfield sites should be given development priority over greenfield sites for the first five years of the land bank. This would provide protection for the first five years in order to allow greenfield sites to be identified in an appropriate manner.

RESOLVED:

That Cabinet be recommended that:

a) subject to outstanding issues being resolved, the proposed scale and distribution of development and strategic housing, employment and infrastructure proposals, as set out in paragraph 49 of the Draft report to Cabinet of the 12 July 2012, should form the basis of the consultation process.

b) as a result of the possibility that a Western Relief Road should not come to fruition for planning or cost reasons, it would be inappropriate to approve large scale developments for inclusion within the draft Core Strategy until the necessary infrastructure had been similarly approved;

c) under Paragraph 18 of the Draft report to Cabinet, the Committee requested that a copy of the package of necessary infrastructure improvements should be made available;

d) under Paragraph 24 of the Draft report to Cabinet, the Committee requested a copy of the commissioning document to Amey to assess the environmental and amenity issues associated with the many changes which had taken place directly adjacent to the old Southern bypass route in recent years;

e) under Paragraph 26 of the Draft report to Cabinet, the Committee requested that the staged assessments should be made publicly available;

f) under Paragraph 49 of the Draft report to Cabinet, the Committee requested that consideration should be given to an alternative plan for the 2,300 proposed houses in Leominster if water phosphate levels could not be satisfactorily improved;

g) under Paragraph 49 of the Draft report to Cabinet, the Committee strongly recommends that Cabinet should include identified brownfield sites for inclusion in the Draft Core Strategy and agrees that these sites should be given priority over greenfield sites for the first five years of the Land Bank Supply; and

h) under Paragraph 53 of the Draft report to Cabinet, the Committee requested that Cabinet should take note of where community consultation has noted significant negative community impact.

18. STRATEGIC DELIVERY PLAN FOR TRANSFORMING ADULT SERVICES 2012-2015

The Committee noted the final draft of the Strategic Delivery Plan for Transforming Adult Services 2012-2015. The Cabinet Support Member (Adult Social Care) introduced the report and highlighted the following principal areas:

a) That the Strategic Delivery Plan had been developed to take account of national policy direction, the demographic profile of Herefordshire and to build on the vision of encouraging people to take responsibility for their own lives and access formal health and social care services only when necessary. It provided a single document setting out the overall approach for adults over the next three years and contributed to the Joint Delivery Plan, the strategic aims of the council and its partners, and was a key part of achieving a balanced budget position.

b) All Councils and Health communities were facing significant challenges due to reduced budgets and increased demographics. There was a need to have sustainable systems and services and which offered value for money. This was a national as well as local issue and the strategic delivery plan set out a transformation programme over three years;

c) Various Council services, NHS Herefordshire, Herefordshire Clinical Commissioning Group, Wye Valley NHS Trust and 2gether Foundation Trust had been involved in the development of the plan, which had been approved by the Health and Wellbeing Board.

In the ensuing discussion the following principal points were made:

- The Assistant Director People's Services Commissioning said that an Adult Social Care Forum would be set up for the Health and Wellbeing Board, and that a progress report on the Delivery Plan would be provided to Cabinet on an annual basis. It was important that the Plan was delivered though the Localities, and their active engagement was being sought.

- The Cabinet Support Member said that whilst the Locality System was not perfect, he had visited three Locality Teams, and had been impressed by the commitment they had shown. Problems that had existed between the Panel and the Locality Teams were being worked through.

- The Assistant Director People's Services Commissioning said that the initial issues that had faced the Service with the introduction of the Frameworki software were being sorted out, and the process was being slimmed down. The Agresso software had been introduced in April 2011, and work was in hand to further reduce the complexity of the system.

- A Member said that the needs of full time carers should be focussed on. He expressed concern at the cost of the service, and suggested that greater efficiencies should be possible using technology based care.

- A Member asked how this Plan would help to deliver the £8m of savings that were required, and asked that a report be provided that gave clarity to the performance and progress of the transformation programme.

RESOLVED:

That:

a) **as part of the Delivery Plan there should be sufficient support for full time carers in order to ensure that they were in a position to continue their caring role effectively;**

b) **a report be brought to the next meeting on the progress that has been made and the benefits that have been accrued as a result of the integration of the Frameworki and Agresso software systems since April 2011.**

c) **a schedule of performance reports outlining the savings that were being achieved through the Strategic Plan for Delivering Adult Services be brought to the Committee on a quarterly basis.**

d) **an emphasis should be put on rolling out the lessons in healthy living received by school children in Herefordshire in order to promote healthy eating in older people.**

The Committee adjourned at 13.34 for a lunch break, and resumed at 14.03.

19. TASK AND FINISH GROUP REPORTS - EXECUTIVE RESPONSES

The Committee noted a report to consider the Executive's response to the recommendations made to it in the following Task and Finish Group Scrutiny Reviews: Adult Safeguarding in Herefordshire, Planning System Review – Development Control and the Operation of the Constitution, Council Procurement Policy and Local Business and Local Employment, Income and Charging and Tourist and Temporary Event Signage.

RESOLVED:

That:

(a) the Executive's response to the findings of the reviews be noted; and;

(b) a further report on progress in response to the Review be made after six months with consideration then being given to the need for any further reports to be made.

20. OVERVIEW AND SCRUTINY WORK PROGRAMME

The Committee considered its Work Programme. During the discussion, the following points were made:

- That, in future, the Clinical Commissioning Group, the West Mercia Cluster and the Wye Valley NHS Trust should be invited to attend the Committee at the same time to ensure that common issues were debated and each would have a chance to respond to matters of concern.

- That the Review of GPs and Out of Hours Services should be undertaken during Autumn 2012.

- Information was sought regarding the latest position concerning:

    - The development of Park and Ride sites particularly as the new Local Transport Plan had been delayed.

- Any current developments concerning cycle way routes – particularly in view of the 'Destination Hereford' package of integrated transport improvements.

- The position regarding the Connect2 Greenway project. How the Greenway is to integrate with the Enterprise Zone. Will there be a car park or a Park and Ride site at the Zone end of the route and was this in the original design.

The Committee agreed that the above information be provided in a briefing note to the Committee.

- Following the increase in academies and various education based services being commissioned through service level agreements, questions were asked regarding the level of activity within the education section of the People's Services Directorate. The Committee agreed that the above information be provided in a briefing note to the Committee.

- The Committee agreed that consideration of the Root & Branch reviews needed to be scheduled appropriately into the work programme.

- As requested earlier in Minute No.18, a report should be scheduled into the work programme regarding the progress and benefits accrued following the integration of the Frameworki and Agresso software systems.

