Agenda Item 6

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health Overview and Scrutiny Committee
Date of Meeting:	28 September 2010
Report Title:	Proposals to Develop or Vary NHS Services
Report From:	Chief Executive

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1. **Summary and Purpose**

1.1. The purpose of this report is to alert Members to proposals from the NHS to vary or develop health services provided to people living in the area of the Committee.

1.2. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

1.3. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services agreed by the Hampshire, Isle of Wight, Portsmouth and Southampton Joint Committee in March 2005. This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006.

1.4. This Report is presented to the Committee in 2 parts:

- *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements
- *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS to substantially change or vary NHS services.

1.5. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire and therefore support the delivery of the Corporate Strategy aim of maximising well being.

Items for Information

2. **South Central SHA: Consultation on proposals to fluoridate drinking water in Southampton and South West Hampshire**

2.1. No further information has been received since the last meeting

Recommendations

2.2. Members are advised of the outcome of the hearing in November 2010 and kept briefed on progress with the Judicial Review.

Items for Action

3. **Hampshire County Council: Joint Scrutiny of Services for Children with Special Educational Needs**

3.1. Responses are expected at the end of September and will be circulated to members as soon as they are available. The HOSC will then be able to decide if it is satisfied with the responses provided, if it wants to request further clarification, and how it wants to monitor progress against the recommendations. The HOSC may wish to request the Children and Young People Select Committee to take forward any concerns members may have in relation to Children's Services.

Recommendations

3.2. That the HOSC agrees how it wishes to proceed once the responses are received.

4. **Hampshire Partnership NHS Foundation Trust: Proposals to modernise adult mental health rehabilitation and psychiatric intensive care.**

4.1. Hampshire Partnership NHSFT will provide a verbal update to the HOSC on the outcome of the consultation and next steps.

Recommendation

4.2. Members highlight any further information required.

5. **NHS Hampshire: Proposals to cease the development of Oak Park Hospital**

5.1. Correspondence with NHS Hampshire and their response following the last meeting of the HOSC is attached at Appendices One and Two. This confirms that innovative and viable options to the services planned at Oak Park Community Hospital are beginning to emerge. These did not exist when the decision was taken to cease the development of Oak Park Hospital. The paper considered by the Trust Board on 23 September is attached at Appendix Three.

5.2. Members have indicated their support for the vision of a 'well being' campus that combines a range of services from health and social care and noted the inclusion of extra care housing. If progressed this represents an enhancement of the services originally planned for the community hospital. Proposals for local beds based on single rooms with specialist clinical 'in-reach' support and complemented by a range of diagnostic, therapy and outpatient services are very positive developments and strongly supported by the members. Concern was expressed that without a firm commitment from the Board to these proposals and clarity about the revenue to support their provision a significant opportunity could be lost.

5.3. The Oak Park Panel met on the 15 September to receive a further update on progress and will report back to the HOSC at the meeting. The Trust Board will decide how it intends to proceed at it meeting on 23 February.

5.4. The HOSC will need to determine if it is satisfied that progress made with identifying alternative provision to the services originally planned for the Oak Park Community Hospital and that the way forward suggested is in the interests of the community affected. If so then members will wish to be clear about the commitment given by NHS Hampshire to implementing the proposals, the timeframes for completion of this work and the availability of the funding streams required to deliver the services. If these issues have been addressed to the satisfaction of members then consideration will need to be

given to the way in which the HOSC wishes to engage with NHS Hampshire as these plans roll forward.

5.5. If members are not satisfied that viable alternatives to the services originally planed at Oak Park exist then the option remains for this issue to be referred to the Secretary of State for Health.

Recommendations

5.6. Members confirm if they are satisfied :

- With the engagement and involvement activities undertaken by NHS Hampshire in identifying a way forward
- That viable alternatives to the services planned for Oak Park Community Hospital have been identified.
- That the way forward proposed by NHS is in the interests of the population affected.

5.7. If members are satisfied arrangements for engaging with NHS Hampshire as these proposals roll forward will be agreed

5.8. If members are not satisfied then the grounds on which a referral can be made to the Secretary of State will be agreed.

