Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 21st March, 2013
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Pope (Chair)
Councillor Lewzey (Vice-Chair)
Councillor Claisse
Councillor Jeffery
Councillor Councillor Parnell
Councillor Tucker
Councillor Keogh

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel

The Health Overview and Scrutiny Panel is responsible for undertaking the statutory scrutiny of health across Southampton. This role includes:

- Responding to proposals and consultations from NHS Trusts and other NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises
- Liaising with the Southampton LINk and responding to any matters brought to the attention of overview and scrutiny by the Southampton LINk
- Scrutinising key decisions of the health agencies in the City and the progress made in implementing the Health & Well-being Strategic Plan and Joint Plans for Strategic commissioning
- Considering Councillor Calls for Action for health matters

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2012/13

2012	2013
21 June 2012	31 January 2013
15 August	28 February
10 October	21 March
29 November	

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for the disabled. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

CONDUCT OF MEETING

Terms of Reference
The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules – paragraph 5) of the Constitution.

Business to be discussed
Only those items listed on the attached agenda may be considered at this meeting.

Quorum
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

Rules of Procedure
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

DISCLOSURE OF INTEREST
Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Personal Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PERSONAL INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:
(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value fo the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

In accordance with the Local Government Act, 2000, and the Council's Code of Conduct adopted on 16th May, 2007, Members to disclose any personal or prejudicial interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer prior to the commencement of this meeting.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETINGS (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meetings held on 31 January 2013 and 28 February 2013 and to deal with any matters arising, attached.

7 TRANSFER OF PUBLIC HEALTH TO LOCAL GOVERNMENT

Report of the Director of Public Heath for the Panel to note the progress being made towards the relevant public health functions being transferred to the local authority, attached.

8 HEALTHWATCH SOUTHAMPTON

Report of the Joint Director of Strategic Commissioning for the Panel to note the progress towards securing local Healthwatch for Southampton, attached.

9 THE NATIONAL HEALTH SERVICE (PROCUREMENT, PATIENT CHOICE AND COMPETITION) (NO 2) REGULATIONS 2013

Report of the Head of Communities, Change and Partnerships, providing the Panel with the background to The National Health Service (Procurement, Patient Choice And Competition) (No.2) Regulations 2013 and the opportunity to comment on the regulations, attached.

10 SOUTHAMPTON SAFEGUARDING ADULTS BOARD

Report of the Head of Communities, Change and Partnerships for the Panel to note an update on the Southampton Safeguarding Adults Board, attached.

11 PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL - RECOMMENDATIONS (Pages 39 - 44)

Report of the Head of Communities, Change and Partnerships, seeking the Panel's agreement of the draft recommendations from the review of public and sustainable transport provision to Southampton General Hospital, attached.

12 HEALTH SCRUTINY 2012/13 - REVIEW

Report of the Head of Communities, Change and Partnerships for the Panel to agree the content for the HOSP contribution to the Scrutiny Annual Report and to note the proposed changes to Health Scrutiny for 2013/14, attached.

Wednesday, 13 March 2013

HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES

Agenda Item 6

MINUTES OF PREVIOUS MEETINGS

Appendix 1 – Minutes of meeting 31 January 2013

Appendix 2 – Minutes of meeting 28 February 2013

Appendix 3 – Attachment to Minutes of 28 February 2013

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 31 JANUARY 2013

Present: Councillors Pope (Chair), Lewzey (Vice-Chair), Claisse, Jeffery, Parnell, Tucker and Dr Paffey

Apologies: Councillors Keogh

33. APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

The Panel noted that Councillor Paffey was in attendance as a nominated substitute for Councillor Keogh in accordance with Procedure Rule 4.3.

34. MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

RESOLVED that the Minutes of the meeting held on 29 November 2012 be approved and signed as a correct record.

Matters arising
Minute no 28. Transfer of Medicine for Older People from Southampton General Hospital to Royal South Hants
The Panel enquired about the equipment on the Upper Brambles Ward. The Panel were advised the equipment had been returned to UHS as the Trust was unable to recruit the right staff to open the ward. The ward however was being used by Solent NHS Trust as staff and equipment had been transferred from the Fanshawe Ward to the Upper Brambles ward space. Upper Brambles was bigger than Fanshawe, so an additional five patients were being cared for. It was requested that an update be provided to the Panel in writing.

Minute no 28. Installation of Digital Mammography equipment
The Panel requested an update on this issue. The Panel were informed that the contact had been signed off with the provider. There was a clear timetable for the works and it was anticipated it would go ahead as scheduled, if not before.

Minute no 30. Southampton Safeguarding Adults Board (SSAB) – Serious Case Review
The Chair of HOSP reported he had met with Carol Tozer, the Chair of the SSAB. It had been agreed that the Panel would receive an annual report from the Chair of the SSAB and she would attend the March meeting.

35. EMERGENCY CARE INTENSIVE SUPPORT TEAM REVIEW

The Panel considered the report of the Chief Officer Southampton City Clinical Commissioning Group seeking support for the recommendations made in the SW Hampshire Unscheduled Care System report. (Copy of the report circulated with the agenda and appended to the signed minutes)

John Richards, Chief Officer – Southampton Clinical Commissioning Group, Chris Ash, Integrated Service Director Southampton and West Hampshire – Southern Health, Alex Whitfield, Chief Operating Officer – Solent, Margaret Geary, Director of Adult Social

Care – SCC, Jane Hayward and Paul Benson, Project Manager – CCG were present and answered questions from the Panel.

A discussion took place around the following key issues:

- "discharge push and pull" planning for patients: The report stated that patients were kept in hospital too long. Discharge planning was being reviewed to ensure that it was carried out from the point of admission. Capacity was to be considered to ensure there were the resources in the right place at the right time. Much work and joined up thinking was taking place, for example ensuring equipment was available 7 days a week rather than only being available during weekdays. An additional one off resource was being made available from the winter pressures funding to build capacity and ease pressures ;
- Assessment of patients needs: It was reported that it was often difficult to assess a patients needs for a home environment when in hospital. Patients might therefore be moved to an intermediate setting where it would be easier to assess their needs and reduce system blockages;
- IT systems: These needed to improve to support the co-ordination of discharge. It was reported that a real time management system had been introduced, called "Urgent Care Dashboard". This informed GP's about the real time admission and discharge status of their patients. The intention was for it to be made more widely available to specific healthcare teams;
- The implementation of the recommendations: These were being monitored. A number had already been implemented and completed whilst others would take longer to implement. It was anticipated that there would be a more robust system within 12-18 months;
- The 4 hour operating standard: This was monitored on an hourly basis. The target had been missed by 0.5% for the third quarter (October- December 2012). The cold weather and snow in January meant that it would be difficult to meet the target for quarter 4.