- The Committee noted that the Vice-Chairman was to attend a meeting to discuss Healthwatch and he would be focusing on the Centre for Public Scrutiny's '10 Questions to Ask'. If there were any issues of concern, these would be reported back to Committee.

RESOLVED: That the two briefing notes be requested and the work programme be amended to reflect the above.

The meeting ended at 15.20 **CHAIRMAN**

Herefordshire Council

MEETING:	**OVERVIEW AND SCRUTINY COMMITTEE**
DATE:	**28 AUGUST 2012**
TITLE OF REPORT:	**NHS MIDLANDS AND EAST STROKE SERVICES REVIEW**
REPORT BY:	**HEAD OF GOVERNANCE**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To consider the arrangements for a review of stroke services.

Recommendation(s)

THAT: the Committee

(a) considers the arrangements for the Stroke Review;

(b) notes the 6 week opportunity to be engaged in the shaping local responses to the best practice specification;

(c) comments on the high level criteria which will inform the External Expert Advisory Group recommendations.

Introduction and Background

1 The NHS Midlands and East Regional Strategic Health Authority Cluster (NHSME) was formed from the three former Strategic Health Authorities: NHS East Midlands, NHS West Midlands and NHS East of England. It is one of the four clusters that will manage the NHS until April 2013. The NHSME Board has agreed to undertake a major review of stroke services to establish the means to make a step change improvement in stroke care across the Cluster.

2 A copy of the report prepared by the Cluster for circulation to OSCs across the NHSME Region is appended.

3 The report

- summarises the arrangements for reviewing stroke services across NHSME in 2012/13;

- draws attention to the opportunity over the summer in shaping options for how the service can deliver a step change improvement in stroke care
- seeks comment on the high level criteria against which recommendations will be made about delivery of a step change improvement in stroke care.

Director for People's Services Comment

4 The Director for People's Services comments that from a local and council perspective she would be keen to ensure the local engagement of public health, adult social care and the third sector in the end to end pathway in Herefordshire. It is essential for the success of stroke services that individuals, families, carers, communities and partners are constructively engaged so that they can play their part in prevention, re-ablement and care and support at home. It will also be important that the challenges of rurality, and the issues for Herefordshire in terms of population and demographics are considered as part of the regional approach.

Appendices

Appendix 1 - NHS Midlands and East Stroke Services Review – Stroke Review – achieving a step change improvement in stroke care.

Appendix 2 Proposed high level criteria against which External Expert Advisory Group will consider options.

Background Papers

- None identified.

Herefordshire Council

NHS Herefordshire

Working together for the people of Herefordshire

NHS Midlands and East Stroke Services Review

July 2012 For Information and Comment

Stroke Review: achieving a step change improvement in stroke care.

Sally Standley, SHA Stroke Review Programme Lead

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1 Purpose of the paper

1.1 The purpose of this paper is:

- to summarise the arrangements for reviewing stroke services across NHS Midlands and East (NHS M&E) in 2012/13;
- to draw attention to the opportunity over the summer in shaping options for how the service can deliver a step change improvement in stroke care
- to seek comment on the high level criteria against which recommendations will be made about delivery of a step change improvement in stroke care..

2 Background

2.1 Stroke is acknowledged as a major cause of mortality and morbidity, accounting for in excess of 40,000 deaths a year in England of which over 12,000 are in Midlands and East.

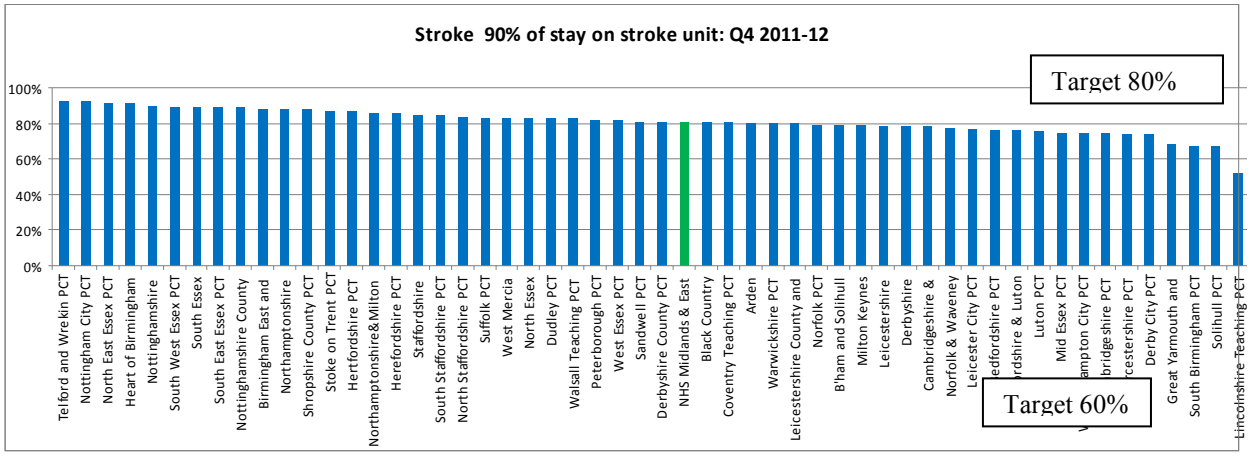
2.2 The UK does not compare favourably with international performance in the management of stroke:

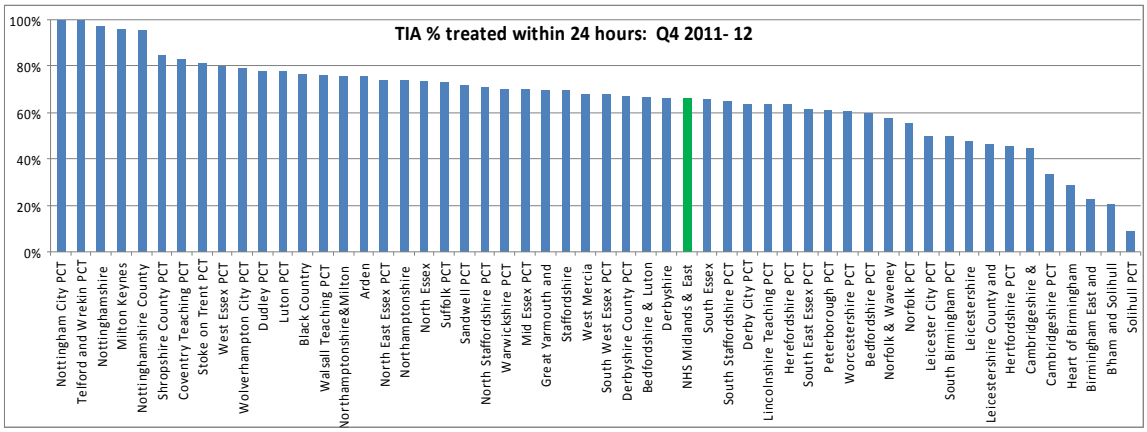
- league tables rank Britain's survival rates for the most common type of stroke as the worst in the developed world;
- OECD statistics comparing 30 developed Western countries, rank UK's death rates after hospital admission for an ischaemic stroke as twice the OECD average, and three times worse than those in Denmark.