6. NHS Hampshire: Proposal to develop integrated Sexual Health Services.

6.1. Proposals relating to changes to sexual health services in Hampshire are summarised at Appendix Four. Additional information giving the detail of these changes is available from the Scrutiny Office.

6.2. There has been substantial engagement with service users to inform the proposals put forward. The consultation will run to 1 December 2010.

Recommendation

6.3. Any views or comments from members are provided to the scrutiny team by 19 November 2010 to inform the consultation process.

6.4. Feedback from members is passed the NHS Hampshire to inform the consultation process

7. Department of Health: Consultation on NHS White Paper 'Equity and Excellence- Liberating the NHS. Draft response

7.1. The draft response of the HOSC to the consultation on the White Paper' Equity and Excellence- Liberating the NHS is attached at Appendix Five.

7.2. The consultation runs through until the 11 October. The consultation document can be found at http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117586

Recommendation

7.3. Members provide any feedback or comment relating to the response to the scrutiny office by 30 September.

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:
N/A

2. Impact on Crime and Disorder:
N/A

Appendix One. Proposal to cease the development of Oak Park Community Hospital. HOSC letter to NHS Hampshire – 29 July

I am writing further to my Committee's meeting on the 27 July 2010 to confirm the HOSC position following further discussions with your officers. I am very aware that we are moving to point at which your Board will decide how to progress with the above proposal and I would be grateful if you could share our views with them prior to the meeting.

Firstly I would like to pay tribute to the sterling efforts of your staff to engage with the HOSC and local people over the last 14 months or so. This has required enormous stamina and I know that there have been some frustrations on all sides as this process has rolled forward. Difficulties and challenges remain and will inevitably be exacerbated by the economic climate in which we all now must operate.

Our aim throughout this process has been to engage constructively with NHS Hampshire in order to ascertain if there were viable alternatives to the services originally planned at Oak Park Community Hospital. There were four keys areas to be addressed from our perspective:

- Ambulatory care
- Local beds for older people requiring intermediate care
- Local beds for people with mental health needs
- Appropriate urgent care provision for this population.

Members acknowledge that significant progress has been made and that potential alternatives to the community hospital have now been identified for ambulatory services and local beds. But we still have some reservations about the provision for urgent care which seem to be a small improvement in GP provided services and do not address the concerns we all have about the presumption that this population can be served by attendance at the QA Accident and Emergency department.

The alternatives that are now emerging did not exist at the time that the decision was taken to revisit plans for Oak Park Community Hospital. They are both innovative and a significant departure from the way in which we have traditionally viewed community hospital services. If we can bring this work to fruition the HOSC believes that this will be an exemplar for Hampshire and beyond as well as providing flexible, tailor made care for people living in the Havant area.

The vision of a 'well being' campus that combines a range of services from health and social care is exciting and, with the inclusion of extra care housing, actually represents an enhancement of the services originally planned for the community hospital. Proposals for local beds based on single rooms with specialist clinical 'in-reach' support and complemented by a range of diagnostic, therapy and outpatient services are very positive developments and strongly supported by the HOSC. We do however continue to have real concerns that this opportunity could be lost without a clear mandate to

proceed with the planning and commissioning of these services from the Board.

Inevitably the ‘devil will be in the detail’ but we must not let technical or parochial issues prevent this vision from becoming a reality. We were somewhat alarmed to learn at our meeting for example that previous assurances that revenue streams to support the original model of service delivery were not now in place and that technicalities relating to the use of resources have yet to be solved. Our understanding is that these issues will be resolved by the time the Board considers how to move forward in September.

The HOSC is firmly of the view that concrete plans for service provision in Havant must now be agreed and the opportunity seized to collaborate with the County’s Adult Services Department to create a ‘well being campus’ in the Havant area. This must include clarity about NHS Hampshire’s commissioning intentions for older people’s mental health care - particularly for the most ill - which is a continuing weakness in the discussions that have taken place. It was clear at our last meeting that this remains an outstanding issue.

The HOSC will also need to understand what urgent care will look like for this population. The additional public health analysis provided to the Panel considering this matter the 5 July 2010 underlined the need for these services to be based in this population. We believe that a longer term ambition to bridge the short distance between Havant Health Centre and the diagnostic facilities to be installed for the ambulatory care services should be explicit and planned now.

