Lancashire County Council

Health Scrutiny Committee

Tuesday, 22 April, 2014 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part 1 (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Meeting Held on 4 March 2014**	(Pages 1 - 8)
4.	**Cabinet Member Response to the Care Complaints Task Group**	(Pages 9 - 18)
5.	**Report of the NHS Health Check Task Group**	(Pages 19 - 64)
6.	**Report of the Health Scrutiny Committee Steering Group**	(Pages 65 - 128)
7.	**Recent and Forthcoming Decisions**	(Pages 129 - 130)
8.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	

Lancashire County Council

9. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will be held on Tuesday 10 June 2014 at 10.30am at County Hall, Preston.

I M Fisher
County Secretary and Solicitor

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday, 4 March, 2014 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

County Councillor Steven Holgate (Chair)

County Councillors

M Brindle	A Kay
Mrs F Craig-Wilson	Y Motala
G Dowding	B Murray
N Hennessy	M Otter
M Iqbal	N Penney
A James	B Yates

Co-opted members

Councillor Julia Berry, (Chorley Borough Council Representative)
Councillor Paul Gardner, (Lancaster City Council Representative)
Councillor Bridget Hilton, (Ribble Valley Borough Council Representative)
Councillor Tim O'Kane, (Hyndburn Borough Council Representative)
Councillor Julie Robinson, (Wyre Borough Council Representative)
Councillor Mrs D Stephenson, (West Lancashire Borough Council Representative)
Councillor Betsy Stringer, (Burnley Borough Council Representative)
Councillor M J Titherington, (South Ribble Borough Council Representative)
Councillor Dave Wilson, (Preston City Council Representative)

1. Apologies

Apologies for absence were presented on behalf of Councillors Brenda Ackers (Fylde Borough Council), Liz McInnes (Rossendale Borough Council), and David Whalley (Pendle Borough Council).

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None disclosed

3. Minutes of the Meeting Held on 14 January 2014

The Minutes of the Health Scrutiny Committee meeting held on the 14 January 2014 were presented

Resolved: That the Minutes of the Health Scrutiny Committee held on the 14 January 2014 be confirmed and signed by the Chair.

4. Lancashire Teaching Hospitals Trust

The Chair welcomed officers from Lancashire Teaching Hospitals Trust (the Trust):

- Karen Partington, Chief Executive
- Carole Spencer, Strategy & Development Director
- Suzanne Hargreaves, Operations Director

They had been invited to attend Committee to provide members with information on:

- Performance
- Winter pressures
- Challenges facing the Trust

Officers from the Trust had previously met with the Health Scrutiny Committee Steering Group on 8 November last year. A copy of the notes of that meeting were attached at Appendix A to the report now presented.

The Care Quality Commission (CQC) had also recently carried out an inspection of the Trust looking at the following standards:

- Care and welfare of people who use services
- Cleanliness and infection control
- Staffing
- Assessing and monitoring the quality of service provision
- Complaints

A copy of their report, which was produced in January, was attached at Appendix B to the report now presented. It identified that 3 out of the 5 inspection areas indicated 'action needed'. These areas were:

- Care and welfare of people who use services
- Staffing
- Complaints

In addition, on 9 December, Monitor (the sector regulator that ensures Trusts are well led and are run efficiently) had written to the Trust notifying them of their

decision to open a formal investigation due to governance concerns. A copy of the letter was at Appendix C to the report now presented.

The Trust had not provided the Committee with any documentation to support the topics to be scrutinised, but delivered a PowerPoint presentation which set out the context, and included actions taken, quarter four (2013/14) key statistics and ongoing challenges. A copy of the presentation is appended to these minutes.

As part of the presentation it was explained that the Trust had a good track record, over a number of years, of sustaining delivery against performance. There were challenges and risks as a health economy and recognition that there were currently few alternatives to hospital admission. Only the Accident and Emergency department offered a 24 hour service, and there were no walk-in centres or urgent care units.

Over the last 18 months the Trust had been working with a 'Clinical Senate' comprising the Trust, the Chorley & South Ribble and Greater Preston Clinical Commissioning Groups, Lancashire Care Foundation Trust and Lancashire County Council to examine how those partners could work better together to develop health and social care services for the people of Lancashire.

It was explained that events last winter leading to missed targets and cancelled surgery had been somewhat predictable and therefore the Trust had brought in external facilitators to review the situation and to help the Trust do things differently in the future. The facilitators were ECIST (Emergency Care Intensive Support Team); NWUMT (North West Utilisation Management Team); and KPMG (a private company providing advice to organisations about regulatory requirements, relationships, risk and service delivery to improve performance).

The Chair thanked officers from the Trust for the presentation, but made the point that it would have been most helpful for the Committee to receive information from them in advance of the meeting in order to enable members to properly prepare and consider appropriate questions.

In response Karen Partington said that LTHT was one of only a few Trusts that published its performance reports on its website each month, including information about quality, safety, workforce etc, and members could access much information that way. The link to the website is provided below:

http://www.lancsteachinghospitals.nhs.uk/performance

She assured the Chair that the Trust would endeavour to provide any information requested.

The Chair then invited members to raise comments and questions. The main points arising from the discussion are summarised below:

- In response to a question about the cost of engaging the facilitators referred to above, it was confirmed that the Trust had paid only for the services

provided by KPMG; all partners within the health service economy had paid an equal amount – the Trust, the relevant Clinical Commissioning Groups, Lancashire Care Foundation Trust and the County Council. Details of the actual amount paid were not to hand and would be provided to members outside the meeting. Karen Partington made the point that it had been important for them to have support from a neutral, external organisation.

- It was explained that the Clinical Senate, which brought together partners delivering health and social care had brought clarity around what needed to be done; there was a better understanding of the pressures on CCGs and social services, and the Senate had allowed for a proper conversation about the challenging times ahead. The Senate continued to evolve moving forward.
- When the Trust had met with the Health Scrutiny Steering Group in November they had been struggling to meet some of their targets. In response to a question now about progress since that meeting it was explained that the Trust was still failing to meet its 18 week target, but plans were in place to bring the Trust back into compliance for April. The way in which 'breaches' were attributed was part of the reason why targets were not being met and focus was now on those patients who were already in 'breach' and urgent cases. The point was made that it was most important to focus on how the care pathway could be improved.
- It was explained that there were various different mortality targets; a team of clinicians from different specialisms met every week to review every death and, if there was a need to investigate further, a separate process would be undertaken.
- The Committee was informed that there had been a meeting with LCFT, the CCGs and the County Council at the end of February following considerable pressure on urgent care services. It had been agreed that there would be a strong focus on making the local health and social care system work effectively and efficiently. Some of the principles were to be tested during March – 'The Perfect Month'. Partners would be working together to make sure patients were accessing the most appropriate care first time, and moving through the health and social care system safely and effectively. There would be a need to ensure no patient who did not need acute care was admitted to hospital, and that patients were discharged as soon as they are medically fit to leave hospital.
- One member suggested that a reduction in the number of nursing staff was causing pressure on the wards – he requested statistics detailing the number of nursing staff employed now and the number employed twelve months ago. The Committee was informed that there had not been a reduction and that the Trust had invested £3m into recruiting nursing staff with the necessary mix of skills. It was acknowledged, however, that staffing was a fluid situation and under constant review to ensure that staffing was maintained at the right levels – there was a huge emphasis on quality and safety.
- Recruitment of suitable, skilled staff presented a real challenge, and this was a national problem. The Trust therefore had to look at ways of supplementing and supporting nurses. Staffing at every level was taken very seriously and the Trust was also looking to recruit overseas from countries such as Spain, Portugal and Ireland.

- The Committee was directed to Board papers on the Trust's website for more information about staffing issues. Board meetings were open to the public and documents would be provided on request.
- The Committee asked that more information be provided to them about issues surrounding recruitment.
- In response to a question about the coding of deaths and whether there had been a 'shifting of goalposts', Karen Partington emphasised that the Trust's coding was 'second to none' and had won awards; it was clinical records that were more important – the Trust was working hard to ensure that all information was consistently and accurately recorded.
- The Committee recognised that it was important to try to keep people out of hospital by providing alternative approaches to prevent hospital admission and to improve discharge arrangements. This would inevitably result in a requirement to re-direct funding. The Trust acknowledged that this was a complex dilemma, not just locally, but nationally too.
- Reference was made to the recently introduced 'Better Care Fund' (formerly Integration Transformation Fund) - a single pooled budget to support health and social care services to work more closely together in local areas. It provided a real opportunity to improve services and value for money by shifting resources from acute services into community and preventative settings. Implementation would be a challenge.
- It was important to build relationships and understand how the pathways would work and ensure that 'gaps' in the pathway were filled, for example there were currently insufficient GPs. The Committee was assured that the Trust was committed to reducing its size.
- One member drew attention to page 29 of the agenda papers (CQC Inspection Report) in which it stated that, at the time of the inspection, only 66% of requests by a ward for additional staff for enhanced care had been met in the previous quarter. She asked if the Trust was now anywhere near meeting the target. Karen Partington said they would be if there wasn't the current need for escalated beds (more people in the hospital than normal bed capacity). There was a lot of pressure on staffing and it wasn't always possible to provide additional staff; much effort was put into providing safe care. She referred again to the importance of getting the pathway right and keeping people out of hospital who didn't need to be there, which would reduce pressure on staff.
- Karen Partington said that she was proud of the CQC reports for Preston and Chorley hospitals because, in the main, both reports were very good – it was her view that the areas in which targets were not being met were minor.
- In response to a question about whether and how the Trust shared good practice with others, it was explained that there were a number of ways, for example, team to team meetings with other Trusts, clinicians working in different hospitals - learning went on across hospitals in many ways. There was still a long way to go, but the Trust was well on its way to understanding how other organisations work.
- It was noted from the Trust's website that the Trust was falling short of its target for appraisals and also its target for mandatory training. Karen Partington acknowledged that both were important issues for the Board. Much

effort had been put into getting appraisal rates up and 'special measures' had been introduced. Regarding the training target, the Board was reviewing whether it was appropriate for some types of training to be treated as mandatory.

- The Chair asked how many outpatient appointments had been cancelled between December and February and how many had been re-arranged to fall in the new financial year. It was explained that, as providers, there was no incentive for the Trust to re-arrange appointments for the new financial year, in fact, as soon as a referral was made the clock started ticking toward the 18 week target and a deferral would increase the risk of not meeting that target. The Trust offered to provide a separate session to explain how commissioners and providers work (differently).
- It was noted that Monitor had raised concerns about governance and a request was made for more information about how the Trust was responding to those concerns.
- It had been noted that the presentation contained many acronyms which made it difficult for people not within the NHS to understand. Assurance was sought that the Trust's website did not similarly contain acronyms.
- It was noted that the CQC report contained several references to 'confused' and 'disorientated' and clarification was sought as to whether 'confused' in this context meant in the clinical sense or as a result of being in unfamiliar surroundings.

Resolved: That,

i. The Lancashire Teaching Hospitals Trust be asked to identify how it would engage with Scrutiny in a more meaningful way;

ii. The additional information requested by the Committee during the course of this meeting be provided by the Trust;

iii. The Committee be provided with a copy of the Trust's response to the Care Quality Commission.

5. Report of the Health Scrutiny Committee Steering Group

On 20 December the Steering Group had received an update on the Health & Care Strategy from Fylde & Wyre CCG and an update on the Domiciliary Care Review from the Adult, Community Services and Public Health Directorate. A summary of the meeting was set out at Appendix A to the report now presented.

It was noted that whilst the county council could not specify a 'living wage' hourly rate for domiciliary care, it was suggested that the county council's own procurement terms might provide for contracts to be entered into with only those providers who pay a living wage. It was agreed that this possibility be explored further.

On 31 January the Steering Group had met with East Lancashire CCG to discuss their system to gather soft intelligence. A summary of the meeting was set out at Appendix B to the report now presented.

Resolved: That the report of the Steering Group be received.

6. Recent and Forthcoming Decisions

The Committee's attention was drawn to forthcoming decisions and decisions recently made by the Cabinet and individual Cabinet Members in areas relevant to the remit of the committee, in order that this could inform possible future areas of work.

Recent and forthcoming decisions taken by Cabinet Members or the Cabinet can be accessed here:

http://council.lancashire.gov.uk/mgDelegatedDecisions.aspx?bcr=1

Resolved: That the report be received.

7. Minutes of the Joint Lancashire Health Scrutiny Committee

The Joint Lancashire Health Scrutiny Committee had last met on 28 January 2014. The agenda and minutes of that and previous meetings were available via the following link for information.

http://council.lancashire.gov.uk/mgCommitteeDetails.aspx?ID=684

Resolved: That the report be received.

8. Urgent Business

No urgent business was reported.

9. Date of Next Meeting

It was noted that the next meeting of the Committee would be held on Tuesday 4 March 2014 at 10.30am at County Hall, Preston.

I M Fisher
County Secretary and Solicitor

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on 22 April 2014

Electoral Division affected:
All

Cabinet Member's response to the Health Scrutiny Committee Care Complaints Task Group
(Appendix A refers)

Mike Banks, Interim Director of Commissioning, Adult Services, Health and Wellbeing Directorate, (01772) 536287
Mike.banks@lancashire.gov.uk

Executive Summary

The Cabinet Member for Adult and Community Services accepts the recommendations of the Care Complaints Task Group report in full. The report raises legitimate concerns which are addressed in the Directorate action plan. The Directorate will continue to work constructively with all our partner agencies in direct response to the recommendations.

The response by the Cabinet Member for Adult and Community Services to the Care Complaints Task Group Report is attached at Appendix A.

Recommendation

Health Scrutiny Committee is recommended to :

(i) Receive the response from the Cabinet Member for Adult and Community Services to the issues raised in the Task Group Report; and

(ii) Note the action plan to the issues raised and the progress made to date.

Background and Advice

It has long been acknowledged that the management of complaints about care in the private residential sector could be improved. About a quarter of all complaints made to the Council about the quality of adult social care services relate to the quality of care provided by contracted providers. The Local Government Ombudsman as the regulator for all Councils considers the Local Authority responsible for the actions not only of its own staff but of any organisations who are commissioned by or carry out any of the Council's statutory functions. Therefore Lancashire County Council has a vested interest in good complaints handling not only for the welfare of people, but also for the Council's reputation. The Cabinet Member and the Council therefore fully supports the intentions of the Care Complaints Task Group and approves the

Lancashire County Council

proposals in this report and has taken action to ensure that the work is owned and undertaken.

Consultations

Consultation has taken place with the Complaints Manager, Heads of Service and the Directorate Senior Leadership Team.

Implications

There are no financial, personnel, Human Rights or data protection issues or legal implications arising from this report

Risk management

The contents of the report may be of interest to the press, and the Communications Team will be aware of its contents.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
Care Complaints Task Group recommendations available here: http://council.lancashire.gov.uk/ieListDocuments.aspx?CId=182&MId=1963&Ver=4	2013	Wendy Broadley Principal Overview & Scrutiny Officer 07825 584684 wendy.broadley@lancashire.gov.uk

Response by the Cabinet Member for Adult and Community Services
to
the Health Scrutiny Committee's Task Group Report
on Care Complaints

Summary

The Cabinet Member and Directorate welcome the report of the Care Complaints Task Group and are happy to have actively collaborated on the development of this document.

We fully accept that there are occasions when the quality and consistency of care services may be found wanting. Although the report uses the term of "complaints" to describe the concerns that people have about care homes, it is acknowledged that the scope of the report covers areas that span complaints, poor standards and safeguarding.

We accept that the Care Complaints report raises legitimate concerns and will continue to work constructively with all our partner agencies on the issues raised.

Recommendations

As the Cabinet Member for Adult and Community Services, having discussed the proposals with the officers involved, I am very pleased to approve the proposals in this report and to take action to ensure that the work is owned and undertaken. The majority of the recommendations of the Task Group which relate to Council responsibilities, are already in the course of action, or can be relatively easily implemented.