RESOLVED that

i) the Panel noted the report on the SW Hants Unscheduled Care System prepared by the national Emergency Care Intensive Support Team, and supported the recommendations made;

ii) the Panel requested an update of the progress on the recommendations in six months; and

iii) the Panel requested information regarding the IT system "Urgent Care Dashboard", including the users.

36. **OUTCOME OF THE CARE QUALITY COMMISSION ROUTINE INSPECTION OF SOUTHAMPTON GENERAL HOSPITAL**

The Panel received and noted the report of the Senior Manager, Communities, Change and Partnerships to note the outcome of the Care Quality Commission routine inspection of Southampton General Hospital. (Copy of the report circulated with the agenda and appended to the signed minutes)

Jane Hayward, Chief Operating Officer – UHS, Michael Marsh, Medical Director – UHS, John Richards, Chief Officer Southampton City Clinical Commissioning Group and Judy

Gillow, Director of Nursing – UHS were present and answered questions from the Panel.

A discussion took place around the following key issues:

- Black alert at the hospital. The hospital was on black alert when the CQC inspection was carried out. Black alert is when the hospital operates at full capacity with no available beds. Normal elective operations would not be carried out during this time. It was reported that between October and the end of January there had been in total 17 equivalent black alert days.
- Staffing: This was a key area of concern. There had been a large number of vacancies and it had not been possible to recruit as quickly as desired. A recruitment exercise had been carried out locally, nationally and abroad. 90 nurses had been recruited to the Trust which would bring down the vacancy rate. The use of agency staff was also discussed. It was reported that on wards, there would be a mix of agency and permanent staff, and if necessary staff would be moved to work alongside agency staff if there were too many agency staff in one area.
- Action Plan: Many of the actions had already been completed. Some actions were still being implemented. The discharge lounge and wait for medication was being reviewed.
- Future inspections: A further CQC inspection was expected in 3-4 months time.
- Concern was raised by the Panel regarding the fact that they had not been made aware of the inspection.

Mr Ayers, Member of the Public was present and with the consent of the Chair addressed the meeting regarding his experience of the system. Harry Dymond, LINK was also present and with the consent of the Chair addressed the meeting. He reported that LINK supported the work that was being carried out.

RESOLVED that

i) the Panel noted the report of the CQC inspection of Southampton General Hospital and the briefing paper from UHS; and

ii) the Panel requested to be notified at the earliest opportunity when future inspections were carried out and action plans produced .

37. VASCULAR SERVICES UPDATE

The Panel considered the report of the Director of Nursing, SHIP PCT Cluster providing an update on the continued development of the network since the last Scrutiny meeting on 29th November 2012. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received an update from Sarah Elliot, Director of Nursing SHIP PCT Cluster, Beverley Meeson (Cardiovascular Network Manager) and Michael Marsh, Medical Director, University Hospital Southampton. It was reported that progress had been made and that there had been positive feedback from the meetings that had been held.

The Panel reported they had been consulted on the National Commissioning Standards for specialised services, however they felt that not enough time had been given to respond.

RESOLVED

i) that the Panel supported the continued development of the network;

ii) that a further update be presented to the Panel on 21 March 2013.

38. **JOINT HEALTH AND WELLBEING STRATEGY**

The Panel received and noted the report of the Director of Public Health regarding the revised draft Health and Wellbeing Strategy. (Copy of the report circulated with the agenda and appended to the signed minutes)

Andrew Mortimore, Director of Public Health and Councillor Stevens, Cabinet Member for Adult Social Care were present and with the consent of the Chair addressed the meeting.

The Panel felt that the revised draft Health and Wellbeing Strategy had improved since they had been consulted on it. It was suggested that transport be included in the strategy.

RESOLVED

i) that the Panel noted the revised draft revised draft Southampton Joint Health and Wellbeing Strategy;

ii) that the Health Overview and Scrutiny Panel be acknowledged in the consultation section of the strategy; and

iii) the Panel recommended transport be included in the Health and Wellbeing Strategy.

39. **PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL**

The Panel considered the report of the Senior Manager, Communities, Change and Partnerships for the Panel to note the update on progress with the review into public and sustainable transport provision, the impact of proposed subsidy reductions for bus transport to Southampton General Hospital and to agree key discussion areas and attendance at the evidence gathering meeting on 28th February 2013. (Copy of the report circulated with the agenda and appended to the signed minutes)

Simon Bell, Public Transport and Operations Manager was present and with the consent of the Chair addressed the meeting.

It was proposed in the budget for 2013/14 that bus subsidies would be withdrawn. The Panel questioned what would happen to bus services should this happen. It was reported that bus companies would look at the commercial viability of the service and that it would not be possible to predict what they would do. It was recognised that there was some overlap between commercial and subsidised services. Concern was expressed by the Panel because the impact of the subsidy withdrawal was unknown and therefore it would be difficult to give a reasoned analysis.

RESOLVED

i) that the Panel noted the update on progress with the review into public and sustainable transport provision to Southampton General Hospital;

ii) that the Panel noted the impact of proposed subsidy reductions for bus transport to the General Hospital; and

iii) that the Chair write to the Cabinet Member for Environment and Transport requesting funding following the review, for areas the Panel deemed necessary , for example cycle / pedestrian access to the hospital.

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 28 FEBRUARY 2013

Present: Councillors Pope (Chair), Lewzey (Vice-Chair), Claisse, Jeffery, Councillor Parnell, Tucker and McEwing

Apologies: Councillor Keogh

40. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Panel noted that Councillor McEwing was in attendance as a nominated substitute for Councillor Keogh in accordance with Council Procedure Rule 4.3.