Once we have this additional information, including timelines for getting the services up and running, we will be in a position to come to a view about whether the revised proposals are in the interests of the local population.

Appendix Two: Proposals to cease the development of Oak Park Hospital. NHS Hampshire response to the HOSC- 31 August 2010.

Thank you for your letter dated 29 July 2010 and your kind words about the efforts of the team to engage the HOSC and local people over the last year or so. I have passed your comments on to those involved and they were greatly encouraged that their hard work, often in difficult circumstances, has not gone unnoticed.

I would like to reassure you that work is progressing well on the Stage 1 business case for ambulatory care and this will be presented to the Board in September. This will cover all technicalities and costings so that the Board can make an informed decision.

I am very pleased that you share our excitement about the emerging partnership plans for a 'well being' campus with the inclusion of extra care housing and nursing home beds. We are working hard to rapidly progress these plans (including bed based services for older people and older people's mental health) and an update and strategic outline case will be presented at the September board. The Strategic Outline Case will identify options for older people's services and recommend a preferred option for the Board. It will also identify options for the reprovision of the older people's mental health beds that were part of the original Oak Park Hospital proposals and recommend a preferred option for the Board. If these options are approved a Stage 1 business case will be worked up, with detailed costings.

I hope that all these papers will provide you with the assurances that you seek on timeframes and costings for the delivery of these services.

I acknowledge that there have been a number of complex issues to be resolved with regard to older people's mental health care and in response to the Committee's concerns we have stepped up our discussions with our providers and local GPs about how the full spectrum of mental health services could be delivered to meet the needs of local people. It is now clear that any new model of care should include community provision, bed based care and also more intensive care in hospital for the small number of people with complex mental health needs.

We now need to engage with clinicians, service users and carers about the intensive care element of mental health provision for the whole of Hampshire and so this element of older people's mental health care for South East Hampshire will remain at St James Hospital until this wider review has been completed.

Finally I am disappointed to hear that the paper submitted to the Committee was not clear about what urgent care would look like for this population. We will be revisiting our document and would like to work with you to devise a clearer picture of urgent care services. I will ask Inger Hebden and Sara Tiller to get in touch with you about this. I understand that David Paynton's presentation on the SHIP urgent care strategy was well received at the meeting and any proposals for urgent care in the area should of course be in line with this strategy.

Appendix Three: Developing Health Services for the Population of Havant and South East Hampshire. NHS Hampshire Board Paper – 23 September 2010.

Appendix Four: Consultation on changes to Sexual Health Services in Hampshire

Executive Summary

Following stakeholder conference in September 2009 & sexual health needs assessment (November 09), NHS Hampshire, in partnership with key stakeholders has developed a new model for integrated sexual health provision. It is proposed that the new model will:

- Reduce inequalities in sexual health
- Improve access to sexual health services by bringing care closer to home
- Reduce the number of consultations people may have attend by integrating contraception & sexual transmitted infections services
- Increase patient choice by developing more services, in more locations especially in general practice & pharmacy, whist maintaining and developing the expertise of specialist sexual health services

Currently there are inequities in access to sexual health services and there is variation in provision across Hampshire and the numbers of sexually transmitted infections, HIV diagnoses and teenage conceptions are increasing. The proposed model for integrated service provision aims to address these issues and many other existing inequalities in current provision by increasing access to specialist integrated services in the community and by utilising the role of enhanced primary care provision.

This consultation document describes what the process of current public and stakeholder engagement to date and clearly sets out our future plans to test out the proposed model. It also describes the proposed model in detail and shows the model in table format.

The sexual health needs assessment gave a clear mandate to look at new ways of delivering sexual health services. Those involved in the need assessment process wanted services to be convenient, close to home, easy to navigate & equitable. Now that a new proposed integrated model has been developed, NHS Hampshire want to test reaction to the proposed model by undertaking consultation with current service users, the public, local practitioners including GPs, pharmacists, local authority & voluntary sector staff to ensure that this service redesign project continues to be informed by public & practitioner feedback.

The consultation process will allow NHS Hampshire to gather feedback and support from General Practitioners from across the PCT as well as from those with a special interest in sexual health and from people living in Hampshire.