Dissapointingly, the only exception is the work which would be required to be undertaken around the 'single point of access' (SPA) for people who wish to complain as a means of simplifying the procedure. Although the Task Group considered complaints about residential care, this is just one element of a much bigger joint NHS and social care complaints process. A complaints protocol is in the process of being reviewed between all NHS organisations and adult social care provision in the Lancashire, Blackburn with Darwen and Blackpool Council areas.

For concerns that are appropriately managed at a complaints level to be managed through a SPA, there would need to be multi-agency agreements in place with all NHS organisations in Lancashire.

Members have rightly identified a complex and confusing picture where Responsibilities to support complainants and for the management of complaints are shared across many other organisations and often overlap:

- Registered providers are expected to receive and respond to complaints through their own processes.

- Healthwatch Lancashire already have enter and view permissions to care homes and perform a 'signposting role' for the public for social care and health.

- The existing 0300 Advocacy Access telephone number offers independent advocacy support to help people to complain about NHS or social care issues in LCC and Blackburn with Darwen 6 days a week.

- The CQC host a national contact point in Newcastle and although will not consider individual complaints will address issues that are deemed in breach of regulation.

- The Local Government Ombudsman also receives complaints and they would currently be expected to receive and investigate complaints for people who fund their own care.

- The information and advice role of Help Direct could overlap with the SPA, and may also provide the complaints advice required.

- The County Council Customer Access function also acts as a contact point for concerns. The Customer Service Centre also hosts the single telephone number for Adult Safeguarding concerns that are then passed on to the Multi-agency Safeguarding Hub. This is proving effective access for people to raise concerns (see below.)

  The OCL Procurement Centre of Excellence (also in the process of a transfer back to the Council) is actively involved with contract compliance issues that are brought to their intention.

- The Multi-agency Safeguarding Hub receives concerns about providers from many sources including the public. Generally people do not differentiate between what is a safeguarding issue and what is a complaint. Consequently, the Lancashire Adult Safeguarding Board has had a long standing agreement that "the safeguarding system" will consider any type of concern. This is important as information received is checked against historical information, and other intelligence about the provider and is then risk assessed against these wider facts by professional decision-makers. The individual concern, depending on its nature can then be routed to be resolved a number of ways:

  - Passed onto complaints system

  - Passed on to contract monitoring teams

  - Passed on for a health or social care review of the individual concerned to check the nature and level of care is right or

  - Escalated into the safeguarding procedures

Whilst it will be difficult to create one single point of contact for all levels of concerns, I agree with the Task Group the need to streamline these and make sure they are effective is in everyone's interest. What has been demonstrated in the MASH model is the provision of a central point that concerns can be channelled to, no matter where they arise across all our systems. What we have also learnt is that viewing a

complaint against the context of previous information and against other agencies' knowledge gives us a much better view of the quality and safety of a provider.

The report makes a number of recommendations which will be actioned as follows:

Appendix A

Number	Recommendations from the report	Action	Timescale and Directorate lead
1.	The Cabinet Member for Adult & Community Services consider having a 'single point of access' for people who wish to complain as a means of simplifying the procedure	The multiagency work that would be needed around the creation of a SPA has the potential to streamline and clarify communication with the public across the Council and NHS in relation to all health and social care complaints. However for that reason, a working group should be formed with all stakeholders, to examine the potential for the creation of such an entity and make recommendations about the viability of such a proposal being delivered. **Commenced**	Mike Banks To commence Spring 2014
2.	Lancashire County Council adopt the following statement as a definition of a complaint and ensure the definition is included in all guidance it provides relating to the care complaints process, including the website - ***'any expression of dissatisfaction about a service that requires a response'***	The LCC website is in the process of being updated. As part of the update to the information on the web, the definition of a complaint will be added to the replacement page information already on the LCC website here: http://www3.lancashire.gov.uk/corporate/atoz/a_to_z/service.asp?u_id=1570&tab=1 **Completed**	Angela Esslinger Spring 2014
3.	Through the Lancashire Care Association and the Social Care Partnership, providers are asked to develop and adopt a robust system for the recording of complaints which includes a sequential record and timescales for response.	Lancashire County Council to introduce this as good practice initially and to then build this into contracts at the next contract update. Compliance checks to be built into future quality and contract monitoring activity. **Commenced**	Mike Banks Brian Monk Summer 2014

4.	Lancashire Workforce Development Partnership (LWDP) is asked to develop and deliver care complaints training to care home providers to include complaints management and resolution.	Lancashire County Council have already discussed the need for the development of good complaints handling with the LDWP and will offer support from the Strategic Customer Quality Team to progress this. **Discussions commenced. Training planning meeting to be held end 9 May 14**	Angela Esslinger To commence Spring 2014
5.	The Care Quality Commission are asked to include Outcome 17 (Complaints) at each and every inspection of care homes they carry out.	This action is out of the scope of County Council control, however, this can be raised with the CQC via the Lancashire Safeguarding Adults Board **To be raised on the agenda**	Mike Banks Spring 2014
6.	OCL contracts monitoring team is asked to ensure that the information included within a care homes complaints procedure is up to date when they carry out their inspections.	The contract monitoring framework for care homes will be enhanced to include a routine check that information included within care home complaints procedures is up to date at each monitoring exercise. **Commenced**	Mike Banks Brian Monk Spring 2014
7.	A copy of the Advocacy poster is posted out to every care home in Lancashire.	To save costs, two emails have already been sent with the poster information through the Procurement Centre for Excellence. Lancashire County Council will use contracts information to identify the addresses of all homes and undertake a mailshot. **Providers identified, posters printed and final covering letter awaiting approval by County Councillor Henig**	Angela Esslinger March 2014

8.	The Cabinet Member for Adult & Community Services is asked to consider changing the term 'preferred provider' as it can appear misleading.	The term 'preferred provider' is already known to cause confusion with the public. The wording as well as the current process is already under scrutiny as part of the care home banding scheme review. **Preferred provider lists are no longer in use from 1 April 14**	Steve Gross Spring 2014
9.	The Health Scrutiny Committee is asked to follow the progress of the 'independent visitor advocate ' pilot study proposal	The County Council has supported the proposal and bid by NCompass (an independent advocacy provider for generic and health/social care complaint advocacy) for money from the Department of Health Innovation Fund. Health Scrutiny Committee will be informed when the Department of Health announces the outcome of the bidding process. **Decision pending**	Angela Esslinger Late Spring 2014
10.	The Health Scrutiny Committee be asked to consider the topics discussed by the task group that were outside the scope of the review for inclusion on the work plan	This action is out of the scope of County Council control.	

Conclusion

Clearly the correct responses to complaints produce learning and improvement. The Cabinet Member and Council has agreed via its emerging Better Care Fund plans with Clinical Commissioning Groups, to develop an integrated and coordinated quality improvement function in localities that can harness all the resources across a number of agencies that are working to improve quality, standards and individual quality of care. This should make better use of the existing capacity to develop and support best practice and leadership in those homes that fall below expected standards.

Health Scrutiny Committee
Meeting to be held on 22 April 2014

Electoral Divisions affected:
All

Report of the NHS Health Check Task Group
(Appendix A refers)

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
wendy.broadley@lancashire.gov.uk

Executive Summary

Attached at Appendix A is the final report of the NHS Health Check Task Group. Councillor Mick Titherington, Chair of the Task Group and County Councillor Steve Holgate, Deputy Chair of the Task Group, will present the report to the Committee.

Recommendation

The Committee is asked to:

i. Support the recommendations of the Task Group, as set out in the report at Appendix A;
ii. Consider the appropriate mechanism for reviewing the responses to the Task Group's recommendations.

Background and Advice

In summer 2013, the Centre for Public Scrutiny (CFPS) was commissioned by NHS England to work with six scrutiny development areas to pilot a review on how the NHS Health Check Scheme was working at a local level. The pilot was to use the Return on Investment Model designed by the Centre for Public Scrutiny.

Following expressions of interest Lancashire County Council and South Ribble Borough Council's Scrutiny Committees were invited to carry out a joint review as part of the pilot.

A joint Scrutiny Task Group was created with four councillors from each Scrutiny Committee. The Centre for Public Scrutiny appointed an Expert Advisor to work with the Joint task Group.

Lancashire County Council

Membership of the Task Group

The task group was made up of the following County Councillors and South Ribble Borough Councillors:

- Cllr Mick Titherington (Chair)
- CC Steve Holgate (Deputy Chair)
- CC Margaret Brindle
- CC Michael Green
- Cllr Ken Jones
- CC Sue Prynn
- Cllr Frances Walker
- Cllr Linda Woollard

Scope of the Scrutiny exercise

The agreed aims and objectives of the review were:

- To enable the County and District Councils to work together and develop joint working methodology from which 2-tier authorities in particular can learn.
- To deliver a scrutiny review which focuses on good practice in the use of Health Checks and captures both local and general learning as set out in the NHS Health Check briefing.
- To use and develop the methodology for calculating the 'rate of return' on scrutiny activity, with reference to the Centre for Public Scrutiny model to measure the return on investment – 'Tipping the Scales!' from targeting groups at greater risk, instead of 20% random targeting.
- To link with the County and District Councils corporate plans

NHS Health Check is a national prevention programme to identify people at 'risk' of developing heart disease, stroke, diabetes, kidney disease or vascular dementia. The term that covers all these conditions is 'vascular disease'.

Everyone between the ages of 40 and 74 in England (almost 15 million people) who has not been diagnosed with vascular disease or already being managed for certain risk factors should be offered an NHS Health Check once every five years to assess their risk.

The risk assessment involves a face to face meeting with a trained person such as a nurse, public health worker or pharmacist and uses questions about family health history and checks such as weight, blood pressure and cholesterol.

At the present time there is a legal requirement for councils with responsibility for public health to commission NHS Health Checks but there is no legal requirement for GP surgeries to provide them.

The report of the task group's investigation together with their conclusions and recommendations is attached as Appendix A.

Consultations

N/A.

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A.

Reason for inclusion in Part II, if appropriate

N/A.

Joint Scrutiny Review of Healthchecks

February 2014

Joint Scrutiny Task Group:

- Councillor Mick Titherington – South Ribble Borough Council (chair)
- Councillor Steve Holgate – Lancashire County Council (vice-chair)
- Councillor Margaret Brindle – Lancashire County Council
- Councillor Michael Green – Lancashire County Council
- Councillor Ken Jones – South Ribble Borough Council
- Councillor Sue Prynn – Lancashire County Council
- Councillor Frances Walker – South Ribble Borough Council
- Councillor Linda Woollard – South Ribble Borough Council

Contents

Foreword

We have pleasure in presenting this joint report from Lancashire County Council and South Ribble's Scrutiny Committees. This first collaborative review of the County Council's Health Scrutiny Committee with a district committee shows the value that working across the two-tiers of local government can provide in improving health and wellbeing for our residents.

This is also the first major Scrutiny review involved Public Health since it was transferred to the County Council last year and had been essential to the success of the review and demonstrated that public health is best placed more closely to the communities that it serves.

Our review is part of a number of pilots across England looking at the effectiveness of NHS Healthcheck's and Return on Investment, which has also been a great learning opportunity and one which adds strength to the outcomes of the review. Our work has been used in a national publication 'Checking the Nation's Health produced by the Centre for Public Scrutiny on behalf of NHS England, which will be used to inform national policy on NHS Healthchecks. A copy of this report is included at Appendix 2.

We would like to thank colleagues on the Task Group (all those listed on page 4) for their invaluable help in our review.

We hope you find the report useful and share our commitment to improving the health and wellbeing of our residents in Lancashire and South Ribble.

Councillor Mick Titherington
Chair of South Ribble Borough Council Scrutiny Committee
Chair of the Joint Task Group

County Councillor Steve Holgate
Chair of Lancashire County Council Health Scrutiny Committee
Vice-chair of the Joint Task Group

Acknowledgements

The Joint Scrutiny Task Group would like to thank and acknowledge the help and support provided by the following people in the review:

Centre for Public Scrutiny:

Linn Phipps – Expert Advisor

Lancashire County Council Public Health Team:

Steve Owen, Karen Slade, Peter Lobmeyer

Public Health England Cumbria and Lancashire Centre:

Diane Draper

GP Surgeries:

- Coastal Road Surgery, Morecambe
- Irwell Medical Practice, Bacup
- Owen Street Surgery, Morecambe
- Padiham Group Practice, Burnley
- Ryan Medical Centre, Bamber Bridge
- Worden Medical Centre, Leyland

Clinical Commissioning Groups:

- Chorley & South Ribble/Greater Preston CCGs
- North Lancashire CCG
- East Lancashire CCG

Scrutiny Team:

- Wendy Broadley – Lancashire County Council
- Darren Cranshaw – South Ribble Borough Council

Introduction

In summer 2013, the Centre for Public Scrutiny (CFPS) was commissioned by NHS England to work with six scrutiny development areas to pilot a review on how the NHS Healthcheck Scheme was working at a local level. The pilot was to use the Return on Investment Modelled designed by the Centre for Public Scrutiny.

Following expressions of interest Lancashire County Council and South Ribble Borough Council's Scrutiny Committees were invited to carry out a joint review as part of the pilot.

A joint Scrutiny Task Group was created with four councillors from each Scrutiny Committee. The Centre for Public Scrutiny appointed an Expert Advisor to work with the Joint task Group.

Review Aims

The agreed aims and objectives of the review were:

To enable the County and District Councils to work together and develop joint working methodology from which 2-tier authorities in particular can learn.

- To deliver a scrutiny review which focuses on good practice in the use of Healthchecks and captures both local and general learning as set out in the NHS Healthcheck briefing.

- To use and develop the methodology for calculating the 'rate of return' on scrutiny activity, with reference to the Centre for Public Scrutiny model to measure the return on investment – 'Tipping the Scales!' from targeting groups at greater risk, instead of 20% random targeting.

- To link with the County and District Councils corporate plans.

What are NHS Healthchecks?

NHS Health Check is a national prevention programme to identify people at 'risk' of developing heart disease, stroke, diabetes, kidney disease or vascular dementia. The term that covers all these conditions is 'vascular disease'.

Everyone between the ages of 40 and 74 in England (almost 15 million people) who has not been diagnosed with vascular disease or already being managed for certain risk factors should be offered an NHS Health Check once every five years to assess their risk.

The risk assessment involves a face to face meeting with a trained person such as a nurse, public health worker or pharmacist and uses questions about family health history and checks such as weight, blood pressure and cholesterol.

At the present time there is a legal requirement for councils with responsibility for public health to commission NHS Healthchecks but there is no legal requirement for GP surgeries to provide them.

What is the Return on Investment Model?

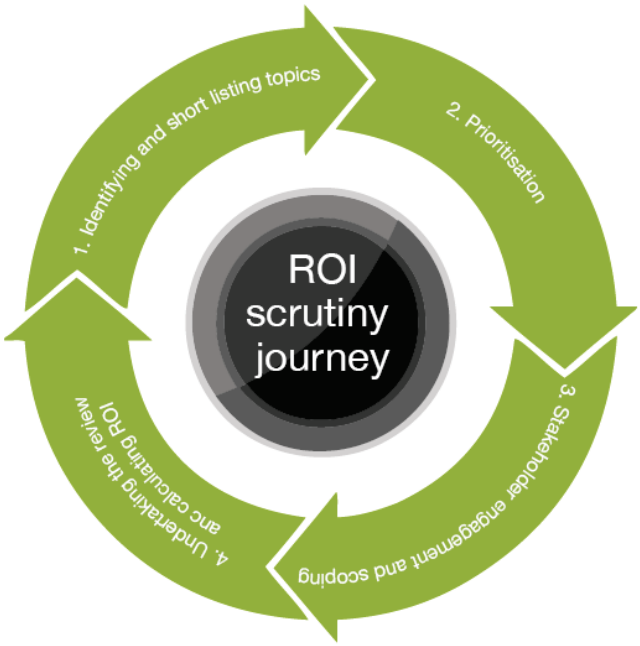
The model is based on 4 stages of a "scrutiny journey", utilising a variety of tools:

1. Identifying and short listing topics: understanding the health inequalities in your area and knowing what strategies to look to, to source ideas for a review of health inequalities.