41. **PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL**

The Panel considered the report of the Senior Manager, Communities, Change and Partnerships for the Panel to note evidence from stakeholders in relation to public and sustainable transport provision to Southampton General Hospital and provide comments on emerging recommendation by 8 March. (Copy of the report circulated with the agenda and appended to the signed minutes)

The following corrections were made to paragraph 6 of the report so it should read:

- The hospital has up to a total of **7,500** staff;
- In the region of **600,000** patients are seen at the hospital each year

The Panel heard presentations and asked questions of the following speakers:

Harry Dymond, SLINK

The Panel noted that:

- that transport to the Southampton General Hospital was often raised at SLINK meetings, particularly for people living to the east of the City and there was confusion over changes to bus services.
- in a recent survey carried out by SLINK transport to health services was reported to be an issue;
- SLINK had detailed their concerns in the report circulated as part of the agenda papers;
- taxi's an were expensive form of transport and those with children find it difficult to get to the hospital using public transport;
- the bus network was fragmented, with different operators, bus routes keep changing and were confusing for users.
- that cost had not been raised as an issue in relation to public transport to the hospital.

Anne Meader, Carers Together (see paper appended to minutes)

The Panel noted that:

- the main issues raised were lack of accessible public transport to the hospital, lack of direct bus routes which required users to change buses a number of times to get to the hospital, timing and scheduling difficult and there was a lack of directions from the motorway to the hospital;
- a planning and customer care survey should be carried out regarding public transport;
- a bus service was provided for hospital staff from Thornhill to the hospital - could there be a public bus service?;
- people could travel long distances to the hospital. Better links were required from the train station, ferry and wider region, possibly a park and ride option for patients and carers;
- co-ordinated care should be centred on the individual, taking into account their requirements.

The Panel discussed the Patient Transport Services and whether people were aware of them. It appeared that information was not readily available and often patients were not made aware of the service. It was acknowledged that when people were unwell it was more difficult to be proactive to find out about options available for transport. GP's often refer people for appointments at the hospital, but it was not clear whether information was given out regarding options for transport.

Tracy Eldridge, Member of the Public

Tracy Eldbridge, Member of the Public was present and with the consent of the Chair addressed the Panel regarding her observations at the hospital and long waiting times for a patient waiting for the patient transport service.

Michael Woodward, Joint Staff Side Chair / Unite UHS on behalf of Unite and Unison

The Panel noted that:

- union staff felt that bus services were unreliable and confusing;
- better information was required regarding bus routes and location of bus stops. Staff who use buses may take multiple buses to travel to work ("bus jumping"), which could be expensive and timing consuming;
- when the bus routes and numbers changed no consultation took place and no information had been available at bus stops and the information about the old buses routes was still advertised.

David Smith – Consultant Anaesthetist and Maria Johnston – Radiographer – Staff Reps UHS

David Smith and Maria Johnston reported they were representatives of staff and they were members of transport strategy and steering groups.

It was noted that:

- there were 10,125 staff contracts and 3,500 parking permits issued to staff;
- the 2020 vision for the hospital was to extend staff working hours until 8 pm in order to offer a longer service for outpatients;

- the main issues raised by hospital staff in relation to travel was the fact that buses services cease at 6 pm and that it was not easy to move about the City - buses travel into the City Centre and out again and therefore more than one bus might need to be used; it is also confusing to know which bus stop yu need to use;
- lighting around the hospital was felt to be poor, particularly at bus stops and was a safety issue. Only the Unilink bus enters Southampton General Hospital which at times of the day could cause problems with movement of vehicles;
- the number of staff travelling to work by bike had increased. Safety of cyclists was an issue, particularly as there were not many cycle path routes to the hospital. It was not possible to report the number of showers at the meeting. Money had been ringfenced for the development of facilities and that space to provide lockers for those cycling to work was being addressed;
- the cost to staff to use the park and ride facility was less than to park at the hospital.

Anita Beer, Interim Deputy Director of Commercial Development – University Hospital Southampton

It was noted that:

- the Trust had been working to improve transport related issues around the hospital such as hospital parking, encouraging cycling and provision of shower facilities. Consultation had been carried out on permits and a park and ride facility was offered to staff. Research had been carried out regarding staff travel patterns;
- knowledge about patients and visitors travel patterns was limited;
- the Trust were keen to work with partners regarding public transport;
- patient questionnaires: Patients at the hospital were routinely issued questionnaires regarding the treatment received but no questions were asked about transport. Questions about transport had not been a priority because they were a healthcare provider, and need to focus on quality of care, dignity and responding to issues raised in the Frances report. UHS would like to work with others to better understand patient and visitor travel;
- the number of showers provided for cyclists was being increased. It was not possible to provide the number of showers available for staff at the meeting. Cycle theft was an issue, on average one bike was stolen a week.
- the Trust work with the bus companies. Bus companies had talked to staff at the hospital to about changes that were introduced last year. A willingness was expressed by the Trust to work with the bus companies.
- it could be difficult to plan travel times to and from the hospital if travel involved using more than one bus, or more than one method of transport when waiting times and potential delays needed to be factored in order to make sure a patient arrives for an appointment on time;
- the Trust was not responsible for the contract for the Patient Transport service, but accepted there are issues in accessing PTS in a timely manner. Publicity of the service was discussed. GP’s were responsible informing patients of the service.

James Smith, Unison Trade Union

James Smith was present and with the consent of the Chair addressed the meeting. Upon hearing rumours that the First Bus service was to potentially remove the bus service after 8 pm a questionnaire had been drawn up regarding bus travel for staff at the hospital. Attempts to contact First Bus had been difficult. Concern was expressed regarding the safety risk for people travelling at night around the hospital.

Ian Taylor, Uni-link Manager and Paul Coyne, Operations Manager – Bluestar and Uni-link

It was noted that:

- Bluestar and Uni-Link were willing to work and engage with the Council and others in relation to bus provision;
- user groups and Steering groups had been established in other parts of Hampshire and the bus groups were invited to attend these meetings and were happy to attend these meetigs;
- a bus service would only be provided if there was the demand to make it commercially viable. Discussions took place around pubic transport and the requirement to be customer focused. Capacity on U6 increasing later this year;
- Southampton University had a very good travel plan and engaged with people using mass media. They have resources and a transport and estates department. Students may be able to help with a survey.

Dervla McKay, General Manager – First South Coast

It was noted that:

- 13 direct services to the hospital. The S1 bus service was currently funded by the Council. The other services were commercial. A range of tickets were available for users;
- it was acknowledged that bus stop locations were not always easy to find, they would consider how to improve;
- customer panels took place in other areas but not in Southampton. The panels had representation from local Councillors, public, local authority transport department and issues such as complaints, fleet changes and disability issues were discussed. It was reported that if a Customer Panel was set up for Southampton they would be happy to attend;
- First South Coast was not linked up to ROMANSE system which supplies up to date bus information. It was anticipated that bus services would link up to ROMANSE in early summer;
- consultation prior to making changes on bus services involves consulting the transport department of the relevant local authority and consulting staff and union representative. The public would not be consulted;
- First South Coast were reviewing the bus services in the light of the budget cut from the Council.