2.3 At its meeting in January 2012, the Regional Cluster Board noted the shortfall in performance compared to national standards of best practice, articulated as long ago as 2008 in the National Stroke Strategy e.g. only 30% of patients receiving a brain scan in under 1 hour (SINAP 2011); only 17% of patients admitted to a stroke unit in under 4 hours of arrival (NAO 2010).

2.4 The Board also noted that although there had been improvements in stroke care relating to the two national vital signs for acute care (figure 1), there remained a variation in practice across the cluster, and considerable shortfall in performance in relation to the whole stroke pathway.

Figure 1





2.5 The Board noted the significant improvement in stroke outcomes achieved in London, following its review of acute stroke services; albeit with recognition that the geography and configuration of Midlands and East differs considerably to that of London.

e.g. Stroke mortality, adjusted for case mix and other factors, was 25% lower in London in 2010/11 than the national average;

e.g. Performance against the two national stroke/TIA vital signs (see figures 2 and 3).

Figure 2:

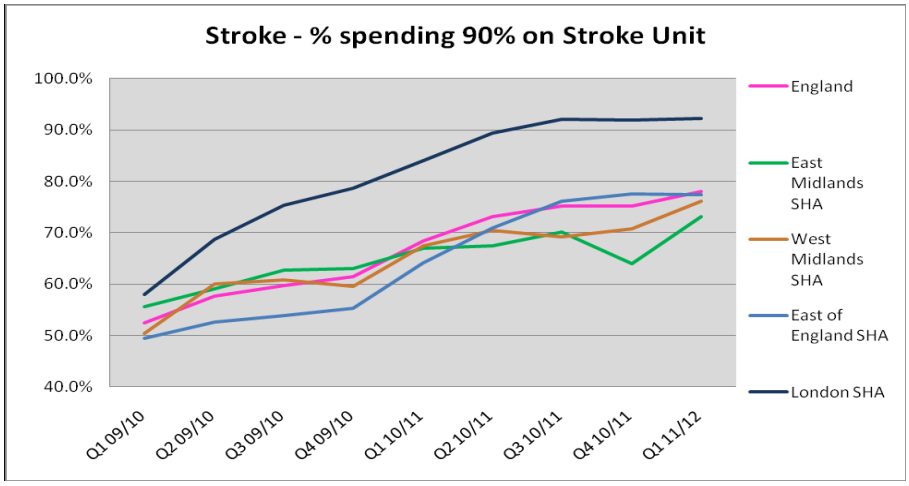
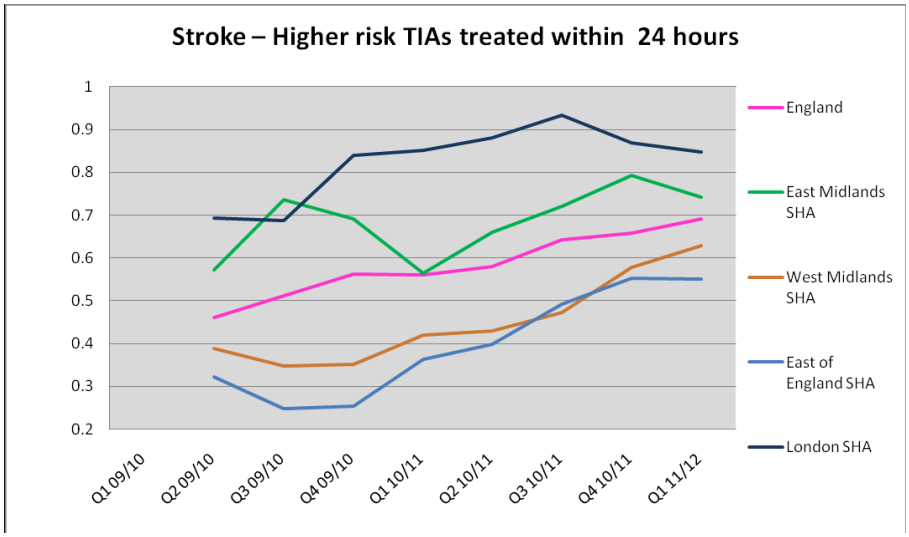
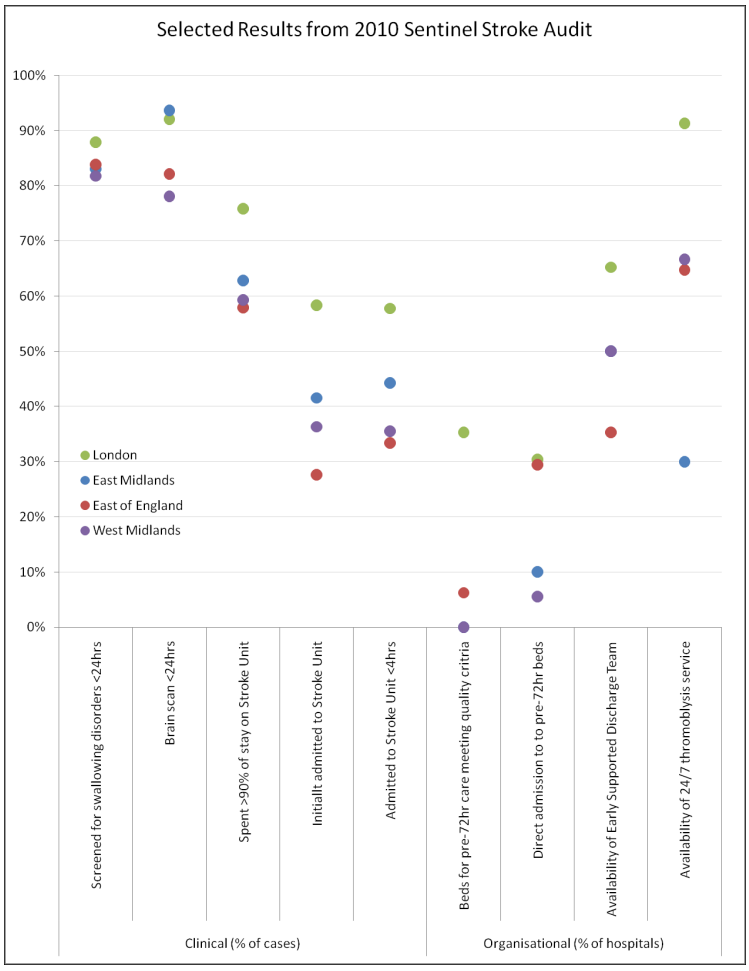


Figure 3:



e.g. Performance against the 2010 National Stroke Sentinel Audit. Although the data is now outdated, it shows that even during the period of transition, the London service compared favourably with the SHAs in the NHS Midlands and East.