2. Prioritisation: to make a good final decision on which topic to choose, using new 'impact statements' that are linked to the policy objectives of the Marmot review.

3. Stakeholder engagement and scoping: broadening out the review via a stakeholder event that uses a wider determinants of health approach to produce the 'Key Lines of Enquiry' for the review.

4. Undertaking the review - designing measures and measuring impact – processes and outcomes: estimating and evaluating the impact of overview and scrutiny, and testing the ways in which a potential "return on investment" may be calculated – measures of process and outcome impacts.



Review Methodology

As part of carrying out this review, the Scrutiny Task Group undertook the following research methodology:

- The Task Group carried out a desktop review of information on NHS Healthchecks and Return on Investment Model.

- At a scheduled meeting of the County Council's Health Scrutiny Committee, which includes representatives of each of the district councils in Lancashire, the approach taken by Clinical Commissioning Groups in Lancashire with regards Healthchecks was probed in detail.

- A sample of six GP surgeries were selected (2 in South Ribble, 2 in the north of Lancashire and 2 in the east of Lancashire) to explore in detail how the Healthchecks were being delivered and the view of health professionals.

- A questionnaire was developed with Task Group Members visiting each of the GP surgeries to collect consistent data to help with the research for the review.

- The Task Group met with representatives of the County Council's Public Health Lancashire Team to look at their commissioning strategy, performance data and gain views on best practice and potential future approaches to Healthchecks in Lancashire.

- The Task Group Chair and Vice-chair attended an Action Learning event in London with the other 5 Scrutiny Development Areas to share information and approaches.

Interview Results

As mentioned above Members of the Task Group carried out interviews with GP surgeries. A copy of the detailed outcomes of the interviews is included at Appendix 2. A summary of the results, which have informed the findings and recommendations are as follows:

- 5 out of the 6 practices interviewed carried out NHS Healthchecks. The 1 practice that didn't carry them out stated the reason as the benefit of doing it against the cost involved and felt they were being financially squeezed through manpower and resources.

- 2 of the practices randomly contact eligible patients randomly targeted based on their demographic, 2 randomly contact eligible patients on their list. 1 practice only conducts Healthchecks when the opportunity arises and doesn't routinely contact patients as they are small businesses and have to ensure they use their resources effectively, especially as the contracts might not be permanent.

- Those that invite patients for NHS Healthchecks send the standard letter of invitation out, followed by reminders with varying levels of response. There was

general comment that engaging with men in their 40s can be difficult, with practice barriers around accessibility to NHS Healthchecks being an issue.

- None of the practices carried out any outreach services with regards Healthchecks, however one practice had done some general outreach at local community events.

- Where outreach was discussed with GP practices they did not feel that Healthchecks carried out by other providers was appropriate because of issues of whether they had the ability and in how follow-ups were dealt with.

- With regards assessing the impact of NHS Healthchecks those who responded felt that this would be measured by long-term outcomes. Although, short-term measures would be when the NHS Healthchecks identified conditions, with the following example:

- Out of 1,395 NHS Healthchecks undertaken up to 1 April 2013, the number of patients identified as being at risk of developing diabetes was 13, hypertension 27 and heart disease 38.

- When asked, it was felt that men in their 40s and people living in deprivation would benefit from a NHS Healthcheck.

Key Findings

The Task Group found the following key findings from the above research:

- The introduction of NHS Healthchecks is not a statutory requirement and was not effectively launched with GPs with the necessary support, advice and guidance.

- There is varied delivery of NHS Healthchecks by GPs across Lancashire.

- Where random selection of NHS Healthchecks is carried out by GPs the invitations issued use national templates, which are not felt to be user-friendly to encourage take-up.

- There is a feeling from GPs that there is an over-complicated bureaucracy associated with carrying out the NHS Healthchecks.

- Due to the short-term nature of the programme and no ongoing commitment to funding GPs feel that it is not worthwhile to invest in the scheme.

- In the main GPs do not feel that the fee they are paid adequately covers their costs or encourages them to champion the scheme.

- The data collected and monitored on NHS Healthchecks is not robust enough to make decisions.

- Where targeting does take place there is a significant Return on Investment using the following example of target group as opposed to a random sample:

  What is the Return on Investment of targeting 50% middle aged men (40-55) instead of the 20% random targeting?

Invest: Cost of targeting NHS Healthcheck	£552,000
To save: Potential benefits of QALYs and ready reckoner	£575,000
Potential Return on Investment	£23,000

A **quality-adjusted life-year (QALY)** takes into account both the quantity and quality of life generated by healthcare interventions. It is the arithmetic product of **life expectancy** and a measure of the **quality of the remaining life-years**

  Notes on caveats and assumptions:

  NHS Healthchecks cost £21 whether delivered by GP or outreach: extra costs to reach an extra 26297 more men is therefore £552,000.

  Assuming take up is increased this means 26,297 more men are checked; on average x 0.09 QALYs per person (this underestimates value for particular cohorts), this generates 2331 QALYs. Each QALY costs (is worth) £247, so the value of these QALYs is £575,668 (based on average populations).

- Scrutiny councillors found the experience of working directly with GP surgeries as part of the review extremely useful and felt that Scrutiny had a great deal to offer Clinical Commissioning Groups (CCGs) and GPs in helping to improve the health and wellbeing of communities.

- Councillors found a general lack of awareness and understanding of how local government worked amongst GP surgeries and how the two could work together to champion local health issues.

- Lancashire County Council Public Health team was piloting limited use of outreach services at work places and other community venues using other providers such as Lancashire Care NHS Trust to deliver NHS Healthchecks. An evaluation of the pilot will take place to inform the future commissioning of NHS Healthchecks in the future.

- Both Lancashire County Council and South Ribble Borough Council take employee health and wellbeing very seriously with relatively large workforces that would fall into the target group for NHS Healthchecks.

Conclusions

The Task Group feels that there is evidence that targeting NHS Healthchecks is an effective way to prevent ill-health, but the current commissioning process with GPs is not effective. The way in which the programme is delivered and monitored is not currently fit for purpose.

Further work is needed to understand the Return on Investment to inform improved commissioning decisions with the new arrangements for Public Health in Lancashire and designing a system that Clinical Commissioning Groups and GPs can buy-into and deliver with confidence.

The role of Scrutiny and elected councillors working in partnership with local health providers is also a key tool in improving the health and wellbeing of local people. This is to be encouraged and further work to understand the various roles should be developed further.

Recommendations

1. Lancashire County Council Public Health Team undertakes a more detailed study to generate more robust data and Return on Investment Calculations, which is transferrable to other preventative health models.

2. The detailed study is used to justify the importance of carrying out NHS Healthchecks to Clinical Commissioning Groups and GP practices in Lancashire.

3. Lancashire County Council's Cabinet Member for Health and Well Being take into account the findings of this review when evaluating the success and future direction of commissioning and delivering Healthchecks through pharmacies, community organisations and other trusted partners.

4. Clinical Commissioning Groups look at how the commissioning and process involved with NHS Healthchecks could be improved, to provide GPs with the support and assurance needed to prioritise and target NHS Healthchecks.

5. Clinical Commissioning Groups provide a briefing to GPs on the function and role of Scrutiny and how they work together in partnership to improve health and wellbeing of our communities.

6. As relatively large local employers, Lancashire County Council and South Ribble Borough Council provide NHS Healthchecks to their employees as part of their employee Health and Wellbeing Plans.

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Appendix 1 Joint Scrutiny Review of NHS Healthchecks – Results of Interviews with GP Practices

GP Practice	Do you currently carry out Healthchecks?	What constitutes a Healthcheck in your practice?	How do you invite and approach eligible patients for a Healthcheck?	What data do you use to inform the way you target Healthchecks ?	Do you think that targeting in relation to you profile data would improve performance against targets?	What do you do about those patients who are invited for a Healthcheck but don't attend?	What kind of outreach do you do, if any, to encourage take-up of Healthchecks ?	If not already the practice, how could you target your approach to have a greater impact on outcomes for at risk groups?	How do you assess the impact of Healthchecks ?	Which groups do you feel would benefit most from Healthchecks ?	How could you measure the effectiveness of Healthchecks ?
Coastal Road Surgery	Yes	Carried out by Healthcare Assistants in accordance with specification, although HBA1C blood test is used which is more thorough.	Randomly – although some targeting of smoking status groups 70 letters a month sent with leaflets and opportunistically. Take up is about 10-15 of those approached. Problem with younger end of target group as they can only make appointments up to 3.30pm because of time of blood collections and they can't miss work to attend an appointment.	See Q5	-	Practice does not follow up and taken the view that 'you can only do so much' and 'if people don't want to' they won't.	Does not engage in outreach work but sees some advantage to workplace checks etc. but equally raises questions of who deals with the results.	At risk identified patients are give advice on diet, exercise, smoking and alcohol cessation and invited back annually for check-ups	There does not appear to be a formal measurement of effectiveness although there is a recognition of long-term benefits by the prevention of conditions being developed.	-	-
Worden Health Centre	Yes	Blood test, pulse, height, weight, blood pressure, urine test, family history and smoking and alcohol history. Then follow-up accordingly.	Public Health Lancashire put out a specification which suggests practices should attempt to reach all eligible patients within 5 years, 20% of our eligible patients a year. We don't do that. We are a small business and need to ensure we use our resources	At risk patients, those with high cholesterol levels, high alcohol intake and/or strong family history of health risk.	As we don't invite patients to attend for Healthchecks – not applicable.	As we don't invite patients to attend for Healthchecks – not applicable.	We don't employ outreach at the moment but we would be willing to share best practice with partners. But stress we don't see this as our remit. How could we share information? What systems	We could employ a 'plan – do – study' approach and measure the effectiveness of the procedure. We could do them on a 5 years basis but this would require co-ordination. Once a problem is identified, patients go onto a recall schedule and healthchecks are	We monitor outcomes and can do audit searches on clinical systems, but don't routinely do so. As an aside, Dr Kelsall suspects that there will be more emphasis on this aspect	The risk groups include patients with high body mass indices, possibly males, but they tend not to turn up. The way forward is to make Healthchecks collaborative – conducting	

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			effectively. We're also aware that the healthcheck contract might not be permanent so we don't want to invest in resources which would become redundant if the contract was not renewed. Also, we are geared up to handle the unwell. The target cohort for healthchecks generally considers itself to be well, so the response to our approach offering a healthcheck is not high. We of course give healthchecks to anyone who requests one and we conduct opportunistic healthchecks on patients who present with other ailments.				are in place?	no longer relevant for them. We suggest research into demographics be conducted to fin which media patients respond best to – radio, television, billboard, etc. The traditional doctor's letter is perceived as being less effective today. We also have plans for our IT systems to enable the sharing of data. In addition, there are concerns that if another provider performs a Healthcheck on one of their patients, which mechanism exists to treat the problem once identified? They were concerned that under 'any qualified' provider rules, private sector diagnostic services could spring up, services which were likely to generate unnecessary worries amongst patients without offering treatment.	going forward	them on the premises of big employers and at football matches for example – perhaps conducted by nursing staff shared across the district, say a nurse employed by Public Health.	

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Padiham Group Practice	Yes	Personal health & family history information, blood test, blood pressure, pulse, heart rate, weight, BMI, advice on exercise, diet alcohol intake, smoking and healthy lifestyle.	Use of internal records to select different groups on a changing basis, through opportunistic appointments, no specific target, those that are least seen encouraged to attend Healthchecks as opportunity presents itself. Letter, noticeboard, website. Letters only tended to generate a 20% response, the call-in board at the surgery is also used to attract the attention of patients waiting to be seen by the GP. This is the most effective method to encourage take up. Invitation to Healthchecks are also offered at consultations. Texts have been used for the last 6-9 months, but for appointment reminders only. A cautious approach is taken in using	Searches on internal records to identify high risk groups in differing categories e.g. risk of stroke or diabetes. Variable groups depending on age and risk factors are also targeted. The practice nurse selects the target groups for each round of invitations to a Healthcheck on a random basis to cover as wide a range as possible.	Yes. Older people could be targeted. Social factors such as poor housing, asthma and respiratory problems are prevalent in the area. With regards targeting in relation to profile data, the information is not up to date and in some cases incorrect.	Reminders are sent, but some patients do not take up the offer of a Healthcheck. The Practice Manager said in the main it was down to individual choice. Face to face contact was more effective – approx. 80% responded.	No external locations involved. However, this is a practice with 9 GPs so any patient who is unable to visits the surgery because of age or infirmity is home visited, usually on the same day as the request for an appointment is made. Healthchecks are offered on the basis to this high risk group – but these checks would be carried out as part of the consultation visit. The use of pharmacies for Healthchecks is not encourage as the Practice Manager did not have confidence in their ability to identify health issues, which may then go unnoticed	Further target the 'hard to reach' groups, especially those that are known to be high risk.	On the number of picked up cases – particular hypertensions and diabetes.	Smokers, obesity sufferers and drug users. Alcohol is also a 'massive' problem. There are many social issues due to the deprivation of the area, where Healthchecks would be of benefit to promote healthy lifestyles. The groups most likely to benefit from Healthchecks are predominantly men in the 40-50 age range and those who are in their 70s and likely to fall away after they reach the upper limit of 74.	Through the promotion of preventative measures, for example the promotion of screening to identify early indictors or symptoms.

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			text messages to avoid raising any alarm or concern.								
Owen Street Surgery	Yes – the surgery has a positive approach to Healthchecks and has been very proactive. They had under-capacity amongst the nursing staff and saw it as an opportunity to utilise spare capacity effectively.	In accordance with that stipulated in the contract with the exception of an HBA1c blood test which is more effective at identifying symptoms of diabetes. The tests are carried out by a Healthcare Assistant and includes blood test, blood pressure, weight, BMI, smoking, alcohol.	Patients are selected randomly but determined a cross-section by using age, gender and geography as factors The surgery adapted the letter template to make it more inviting. 50/60 letters a month sent out. After six weeks if the patient has not responded a reminder is sent and if still no response a third letter is sent. Also, opportunistically – word of mouth, clinicians, reception staff.	See Q5	The surgery is reasonably happy with its current targeting but is open to considerations. Age is one – it could be argued that the younger the client the Healthcheck is given, the greater the opportunity to take early preventative measures. On the other hand those approaching 74 will fall out of eligibility categories within the year so maybe they should be targeted.	See previous answers, but we did not ascertain if the surgery followed this up in any way.	The GP was unsure what was meant by outreach and the discussion developed into the use of authorised providers and using supermarkets and football matches etc. but this was not well received. It raises the questions 'who takes responsibility for the results?'. Feasible but to complex – did not see it as an opportunity.	Surgeries have limited information in relation to occupation and this practice would find it difficult to target other than randomly.	There is no formal way of determining impact as much of the benefit will be seen in the long-term preventing the development of the debilitating conditions although the practice has been able to present figures that showed 862 Healthchecks had been carried out to 1 April 2012 and 533 since 1 April 2013. From these checks the number of patients identified as being at risk of developing diabetes was 13, hypertension 27, heart disease 38.	Se Q8 response. Although they recognise that people living in areas of deprivation are harder to reach and less likely to engage in preventative programmes.	The surgery takes a proactive approach to the 'prevention is better than cure' believe and believe the effectiveness will be measured less by patients presented themselves for treatment of preventing premature deaths.