Simon Bell, Public Transport and Operations Manager and Dale Bostock, Active Travel Officer – Southampton City Council

- it was reported that cycling routes were to be reviewed with the intention of promoting cycling, particularly for the less confident cyclist;
- most cycle routes were on road but looking to improve;
- the complaints system was being used to address issues raised by members of the public;
- there was clearly a lack of information as buses do exist for some of the routes raised tonight – ie from the ferry and train station;
- Travel Line was available to provide information;
- it would be useful to have patient and visitor survey data to improve planning.

RESOLVED:

i) that the Panel requested the further information from speakers at the meeting, detailed below:

- Anne Meader, Carers Together - details on the main areas of concern;
- James Smith, Unison Trade Union – details on the questionnaire that had been produced for staff in relation to bus provision;
- Anita Beer – details of staff showers on site;
- Dervla McKay, First South Coast – details of the consultation carried out prior to the reduction in bus services in April 2012;

ii) that the Panel recommended that a Steering Group be established for public transport in Southampton, including providers and users;

iii) the Panel recommended that survey work be carried out to establish how patients and visitors travel to and from the general hospital and the results used to inform future service planning;

iii) the Panel recommended that survey work be carried out to establish how patients and visitors travel to and from the general hospital and the results used to inform future service planning;

iv) the Panel recommended early engagement between the hospital and its staff and public transport providers regarding the proposed extension of working hours for staff at the hospital; and

v) that the Panel agreed to consider the Patient Transport Service in more detail in at a future meeting in order to better understand how the services are managed, publicised to patients and concerns with the current service. Commissioners and Providers of the service to be invited.

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Presentation to Health Overview and Scrutiny Panel

28 February 2013

This discussion paper has been prepared using the reported experiences of a wide number of people using the hospitals in Southampton over several years.

Patient Surveys

- In 2000 a Patient User Group (PUG) was formed in the Elderly Care Wards. This was extended to Medicine 4 years later. It ceased to meet in 2010 when the Trust became a Foundation Trust
- In 2003 and 2005 - the PUG did two patient and visitor surveys - both reported that car parking and travel to the hospital needed improving. The reports included:
  - Parking - cost, lack of spaces, lack of information for patients and visitors about concessions, which car park to use, etc. Some action on parking was taken as result - but it did not address the wider issues on travel to and from the hospital
  - Some of these were
    - Lack of accessible public transport
    - Lack of direct transport routes to the hospital sites
    - Number of time people had to change buses on the way to and from the hospital
    - Timing and schedules of the buses - how to find the right bus stop and the right bus
    - Directions from the motorway to the hospital
    - Cost of taxis to use as alternatives
    - Need for more disabled parking spaces
    - Distance of the disabled car park from the entrance (and to the wards and appointments in the hospital)
    - Some of these haven't changed e.g. directions from the motorway - but the development of sat navs have helped with this

Car Parking

- In looking at the issues - it is impossible to ignore car parking on site because it is an integral reason why public transport should change and improve.
- Car parking used to be provided free of charge - charges were raised originally to prevent or discourage parking by people, who work elsewhere in Southampton, from

using the car park and going to work thus preventing parking by people going to the hospital .

- A multi story car park was not built at the front because of objections from neighbours
- Pay car park - OK - some tweaks would improve - but on balance good - and the income enhances hospital services - BUT needs greatly improved communication and information made available for users
  - not enough spaces
  - will always have people who come on site even if they could park elsewhere or use other transport
  - not clear which is nearest car park to appointments on site
  - long distances from car park to wards for older people
  - not clear to patients and relatives about concessions - often pay for a long time before finding out about concessions - not all staff seem to know about it or promote it
  - better customer care would be helpful - the patients and visitors are the clients of the hospital - and a culture change is probably needed.

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In considering the current situation, I have been struck by the number of car parks there are in Southampton (over 50).

They use business marketing and planning as well as customer care to ensure that their customers can access major shopping areas - by car or by public transport.

In this day and age shouldn't we be looking at similar issues for transport to the hospitals?

==

Transport - UHS Hospitals

- UHS is a major transport HUB - over 500,000 patients seen on site each year - with consequently high numbers of visitors and relatives.
- If it was a shopping mall - it would be treated as a major business opportunity with potential customer care issues and both business plans and marketing plans would ensure sufficient public transport and car parking to encourage shoppers.
- It is my understanding that currently 2 public transport service routes go to the hospital - and for a city the size of Southampton that feels inadequate

Presentation to Health Overview and Scrutiny Panel

28 February 2013

- I understand there is a bus service from Thornhill to UHS for staff to get to work - it has a fixed low journey cost - is it publicised and available for patients and visitors?
- Is the transport accessible? Is it user friendly?
- Could the idea not be extended to other areas by judicious changes to timetables?
- It could be helpful to look at
    - **Distances from different parts of Southampton to the hospital** - change of buses and time taken
    - **Distances from the train station** e.g. Bognor lady in 80s - two buses in Soton - train - two buses the other end
    - **Distances from IOW** - ferry - what bus to the hospital?
    - **Distances from places like Jersey - Southampton Airport, Eastleigh Parkway**
    - Routes from these points to the hospitals could include other current stops but add in the additional destinations to and from the hospitals
    - I understand there is one bus from the ferry to the hospital for people coming for treatment for cancer - if you miss the return journey - it means a taxi - why not a regular service route? It needs to be well advertised and have a number of stops for others to use it.
    - There is a regular free bus from the railway station - goes to West Quay, Town Quay - Red Funnel and other commercial interests pay for it

      Why can we not arrange something similar to the hospital, even if passengers are charged, from station and IOW ferries?

        - Why not a single bus journey from different parts of the City to the hospitals?
        - Why not a bus from railway station to hospital?
        - Why not a bus from IOW Ferries to hospital?
        - Why not a bus from Eastleigh - airport and train station
- Why not a minibus system running regularly from different parts of the City to the Hospitals, and between the hospitals?
- What about better use of voluntary transport?
- What about better communication and information that is available and understood by patient and carers and the general public.
- Good publicity and easily understood journey planning is essential

Presentation to Health Overview and Scrutiny Panel

28 February 2013

Better still - Park and Ride

- There are approximately 50 car parks in Southampton - but where are the Park and Ride facilities? They are made available for major events such as football - what about visiting hospital patients and outpatient appointments?