The consultation will close on the 1 December 2010.

Appendix Five: Department of Health: Consultation on the NHS White Paper 'Equity and Excellence – Liberating the NHS – Draft response

The ambition for there to be real democratic representation and legitimacy in the NHS is to be welcomed and we would agree that elected councillors and councils have a real role to play in ensuring that the NHS is answerable to local communities. It was therefore disappointing that the proposals set out in the paper seem to remove local accountability through existing scrutiny arrangements and instead directs the accountability of GP Consortia to an unelected and remote national body- the NHS Commissioning Board. The accountability of GP Consortia needs to be firmly rooted in the communities they serve. Strategic Health Authorities are already rebranding themselves as the regional arms of the national NHS Commissioning Board. We do not believe this improves accountability nor is it an effective driver of service improvement. It will result in local democratic influence being reduced rather than enhanced.

Our experience of working with SHAs, CQC and other national regulators is that they are ineffectual in addressing local performance issues and responding to the issues raised by local people. Monitor has refused to refer major service variations to the IRP even where changes in service location clearly have a significant impact on service users. Local councillors, through their HOSCs and other scrutiny arrangements have a demonstrated track record of identifying and addressing issues that are important to local people.

The scope for a Health and Well-being Board (H&WbB) that includes Executive members, public health professionals, GPs and other commissioners to drive health improvement and further integrate health and social care is strongly supported. However the role of the executive function (i.e. decision making) of Local Authorities and the NHS as opposed to the role of elected members holding those making the decisions to account (i.e. a democratic governance function) should not be confused. This distinction enables there to be a focus on driving the business agenda forward as well as giving voice to the elected representatives of communities.

Under the arrangements proposed elected members would be one of a number of potentially competing interests on the H&WbB and would probably hold Executive portfolios. The scope for other councillors to inform and influence decisions made by the Board would be reduced. This detracts from rather than strengthens the role of the democratically elected member in holding local, publically funded services to account.

It would clarify matters greatly if the reference to scrutiny as a role for the H&WbBs was simply removed and the role of local councillor scrutiny extended to issues that affect the health and well being of the population affected by the issue under consideration. This builds on the role of the HOSC which is already well established and maintains a credible mechanism for ensuring an effective local democratic voice. It also frees those actually

driving the integration and commissioning agenda to get on with the significant changes required and the challenges the current financial climate will bring – some of which will inevitably result in difficult and contentious decisions.

Our response to the specific questions raised in the consultation paper is attached.

Q1 Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?
The role of Health Watch is different from that of LINks and it will be necessary to determine the different skills and competencies that will be required in order to fulfil this new function. Seeking patient's views is not the same as acting as a champion and it will be important that existing roles and networks are not duplicated. Local councillors for example are already well placed as the 'eyes and ears' in their communities and have a good understanding of the issues affecting their population. It could therefore be argued that they are better placed as consumer champions.

Seeking the views of patients and the public is a complex area that requires specific skill sets. These already exist in many local authorities- in the current economic climate it is difficult to make a case for duplicating this work.

Q2 Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?
We would not agree that lay people and volunteers should take on this role. Our preference would be for this type of support either to be required via existing PALS services (although this does raise issues of independence of advice) or though a local office of the NHS Ombudsman. We do not agree that this service should be provided nationally unless there can be guarantees of a level of local profile.

If the intention is for Health Watch to act a local CAB for health and social care consideration needs to be given to this service being provided by existing CABx. These services are highly valued and under increasing pressure from tightening budgets. Again the duplication is unnecessary.

Q3 What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?
It is difficult to see how HealthWatch can be representative of the local community as suggested at paragraph 18; the only truly representative member of their communities is the locally elected member. If this role is to be effectively discharged give local authorities the discretion to use the funding as they see fit in order to deliver to agreed standards.

Q4 What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?
We would agree that improvements in integrated working across health and social care are required. Freeing up the way in which funding is allocated and

greater flexibilities for genuinely pooled resources (both personnel and budgets) will help with this. Quality standards and inspection have a role to play but the advantages of greater integration will vary across health communities. There is potential for the H&WbB envisaged to have a strengthened role in this respect but this needs to be coupled with clear duties for partnership and co-operation. Local Authorities also tend to have more developed arrangements for commissioning 0.services flexibly according to individual need - this needs to be built on in the new arrangements.