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Irwell Medical Practice	Yes	Blood test (no urine test unless BT indicated diabetes), blood pressure, heart rate, weight, height, BMI, lifestyle advice on alcohol, diet and exercise. Dementia checks on over 60s, dementia checks on under 60s where referred on for specific reviews and considered appropriate. The practice manager commented that they were limited in what they could do in relation to dementia cases because of resource capacity, lack of funding and lack of resources for nurses. No investment in primary care!	Targeted monthly search in the 40-74 age range for those without chronic diseases. This is done on a rota basis from 40 years upwards in age stages. Approximately 100 patients a month. All new patients are routinely given a Healthcheck. Invitation letter and explanatory leaflet. 3 letters per patient are sent to try to encourage maximum response. Men in their 40s are not responsive as other groups in the target range. Website used more by younger patients. Text – the response is not good.	Monthly search of the records or opportunistic by patient contact. Clinical database from the service spec. Patients without chronic conditions are identified from the database as these are the ones least likely to visit the practice, but respond well to Healthcheck invitations.	Yes. High COPD, high smoking levels, asthma, CVD and alcohol. Social factors including damp living conditions, unemployment (young unemployed) all contribute to the need to target healthchecks. The data as presented is difficult to understand. Data group meetings do help to explain the data. Sometimes the data does not reflect exactly what is going on in the practice.	Reminder letters are sent out. Men in their 40s less likely to respond.	Use of website. They recently held a Health Day at the Co-op car park to promote healthy lifestyles providing information and advice. The practice promotes health awareness and healthy diets at the local school. They are looking to do more in the community through schools and organisations that support local group e.g clubs for blind people. They refer patients to the Falls Clinic and Baby Clinic and target young mums who lack parenting skills. The Practice Manager pointed out that anyone irrespective of age could request a Healthcheck.	To further target at risk groups, more resources and more time would be needed. The problem is a lack of resources.	By identifying and picking up on conditions like hypertension and blood pressure. Ensuring follow up has an impact on the workload, reflecting the lack of resources.	Those in the age range 50-60 years and men in their 40s. Healthchecks would benefit patients across the board.	It would be 2-5 years before results could be assessed – the Change for Life programme is still on-going. The Practice Manager commented that they were only paid for the initial Healthcheck and not paid for high risk and other categories and 12 monthly reviews. Lack of resources was an issue and funding needs to be reviewed. The practice consisted of 8 partners – 4 full time and 4 part time, 1 registrar, 1 FY02, 1ST2 and always 4 students.

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Ryan Medical Centre	No – and haven't done for 12 months The benefit of doing it against the cost. The target area was 40-74 you had to do three letters for those who didn't attend and the template you had to fill in to assess the percentage risk could take up to 1 hour. The Doctors routinely check for diabetes or cardio-vascular disease as part of their normal doctor/patient relationship. There was a view at that some sort of check on males 45-55 would be beneficial as this was the group that didn't routinely attend surgery and were of an age when something could be done about the symptoms. They felt they were being financially squeezed both manpower and resources and were still awaiting payments from August onwards. Health visitors were no longer based in the practice. Previously this enabled GPs, health visitors and district nurses to discuss informally patient care. As the health visitors and district nurses are no longer areas based they do not now cover the same area as the GP practices. As note – the information requested by NHS England for data regarding flu jabs was only 48 hours notice.										

Checking the Nation's Health

The Value of Council Scrutiny

cfps Centre for Public Scrutiny

accountability, transparency, involvement

Contents

The Centre for Public Scrutiny
The Centre for Public Scrutiny (CfPS), an independent charity, is the leading national organisation for ideas, thinking and the application and development of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and service users.

Public Health England
Public Health England's (PHE) mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

About NHS Health Check
The Global Burden of Disease 2012 Study highlighted the need to tackle the increasing trend in people dying prematurely from non-communicable disease. The UK is falling behind other countries and we need to take urgent action. The NHS Health Check programme systematically addresses the top seven causes of preventable mortality by assessing the risk factors: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. We know that there is a huge burden of disease associated with conditions such as heart disease, stroke, type 2 diabetes and kidney disease and that many of these long term conditions can be avoided through modifications in people's behaviour and lifestyles.

Commissioning and monitoring the risk assessment element of the NHS Health Check is one of the small number of public health functions that are mandatory and detailed in the Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013. Supporting local authorities to implement this programme is one of Public Health England's priorities.

Acknowledgments
This publication has been written by Su Turner, Principal Consultant at the Centre, and Rachel Harris Expert Adviser for the Centre. We are very grateful to the councillors, officers, partners and their Expert Advisers from the five Scrutiny Development Areas for their hard work and commitment to the programme.

Foreword

The NHS Health Check programme is a world-leading programme and a key component of this Government's priority to reduce premature mortality. It gives us an unprecedented opportunity to tackle the UK's relatively poor record on premature mortality by focusing on the risk factors that are driving the big killers. We know that high blood pressure and cholesterol, smoking, obesity, poor diet, physical inactivity and excessive alcohol consumption increase the risk of diseases that we can – and should – do more to prevent, such as heart disease, stroke, type 2 diabetes and kidney disease.

The NHS Health Check programme is the first approach this country has taken to address these risk factors at a population level, and in a systematic, integrated way. We believe it could also be a powerful way to reduce health inequalities, because we know that the burden of chronic disease tends to fall more heavily on those who are most deprived.

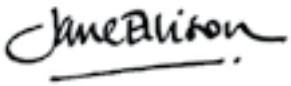
If NHS Health Check is going to realise this potential, it will require highly effective implementation. This report from the Centre for Public Scrutiny marks a valuable contribution to this effort, by providing a process for how local areas can undertake their reviews of local NHS Health Check programmes. The five case studies in this report illustrate local scrutiny in action; namely the opportunity it gives local councillors, commissioners and GPs, among others, to ask tough and practical questions: how will the NHS Health Check programme improve outcomes for those with the worst health? How will NHS Health Check be integrated with the work of health and wellbeing boards? What does best practice look like?

These challenges are the local counterpart to the national challenge set out in last year's NHS Health Check implementation review and action plan, which was led by Public Health England. This plan identified the need for greater consistency of delivery, the need for new governance structures and evaluation as well as the importance of data flows across the health and social care system.

Independent reviews can play an important role in meeting these challenges, by encouraging stakeholders to search for practical solutions that are adapted to local circumstances – how best to collect data, for instance, or how best to explain to users the aims and benefits of the programme. We need to make sure that these insights are shared, and that the questions prompted by these reviews are useful to others, who may be embarking on their own reviews of local NHS Health Check programmes.

Ultimately, though, the power of these reviews is not in coming up with a uniform set of recommendations, but in providing a forum, in which local clinicians, public health professionals and elected officials can develop a shared understanding of how to improve the health and wellbeing of their communities. The hope is that these reviews will help them to find their own way of working together. It is these relationships that will be vital to the success of NHS Health Check implementation.

I am delighted to introduce this report, which I hope will prove a valuable resource to all those who commission, deliver and support the NHS Health Check programme.



Jane Ellison MP
Parliamentary Under Secretary of State for Public Health

Introduction

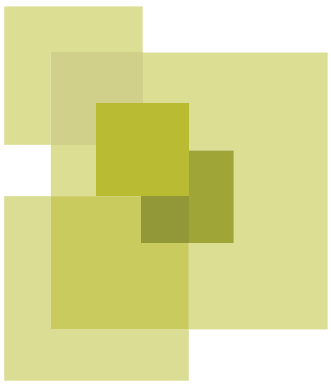
NHS Health Check is a national illness prevention programme to identify people 'at risk' of developing heart disease, stroke, diabetes, kidney disease or vascular dementia. It was introduced on a phased basis in 2009 and at that time Primary Care Trusts were expected to roll it out over five years. However, there was considerable variation across the country which meant that when local authorities took on responsibility for NHS Health Check in April 2013 they took on local programmes at different stages of implementation.

Early in 2013, a review of the lessons learned from the programme's implementation was used to develop a 10 point action plan. The implementation review and action plan set out the work that will be undertaken with key partners to support effective implementation across the country and realise the programme's potential to reduce avoidable deaths, disability and inequalities. The 10 point action plan covers:

- Leadership
- Improving take-up
- Providing the Health Check
- Information governance
- Supporting delivery
- Programme governance
- Provider competency
- Consistency
- Proving the case
- Roll-out

Councillors' scrutiny role can be a powerful lever for improving local health services, alongside other incentives in the system. Recognising this, the Centre for Public Scrutiny (CfPS) was identified as a key partner in delivering the 10 point action plan and was asked to support some local areas to undertake scrutiny reviews of their local NHS Health Check programmes to:

- Understand the benefits of the NHS Health Check programme to local areas (costed and consequential benefits).
- Understand the barriers to take up and how it can be improved.
- Promote the role of scrutiny to all councils and NHS Health Check teams.
- Increase the use of scrutiny reviews to assess NHS Health Check programmes.



CfPS worked with the following five areas to help them to carry out a scrutiny review of their local NHS Health Check Programme:

- Devon County Council
- London Boroughs of Barnet and Harrow
- Lancashire County Council and South Ribble Borough Council
- London Borough of Newham
- Tameside Metropolitan Borough Council

This publication contains the learning gathered from these areas – collectively via the outcomes of a national learning event and individually via short case studies at the end of this publication. It provides useful insight for councils and for NHS and Public Health colleagues.

Public Health England, CfPS and the five areas were aware from the outset that reviewing NHS Health Check was set against a backdrop of structural changes to the health system:

- The new health landscape created by the Health and Social Care Act 2012 was being implemented – including the creation of Public Health England.
- Public health responsibilities, including the commissioning of the NHS Health Check programme, were moving from the NHS to Local Authorities.

Using CfPS' return on investment approach (see details at appendix one) has reinforced the value of scrutiny as a way to build relationships. The case studies in this publication illustrate that there are significant opportunities for improving understanding and working relationships between councillors and primary care practitioners. Reviews of NHS Health Check programmes have led to closer working between GPs and councillors – two groups that are fundamental partners in improving the health and wellbeing of local communities.

The lessons from the five reviews chime really well with the actions that are being taken forward nationally by the NHS Health Check programme. As you will read, opportunities for improved leadership, quality, consistency and integration that are identified within the 10 point action plan have been confirmed by the CfPS support programme.

The five areas found that there were challenges and opportunities around leadership, culture and relationships; and information and communication. This publication looks at these through the lens of CfPS' principles of:

Accountable - improving leadership for whole system pathways.

Inclusive - developing relationships and cultural understanding.

Transparent – understanding information and getting communication right.

The recommendations within this publication are equally applicable to local areas as they seek to improve local population health; or to national health organisations who support and advise (including how councillors and council scrutiny have a valid role in health improvement).

The five areas also suggested questions that other councils may find useful (see appendix two).

Accompanying this publication is a series of briefings for council scrutiny:

- Improving take-up.
- Barriers and solutions to delivery of effective NHS Health Check.
- Understanding data (launched December 2013).

Accountable – Improving leadership and whole system pathways for health

Improving leadership

All five areas reported confusion about responsibility for leading local NHS Health Check arrangements. Although professionals in the system are aware of their responsibilities for delivering a NHS Health Check Programme, it is not clear to the wider health and wellbeing sector or local populations.

All areas were interested in improving take up of the NHS Health Check, however they found that variations in commissioning and the commitment of GPs were local barriers to take up.

They concluded that whilst attention is placed on inviting and carrying out NHS Health Checks, it is important for leaders of local programmes to ensure that there are effective follow-up procedures in place – either to ensure that people attend a NHS Health Check appointment or that if they are identified at risk – follow up action is taken.

Areas also reported a desire to work with NHS England as the commissioner of primary care but were unclear how to best engage local area teams.

Recommendations

- Further clarify roles and responsibilities within the health system (including the NHS Health Check programme - nationally and locally).
- Emphasise the quality of follow-up action to reap the benefits of early interventions.

Whole system pathways – embedding NHS Health Check

What became clear is that the NHS Health Check programme as a health improvement tool needs to be 'plugged in' to a wider 'improving health' pathway. Areas found that some GPs chose not to engage with the programme because the validity of the NHS Health Check as part of the whole system remained an issue of debate.

> *"GPs are geared up to deal with the unwell whereas NHS Health Checks are for people who are apparently well."*
>
> **Quote from programme participant**

Concerns also surfaced about the clarity, consistency and quality of feedback to patients following NHS Health Checks. Questions arose about how NHS Health Check can be used to encourage and support people to make lifestyle changes. Programme participants felt there were opportunities to maximise the impact of NHS Health Checks by embedding them within the work of health and wellbeing boards.

Recommendation

- The NHS Health Check programme needs to be 'plugged in' to the local health system, the preventative agenda and the work of health and wellbeing boards.

What practical steps helped?

Devon's review helped to develop the local approach to NHS Health Checks. Their approach to the review strengthened both their internal and external relationships and flagged up their intent as community leaders to embed public health improvements for their most socially isolated groups. The strong leadership focus of the review also helped to kick start relationships with local area teams.

London Borough of Newham found that whilst public health professionals understood lines of accountability there was not a shared understanding across the wider system. The transfer of public health allowed for clarity of this and the review and its recommendations have gone some way towards plugging this gap. The review took an asset based approach - supporting GPs to improve their NHS Health Check programme via their Clinical Effectiveness Group and using their expertise, adding to the clinical collaboration perspective of the review.

Inclusive – Developing relationships and cultural understanding

Developing relationships

In some areas, the reviews were pivotal to changing and enhancing the relationship between council scrutiny and local public health teams. For many, there had not been the opportunity for councillors and public health teams to work together and scrutiny provided a catalyst.

Focusing together on improving the outcomes and effectiveness of a new area of council commissioning has highlighted how closer working and sharing data and insight can move services forward. All areas reported the positive impact of outcomes and recommendations from scrutiny on commissioning of preventative interventions.

All areas agreed that the approach to identifying and hearing from stakeholders was a very effective element of the CfPS support. The approach leads scrutiny to move beyond its traditional audience and thematic workshops produced a better understanding of issues to be tackled by commissioners. Further details are included within the case studies.

Three areas recognised the need to foster relationships across tiers of local government and between councils to support health improvements. The return on investment approach was a good way to achieve closer working with robust recommendations.

Recognising the contribution of other organisations and partnerships can also help share learning about ideas for future working. The Community Hub model developed by Devon & Cornwall Probation Trust inspired a recommendation about developing a whole person 'one stop' approach for socially isolated and hard to reach groups.

Recommendations

- A commitment to develop relationships constantly and consistently can help local areas achieve better health outcomes.
- Moving beyond traditional stakeholders can strengthen the outcomes and value of scrutiny.

Understanding cultural differences

Evidence emerged in some areas that the cultural differences between the NHS 'clinical model' and councils' 'social model' need to be better understood so that a shared health and care improvement culture can be developed.

Areas found that the natural focus of clinicians and GPs is the patient and the symptoms that present to them (the clinical model); whilst the council and councillors naturally focus on what is impacting on poor health – the causes of the causes and the wider determinants of health (the social model). By blending these skills (as advocated by the Institute of Health Equity's Fair Society, Healthy Lives (Marmot) review on health inequalities) a better understanding of communities can be gained leading to better action to support health.

Scrutiny has been shown to be an effective way to build on the common ambition of GPs and local councillors to improve the health of local people. Scrutiny of the NHS Health Check programme can be a catalyst to strengthen relationships between councillors and primary care.

Recommendations

- Develop a universal language for health locally that all partners can understand.
- The knowledge and experience of councillors can enhance the work of health partners and commissioners to improve health and health services.

What practical steps helped?

Tameside Metropolitan Council's stakeholder event provided the vehicle to get everyone together to look holistically at improving a service. It allowed for open and honest dialogue between public health professionals, GPs and the commissioners – something that wouldn't have taken place without the review. Using the CfPS approach helped scrutiny to move at a pace which led to massive benefits. They will be using the model again within future reviews.

Transparent – Understanding information and getting communication right

Understanding information and data

All areas encountered challenges with the collection, consistency or analysis of data to help them explore issues and support their findings. Inconsistent data collection by different agencies, particularly at general practice level, was highlighted as a barrier to understanding the financial value of care pathways. This translated in to a lack of confidence in some areas about the validity of data.