  With the numbers indicated earlier - there is good commercial reason for providing Park and Ride as well as a good customer care reason

Regional Issues

- Signposting from motorway - still abysmal
- As regional centre - shouldn't we be looking at wider transport issues as well as improving the current situation?

The new in-words are

- **Coproduction** - which effectively means including the people most affected by your project, service or business in planning, implementing and monitoring your service.

  This could also be known as customer care - and be looking at affordable, accessible, available and quality transport facilities which match customer needs.

  That is providing what is needed rather than expecting everyone to fit in with what is provided

  It should include staff e.g. transport between hospitals for staff is available also Thornhill bus.

  But what about patients and visitors - are they included in the planning and implementation? Are they consulted on what is needed?

- **Person centred coordinated care** - not just health and social care but looking at the holistic needs of clients/patients/visitors which should cover the needs of the person to access services - and this includes realistic and affordable, accessible transport available to meet appointment and visiting times. Or adjusting visitor times to meet available transport? Working together to get the best outcome

- **Please see National Voices and HealthWatch Communities**

Is it beyond the realms of possibility that we consider customer care, coproduction and person centred coordinated care to plan and provide effective transport and services to meet customer care needs at the hospitals?

It could improve levels of attendance and reduce costs of overheads and missed appointments.

Presentation to Health Overview and Scrutiny Panel
28 February 2013

Perhaps we could use the new Better Bus Area initiative (published in February 2013) to work in partnership to get a better service for those with health needs?

Good basic services could be enhanced by listening to customers and potential customers and adjusting accordingly.

Private service provision of any kind offer quality services, adjust and respond to customer feedback and support customer need. Why not NHS services?

Whatever we do - please think outside the traditional answers and let's be innovative and inclusive for the benefit of service users and carers.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		TRANSFER OF PUBLIC HEALTH TO LOCAL GOVERNMENT		
DATE OF DECISION:		21ST MARCH 2013		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Martin Day**	**Tel:**	**023 80917831**
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

Local authorities will become responsible for a number of public health functions from April 2013. This report summarises the key local authority public health functions and it highlights some of key activities being undertaken to ensure public health will operate effectively as a local authority service from April.

RECOMMENDATIONS:

(i) That the progress being made towards the relevant public health functions being transferred to the local authority be noted.

REASONS FOR REPORT RECOMMENDATIONS

1. To update the scrutiny panel on actions being taken to transfer a range of public health functions to the council from 1st April 2013.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. The Health and Social Care Act 2012 transfers public health from the NHS to local authorities and a new body called Public Health England from April 2013. A significant amount of work has been undertaken in both the council and the PCT to ensure the smooth transfer of staff and the seamless transition of the service and activities. A transition plan, approved both by the PCT and SCC Cabinet, was submitted to South Central Strategic Health Authority in March 2012.

4. Political leadership for public health in Southampton will be with the Cabinet Member for Communities, reflecting the cross-Council nature of public health. The ring-fenced public health grant will be in the cabinet member's portfolio. The Council's Director of Public Health will be its principal adviser on health, fulfil a range of statutory responsibilities, be the senior officer lead responsible

for ensuring all the new public health functions are delivered, and for the Health and Wellbeing Board. The Health and Social Care Act also makes it a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population, and for the City Council to publish it. The Cabinet has approved in principle a scheme of delegation to the Director of Public Health. The scheme of delegation will be considered by the Governance Committee on 19th March, and then be presented to Council for determination on 20th March.

5. Public Health will be a function that needs to input into and influence work across the Council. With the function being located in the People Directorate there will be strong connections to the work of children's and adult social care, housing services, and port and environmental health. To ensure opportunities to tackle wider determinants of ill health are maximised, Public Health will work with the new Place Directorate to co-design and support work programmes that link health improvement with private sector housing, transport, community safety and economic development. Through the Communities portfolio, Public Health will contribute to work on tackling poverty, Families Matter and equalities. The overall public health programme will be shaped by the Joint Health and Well-being Strategy, and deliver improvement across a range of prioritised outcomes, drawn from the national Public Health Outcomes Framework, which has links to, and a number of shared outcomes, with the frameworks for adult social care and the NHS.

6. Public Health Southampton comprises 20 posts representing 16.9 whole time eqivalents. It is a multi-disciplinary public health team with support staff transferring from NHS Southampton which will continue to deliver public health functions and responsibilities (the "core team"). These functions include:

- health surveillance and needs analysis
- health protection (including emergency preparedness)
- population health care advice (including effectiveness and priority setting)
- commissioning health improvement services

collaborative programmes to tackle causes of ill health

Transfer of Public Health Staff

7. To assist with the smooth transfer of the function, public health staff were relocated from PCT premises to the civic centre in March 2012. The transfer of staff to the Council will be covered by a Transfer Scheme drafted by lawyers acting for the Department of Health. This is consistent with arrangements for other Public Health Services and staff across the country, transferring to Local Authorities on 1st April 2013.

Local Authority Public Health Responsibilities

8. Local Authorities will be specifically responsible for commissioning the following services. Those marked * are mandated services in legislation,

however, many of the others are required to make delivery of those mandated services a reality.

- NHS Health Check assessments*
- The national child measurement programme*
- Comprehensive sexual health services - including testing and treatment for sexually transmitted infections, conception outside of the GP contract and sexual health promotion and disease prevention*
- A new expanded local authority role for public health - health protection including assurance of infection control, incidents, outbreaks and emergencies with a specific leadership role for Emergency Planning, Resilience and Response*
- Public health leadership, advice and support to NHS commissioners*
- Tobacco and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5 to 19 (and in the longer term all public health services for children and young people)
- Interventions to tackle obesity, such as community lifestyle and weight management services
- Locally led nutrition initiatives
- Increasing levels of physical activity in the local population
- Public mental health services
- Dental public health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Local initiatives on workplace health
- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion
- Local initiatives that reduce public health impacts of environmental risks

Public Health Protection

9. From April 2013 the local authority will become responsible for all aspects of public health protection, supported by Public Health England. This will include community infection prevention and control. Other issues where public health may be called on would include chemical spills, natural disasters and the covert deliberate release of biological and chemical agents. The local authority will be expected to provide public health leadership in such circumstances and action to mobilise the NHS response.