Figure 4:



2.6 It was agreed that a major review of stroke services should be undertaken in NHS M&E, to establish the means to make a step change improvement in stroke care across the Cluster; making clear recommendations before the SHA's abolition in March 2013. There is a significant challenge in the timescale, even before taking account of the structural change in many of the key stakeholder organisations, i.e. the abolition of the SHA and PCTs; emergence of Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards; and the in year changes to Stroke Networks and Observatories, the details of which are both not yet clear. None the less, partners have agreed to work together to deliver this in the expected timescale, in the interests of improving patient care.

3 Structure and Process of the Review.

3.1 The Review has been commissioned by NHS Midlands and East. It will establish a clear strategic vision and implementation plan, and make an explicit recommendation, as a 'strategic steer', to CCGs to guide their commissioning in 2013/14 and beyond. In commissioning stroke services, and working to achieve best practice and an improved return on investment, the CCGs will be performance managed by the National Commissioning Board (NCB)

3.2 The Review is being led by Cambridge University Health Partners (CUHP); one of the five academic health science partnerships (AHSC) in the country, and the only one in NHS Midlands and East. It is being undertaken with local leadership of the nine clinically managed Stroke Networks across NHS M&E. Deloitte have been commissioned to undertaken elements of the Review which the NHS partners do not have capacity for in the timescale, in particular the modelling associated with the Review, and supporting documentation of a best practice specification, against which the review is being undertaken.#

3.3 To supplement the NHS M&E Board's recommendation to CCGs, commissioners will receive a Commissioning Toolkit which will include the health economics for investment; guidance for inclusion in contracts to optimise delivery and outcome; and guidance on splitting tariffs where necessary.

Project Board

3.4 A Project Board has been established, chaired by Professor Tony Rudd, Royal College of Physicians Stroke Lead, and stroke physician at Guys and St Thomas' NHS Foundation Trust. Membership reflects representation of key stakeholders, and provides governance to the Review. Membership is set out at Annex A.

3.5 There are three sub groups working to the Project Board:

- **Data and modelling:** this includes establishing a baseline and evaluation of the outcome of the review; modelling to identify the optimum configuration of services, and to ensure that the impact of any proposals have been identified and taken into account'. The group is chaired by Matt Ward, West Midlands Ambulance Service;
- **Service User and Carer Forum:** this helps shape and provide comment on emerging proposals for the review overall, and supplements local service user and carer engagement at a network level;
- **Education, Training and Workforce:** this includes production of toolkits to support providers in responding to the outcome of the review; and a commissioner toolkit to support CCG's in commissioning its implementation.

External Expert Advisory Group

3.6 An External Expert Advisory Group (EEAG) has been established; chaired by Dr Damian Jenkinson, the DH's Interim Director for Stroke; and NHS Improvement Lead for Stroke. The Group has produced an evidence based best practice specification for the whole stroke pathway, to guide the service in being clear about what needs to be provided to achieve a step change improvement in outcomes. Deloitte has worked with the EEAG to help document this vision.

3.7 EAAG has a strong membership, with a combination of national expertise, and experience in the major review and implementation of improvement to stroke services, in both urban and rural areas. Membership is set out at Annex B.

Clinical Leads within NHS M&E

3.8 The 9 Stroke NHS M&E Networks have each identified a medical, nursing, and therapy clinical lead, to lead engagement at a local level. They are supported by the Network Director and other network team members. The Networks in each region (ie. E Midlands, W Midland and East of England) have identified a medical, nursing and therapy lead, drawn from the nine, who can represent the region at the Project Board, and in discussions with the EEAG and other fora.

Communication and engagement

3.9 Professional communication and engagement expertise is provided from the Strategic Health Authority, working closely with local stroke networks. A Review Bulletin is produced; and 'flash reports' from Project Board meetings setting out key decision and actions. All papers (Project Initiation Document (PID), terms of reference, minutes etc), and the source documents which have informed the EEAGs best practice specifications are available on the SHA's public facing web site: https://www.eoe.nhs.uk/page.php?page_id=2266 .

3.10 Local engagement is being driven by the 9 Stroke Networks, each of which has refreshed the membership of its Stroke Advisory Group to ensure representation from all relevant stakeholders; and developing a locally appropriate set of arrangements to maximise engagement to contribute to the review. We are working to make the review as open and transparent as possible.

3.11 If as part of the review it is necessary to undertake a period of formal consultation on the emerging recommendations, this will take place for the area concerned, rather than be part of a regional cluster wide consultation process. This will maximise local opportunity to engage in issues relevant and pertinent to the area, and avoid an unnecessary process being undertaken for the remainder of the region.

The focus of the review.

3.12 The Review is being undertaken with the following guiding 'principles':

- It will cover the whole stroke pathway from primary prevention to end of life. To achieve gains in health outcome, and productivity, it is essential that the whole pathway of care is reviewed, not just the provision or configuration of acute services;
- It will work to build on existing work, rather than duplicate or start work again. This is particularly pertinent to E Midland and W Midlands, and around Hinchinbrook Hospital in the East of England where considerable work has recently been undertaken to review acute stroke care;
- The work will be driven and undertaken where ever possible through the auspices of the 9 Stroke Networks. They already have strong clinical leadership for stroke; established relationships with local providers and commissioners (albeit with the latter changing from PCT to CCG in

2012/13); and a clear understanding of the strengths and weaknesses of current provision;

- The solutions for the three regions within the Cluster may differ considerably; one size will not be expected to fit all, not least because of urban and rural differences;
- It will draw learning from existing work undertake in the regional cluster, and from other parts of the county which have recently undertaken effective review and improvement to stroke care.

The process of the review

3.13 The EEAG has developed an evidence based Best Practice Specification covering the whole stroke pathway, divided into 8 phases:

a) Primary prevention

b) Pre hospital

c) Acute: i) hyper acute, ii) acute, iii)TIA, iv) tertiary care (neuro surgery)

d) In hospital rehabilitation

e) Community rehabilitation (inc Early Supported discharge)

f) Long term care and support

g) Secondary prevention

h) End of life

This sets out the expected features of care provided at each point on the pathway, workforce requirements, metrics for monitoring performance etc.