An important lesson from the programme was that clinicians and health professionals are used to working with absolutes whereas scrutiny is more comfortable with possibilities and insight. For example, public health professionals wanted to provide detailed, statistically accurate information and data (which could take longer to produce) but councillors were happy to receive less academically robust figures, together with strong experiential evidence and public health team insight. The reviews generated considerable learning about which partners held useful information, for example:

- Clinical Commissioning Groups understand and have access to national acute care costing information as well as GP practice information. It is essential that scrutiny develops contacts with their CCGs and general practices so that they work alongside each other.
- Information about public health outcomes is often available from national organisations and charities that hold robust data banks based on specific areas of interest that can be useful for return on investment calculations.

Some areas used particular methods to test performance data. Examples included: commissioning a community researcher; direct questionnaires to GPs to establish take up levels; concentrating on gathering in depth information from a few sources.

All the areas recognised the validity of financial return on investment as a proven and important demonstrator of the effectiveness of the NHS Health Check programme. But they also found 'softer' qualitative return on investment is equally important and gave weight to the potential of the NHS Health Check programme as a key tool to improve public health. For example, the actions that can move people towards recognising their own responsibilities for improving or maintaining their personal health is an essential part of the improvements that the NHS Health Check programme is seeking to make. The drivers for changes in personal behaviour may include improving neighbourhood interactions or bringing services into one place to improve accessibility and outcomes from the NHS Health Check programme.

Recommendations

- The variation in the quality and nature of data held at GP practices needs to be reviewed at a national level alongside consideration of how population statistics could be standardised. There is a need for consistent data collection, particularly around quantifying hard to reach groups and clearer standard measurements of comparable performance and NHS Health Check take up rates. They need to be readily available and usable by local authority commissioners.
- Review and revise local data sharing protocols and consider easily accessible mechanisms to pool partners own knowledge about alternative information sources.
- Commission services from a variety of sources including 'drop-in' services for people unable to attend their GP during working hours and monitor follow-up.

Communication

Communication was a key feature that emerged at the learning event – both with the public about the NHS Health Check programme and within and across stakeholders about how to best incorporate NHS Health Check in to local actions to improve health. Improving communication across the partners in the local health system would allow for a better sharing of information leading to improved services.

Most reviews sought to gather public views on the NHS Health Check programme, and concluded that, despite national publicity, there remains a lack of public awareness about the aims, objectives and benefits of the programme. Feedback from some people indicated an awareness of the NHS Health Check programme but an anxiety that it might identify medical conditions that could not be treated.

Recommendations

- Provide clear public information about the benefits and process of a NHS Health Check and the support available to participants with health issues and consider targeted promotion.
- Consider a NHS Health Check scrutiny review to see who does what, to generate a local understanding of the breadth of the programme.

What practical steps helped?

London Boroughs of Barnet and Harrow tested public opinion about their NHS Health Check programmes by commissioning an engagement specialist and concluded that there was not a great understanding by the public on what NHS Health Check is and how to access it.

Lancashire County Council and South Ribble Borough Council created an effective “drill-down” questionnaire that generated a new set of qualitative information about GPs’ views of their experience with the NHS Health Check, and why many GP practices do not feel it worthwhile to engage with the programme. This review also demonstrated the value of district council scrutiny and the added dimension that district councillors can add to scrutiny.

The value of good scrutiny

Good scrutiny and accountability involves different people in different ways – citizens, patients and service users, elected representatives, service providers and commissioners, inspectors and regulators. Four mutually reinforcing principles, leading to improved public services, need to be embedded at every level:

- Constructive 'critical friend' challenge.
- Amplifing the voice and concerns of the public.
- Led by independent people who take responsibility for their role.
- Drive improvement in public services.

Using these principles, CfPS has again highlighted the benefit that scrutiny can bring to other partners seeking to improve health and health services.

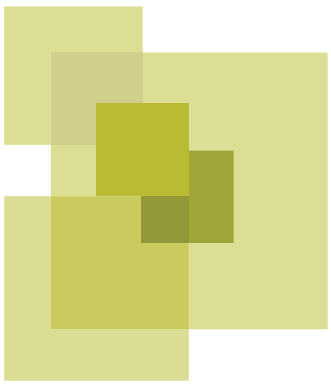
Why scrutiny - what's the added value?

- Scrutiny is independent.
- Scrutiny adds value to councils' corporate leadership and it supports health improvement by taking a proactive approach.
- Can bring the NHS / GPs and councils / councillors together by providing a neutral space to work through issues and identify solutions.
- Uses councillors' unique democratic mandate as a 'conduit between the public and their services', enables them to test whether what is provided meets community needs and aspirations.

The added value of a return on investment approach

In addition to the value described above the return on investment approach:

- Allows areas to move away from a traditional 'committee meeting' approach and explore an 'action learning' approach.
- Involves a wider group of stakeholders from across the whole system bringing more ideas and contributions to the review process.
- Uses quantitative and qualitative outcomes to provide evidence for improving joint working and the pooling of resources.
- Keeps scrutiny focused on outcomes when scoping and undertaking a review.
- Provides an opportunity to use return on investment to demonstrate the value of scrutiny, alongside internal council performance measures.



The added value of scrutiny to public health

All five reviews secured the involvement of their local public health teams, and as you have read contributed to improved understanding and working relationships. Below are quotes from public health professionals involved with the programme.

Tina Henry, Consultant in Public Health and NHS Health Check lead, Devon County Council commented:

> *The work undertaken by scrutiny on NHS Health Checks has been very timely and has raised the profile and understanding of the programme. The process allowed independent engagement with a wide range of stakeholders and providers to determine next steps in rolling out the programme. The intelligence work and feedback from the focused sessions will be used to inform the model of delivery to increase take up.*

Gideon Smith, Consultant in Public Health Medicine, Tameside MBC

> *The Tameside Health Checks Scrutiny Review has been extremely timely and supportive to the process of rethinking the local programme within the context of transition from NHS to local authority commissioning responsibility. The Stakeholder Workshop was particularly helpful in gauging the concerns, commitment and potential contributions of interested parties, and facilitating the development and delivery of a re-invigorated local programme.*

Summary and further recommendations

This programme demonstrates the diversity of good scrutiny to tackle local health inequalities in the best way suited to localities. The reviews have gone some way to overcome some scepticism regarding the validity of the NHS Health Check programme. We believe that council scrutiny has been a valuable way to independently review the roll-out of the NHS Health Check programme – with findings that can be used locally and nationally to inform commissioning decisions.

Specific recommendations have been made throughout this publication. In addition to these, below are some wider final recommendations from our observations:

- Council scrutiny can be an effective public health tool and can help areas to fully understand the health of their population and how services can improve to meet this need.
- Council scrutiny can be the bridge in developing effective working relationships – combining the knowledge of the health community and councillors in developing solutions to improving community health and wellbeing.
- The NHS Health Check programme needs to be accepted as part of a whole system review of the abiding problems of health inequalities, self-responsibility and the prevention agenda. This would enable commissioners to co-operate and to develop improved services that encompass both health and social care and continue to integrate patient pathways at all stages of their interaction with the system.
- Areas need to develop clear lines of accountability to ensure effectiveness across councils' public health role, Clinical Commissioners and general practice.
- There needs to be a continued drive towards integrated working between public health, health and wellbeing boards, council scrutiny and local Healthwatch.

Information flow is critical across all sectors of the health economy (including people who use services), with public health retaining a vital source of data and information. Partners should aspire to transparent data that can be understood by professionals and people who use services.

Appendix one – Case studies

Tipping the Scales

http://cfps.org.uk/health-inequalities

Valuing Inclusion

http://cfps.org.uk/health-inequalities

CfPS' return on investment approach to scrutiny

In 2011 CfPS developed an approach to council scrutiny that captures the potential return on investment of a review and its recommendations. This approach has been published in our previous publications.

Each area that took part in the programme was supported to use the return on investment approach to ensure that their review was outcome focused and realised 'costed and consequential' benefits.

Over the following pages you will find out more about the scrutiny reviews that each of the areas undertook.

The case studies particularly focus on:

- Why the issue was important
- Successes and challenges
- Learning points
- Qualitative benefits
- Measuring return on investment

One of the main benefits of reviewing NHS Health Check using the return on investment approach was the opportunity to involve all stakeholders in designing the review and the key lines of enquiry. Whilst stakeholder engagement is not a new concept, in a return on investment approach it focuses the review on the policy objectives of the Institute of Health Equity's health inequalities review (Marmot) – evidence based objectives to reduce inequalities.

In assessing the potential return on investment, changes in ways of working and a focus on health inequalities will no doubt realise a financial saving both in terms of joined up delivery and less money spent within the health service, however this is difficult to quantify and assign credit to the review alone. Therefore in order to determine the potential return on investment that the review could realise, a number of assumptions need to be made.

CfPS' return on investment approach it is not an exact science. The five areas did not use health economists or finance professionals, but they did use information, data and costings that were either available nationally, provided locally or collected by themselves. The calculations (summarised in the case studies) represent the potential return on investment if the recommendations are accepted and implemented.

The case studies have been provided by the areas themselves.

Case Study: London Boroughs of Barnet and Harrow

The London Boroughs of Barnet and Harrow have had a joint public health service from April 2013 which is hosted by Harrow. The review provided an ideal opportunity to transfer knowledge from the two areas and ensure that the NHS Health Check programme develops appropriately.

Successes and qualitative benefits

- Testing public views of the NHS Health Check programme within specific community groups.
- The review identified differences in how the programme has been commissioned and delivered within the two Boroughs.
- The review helped to develop relationships between scrutiny and public health services, the two scrutiny committees and their communities.

Challenges

- The review highlighted some challenges for public health and the local authorities in dealing with issues relating to a transferred shared service.
- The complexity of the issue and its role within a wider pathway could have caused the review to be unwieldy.
- The financial modelling using the ROI model was difficult with the lack of availability of data.
- Engagement with GPs was difficult.

Learning points

- ROI is an excellent tool for demonstrating the economic benefits that scrutiny can deliver.
- The opportunity to look to other boroughs and alternative delivery models brought useful insight to local discussions.
- Public health faces a new challenge operating in a political environment.
- The scrutiny review highlighted that the public are not aware of NHS health checks.
- A balanced approach needs to be taken – people need to be encouraged to make lifestyle changes.

Key Recommendations

The review has made clear recommendations to influence the future commissioning of the NHS Health Check programme:

- Accessibility, promotion and take up.
- Aligning financial incentives.
- A whole system scrutiny of care pathways.

ROI question and calculation

What would be the return on investment if we improve take up of the Health Check amongst specific groups?

Invest : Cost of additional checks	Harrow – £93,225 Barnet - £81,575 Total - £174,800
To save : Potential savings	Harrow = £1,262,105 Barnet = £2,834,882 Total = £4,096,987
Potential return on investment	**£3,922,187**

Assumptions

Average cost of a NHS Health check = £25 (local data on spend for Barnet) – using this as the basis:

Harrow (12/13) 3729 checks cost £93,225 (Of those 65 cases of those at risk of a heart attack).

Barnet (12/13) 3263 checks cost £81,575 (Of those 146 cases of those at risk of a heart attack)

The British Heart Foundation report cost of treating heart attacks as £19,417 per case.

Calculation uses a doubling of costs and cases to illustrate ROI

For more information use this link to the review report:

http://committeepapers.barnet.gov.uk/documents/s12062/NHS%20Health%20Checks%20Scrutiny%20Review.pdf

Case Study: Devon County Council

The NHS Health Check programme in Devon was in its infancy, and the committee saw the opportunity to actively contribute to policy development using the ROI model. The committee pursued their instinctive observation that the NHS Health Check programme should be of most benefit to people in groups with the poorest health outcomes and framed their review around rural and urban socially isolated groups.

Successes and qualitative benefits

- Raised awareness of the role of scrutiny and the value it can bring.
- Strengthened relationships with public health colleagues, including monthly meetings with the Director of Public Health.
- Had a high response rate to a qualitative GP survey that was developed with assistance from the two Clinical Commissioning Groups in Devon.
- Gained insight in to the take up of NHS Health Checks in rural areas via the Farming Community Network Devon.
- Heard from a range of expert witnesses including local Veterans groups, the Probation Trust, drug and alcohol service providers and outreach health services for homeless people.
- Synthesised all the information in to a template to engage with hard to reach groups across Devon.
- Structured short 'deep dive' reviews can produce locally relevant policy insights.

Challenges

- The availability of comparable local quality data and discrete service costing's to use for measurement. They endeavoured to meet this challenge by balancing and using conflicting or small sample data to widen their understanding of the evidence.

Learning points

- NHS Health Check programme is a gateway to realising the potential of health improvement and ensuring that marginalised groups are included.
- Mental Health should be integral to the consideration of health and wellbeing and included in the Health Check programme.
- There needs to be a whole person approach in considering the health and wellbeing of everyone, particularly vulnerable or hard to reach groups.
- NHS Health Checks need to be accessible - timing, location, information and trust.
- The ROI model gave a framework and a rigour that could be shared with key stakeholders and used to include them and members together from the beginning.

Recommendations:

The task group put forward nine recommendations backed by their findings covering:

- The importance of whole system approaches from all agencies to commissioning strategies.
- Improvements to the understanding and systems approach to the NHS Health Check programme for vulnerable groups.
- The County Council visibly taking up the role of health promotion and Health Check take up.

ROI question and calculation

What would be the ROI of improving the access to NHS Health Checks for our less accessible and most isolated groups?

Invest : Cost of targeting NHS Health Checks (based on 1000 smokers)	£183,000
To save : Potential savings	£323,500
Potential return on investment	**£140,500**

Assumptions and caveats

Review costs calculated 165 hours x £9.81 (Devon median wage) ; In 2013, NHS expenditure on care on smokers will be £39.7 million (122,724 smokers with av. care cost of £323.50 per person per year). **http://www.ash.org.uk/localtoolkit** ; Each NHS Health Check costs £24 ; Smoking cessation costs are £159 **http://www.smokinginengland.info/stop-smoking-services**

Therefore cost of intervention per person is £183.

Calculation based on targeting 1000 smokers with a 100% success rate.

For more information use this link to the review report:

http://www.devon.gov.uk/loadtrimdocument?url=&filename=CS/13/35.CMR&rn=13/WD1206&dg=Public

Case Study: Lancashire County Council and South Ribble Borough Council

The Review sought to identify the value of greater targeting of the NHS Health Check programme on those whose health and wellbeing could benefit most, as opposed to randomly selecting 20%. As data was discussed with the DPH and GPs, it became apparent that increasing the take-up was a factor at least as important as targeting the invitation; and that middle aged men are generally the highest risk group, being the least likely to look after their health or attend a NHS Health Check.

Successes and qualitative benefits

- High involvement of councillors.
- Developed 2-tier collaboration of county and district councils working together on a health scrutiny review - demonstrates districts can influence health.
- Engaging public health created a practical example of the kind of data that health scrutiny wants to use – a model for further projects.
- Created a way to gain engagement of GPs and general practices.
- Developed an effective "drill-down" questionnaire to seek the views of GP's.
- Generated a new set of qualitative information on GPs' views of their experience with the NHS Health Check programme, and why many GP practices do not feel it worthwhile to engage with the programme.

Learning points

- Need to "front load" information more extensively - need to think more at the start about what information is needed and the context.
- Public health teams are used to working to longer timescales and want to provide accurate data.
- This approach to generating data illuminated understanding of the choices that GPs make, and why there are the tensions in aspirations between the GP practice as a small business model versus centrally-chosen NHS policies.
- GPs have interesting and helpful views on the best ways to increase take-up.

Key recommendations

- Undertake a deeper study to generate more robust data and ROI calculation, and a transferrable model.
- Commission the NHS Health Check programme focusing on widening the range of locations for delivery (e.g. football matches) and providers commissioned to deliver.
- NHS England be asked nationally to calculate whether it would be cost-effective to pay GPs more to carry out a NHS Health Check.
- NHS England calculate the benefits of extending the age range to say 35 (perhaps particularly for men) so as to maximize the benefits of early prevention.

ROI question and calculation

What is the ROI of targeting 50% middle aged men (40-55) instead of the 20% random targeting?