Partnership with the Southampton CCG: The Local Public Health Advisory Service

10. One component of the new LA responsibilities for public health includes a Public Health Advice Service or "Core Offer" to Clinical Commissioning Groups (CCG). As the council is co-terminus with Southampton City CCG, the Public Health Advice service is with a single CCG, which helps align partnership planning and shared programmes. The elements of public health advice have been laid out in a memorandum of understanding that has been negotiated as part of the NHS transition into CCGs and new public health accountabilities and responsibilities. This was initially termed the "Core Offer", but is now know as the public health advice service. The Southampton memorandum of understanding covers two years to include the transition year 2012-13 and the first year of health act implementation in 2013-14. It is under active review by the PH team and the CCG in the transition year.

RESOURCE IMPLICATIONS

Capital/Revenue

11. Public Health transfers to the local authority with a budget that is ring-fenced for a period of 2 years. With a number of public health functions transferring to Public Health England, it is not simply a case of transferring the existing PCT public health budget to the local authority. The Department of Health published the 2013/14 and 2014/15 budget allocations to enable local authorities to fulfil the public health function on 10th January 2013. The budget allocation announced for Southampton is £14.313m for 2013/14 and £15.050m for 2014/15. The final Public Health spending plan for 2013/14 is currently being compiled and from work completed to date is not expected to exceed the grant allocation announced. From April the budget will be subject to the standard council budget reporting and monitoring processes, and public health will be fully included in the budget setting process for 2014/15.

12. The Public Health Grant is ring-fenced for public health activities in local authorities in the next 2 years. Details of the grant conditions have been published. The key points from the conditions are:
    - The DH will monitor grant spending against identified responsibilities and outcomes.
    - Three quarterly returns will need to be made to the DH followed by a "Statement of Grant Usage" to be signed by the Chief Executive after the year end.
    - External auditors will be examining grant spending.

13. Approximately 230 existing contracts/agreements/services will be transferred to the council. These have a total value of £12.6m, which includes one very big contract with Solent with a value of approximately £4.5 million.

Property/Other

14. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15. Local authority public health responsibilities are set out in the Health and Social Care Act 2012.

Other Legal Implications:

16. None.

POLICY FRAMEWORK IMPLICATIONS

17. None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None.	

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		HEALTHWATCH SOUTHAMPTON		
DATE OF DECISION:		21ST MARCH 2013		
REPORT OF:		JOINT ASSOCIATE DIRECTOR OF STRATEGIC COMMISSIONING		
CONTACT DETAILS				
AUTHORS:	**Name:**	**Martin Day** **Matthew Waters**	**Tel:**	**023 80917831** **023 80834849**
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STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The Health and Social Care Act 2012 requires local authorities to establish local Healthwatch as a vehicle to succeed and build upon the Local Involvement Networks (LINKs) as a voice for patients and the public on health and care services. In addition it will undertake the additional new roles of providing information, advice and signposting on services, and NHS complaints advocacy. This paper provides an update on the arrangements for securing local Healthwatch for Southampton.

RECOMMENDATIONS:

(i) That the Scrutiny Panel notes the progress towards securing local Healthwatch for Southampton.

REASONS FOR REPORT RECOMMENDATIONS

1. To inform the Health Overview and Scrutiny Panel of the arrangements for securing local Healthwatch.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. A range of alternative options were considered and rejected. These included:

- Splitting the functions of Healthwatch into separate contracts. This was rejected on the grounds that there are significant benefits to Healthwatch in terms of gathering evidence, linking outcomes across all functions and the management of a single service. The splitting of functions would reduce these advantages.

- Negotiated tender arrangements. While this would have allowed a tender to be issued earlier, there would have been significant negotiation required after any tender process. This would have included negotiation on the final price.

- Grant aid was also considered, but rejected as this would have still required a decision on either:
  - grant aiding a single agency, of which none appeared to have all the skills to meet the requirements; or
  - grant aiding more than one agency and splitting the functions across those agencies, a decision already rejected.

DETAIL (Including consultation carried out)

Background

3. Healthwatch is established under the Health and Social Care Act 2012 to act as a strong and independent voice of patients and services users of health and care services. Healthwatch England was established in October 2012 as the national body, and each upper tier local authority is required to secure local Healthwatch to operate in their area. Local Healthwatch will be responsible for the following activities:
   - Community Engagement and Research
   - Evidence, Insight and Influence
   - Information and Advice
   - NHS Advocacy Service.

4. A number of activities were undertaken in 2012 as steps towards developing Healthwatch Southampton. These included a series of consultation and engagement events between April and July, and market development workshops for potential providers in autumn 2012.

   Following these workshops small grants were made available to facilitate potential groupings of providers to undertake development activities necessary to prepare themselves for any tender submission. Agencies had to be properly constituted and have a realistic plan to develop a consortium bid, with one lead agency.

   A major project was also commissioned to document the Southampton LINk legacy, and this is now coming to a very successful conclusion. It will aid handover of crucial information to the new Healthwatch service.

5. The Health Overview and Scrutiny Panel has received a series of reports summarising the key issues in developing local Healthwatch services. Members will recall that the introduction of Healthwatch has been delayed twice, and the final regulations providing details of the requirement for local Healthwatch were not laid before Parliament until December 2012.

Securing Local Healthwatch In Southampton

6. Whilst the Council's original plans would have secured Healthwatch by 1st April 2013, there have been a number of delays as a result of the delay in the

Department of Health publishing the final regulations, and in the Council determining the final budget for local Healthwatch – again, following delays in the final grant settlement being announced by central government.

7. The key requirement of the tendering process is to secure a high quality, sustainable Healthwatch service capable of acting in the best interests of the people of Southampton over the longer term. The decision was taken to include all elements of the service within one tender process, rather than tendering for separate elements, thereby enabling better management of all parts and the stronger coordination of local services. This has however, required the Council to enter into two short-term arrangements to cover the initial period from April until the new service commences (see Next Steps below). These short-term arrangements will enable the full service to be operating shortly after April, negating further tendering or the combining of functions at a later date.

8. A competitive tendering process has been used to meet the Council's requirements as set out in the Contract Procedure Rules. A maximum price for the tender has been specified which is in line with the budget decision. It will measure tender submissions on a basis of 70% Quality; 30% Price.

9. There was a balance to be struck between publishing a tender document early, which would allow time for Healthwatch to be up and running by 1st April, and waiting until all the information was in place to enable a better informed specification to be prepared. The latter route was followed to secure the best service for the longer term, enabling price information to be included, and ensuring all legal requirements would be met, without the need to renegotiate any potential changes, as a result of the final regulations possibly containing details that had not been previously foreseen, potentially resulting in a failed tender.