3.14 Before being completed, Networks have had opportunity to ensure that its content is clear, and to comment on any areas of query or omission. This has also had the advantage of extending the period of the networks being familiar with its content, which is otherwise very challenging.

3.15 The Specification was being presented to local system at the end of June to encourage their local proposals of how they can achieve the required step change improvement in outcome. Local systems will have a six week period over the summer to consider this. They will also be given a framework for the response, and the high level criteria against which EEAG will make a recommendation.

3.16 The timescale is challenging, particularly as it is over the summer months, but extending beyond this is not possible if the Review is to conclude with a formal recommendation by March 2013. Networks are coordinating and supporting this process as a local level, and are responsible for maximising local engagement. Responses are being presented back to the EEAG for consideration, along side other scenarios that emerge from the modelling.

3.17 In making its recommendations, EAAG will link with the Network clusters' clinical leads (i.e. 3 x 3) for clarification of proposals where necessary. Where issues relate specifically to an individual network's area, and EEAG requires clarification, or where consensus hasn't been reached at a local level, EAAG may want to meet with the relevant network's clinical leads themselves rather than the network cluster clinical leads (s).

3.18 EEAG will make a formal recommendation to the Project Board, which will consider whether the proposals constitute major change for any part of the NHS M&E. The SHA will consider this conclusion, and if necessary require a period of formal consultation; after which it will consider the formal response to consultation and make a decision about the outcome of the review. The SHA's decision will take the form of a 'strategic steer' to the CCGs which will take on responsibility for commissioning Stroke services from April 2013.

Timeline for the Review

3.19 Key points in the time line include:

- June 2012 EEAG develops the evidence base best practice specification; distributed to local systems by the end of June
- June to August 2012, **6 weeks period during which local systems respond to the Specification**
- August 2012 EEAG develops its recommendations
- Sept 2012 Project Board considers the recommendation and identifies the need for a period of formal consultation
- Oct-Dec 2012 period of formal consultation (3 months)
- January 2013 response to consultation, and further work if necessary to refine proposals
- March 2013, SHA Board meeting to consider the outcome of the Review, and make recommendation to CCGs.

3.20 The full Review timetable is presented as a Gant chart in Annex C.

Criteria against which EEAG will make its recommendations

3.21 A set of high level criteria have been proposed, to inform EEAG's recommendations. Comment is welcomed on these criteria before they are finalised.

a) Service configurations meet best practice, and can demonstrably improve:
   - clinical outcomes *e.g. 30 day mortality*
   - quality of life outcomes *e.g. Level of disability at 30 days*
   - patient experience of stroke services *e.g. Patient satisfaction of rehabilitation services*

b) Services are cost effective and financially sustainable

c) Service provision is geographically and socio-economically equitable, reaching the whole area population

d) Service provision effectively handles and manages population flows into, and out-of, area

e) Services support the whole stroke pathway, end-to-end, from prevention to long term care or end of life care

f) Services are coordinated by local stroke networks demonstrating collaboration between providers along the whole stroke pathway

g) Stroke service configurations support the delivery of other, in particular acute, services

h) Service provision is clinically sustainable.

3.22 Comment is sought by 1 August 2012 on whether these are the right criteria.

4 Engagement of Health and Well Being Boards, and Overview and Scrutiny Committees

4.1 Directors of Public Health are acting as the key conduit to health and wellbeing boards, in particular to support effective primary prevention activities and interventions. The Herefordshire and Worcestershire Cardiac and Stroke Network will be briefing you and supporting local commissioners (PCTs and CCGs) in engaging with our local OSC.

4.2 OSCs, amongst other stakeholders, are therefore invited to comment on the high level criteria against which the EAAG will make a recommendation for NHS M&E achieving a step change improvement in stroke outcome. This will need to take place before EEAG's deliberations in late August/early September 2012.

5 Evaluation

5.1 Over the summer the Review will establish the region's baseline to support evaluation of the Review's impact on improving clinical outcomes and return on investment. Discussions are underway to use the same parameters as the reviews of London, Manchester and other areas recently reviewing their stroke services.

6 Recommendation

6.1 Herefordshire OSC is asked to:

a) be aware the arrangements for the Stroke Review;

b) note that their primary points of contact are their local commissioners, supported by their local Stroke Network;

c) note that if consultation is required this will be determined in September/October 2012; proposals will be subject to a period of formal consultation; it is proposed that consultation be undertaken in the affected areas, rather than a region wide consultation;

d) comment on the high level criteria which will inform EEAG's recommendations.

Paul Edwards
Associate Director of Commissioning
NHS Herefordshire
July 2012

Annex A: Stroke Review Project Board Members:

Prof Tony Rudd, (Chair), Royal College of Physicians Stroke lead; Consultant Guy's and St Thomas' London

Barbara Zutshi, National Stroke Improvement Team

Chris Larkin, Stroke Association

Rebecca Larder, Network Link Director – East Midlands

Prof Tom Robinson, Clinical lead – East Midlands

Dawn Good, Nursing lead – East Midlands

Therapy lead – East Midlands

CCG rep – East Midlands

Jonathan Webb, Service User & carer rep, East Mids

Genevieve Dalton, Network Link Director – EoE

Dr Anthony O'Brien (interim), Clinical lead – EoE

Suzanne Helliwell, Therapy lead – EoE

Moira Keating, Nursing lead – EoE

Dr Brian Houston, CCG rep – EoE

Katrina Power Luton CCG

Jim Barker, NHS Norfolk and Waveney

Rob Wilson, Network Link Director – West Midlands

Dr David Sandler, Clinical lead – West Midlands

Dr Tony Kenton, Shared Clinical lead – West Midlands

Dr Indira Natarajan, Shared Clinical lead – West Midlands

Jacqui Winter, Therapy lead – West Midlands

Paula Bourke, Nursing lead – West Midlands

Dr Liz Pope, CCG rep – West Midlands

Janette Adams, Service User & carer rep, Herefords& Worcs

Norman Phillips Service User and Carer rep, Coventry and Warwickshire

Elaine Yardley, Social care, Nottingham

Matt Ward (Chair of data, modelling and information group) WM Ambulance Service

Prof Robert Harris, Director, NHS M&E

Jon Cook, Head of Reconfiguration, NHS M&E

Sally Standley, Stroke Review Programme Lead, NHS M&E; Cambridge University Health Partners

Alida Farmer, Project Manager NHS M&E

Helen Jackson, Communications Lead NHS M&E

Dr Anne McConville, Acting Regional Dir Public Health

Clare Hilitt ,North Trent Stroke Strategy Project (corresponding)