Invest : Cost of targeting NHS Health Check	£552,000
To save : Potential benefits est. by QALYs & ready reckoner	£575,000
Potential return on investment	**£23,000**

Notes caveats and assumptions

NHS Health Checks cost £21 whether delivered by GP or outreach: extra costs to reach an extra 26,297 more men is therefore £552k.

Assuming take up is increased this means 26,297 more men are checked; on average x 0.09 QALYs per person (this underestimates value for particular cohorts), this generates 2331 QALYs. Each QALY costs (is worth) £247, so the value of these QALYs is £575,668 (based on average populations). QALY = Quality adjusted life year.

For more information use this link to the review report:

www.southribble.gov.uk/scrutiny.

Case Study: London Borough of Newham

Newham has a high prevalence of preventable illness such as diabetes and had been heavily involved in early stages of the NHS Health Check programme. As a result of this involvement their programme had been front loaded (invested in early), so as the NHS Health Check programme implementation progressed nationally, statistics appeared to show that they were falling behind. Research from the pilot had also identified variations within the GP clusters.

Successes and qualitative benefits

- A strong collaborative approach between scrutiny and public health resulting in excellent support to this project.
- Local Healthwatch enthusiastically engaged with the review and ran own patient forum.
- Engagement with the Clinical Commissioning Group allowed for patient feedback, which correlated the views of the patient forum.
- A short, sharp questionnaire to those who administered the NHS Health Check programme allowed front-line feedback.
- The review has prompted a more detailed cost benefit analysis of health checks to inform future commissioning of the NHS Health Check programme.
- A good example of how scrutiny can add value to health and wellbeing boards and influence commissioning decisions.
- Strengthened partnership relationships.

Challenges

- Discrepancies in how data was collected and reported by the different agencies meant that it was difficult to correlate and gain meaningful conclusions.
- Obtaining clear financial information on the cost of providing health services was a considerable challenge.

Learning points

- Clinicians work with absolutes whereas scrutiny is more comfortable with possibilities and insight. Bridging that gap so that both are comfortable with the outcomes is essential.
- The “softer” qualitative ROIs are equally as important as quantitative ROIs.

Key recommendations

At the time of writing the final conclusions and recommendations had not been determined, but emerging issues include:

- The need to complete a review of options and funding for NHS Health Check as part of the wider preventative agenda.
- The need to reduce practice variation.
- That a collaborative partnership agreement is required.
- Statin prescribing increase in line with Clinical Effectiveness Group guidelines.

ROI question and calculation

What is the ROI of supporting the GP clusters in improving NHS Health Check take up and follow through?

The review also focused on the qualitative nature of ROI which is harder to quantify. This included the benefit of developing new relationships with the commissioners and providers to create a new vision for the future commissioning and delivery of NHS Health Checks locally.

The review did notionally model a potential financial return on investment with a focus on strokes.

Invest : Cost of targeting NHS Health Check		£35,000 (1000 additional checks)
To save:	£75,000	3 people identified at risk
Potential return on investment		**£40,000**

Assumptions and caveats

Cost of treatment for a stroke = £25K (British Heart Foundation average) ; Cost of undertaking a NHS Health Check £35 (excl. admin fees) ; Research shows for every 10,000 checked 30 are identified as having risk factors for stroke (verified by the Clinical Effectiveness Group at Queen Mary University of London). Based on a crude calculation and the cost of acute medical care and rehabilitation will vary depending on the patient and other variables – including other interventions.

For more information use this link to the review report:

https://mgov.newham.gov.uk/ieListMeetings.aspx?CommitteeId=1227

Case Study: Tameside Metropolitan Borough Council

Tameside MBC had already achieved above average take up of NHS Health Check programme across the Borough but wanted to develop its community model of delivery. The public health team were undertaking a series of reviews of their services and through working closely with the Health and Wellbeing Improvement Scrutiny Panel wanted to identify and consider how best to utilise a community or GP based approach for the delivery of NHS Health checks.

Successes and qualitative benefits

- Held a stakeholder event attracting over 40 delegates from 14 organisations connected to NHS Health Checks. The event enabled participants to discuss the benefits, opportunities and challenges in the delivery of integrated GP and community based models.
- The review helped to create new and improve existing partnerships between the Council, CCG and a range of other partners and stakeholders.
- In addition to supporting the review process the stakeholder event also benefitted public health directly in allowing them to make contact and connections with the lead officers from relevant organisations in relation to the delivery in Tameside.
- The review helped to raise the profile of the NHS Health Check programme and identify areas where take-up could be improved, e.g. through publicity and marketing.

Challenges

- A significant challenge identified during the course of the review was the need for further development around communication between partner organisations linked to NHS Health Checks.

Learning Points

- The event required financial and staff resources – but this investment led to a successful outcome.
- The need for data to accurately calculate the ROI.
- The review of NHS Health Checks was undertaken following a level of transition from the Clinical Commissioning Group to the Public Health Team at Tameside Council and this caused some concerns around the sharing of information.

Key recommendations

At the time of writing the final report had not been approved but review recommendations are likely to include:

- A marketing campaign to promote the availability and benefits of NHS Health Checks.
- Utilising community centres and engagement with leaders of hard to reach communities.
- The use of electronic invites and reminders.
- A primary and community based approach to the delivery of NHS Health Checks in the borough.
- Work with local pharmacies to improve the delivery of community based Health Checks in the borough.
- Further work with Tameside Sports Trust to explore further commissioning opportunities.

ROI question and calculation

Identifying and considering how best to utilise a community or GP based approach to the delivery of NHS Health Checks and appropriate targeting?

Invest : Cost of 10% increase in NHS Health Checks	£5,708
To save : Potential savings	£28,500
Potential return on investment	**£22,792**

Assumptions

Total cost of NHS Health check programme 12/13 £567,412 including delivery in community settings

In Q1/Q2 (6 mths) of 2012/13 there were 3,976 delivered assuming therefore 7,952 over 12 mths.

Cost of a NHS Health Check £71.35

Calculation based on 10% increase 80 patients (80 x £71.35 = £5,708). Of 8000, 11.4% identified as being at risk of stroke

Cost of treatment for a stroke = £25K (British Heart Foundation average)

1.14% out of 80 would give a £28,500 saving

Reports once approved will be available at:

http://www.tameside.gov.uk/scrutiny/reports#pers

Appendix two – 10 Questions for council scrutiny about NHS Health Check

Interested in carrying out your own review of NHS Health Check? Here are 10 questions to consider before you start. You will also find additional questions in the supplementary briefings sitting alongside this publication.

1 **How has the NHS Health Check programme been commissioned so far and who measures outputs and outcomes from it?**

2 **What do we understand about the NHS Health Check programme, how and where they happen, and the intended positive benefits for our population?**

3 **How is data about outputs and outcomes collected? Are there local systems for collecting as well as national? Can we learn anything from the experience of NHS Health Checks elsewhere?**

4 **Do we understand which sections of our local population have the poorest health outcomes and how the NHS Health Check programme will improve them? If not, who can tell us about this?**

5 **How is the commissioning of the NHS Health Check programme intended to contribute to improving the content of the Joint Strategic Needs Assessment and how does it contribute to joint health and wellbeing strategic outcomes? How is this aspect monitored and by whom?**

6 **Who has actually taken up the NHS Health Check so far and what impacts have been observed? Do we have evidence to hand about the effectiveness of the current or intended programme from existing providers and clinical commissioners?**

7 **Who provides the NHS Health Check and how does this currently relate to population coverage and the Public Health Outcomes Framework?**

8 **To what extent are clinicians and service users currently involved in commissioning the NHS Health Check programme locally? How is their contribution used?**

9 **Are there any national or local organisations and charities with specific focus on health conditions that the NHS Health Check programme seeks to prevent, that might provide an external critical friend or specialist knowledge that could be useful?**

10 **How does the baseline information we have in front of us compare to other local authorities; and what ideas do they have for taking this programme forward? Have we got comparable best practice examples to consider?**

Notes

Notes

The Centre for Public Scrutiny
Local Government House
Smith Square
London SW1P 3HZ

44 (0) 20 7187 7362

CfPS is a registered charity no 1136243

February 2014

Health Scrutiny Committee
Meeting to be held on 22 April 2014

Electoral Divisions affected:
All

Report of the Health Scrutiny Committee Steering Group
(Appendices A and B refer)

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
wendy.broadley@lancashire.gov.uk

Executive Summary

On 21 February the Steering Group received an update from Debs Harkins, Director of Health Protection and Policy, on Public Health issues. A summary of the meeting can be found at Appendix A.

On 14 March the Steering Group met with Dr Jay Chillala from Central Manchester University Hospitals and Julian Blackhouse from the Institute of Diabetes to discuss the issue of diabetes. A summary of the meeting can be found at Appendix B.

Recommendation:

The Health Scrutiny Committee is asked to receive the report of the Steering Group.

Background and Advice

The Scrutiny Committee approved the appointment of a Health Scrutiny Steering Group on 11 June 2010 following the restructure of Overview and Scrutiny approved by Full Council on 20 May 2010. The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Liberal Democrat Groups.

The main purpose of the Steering Group is to manage the workload of the Committee more effectively in the light of the increasing number of changes to health services which are considered to be substantial. The main functions of the Steering Group are listed below:

- To act as the first point of contact between Scrutiny and the Health Service Trusts;
- To make proposals to the main Committee on whether they consider NHS service changes to be 'substantial' thereby instigating further consultation with scrutiny;

Lancashire County Council

- To liaise, on behalf of the Committee, with Health Service Trusts;
- To develop a work programme for the Committee to consider.

It is important to note that the Steering Group is not a formal decision making body and that it will report its activities and any aspect of its work to the full Committee for consideration and agreement.

Consultations

N/A.

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A.

Reason for inclusion in Part II, if appropriate

N/A.

NOTES

Health OSC Steering Group
Friday 21 February 2014

Present:

- County Councillor Steve Holgate
- County Councillor Fabian Craig-Wilson
- County Councillor Margaret Brindle

Apologies:

- County Councillor Mohammed Iqbal

Notes of last meeting

The notes of the Steering Group meeting held on 31 January were agreed as correct.

Public Health

Debs Harkins, Director of Health Protection and Policy, attended Steering Group to discuss with members the recommendations from Committee on 14 January, which were:

It was agreed that:

i) A list of programmes of work being undertaken by Public Health be provided to the Health Scrutiny Committee. The list to include the responsible officer, timescales, how objectives would be achieved; and how outcomes would be measured.

ii) A workshop be held to enable members of the Health Scrutiny Committee to consider the programme of work referred to at (i) above and identify topics for further scrutiny

iii) It be recommended that a greater number of decisions taken within the County Council be subject to a health and wellbeing impact assessment

During the discussion the main points were:

- Different ideas for ways to scrutinise topics for the future – keeping it focused, manageable etc., the value of external NHS orgs coming to scrutiny and the level of influence we have in the work they do.
- Public health as an internal LCC service enable the committee to exert greater influence so that should be the main priority of members – particularly in view of the Better Care Fund.
- For next 12 months the committee to look at more internal services rather than NHS – Public Health and Social Care.
- Arrange for quarterly meetings with CQC/Monitor to discuss the issues of the Trusts in Lancashire – this could identify concerns to take up with the PH team (such as health care acquired infections).

- How do we measure the effectiveness of the different forms of PH communications e.g. radio advertising?
- The Health Check Programme has a 30K budget for communications – this takes many different forms and includes paid advertising. Have some targets to achieve for the campaign. Twitter and Facebook have had unprecedented take up. Intention is to deliver HCs from alternative providers e.g. pharmacies.
- Health Living Pharmacies – mainly in the east at the moment but will be rolled out across the county.
- Hard to reach population – this is an issue for any programme or service delivery – needs innovative ways of thinking.
- Ethnic minority groups – issues with female patients seeing a male doctor.
- Armed forces veterans – have an LCC champion and often local councils have one too.
- Difficulties around the business model of GPs and how they can be 'told' to do things differently. – How do we effectively influence them?
- Thinking about the health of socially excluded groups and more how our public health services reach these individuals – maybe focus on one group/one service to scrutinise
- Community covenance – county and districts signed up to this.
- Business plan – by early April – workshop to take place tail end of April. To include responsible officers, targets, costs, measures etc. Priorities and milestones, what resources are needed
    - P1 – addressing the impact of the economic downturn on health and wellbeing
    - P2 – tackle health inequalities by implementing the Marmot recommendations
    - P3 – reduce the impact of long-term conditions and an ageing population
    - P4 – improve quality, safety and health resilience
- All four to be briefly explained prior to the workshop – so members don't go into the work shop cold.
- Each priority is being looked at in detail by the district teams to identify delivery mechanisms/commissioning decisions/areas of influence
- CAMHS is a good example of fragmented arrangements and there is the danger that no-one takes the lead on quality service design and delivery. PH has the responsibility for the emotional wellbeing of children.
- Future ideas include integrated well being services – research shows that people from deprived areas had more than one unhealthy behaviour whereas those living in more affluent areas are more likely to only have one.. Prevention services tend to be delivered separately, i.e. smoking cessation, nutrition etc – these need to be joined up into one service so patient is receiving a more holistic approach. These will bundled with Help Direct and offered to the 'well' to keep them well – single access and assessment.
- Another opportunity is to look at the other issues that influence health, income, housing etc.
- Liaise with CCGs to ask them about what they are doing PH wise
- Let all GPs know what we're going to look at – maybe make them a focus of scrutiny.
- Workshop to be split into 4 groups (one per priority) – to look at 4-5 priorities for the work plan
- Need to hold Cabinet Members to account a bit more.

Quality Accounts
Members agreed to the historic approach to providing a response to QAs, by producing a summary of the engagement a Trust has had with members over the previous twelve months.

Dates of future meetings
- 14 March – Dr Jay Chillala – Diabetes & F&WCCG long term strategy development update.
- 4 April – Janice Horrocks on behalf of Southport and Ormskirk Health Trust re Care Closer to Home.
- 2 May – Mark Hindle, Chief Executive, Calderstones.
- 23 May – East Lancs Clinical Commissioning Group re proposals for Health Access Centre in Hyndburn.

NOTES

Health OSC Steering Group
Friday 14 March 2014– Scrutiny Chairs Room (B14a)
2.00pm

Present:

- County Councillor Steve Holgate
- County Councillor Margaret Brindle

Apologies:

- County Councillor Mohammed Iqbal
- County Councillor Fabian Craig-Wilson

Notes of last meeting

The notes of the Steering Group meeting held on 21 February were agreed as correct.

Diabetes

Dr Jay Chillala from Central Manchester University Hospitals and Julian Blackhouse from the Institute of Diabetes attended the meeting

Members were taken through a presentation (copy attached) on the issues and statistics surrounding diabetes and the main points were:

- Network manages a range of projects to look at all the different work going on across the country – see where joining up can be done etc - Still big challenge
- Possibly play a role in helping the diagnosis in care homes – study done to determine the %. – both nursing & care homes identify about 10%
- Inpatient stays – if have diabetes end up staying longer as a consequence even if that's not why they went in - Think Glucose campaign in hospitals
- Medication in hospitals – work being done on this to reduce the number of errors.
- Area of education for care/nursing homes to be done to cope with diabetes both diagnosis and treatment.
- Jay to send reference to Good Clinical Practice Guidelines for Care Home Residents with Diabetes.
- Lots of new medicines coming out but not always appropriate for elderly population due to potential kidney problems
- National Home Care Audit – snapshot of the inconsistencies – due to release the full report end of April, Julian to provide a link.
- Mixed response to specific checks carried out by GPs – regular eye checks but not feet checks.
- Need to find out whether the HWB have diabetes as a priority.
- Diabetes champion – within a care home setting-to receive training and pass on to other staff in their organisation
- Asked members to influence the ability to provide training – maybe ask CC Ali how he will progress this.