10. The delay in tendering for this service has allowed the City Council to write a comprehensive Service Specification and Terms and Conditions. The tender documents are based on:
    - Two provider information days held in September / October 2012;
    - Confirmation of the budget given in February 2013;
    - The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 which was laid before Parliament on the 17th December 2012;
    - Discussions with other local authorities regarding their tender documents and procurement process; and
    - Advice from the Health and Social Care Partnership.

    The robustness of the tender documents will enable Healthwatch Southampton to work within coherent guidelines and provide direction for a high quality service. The tender has been advertised on 12th March, and is

due to commence in May and June 2013.

Next Steps

11. A number of actions are underway to secure interim arrangements until the contract comes into effect. The NHS complaints advocacy service in the interim will be provided by the organisation currently supplying the Independent Complaints Advocacy Service (SEAP). This service has been provided at a regional level, and the provider has indicated it will continue to register and process requests for support from Southampton. When the new contract comes into effect, any live cases will be transferred to Healthwatch Southampton.

12. Discussions have taken place with Southampton Voluntary Services who currently act as host to the LINk, to continue to support the activities that are currently the responsibility of the LINk beyond the period when the LINk ceases exist. At the same time, conversations have continued between the LINk Chair and Steering Group, offering them a continuing role in the transition period.

13. The two short term measures above will operate under the Healthwatch logo, ensuring that Southampton meets it obligations prior to the longer term service coming into full operation.

RESOURCE IMPLICATIONS

Capital/Revenue

14. The Council has set a revenue budget for 2013/14 of £200,000 for local Healthwatch.

Property/Other

15. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

16. The framework for local Healthwatch is set out in Sections 183 – 189 of the Health and Social Care Act 2012. Further requirements are set out in the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012.

Other Legal Implications:

17. None

POLICY FRAMEWORK IMPLICATIONS

18. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		THE NATIONAL HEALTH SERVICE (PROCUREMENT, PATIENT CHOICE AND COMPETITION) (No.2) REGULATIONS 2013		
DATE OF DECISION:		21 March 2013		
REPORT OF:		HEAD OF COMMUNITIES, CHANGE AND PARTNERSHIPS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Caronwen Rees**	**Tel:**	**023 80832524**
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STATEMENT OF CONFIDENTIALITY

None.

BRIEF SUMMARY

This paper provides the Panel with the background to The National Health Service (Procurement, Patient Choice And Competition) (No.2) Regulations 2013 and the opportunity to comment on the regulations.

RECOMMENDATIONS:

(I) The Panel are asked to note The National Health Service (Procurement, Patient Choice And Competition) (No.2) Regulations 2013 and consider if they wish to comment on them.

REASONS FOR REPORT RECOMMENDATIONS

1. To inform members of the opportunity to respond to The National Health Service (Procurement, Patient Choice And Competition) (No.2) Regulations 2013, currently before Parliament.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. On 13 February the Government laid before Parliament The National Health Service (Procurement, Patient Choice And Competition) Regulations 2013 to be made using the negative procedure and come into effect on 1 April 2013. The regulations are made under Section 75 of the Health and Social Care Act 2012. The regulations were intended to help ensure that commissioners' decisions on buying clinical services are transparent and fair, and that they

improve the quality and efficiency of health care services for patients.

4. After they were laid, concerns were raised about the extent to which competition was going to be used. The Government received representations form lobby groups and the medical professions including a letter signed by more than 1000 doctors expressing concern. The Government stated that the regulations went no further than the set of procurement guidelines issued in March 2010. However, on Tuesday 5 March the Health Minister agreed that as the wording of the regulations had "inadvertently created confusion" it would be withdrawing the first draft of the regulations to rewrite them.

5. Revised regulations, (appendix 1) were laid in Parliament on11 March 2013 and will come in to effect from 1 April. Accompanying the regulations is a note of changes (appendix 2), and explanatory memorandum (appendix 3).

6. The regulations are again being made using the negative procedure. Under the negative procedure there are 40 days, within which MPs or Members of the House of Lords may request a debate. If there are no objections to an SI subject to the negative procedure then the regulations are passed. As with the previous regulations, the House of Lords Secondary Legislation Scrutiny Committee has signalled its intent to look at the regulations.

7. Lobby Group 38 Degrees contacted the Chair of the Panel in February with a request to address the Panel regarding the regulations. They will be invited to address the Panel regarding the revised regulations at this meeting. Members will want to consider if they wish to make any representations regarding the regulation to the Health Minister, Clarke to the House of Lords Secondary Legislation Committee or other Parliamentary representative.

RESOURCE IMPLICATIONS

Capital/Revenue

8. None.

Property/Other

9. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

10. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

11. None.

POLICY FRAMEWORK IMPLICATIONS

12. None

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013
2.	Note of Changes to the Regulations
3.	Explanatory Memorandum

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equ Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Papei	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

1.	None	

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STATUTORY INSTRUMENTS

2013 No. 500

NATIONAL HEALTH SERVICE, ENGLAND

PUBLIC PROCUREMENT, ENGLAND

The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

Made - - - -	*6th March 2013*
Laid before Parliament	*11th March 2013*
Coming into force - -	*1st April 2013*

The Secretary of State for Health makes the following Regulations in exercise of the powers conferred by sections 75, 76, 77 and 304(9) and (10) of the Health and Social Care Act 2012(**a**).

PART 1

General

Citation, commencement, interpretation and application

1.—(1) These Regulations may be cited as the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 and come into force on 1st April 2013.

(2) In these Regulations—

"the 2006 Act" means the National Health Service Act 2006(**b**);

"the 2012 Regulations" means the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012(**c**);

"the Board" means the National Health Service Commissioning Board(**d**);

"CCG" means clinical commissioning group(**e**);

"health-related services" and "social care services" have the same meaning as in section 62(11) of the Health and Social Care Act 2012;

"patient" has the same meaning as in the 2006 Act(**f**);

(**a**) 2012 c. 7.
(**b**) 2006 c. 41.
(**c**) S.I. 2012/2996.
(**d**) The National Health Service Commissioning Board is established by section 1H of the National Health Service Act 2006 (c. 41) ("the 2006 Act"). Section 1H is inserted by section 9(1) of the Health and Social Care Act 2012 (c. 7) ("the 2012 Act").
(**e**) A clinical commissioning group is a body established under section 14D of the 2006 Act. Section 14D is inserted by section 25(1) of the 2012 Act. *See also* section 1I of the 2006 Act, inserted by section 10 of the 2012 Act.
(**f**) *See* in particular section 275(1) of the 2006 Act.