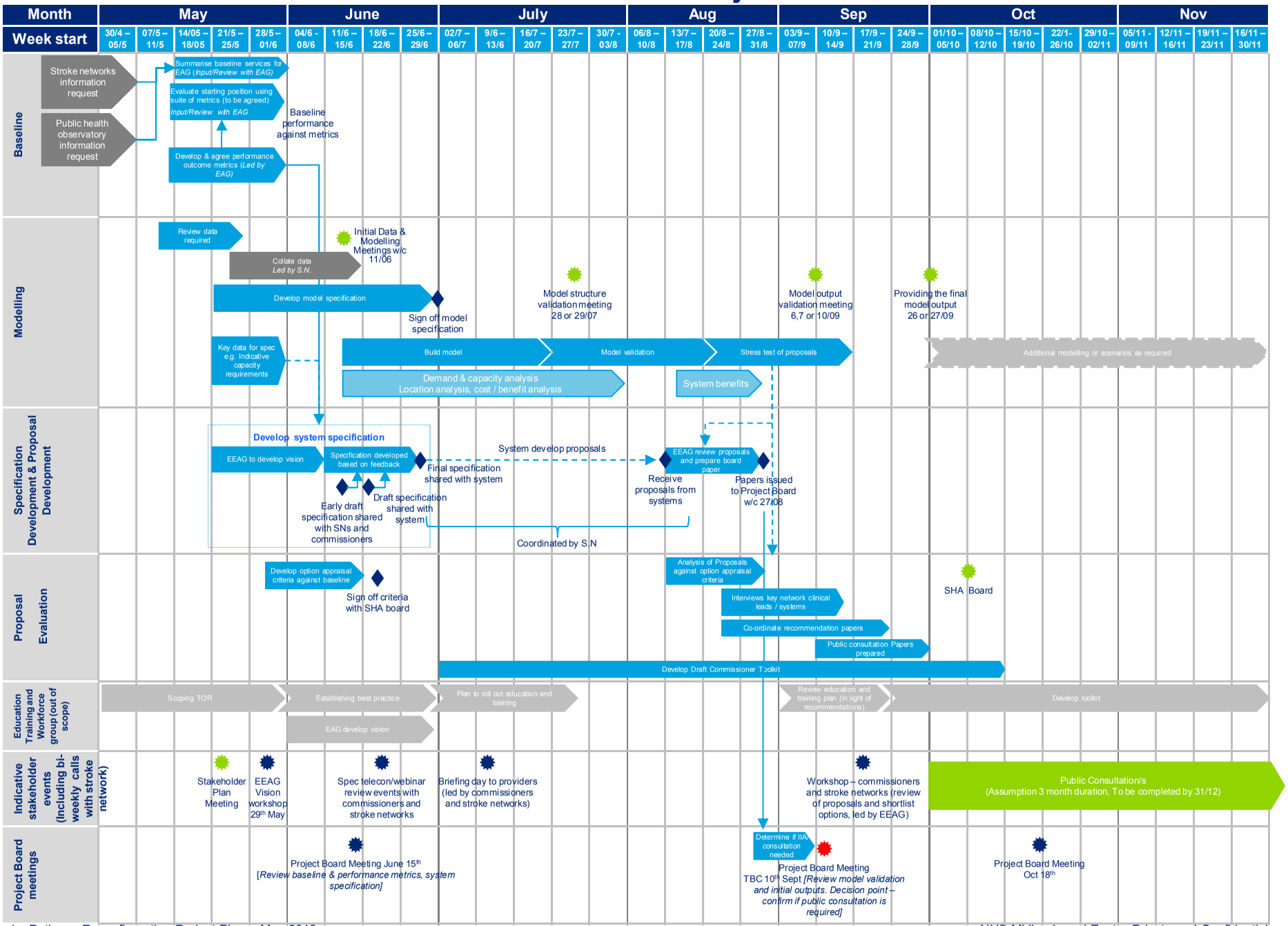
Chris Larkin, NW Stroke Association

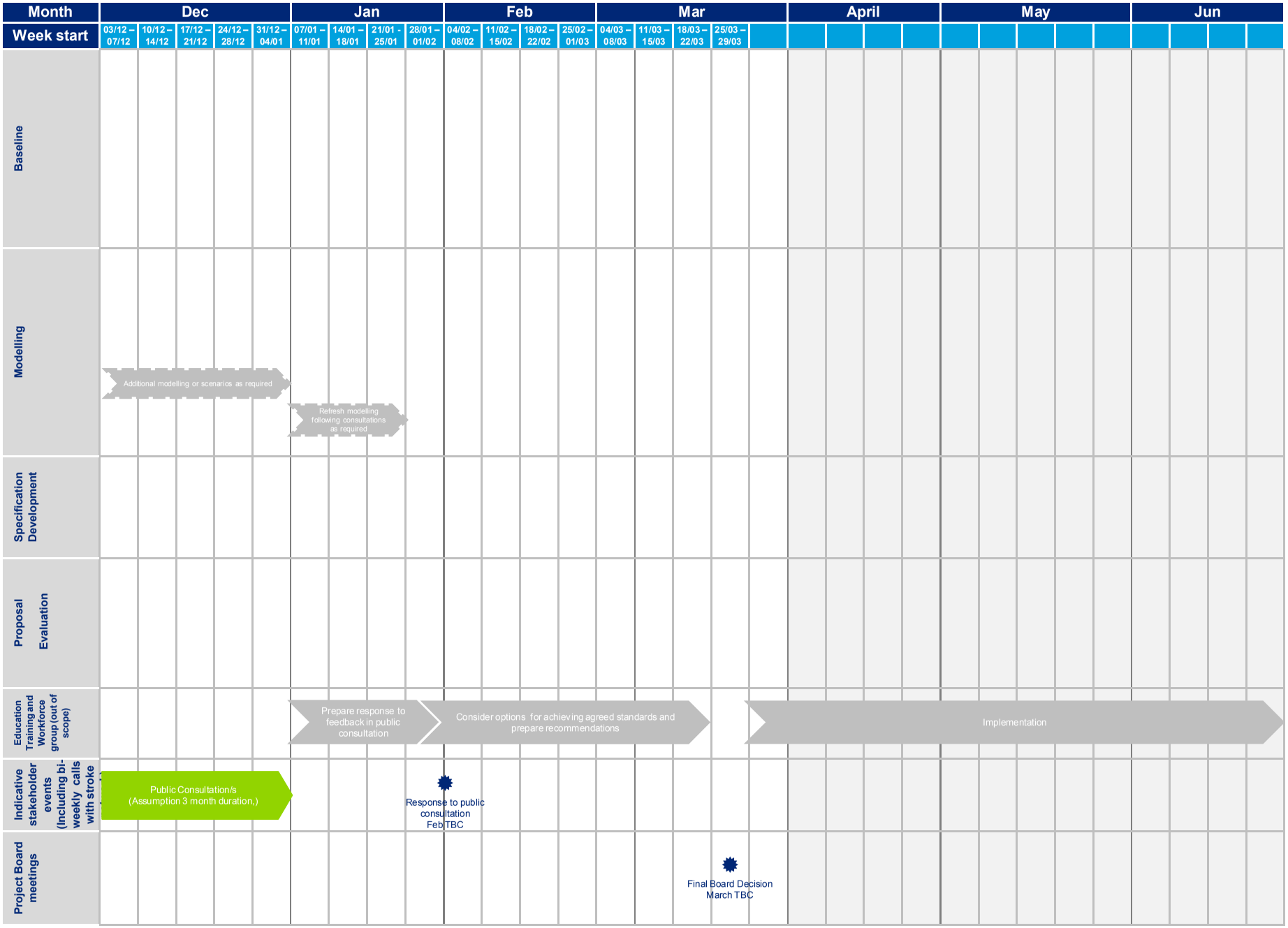
ANNEX B: External Expert Advisory Group members:

Dr Damian Jenkinson, Interim Director, Stroke, NHS Improvement.
Prof Tony Rudd, Director of the Royal College of Physicians Stroke Programme Consultant Stroke Physician Guy's and St Thomas' NHS Foundation Trust
Peter Moore, Stroke Association
Dr Jane Williams, Consultant Nurse in Stroke Care at Portsmouth Hospitals NHS Trust
Prof Caroline Watkins, Professor of Stroke and Older People's Care and Director of Research. University of Central Lancashire
Dr Charlie Davey, Consultant Neurologist (with special interest in stroke), Royal Free Hospital
Adrian South, Deputy Medical Director, South Western Ambulance Service NHS Foundation Trust
Sarah Gillham, Stroke lead, NHS Improvement
Mirek Skrypak, Occupational Therapist, and Chair North Central London Stroke and Cardiovascular Network, Life after Stroke Group.
Claire Fulbrook-Scanlon, Joint Clinical Stroke lead, Avon, Gloucestershire, Wiltshire and Somerset Cardiac and Stroke Network
Barbara Zutshi, Stroke Lead, NHS Improvement
David Roberts, Director of Adult Social Services, London Borough of Bromley
Prof Helen Rodgers, Clinical Professor of Stroke Care, Newcastle University

NHS Midlands and East – Stroke Service Review Project Plan v0.7

Annex C




Month
Dec
Jan
Feb
Mar
April
May
Jun
Week start
03/12 – 07/12
10/12 – 14/12
17/12 – 21/12
24/12 – 28/12
31/12 – 04/01
07/01 – 11/01
14/01 – 18/01
21/01 - 25/01
28/01 – 01/02
04/02 – 08/02
11/02 – 15/02
18/02 – 22/02
25/02 – 01/03
04/03 – 08/03
11/03 – 15/03
18/03 – 22/03
25/03 – 29/03
Baseline
Modelling
Additional modelling or scenarios as required
Refresh modelling following consultations as required
Specification Development
Proposal Evaluation
Education Training and Workforce group (out of scope)
Prepare response to feedback in public consultation
Consider options for achieving agreed standards and prepare recommendations
Implementation
Indicative stakeholder events (including bi-weekly calls with stroke
Public Consultation/s (Assumption 3 month duration,)
Response to public consultation Feb TBC
Project Board meetings
Final Board Decision March TBC

Proposed high level criteria against which External Expert Advisory Group (EEAG) will consider options:

a) Services will cover all of the stroke patient's care from prevention through to long term care or end of life

b) Irrespective of where people live or their socio economic status, people across NHS Midlands and East will have access to care possible.

c) Organisations can show that they will work together to deliver the services people need; working across health and social care; and for people whose care involves organisations outside the area

d) Services take into account people who are living and working in the area as well as those that travel through that area

e) Plans include all services that the patient will need eg medical, nursing, therapy, psychological support etc; all are of equal importance

f) Plans will enable an improvement in stroke mortality, in patient's quality of life, and their experience of care

g) Services are cost effective and financially sustainable

h) Service provision is clinically sustainable.

Herefordshire Council

MEETING:	**OVERVIEW AND SCRUTINY COMMITTEE**
DATE:	**28 AUGUST 2012**
TITLE OF REPORT:	**CONSULTATION ON LOCAL AUTHORITY HEALTH SCRUTINY**
REPORT BY:	**HEAD OF GOVERNANCE**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To consider a response to a consultation on Local Authority Health Scrutiny.

Recommendation(s)

THAT:

(a) the response to the consultation set out in the report be approved, subject to any comments the Committee wishes to make; and

(b) the Head of Governance be authorised to finalise the response after further consultation with the Chairman and Vice-Chairman of the Committee.

Key Points Summary

- The Department of Health has issued a consultation paper on arrangements for local authority health scrutiny. The consultation runs until 7 September 2012.

- The consultation relates to the power to refer proposals for "substantial variations" or "substantial developments" to NHS Services to the Secretary of State.

- Under the current system, NHS bodies must consult the relevant Health Overview and Scrutiny Committee (HOSC) on any proposals for "a substantial variation" in the provision of the health service or "a substantial development" of the health service. A HOSC can refer proposals to the Secretary of State if they do not feel that they have been adequately consulted by the NHS body proposing the service change, and/or do not believe that the changes being proposed are in the interests of the local health service.

- The consultation paper notes that since the health scrutiny provisions were implemented in 2003, NHS organisations, health services and local authorities have changed substantially. The Government considers 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.

- The proposals for service reconfiguration and referral are broken down into four main areas: requiring local authorities to publish a timescale for making a decision on whether a proposal will be referred; requiring local authorities to take account of financial considerations when considering a referral; introducing a new intermediate referral stage for referral to the NHS Commissioning Board for some service reconfigurations; requiring the full council of a local authority to discharge the function of making a referral.
- A draft response to the questions contained in the consultation document is set out in the report.

Alternative Options

1 There are a several possible alternative responses. The Committee could also decline to submit a response at all.

Reasons for Recommendations

2 The report provides an opportunity for the Committee to consider and respond to the Department of Health's consultation on local authority health scrutiny.

Introduction and Background

3 The Department of Health has issued a consultation paper on arrangements for local authority health scrutiny. The consultation runs until 7 September 2012. The consultation relates to the power to refer proposals for "substantial variations" or "substantial developments" to NHS Services to the Secretary of State.