- Agreed to send HW's contact details to them to take that relationship forward. (And LCA)
- Type 1 – happens in younger patients (16-18). Don't have insulin in their blood and therefore need injections
- Type 2 – have the hormone but it doesn't work very well
- New innovations in the treatment of particularly Type 1.
- Julian to send us the 7 point plan for care homes
- Jay to provide details of the facilitator of the older men's network – for Margaret.
- Corn syrup – is there increasing usage? Jay not aware but not looked at this area in depth.

F&WCCG- Health & Care Strategy (Draft)
Dr Adam Janjua and Pippa Hulme attended Steering Group to discuss the draft Health & Care Strategy for the CCG and seek comments from members prior to it being published.

Adam took members through a presentation on the key issues within the strategy (copy attached) and the main points were:

- Lots of long term conditions and an elderly population – 28% more people over 70 by 2022 and double 85+ by 2030
- Although it's called a strategy it's more a vision as its doesn't go into detail – that will be in the 2 and 5 year plans
- Felt people would be less likely to engage when there's lots of detail but more likely to discuss the direction of travel/vision
- Will be a £6m gap in terms of cost and frequency of hospital based services.
- Info gathering sessions have happened in different venues at different times – hopefully enabled as many as possible to attend.
- Cap on acute care spend is agreed within the contract – big leap of faith to take money out of acute care to put into community based care.
- Plans aligned with providers to enable a more integrated approach to service movement.
- Trying to get acute trusts to use their staff differently – ie in the community.
- CCG already do care plans for the most vulnerable and those most likely to go to hospital if need medical help but unaware of alternative methods.
- Interventions of limited clinical value – tattoo removal, breast enlargement etc – these would be dealt with on an individual basis.
- CCG recognised that the plan does need to give regard to public health in terms of the long term.
- Wanting to work with local schools in terms of lifestyle choices that affect health. – Adam has a range of ideas.
- Try to replicate the stop smoking etc on the same way that driver awareness courses are run.
- Would also like to do something with supermarkets and alcohol – some unit information next to the beers/wine aisles
- End of life care is part of the 5 year plan – LCC has a bereavement service – not all GPs aware of this.
- Thinking about doing a directory of services for the CCG so patients can see what they can access.

Appendix B

Dates of future meetings

- 4 April – Janice Horrocks on behalf of SOHT re Care Closer to Home
- 2 May – Mark Hindle, Chief Exec, Calderstones
- 23 May – ELCCG re proposals for Health Access Centre in Hyndburn

FYLDE AND WYRE
HEALTH AND CARE STRATEGY 2030

Our Vision for a Healthier Future

A DRAFT DOCUMENT FOR DISCUSSION

Fit & Well

NHS
Fylde and Wyre
Clinical Commissioning Group

Who we are

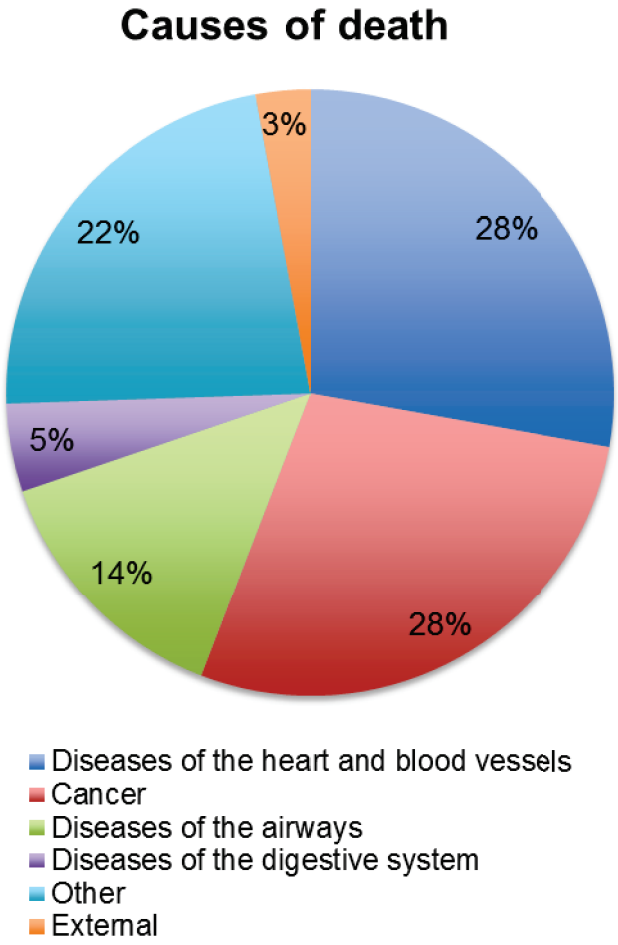
- NHS Fylde and Wyre Clinical Commissioning Group (CCG) is responsible for planning and buying health services in the area. This is known as ‘commissioning’.
- Led by family doctors (GPs), the CCG serves a population of 152,000 people across the Fylde and Wyre area.
- The CCG receives a set amount of money from the government – £196m this year – and is committed to spending this wisely for the benefit of local people.






The challenges we face

- An ageing population – by 2022 there will be 28% more people aged over 70; by 2030 the number of people aged over 85 will have doubled.
- The numbers of people with diseases of the heart and blood vessels, diabetes, kidney disease, stroke and dementia are higher than the national average.
- The numbers with complex long-term conditions are set to rise.



The challenges we face

- Unacceptable health inequalities: in the most deprived parts of Fylde and Wyre men die, on average, 10 years younger than those in more affluent areas. For women the difference is six years.
- We spend more than the national average on treatments for bone and muscle problems, heart and breathing diseases, as well as cancer and mental health, and yet patients report worse outcomes.
- Flat funding will leave a local funding gap of at least £6.2m by 2021 if the NHS continues delivering services in the same way.

We are driven by patient need and ensuring high quality care, but we also need to ensure every penny counts so that we can provide the best care to the maximum number of people.

Developing our vision

- Our aim:
  - to create a health service that keeps people well
  - to make sure that when people are unwell, they can get high quality treatment or advice as close to their home as possible
- We want to develop a long-term vision for health services to tackle some of the significant problems we face.
- Our vision needs to be shared by our partners and the public –
  we can't do it alone.

Gathering views

- Sought views to develop the first draft of the vision (Oct-Dec 2013). Included:
  - Focus groups for patients and the public
  - Event for partner organisations
  - Many other events and surveys
- Testing vision now:
  - More focus groups
  - Representative telephone survey of 1,000 people
  - Draft document out for comment
  - Use of the media, internet and partner channels

Priority service areas

- Planned care
- Unplanned care
- Long-term conditions
- Mental health and dementia
- Children and maternity
- Learning disabilities
- Cancer
- End of life

Vision for planned care

- Wider range of high-quality services within the community so people have easier and earlier access to planned care, with many services available seven days a week.
- GP practices coordinate health and social care, and have overall responsibility for a patient's care.
- People have the information and support they need to make informed choices about their health and healthcare, and are better equipped to take control of their own health conditions.
- People only go to hospital for treatment that can only be carried out safely there. This means, over time, fewer hospital beds are needed.

Vision for unplanned care

- Improved access to community-based services and better use of technology, e.g. telehealth, to support people at home.
- Joined-up health and social care services.
- People likely to need urgent care actively supported to stay well.
- Better information so people know what services are on offer and how to access them.
- Fewer people going to A&E / using emergency services who don't need to.

Vision for long-term conditions

- Everyone with a long-term condition has a personal care plan accessible by all relevant agencies.
- General practice coordinates a broad range of care in a community setting, including in a patient's own home.
- Healthcare professionals focus on identifying people at risk of developing long-term conditions.
- People have access to a wide range of clinical and healthy lifestyle support, including self-help and management programmes.
- Telehealth used by individuals to monitor and manage their condition at home.
- Fewer people admitted to hospital. When they are, it is for as short a time as possible.

Vision for mental health & dementia

- Greater focus on helping people stay well.
- People mainly access care from home or in a community setting, with support available 24/7. Support via the internet integral to the service.
- Specialist services centralised to deliver the highest quality of care.
- Seamless transition between children's and adult support.
- Fylde and Wyre – a 'dementia friendly community'.

Vision for children and maternity

- Better coordinated, community-based services, with technology used to widen access.
- Seamless transition between children's and adult support.
- Expectant mums supported to make choices about where and how they have their care needs met.
- Health promotion services, such as support to stop smoking, tailored to individual needs.
- More babies still breastfed at eight weeks.

Vision for learning disabilities

- Greater focus on supporting people with a learning disability to keep well.
- More services jointly commissioned to ensure joined-up care.
- All health services make reasonable adjustments to meet the needs of patients with a learning disability.
- Practices proactively identify and manage health risks for their learning disability patients.
- Seamless transition between children's and adult support.

Vision for cancer

- Fewer people develop cancer due to better awareness of keeping well; supported by teaching cancer prevention in schools.
- Waiting times for referrals for suspected cancers reduced from the current two weeks to a maximum of one week.
- Patients managed within community-based settings where more tests and treatments are carried out.
- A named healthcare professional has responsibility for an individual's care.
- Survivorship through motivational training – part of a patient's treatment.

Vision for end of life care

- Advanced planning to identify those approaching the end of life to ensure their wishes are fulfilled.
- Strengthened community-based teams to support patients to die according to their wishes.
- Improved training for NHS staff and staff employed by care providers, particularly with regard to communicating with patients and their carers.
- People offered a discussion about their end of life wishes.
- The needs of carers appropriately assessed, with support offered pre- and post- bereavement.
- Providers of care coordinated to ensure a joined-up service and consistent standards.

Summary

- There are a number of common themes:
  - more support to help you manage your condition at home and keep fit and well
  - better information to support you to make choices about your health and healthcare
  - more coordinated and integrated health and social care planned around your needs
  - access to many services seven days a week
  - more community and home-based care
  - care in hospitals for specialist treatment only
- We think that GP practices should be at the heart of delivering these changes.
- As well as coordinating your care, we think practices should be able to decide how to tailor services to meet the community's needs.

Summary

HOSPITAL CARE

- Care in hospitals only where it is not safe for you to be treated in your home or community

COMMUNITY-BASED SERVICES

- More community-based services, many run seven days a week

GROUPS OF PRACTICES

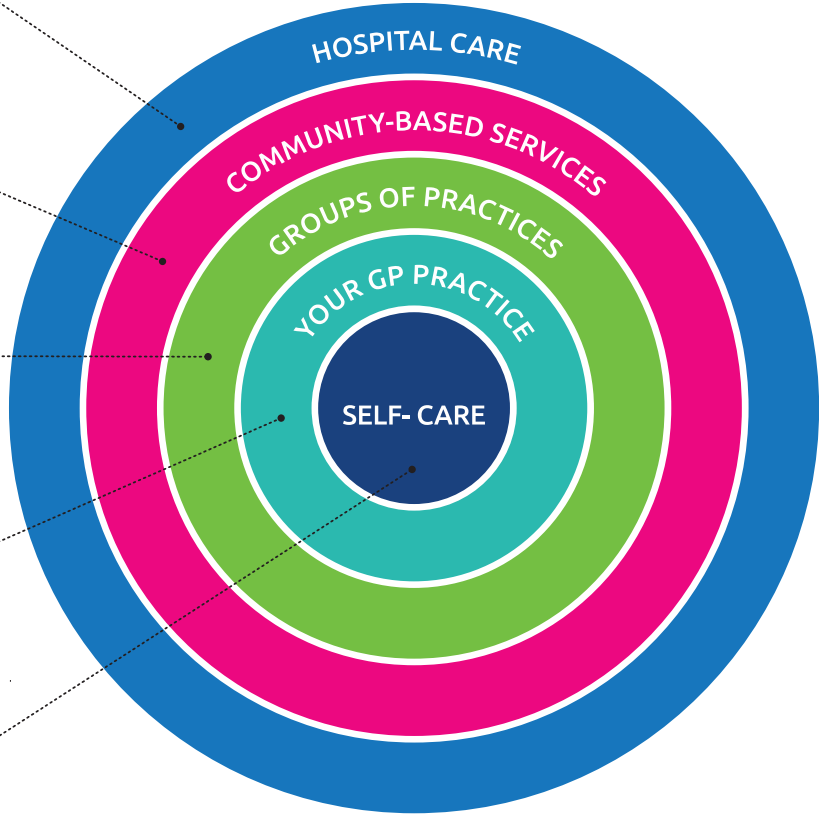
- Groups of practices coordinating community-based care to make sure services meet the needs of the local population

YOUR GP PRACTICE

- Identifying your needs and coordinating your health and social care

SELF-CARE

- More support to help you manage your condition at home and keep fit and well



Engagement to date

- Email distribution using comprehensive stakeholder list – including member practices, patient interest groups, VCFS, councillors, and MPs
- Face to face engagement with Fylde, Wyre and Lancashire County councils – OSCs and officers
- Presentations to Fylde and Wyre Health and Wellbeing Partnership, PPE Group, GP practice managers, staff and Council of Members
- Provider workshop – 27 attendees; GP practice event – 97 attendees
- Engagement with schools – 110 children (Kirkham)
- Community engagement – listening cafes, focus groups – 320 people
- Enquiry line responses – 36 responses
- Qualitative engagement and feedback from approximately 1,800 people
- Quantitative feedback (MORI) – 1,004 people

Key themes

- Broad support for the strategy/vision
- Is a 16 year strategy sustainable or realistic? (in context of change – political, financial, medical, technological, etc.)
- The strategy is strong on the “what” but not on the “how”
- Prevention needs to be given greater prominence
- Many partners are relied upon but not referenced (councils, VCFS, patient interest groups)
- CCG will need to demonstrate that people can influence health decisions
- Services need to be coordinated and integrated

Key themes

- Information about services and conditions needs to be readily available
- Transport provision needs to be a key consideration in all developments
- Waiting times need to be improved
- Needs to be more recognition and support for self care and to promote personal responsibility
- Need to recognise that each locality/community is different with different needs

Stats from MORI: 1,004 interviews

- 85% – local NHS provides a good service (cf. 77% in *Public Perceptions of the NHS*)
- 78% – national NHS provides a good service (cf. 66% in *Social Care Tracker*)
- Perception of quality directly related to how informed a person is
- Good service: 'No problems' (35%); Good quality of care (25%); Efficient (20%); Good GP (19%); Good GP access (11%)
- Poor service: Poor hospital care (29%); Poor GP access (21%); Wait too long for GP apt (21%); Poor GP service (16%)
- 60% have heard of the CCG. BUT only 6% know 'a great deal'; 17% 'a fair amount'; 23% 'just a little'
- 78% heard of health challenges; 42% 'a fair amount'; 22% have not
- Awareness higher from 55-74 year olds and higher social grades

Experiences of coordinated care

- 21% have a long-term condition (LTC); 15% are unpaid carers
- 75% with LTC know who to contact about their care; 42% have a specific health professional
- 54% have a regularly reviewed care plan; 33% do not
- 43% have to repeat medical history when they see a health professional; 47% do not

Providing community-based care

- 83% support practices working together to address NHS challenges – 54% ‘strongly support’
- Support higher where people are more satisfied with NHS services (85% cf 70%), and where people are younger
- Huge support to move end of life care and rehab to community; more caution for tests. Mirrors national research re moving ‘clinical’ services
- High support to move post-hospital care, particularly among parents
- Strong agreement to give people tools and freedom to manage their condition, and use of new technologies to do this (86%)
- 86% agree practices should coordinate care; 74% support idea of practices providing different services based on needs
- 33% support measures to ‘reduce hospital beds’ – greatest opposition in 55-77 age group

Communication and engagement

- People with LTC are less satisfied with information provision
- 63% likely to speak to a health professional (most trusted = GP; 57% would make an appointment); 45% internet. Very few look at local sources of information, e.g. the media
- Older residents more likely to want to talk to a health professional; younger residents more likely to use the internet
- High support for using technology for transactional healthcare (e.g. repeat prescriptions), with most support from 16-34 age group
- Less support to use technology for more 'clinical' services – getting tests online (62%); online consultation (48%)
- Over 75s: 28% wouldn't find any technological applications useful
- People with LTC also not as supportive