Q5 What further freedoms and flexibilities would support and incentivise integrated working?
Clear lines of local accountability for delivery of integrated working that link directly back to communities is essential- this is currently absent in the proposals. This should be supported by clarity about the information that is shared across partner agencies, including management information where this relates to the services that are funded from the public purse.

Q6 Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?
Yes- that gives authority to act but needs to be applied to all partners. Any statutory powers need to be complemented by clear governance arrangements to ensure decisions can be robustly scrutinised by the people/communities affected.

Q7 Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?
Yes- this strengthens the authority with which the Board is able to act. Some good progress has been made in taking forward joint working but this needs to be built upon. Given the variation across our respective populations there should be local flexibility for determination of the membership of the H&WbB.

Q8 Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?
The first three roles identified are potentially very powerful and could be real drivers for change on the system. The fourth role confuses the distinction between the role of local government in decision making and democratic accountability - i.e. the H&WbB would both drive and scrutinise service change and reconfiguration. It may be more appropriate for the H&WbB to consider referring a matter for member led scrutiny- Cabinet members and full Council can already do this.

Q9 Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?
No comment

Q10 If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's

trusts?
No comment

Q11 How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?
County Councils deal with this issue on a regular basis across a range of partnerships and networks. HOSCs for example currently have requirements placed on them to work together on cross boundary issues and local practice has been to involvement districts in matters referred to the HOSC as appropriate. There is also scope for any district to refer a matter of concern to the HOSC. Existing arrangements can therefore be used to support this aspect of cross authority working.

Q12 Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?
Care needs to be taken to ensure that the H&WbB does not become a committee that is too inflexible and bureaucratic to respond innovatively and quickly to emerging issues. Membership should be open to local determination and circumstances.

The notion that services that are commissioned at different levels in the health system- with each element having a place on the Board - is interesting but probably too complex. The document refers to the clinically technical specialist services being commissioned remotely by the NHS Commissioning Board but there are also wide range of other services that would not fall into the 'local' category- e.g. ambulances – that need to be considered. Family health and maternity services are often at the heart of communities and it will be essential that local accountability is clear.

Q13 What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?
Clear lines of local accountability for all participants on the H&WbB and a duty to co-operate and respond to issues raised by communities or their representatives. HOSCs already have a track record of resolving disputes locally and this should be built on to ensure transparency and openness in the health system.

Q14 Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?
No- as stated above we consider this to be a significant weakness in the current proposals as it confuses the distinction between decision making and accountability. Work undertaken previously by the Department of Health and other national bodies- such as the Centre for Public Scrutiny, has highlighted the progress made by HOSCs in discharging their functions and influencing service delivery- we have numerous examples of this locally- ranging from service specific interventions to cross authority/cross sector working. This

flexibility and focus will be difficult to maintain in the structure suggested in the draft proposals.

Q15 How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

Current duties placed on HOSCs emphasise local resolution as well as the requirement to work together on issues that cross local authority boundaries. We believe that these arrangements have worked well and HOSCs have demonstrated that they can make a real difference to local service provision. They generally have not used their referral powers lightly or inappropriately.

Q16 What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

This question highlights the contradictions in the proposals. If the scrutiny powers are subsumed into the Board then there will not be effective scrutiny. The function needs to sit outside the Board but with links into it- similar to the observer status that many HOSC Chairmen have on NHS Boards.

Alternatively- keep the decision making and accountability separate by setting a H&WbB made up of elected members and support local authorities to establish a Health and Well being Executive that can take forward the decision making roles identified and is locally accountable.

Q17 What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?

Consideration needs to be given to ensuring that the principles of the NHS are preserved whatever arrangements are put in place – health services provided according to need and free at the point of delivery. Different commissioning decisions could mean that some are unable to access services- reinventing the 'post-code' lottery. People who have a high level of health need must not be disadvantaged in terms of access based on cost.

Some appeal system for any one who feels that they have been unfairly disadvantaged by commissioning decisions would be helpful.

Q18 Do you have any other comments on this document?