4 Under the current system, NHS bodies must consult the relevant Health Overview and Scrutiny Committee (HOSC) on any proposals for "a substantial variation" in the provision of the health service or "a substantial development" of the health service. A HOSC or a joint HOSC can refer proposals to the Secretary of State if they: do not feel that they have been adequately consulted by the NHS body proposing the service change, and/or do not believe that the changes being proposed are in the interests of the local health service.

5 The consultation paper notes that since the health scrutiny provisions were implemented in 2003, NHS organisations, health services and local authorities have changed substantially. The Health and Social Care Act 2012 Act will bring about further structural reforms with the introduction of the NHS Commissioning Board, Clinical Commissioning Groups (CCGs), health and wellbeing boards and Healthwatch. The Government considers 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.

6 The proposals for service reconfiguration and referral are broken 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.

7 The consultation paper indicates that it proposes to preserve the health scrutiny provisions in the current Regulations 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;

8 The Health and Social Care Act 2012 Act has, however, 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.

9 A copy of the consultation document has been circulated separately to Members of the Committee.

10 A draft response to the questions set out in the consultation document is set out in the report below.

11 The Government has indicated that it will publish is response to the consultation exercise in the Autumn. Regulations and statutory guidance will then follow.

Key Considerations

12 The main elements of the consultation document are summarised below. Members are asked to refer to the consultation document for the full detail. The questions included in the consultation document are set out together with a draft response for discussion.

Timescales

Under the 2002 Regulations, a HOSC can decide to refer a reconfiguration proposal at any point during the planning or development of that proposal. The Government has had feedback from both the NHS and local authorities that the absence of clear locally agreed timetables can lead to considerable uncertainty. Some have expressed a view that timescales should be specified in regulation. The Government believes that imposing fixed timescales in this way would be of limited value.

The Government proposes that the NHS commissioner or provider must publish the date by which it believes it will be in a position to take a decision on a proposal, and notify the local authority accordingly. Local authorities must then 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.

Questions in the Consultation Document

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?

Draft Response

It would be helpful if regulations placed a requirement on the NHS and local authorities to publish clear timescales as proposed in the consultation document. This would provide greater clarity to organisations and the public and help to manage the process.

Indicative timescales are not necessary. As the consultation document recognises, each reconfiguration scheme is different and it is therefore right to allow local flexibility. It could be argued that indicative timescales would inject more discipline into the process, but if they are indicative they would not be binding and could prove an unnecessary and unhelpful distraction potentially creating a bone of contention where none need exist.

Financial Sustainability of Services

(This is a complete extract from the consultation document)

"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 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 view.

Draft Response

A decision to request a referral should have regard to relevant financial and resource considerations. These would be two factors that would normally be taken into account in considering proposals for change and alternative options.

However, whilst recognising that there are financial pressures, financial and resource considerations are only some of the factors that need to be considered. They are part of the picture alongside, for example, matters identified in the Government Guidance of 2003 such as accessibility of services, the impact of the proposal on the wider community, and the patients affected.

It is unreasonable to require the local authority to offer alternative costed proposals.

Referral to the NHS Commissioning Board

The Government is seeking views on the role of the NHS Commissioning Board (NHSCB) in the resolution of any disputes between the proposer of change and the local authority where service reconfiguration proposals are commissioned by CCGs, particularly where the local authority is considering a referral to the Secretary of State.

One option in the consultation paper is to introduce a formal intermediate referral stage, where local authorities make an initial referral application to the NHS Commissioning Board. (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)

The other option is 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.

The Government does not have a preference between the formal and informal methods set out above.

The consultation paper notes that "Government believes the formal 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, it is 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."

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?

Draft Response

It is difficult to see what benefit a first referral stage to the NHSCB would bring. It is likely that the NHSCB would have been heavily involved in developing service proposals. There would appear to be ample scope for the local authority to work formally and informally with the NHSCB without introducing a formal, time consuming referral stage.

Full council agreement for referrals

Under existing regulations, it is for the HOSC to determine whether to make a referral to the Secretary of State for Health.

The Government believes that given the enhanced leadership role for local authorities in health and social care, the referral function should be exercised only by the full council.

It notes that 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.

The Government believes that the additional assurance provided by full Council agreement to a referral 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.

Draft Response

This should be a matter for local discretion. The authority can provide a mechanism to resolve any potential conflict between the role of the Health and Wellbeing Board and its scrutiny function if it considers it necessary.

Full Council is not necessarily the best forum for considering a "full suite of evidence to support any referral recommendation".

The timetable of meetings for Council is agreed at the start of the municipal year and is comparatively inflexible. The need to seek Council's approval to a referral could build unnecessary delay into the consideration of reconfigurations. Additional Council meetings would incur unnecessary additional costs to the authority.

Joint Overview and Scrutiny

The current regulations enable the formation of joint scrutiny arrangements where a local NHS body consults more than one HOSC, but do not require them to be formed, although there is a Direction form the Secretary of State that this should happen. The Government proposes to include in the regulations that a joint HOSC **must** be appointed when an NHS body consults more than one HOSC and that body alone will have the right to exercise health scrutiny powers in relation to that proposal.

An individual authority would still be able separately to refer a proposal considered by a joint HOSC to the Secretary of State, with the backing of their full council.

The discretion to form a joint scrutiny arrangement for other purposes would remain.

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?

Draft Response

This County's experience of a Regional consultation exercise demonstrated the practical difficulties associated with the establishment of a Joint OSC.

The formation of Joint OSC's should be a matter for local discretion. If the authorities affected wish to work together, all well and good, and guidance may well usefully encourage this approach. However, if there is an unwillingness to work together from the outset it is unlikely that the process will work smoothly and effectively.

A joint arrangement, particularly operating over a wide geographical area, can lead to a loss of local accountability and be detrimental to the public's ability to participate in consideration of proposals affecting vital services.

It is essential that if Regulations do include the requirement that Joint OSCs **must** be established that the right of individual local authorities to refer proposals to the Secretary of State for review is preserved.

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?

Draft Response

No response to these questions is proposed.

Community Impact

13 The potential changes do not have a significant community impact.

Equality and Human Rights

14 The Department of Health's equality analysis states that the evidence it is aware of shows no direct impact on particular equality groups

Financial Implications

15 If additional full Council meetings had to be called additional costs would be incurred. These can, however, be managed within the Council's overall budget.

Legal Implications

16 The Council may need to revise its procedures to comply with the Regulations when made.

Risk Management

17 There are no particular risks identified.

Consultees

18 Relevant officers have been consulted.

Appendices

- None

Background Papers

- None identified.