Choice

- Choice of GP surgery – 92% say it's important; choice of hospital 88%
- People with LTC more likely to want choice of hospital consultant compared to those who don't (75% cf. 67%)
- People generally confident to choose a GP surgery and hospital
- 81% think choice of treatment is important, but only 67% feel confident making a choice – need to support patients understand options and pros/cons
- People likely to speak to GP re choice (52%), then non-NHS websites (20%); friends/family (19%); NHS websites (13% NHS choices; 11% other; 6% local hospital)
- Older people – speak to GP; younger people – websites

Patient access

- Adults with high temp/sore throat – 30% NHS 111; 19% walk-in-centre; 7% A&E
- Why? Quick advice (20%); don't know options (18%); repeat what done before (13%)
- Child with high temp/sore throat – 34% walk-in-centre; 30% A&E; 29% NHS 111
- Why? Quick advice (23%); don't know options (16%); staff experienced (10%)
- Parents more likely to know about options available OOH

You said, we did…

You said…	We did…
Helping to keep people well should be a top priority	Health promotion, education and supporting people to self-care – a key theme
Care is often fragmented, and the different agencies providing services are not coordinated	A named person from your GP practice will be responsible for coordinating an individual's care – 86% of those who took part in our telephone survey agreed
Learning disabilities should be specifically addressed	Learning disabilities is now a specific priority
85% of those who took part in our telephone survey said people should be given the tools and the freedom to manage their long-term condition	We will strengthen community-based support to enable people to better manage their conditions and stay as well as possible

You said, we did

You said…	We did…
Need better information about services and how to access them	Better communication – including the use of new technologies – is a key theme
People at the end of their lives need more choice, and families/carers need better support	We are proposing better training for health professionals, and pre- and post-bereavement support for carers
Stroke and diabetes should be specific areas of focus	Both of these affect large numbers of people locally and are priority areas for us. We had to give the document a structure, which is why they are under the heading ‘long-term conditions’, but this does not in any way diminish their importance
Services should be tailored to the needs of individual communities	Groups of GP practices will coordinate community-based services; these services should be tailored to the needs of the local population – 74% of those who took part in our telephone survey agreed

You said, we did

You said…	We did…
Health problems, e.g. cancer or long-term conditions, need to be identified earlier	We want to boost screening and support for those at risk
The CCG won't be able to achieve its vision alone	We have endeavoured to involve partner agencies in the development of our plans. We have also strengthened the narrative about partnerships in the document
Carers are vitally important. Their contribution needs to be reflected, and they need more support	Carers are key partners. Our telephone survey revealed that 15% of people class themselves as unpaid carers. We want all carers to have a joined-up assessment to identify their needs and specific support requirements
A strategy looking to 2030 is not realistic. It also needs to have more about how you will actually achieve your vision	This document is meant to set out a high-level vision for the future that will be our 'guiding path'. We are developing detailed two and five year plans which will set out how we aim to achieve our vision, and these will contain measurable targets

You said, we did

You said…	We did…
Concern that GP practices would not have the capacity to coordinate people's care or services across neighbourhoods	We are working with GP practices at the moment to develop this new way of working, and as part of this will agree what level of support they will need to ensure they are effective in the future
There needs to be better after-care and support in the community after patients have been discharged from hospital	Providing better community-based health services is a key part of our plans. Our vision is that people will leave hospital sooner due to better community-based support, with follow-up outpatient appointments carried out in a community setting as well
People should take more responsibility for their own health – the NHS can't be expected to do everything	We aim to widen access to self-help, self-management and healthy lifestyles support. We think everyone should do their bit to keep as fit and well as possible
There is no mention of sexual health services, alcohol or substance misuse services	The CCG does not commission these services. However, we do work with our partner commissioners to make sure services are joined-up and this has been given particular mention in relation to Children & Young People

You said, we did

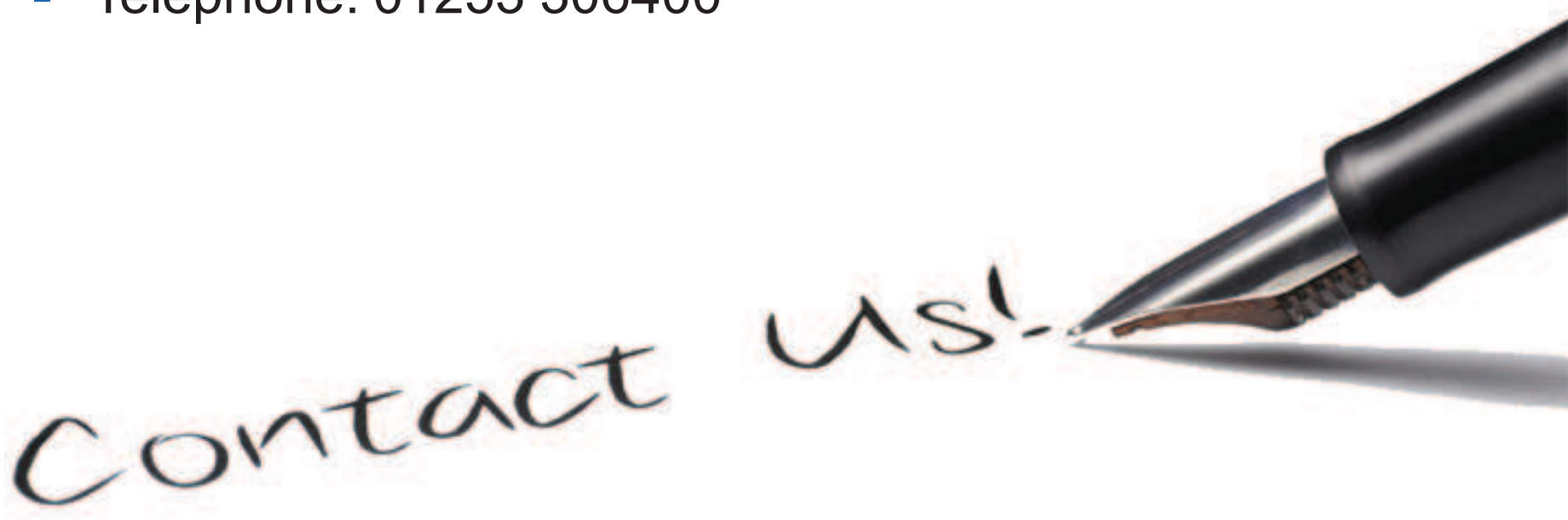
You said…	We did…
43% of people with a long-term health condition say they have to repeat their medical history every time they see a health professional	Everyone with a long-term health condition will have a personal care plan which will be linked their GP record and will be available electronically. This will be available to all of the organisations involved in a person's care
Access to mental health services is poor, and better information about mental health and dementia services is needed	We aim to commission a single entry point for mental health services for people of all ages to improve access
Support for people with learning disabilities is variable across all services, suggesting that health professionals lack knowledge about the needs of people with learning disabilities	We will work with Health Providers to ensure that appropriate support to meet the needs of people with a learning disability is available.
Don't use NHS jargon!	We have tried to use plain English, and have included a glossary
Need to ensure that palliative care is available for Children & Young People	We agree and will use the development of personal health budgets to enable the tailoring of support to meet the needs of children & young people. Our local hospice does provide services and support to children which is funded through charitable donations and some national funding. We will ensure that anything we develop links appropriately to their provision

Next steps

- A final document outlining a shared vision for the future will be published in April 2014.
- The document will include a ‘you said, we did’ section so people can see how their views made a difference.
- We will involve people as we develop detailed plans.
- Welcome your thoughts on our strategy, and how we strengthen our communication and engagement processes.

Contact us

- Email: enquiries@fyldeandwyreccg.nhs.uk
- Website: www.fyldeandwyreccg.nhs.uk
- Telephone: 01253 306400



Dr Jay Chillala. Consultant in Elderly Care, Trafford, CMFT.Interest in Diabetes
Julian Backhouse

HEALTH STEERING GROUP MEETING

Background

- June 2011 Work Planning Meeting OSRC
- To investigate the issue of diabetes and impact on Lancashire residents
- 17th July 2011. Meeting
- Julia Hobbs : Older Peoples Network Coordinator. IDP
- Jay Chillala:

IDOP : Institute of Diabetes for Older People

Julian Backhouse

- Supporting OPDN activity across UK
- Background in NHS & Social Care
- Coordinating projects including Care Home Audit work, major european projects focussed on frailty
- Working with partners to create training resources and courses for health and social care workers

Diabetes Is a Growing Challenge

- Rates of diabetes doubled last 15 years in England
- 2010 : 3.1 Million people estimated to have diabetes

  2.34 m diagnosed
- 2020 predicted rise 23%.Total 3.8 m
- Diabetes in Care Homes 27%

Lancashire: total Population > 65 with diabetes

- 2012 27,581
- 2015 29,743
- 2020 32,228
- 2025 34,968
- 2030 38,659

A growing challenge

- Half of all people with diabetes are > 60
- Risk of type 2 diabetes increases with age
- Strong link with obesity, lack of exercise and ethnicity

Health Profile 2012 Lancashire

- Life Expectancy
- 10.3 years lower for men
- 7.6 years lower for women
- In most deprived compared to least deprived areas
- Early Deaths from heart disease and stroke worse than England Average
- Diagnosis of diabetes worse than England Average: 55,307 on GP register

NHS Spending on Diabetes

- Services :4% budget, £3.9 billion
- Diabetes Medicines : 8.4% total budget

£725 million

- Inpatient : people with diabetes account 15-20% bed days

Complications

- Cardiovascular disease
- Stroke
- Dementia
- Renal failure
- Blindness
- Tissue damage causing ulceration/amputation
- Medication errors, 1 in 3 patients
- Inpatients 10% more likely to die

- Val Wilson: Cabinet Member Health+ Wellbeing(HWB)
- Debs Harkins: Joint Health Unit
- HWB strategy
- Public Health moving to LCC
- CCG : Clinical Commissioning Group set up
- Discussion population/budget/area covered

Implications for Social Care

- 27% of people in care (residential & nursing) homes have diabetes.
- Proportion undiagnosed
- Half of residents admitted to emergency care /year
- Important everyone involved in care understands diabetes

Problems for Older People

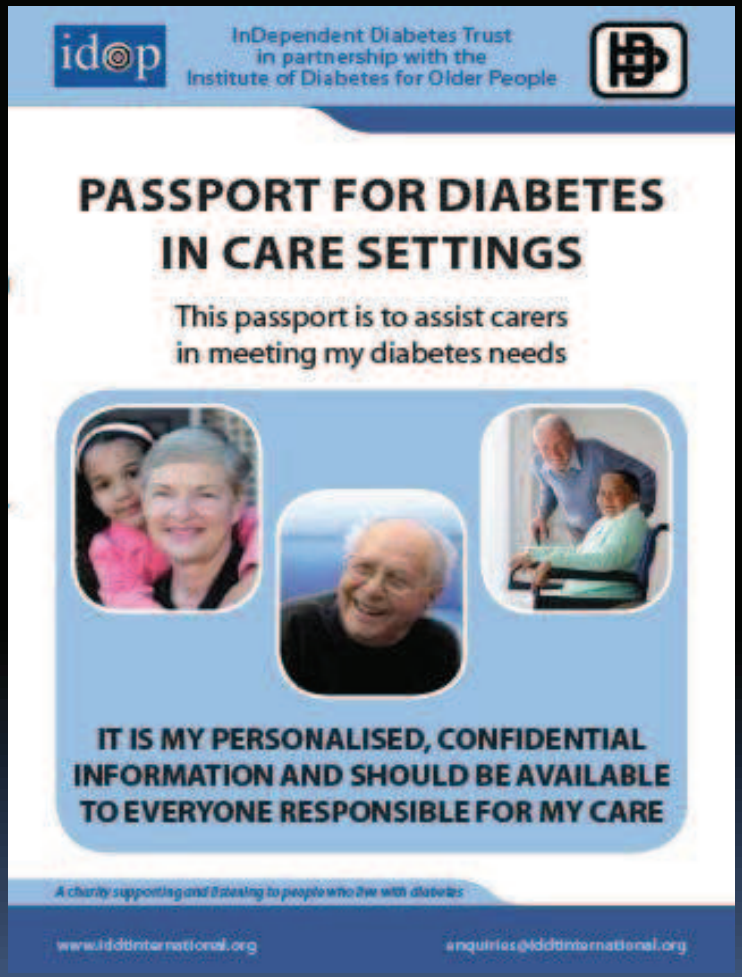
- Frailty
- Lack of dexterity
- Poor memory
- Poor eyesight
- Carer visits :

? Medication compliance/clinic appts/nutrition/hydration

Good Clinical Practice Guidelines for Care Home Residents with Diabetes

National Care Home Audit

- 1/5 residents self medicated with no checks
- 60% homes(2046) no designated member of staff with resposibility in diabetes
- 64% homes no policy for screening
- 1/10 residents had diabetes(27%)
- 35% homes have no written policy for hypoglycaemia


idop
InDependent Diabetes Trust
in partnership with the
Institute of Diabetes for Older People
PASSPORT FOR DIABETES
IN CARE SETTINGS
This passport is to assist carers
in meeting my diabetes needs
IT IS MY PERSONALISED, CONFIDENTIAL
INFORMATION AND SHOULD BE AVAILABLE
TO EVERYONE RESPONSIBLE FOR MY CARE
A charity supporting and listening to people who live with diabetes
www.iddtinternational.org
enquiries@iddtinternational.org

Issues in Care Homes: finding a way forward

- Do care homes have regular foot checks?
- Diabetes Champion
- Criteria for listing, diabetes checks carried (feet/blood), screening
- Domicilary Carers ? Pick up problems
- Acute trust savings, domiciliary visits
- Diabetes training for chefs care homes

Supporting Change

- Care home providers to sign up to diabetes website: information and guidance. Free
- Education: people find out info when they have condition
- ? Next steps
- Older Peoples Diabetes Network – OPDN
- Institute of Diabetes for Older People - IDOP
- Older men's network

Thanks for your time

For further information :

- Julian Backhouse – julian.backhouse@beds.ac.uk
- IDOP Website – www.instituteofdiabetes.org/

Health Scrutiny Committee
Meeting to be held on 22 April 2014

Electoral Division affected: None

Recent and Forthcoming Decisions

Contact for further information:
Wendy Broadley Office of the Chief Executive, 07825 584684
wendy.broadley@lancashire.gov.uk

Executive Summary

To advise the committee about recent and forthcoming decisions relevant to the work of the committee.

Recommendation

Members are asked to review the recent or forthcoming decisions and agree whether any should be the subject of further consideration by scrutiny.

Background and Advice

It is considered useful for scrutiny to receive information about forthcoming decisions and decisions recently made by the Cabinet and individual Cabinet Members in areas relevant to the remit of the committee, in order that this can inform possible future areas of work.

Recent and forthcoming decisions taken by Cabinet Members or the Cabinet can be accessed here:

http://council.lancashire.gov.uk/mgDelegatedDecisions.aspx?bcr=1

The County Council is required to publish details of a Key Decision at least 28 clear days before the decision is due to be taken. Forthcoming Key Decisions can be identified by setting the 'Date range' field on the above link.

For information, a key decision is an executive decision which is likely:

(a)to result in the council incurring expenditure which is, or the making of savings which are significant having regard to the council's budget for the service or function which the decision relates; or

(b)to be significant in terms of its effects on communities living or working in an area comprising two or more wards or electoral divisions in the area of the council.

Lancashire County Council

For the purposes of paragraph (a), the threshold for "significant" is £1.4million.

The onus is on individual Members to look at Cabinet and Cabinet Member decisions using the link provided above and obtain further information from the officer(s) shown for any decisions which may be of interest to them. The Member may then raise for consideration by the Committee any relevant, proposed decision that he/she wishes the Committee to review.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no significant risk management or other implications

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A

Reason for inclusion in Part II, if appropriate

N/A