"provider" means a person who provides health care services for the purposes of the NHS(**a**), or is interested in doing so;

"relevant body" means a CCG or the Board.

(3) References to a "contract" in these Regulations include an NHS contract (which has the same meaning as in section 9 of the 2006 Act).

(4) These Regulations do not apply in respect of pharmaceutical services, including local pharmaceutical services, under Part 7 of the 2006 Act.

PART 2

Requirements as to procurement, patient choice and competition

Procurement: objective

2. When procuring health care services(**b**) for the purposes of the NHS (including taking a decision referred to in regulation 7(2)), a relevant body must act with a view to—

(a) securing the needs of the people who use the services,

(b) improving the quality of the services, and

(c) improving efficiency in the provision of the services,

including through the services being provided in an integrated way (including with other health care services, health-related services, or social care services).

Procurement: general requirements

3.—(1) When procuring health care services for the purposes of the NHS (including taking a decision referred to in regulation 7(2)), a relevant body must comply with paragraphs (2) to (4).

(2) The relevant body must—

(a) act in a transparent and proportionate way, and

(b) treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership.

(3) The relevant body must procure the services from one or more providers that—

(a) are most capable of delivering the objective referred to in regulation 2 in relation to the services, and

(b) provide best value for money in doing so.

(4) In acting with a view to improving quality and efficiency in the provision of the services the relevant body must consider appropriate means of making such improvements, including through—

(a) the services being provided in a more integrated way (including with other health care services, health-related services, or social care services),

(b) enabling providers to compete to provide the services, and

(c) allowing patients a choice of provider of the services.

(5) A relevant body must, in relation to each contract awarded by it for the provision of health care services for the purposes of the NHS, maintain a record of—

(**a**) *See* section 64(3) and (4) of the 2012 Act for the meaning of "health care services" and "the NHS".

(**b**) Section 75(2) of the 2012 Act provides that requirements imposed by these Regulations apply to an arrangement for the provision of goods and services only if the value of the consideration attributable to the services is greater than that attributable to the goods.

(a) in the case of a contract awarded by the Board, details of how in awarding the contract it complies with its duties under sections 13D, 13E and 13N of the 2006 Act(**a**) (duties as to effectiveness, efficiency etc, improvement in quality of services and promoting integration);

(b) in the case of a contract awarded by a CCG, details of how in awarding the contract it complies with its duties under sections 14Q, 14R and 14Z1 of that Act(**b**) (duties as to effectiveness, efficiency etc, improvement in quality of services and promoting integration).

Advertisements and expressions of interest

4.—(1) The Board must maintain and publish details of a website dedicated to—

(a) advertising by relevant bodies of opportunities for providers to provide health care services for the purposes of the NHS, and

(b) publication of records which must be published under regulation 9(1).

(2) Where advertising an intention to seek offers from providers in relation to a new contract for the provision of health care services for the purposes of the NHS, a relevant body must publish a contract notice on the website maintained by the Board under paragraph (1).

(3) A contract notice must include—

(a) a description of the services required to be provided, and

(b) the criteria against which any bids for the contract will be evaluated.

(4) A relevant body must secure that arrangements exist for enabling providers to express an interest in providing any health care service for the purposes of the NHS.

(5) In this regulation, "contract notice" means a notice inviting offers to provide the services to which the contract to be awarded is to apply.

Award of a new contract without a competition

5.—(1) A relevant body may award a new contract for the provision of health care services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider.

(2) For the purposes of paragraph (1), a relevant body is not to be treated as having awarded a new contract—

(a) where the rights and liabilities under a contract have been transferred to the relevant body from the Secretary of State, a Strategic Health Authority or a Primary Care Trust; or

(b) where there is a change in the terms and conditions of a contract as a result of—

(i) a change in the terms and conditions drafted by the Board under regulation 17 of the 2012 Regulations (terms and conditions to be drafted by the Board for inclusion in commissioning contracts), or

(ii) new terms and conditions drafted by the Board under that regulation.

Conflicts between interests in purchasing health care services and supplying such services

6.—(1) A relevant body must not award a contract for the provision of health care services for the purposes of the NHS where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract.

(**a**) Sections 13D, 13E and 13N are inserted into the 2006 Act by section 23(1) of the 2012 Act.
(**b**) Sections 14Q, 14R and 14Z1 are inserted into the 2006 Act by section 26 of the 2012 Act.

(2) In relation to each contract that it has entered into for the provision of health care services for the purposes of the NHS, a relevant body must maintain a record of how it managed any conflict that arose between the interests in commissioning the services and the interests involved in providing them.

(3) An interest referred to in paragraph (1) includes an interest of—

(a) a member of the relevant body,

(b) a member of its governing body,

(c) a member of its committees or sub-committees or committees or sub-committees of its governing body, or

(d) an employee.

Qualification of providers

7.—(1) For the purpose of taking a decision referred to in paragraph (2), a relevant body must establish and apply transparent, proportionate and non-discriminatory criteria.

(2) The decisions are—

(a) determining which providers qualify to be included on a list from which a patient is offered a choice of provider in respect of first outpatient appointment with a consultant or a member of a consultant's team,

(b) determining which providers qualify to be included on a list from which a patient is otherwise offered a choice of provider,

(c) determining which providers to enter into a framework agreement with, and

(d) selecting providers to bid for potential future contracts to provide health care services for the purposes of the NHS.

(3) When taking a decision referred to in paragraph (2)(a), a relevant body may not refuse to include a provider on a list where that provider meets the criteria established by the relevant body for the purposes of that decision.

(4) When taking a decision referred to in paragraph (2)(b), a relevant body may not refuse to include a provider on a list where that provider meets the criteria established by the relevant body for the purposes of that decision, except where to do so would mean exceeding a limit set by the relevant body on the number of providers to be included on the list.

(5) When taking a decision referred to in paragraph (2)(c), a relevant body may not refuse to enter into a framework agreement with a provider that meets the criteria established by the relevant body for the purposes of that decision, except where to do so would mean exceeding a limit set by the relevant body on the number of providers who are to enter into the framework agreement.

(6) When taking a decision referred to in paragraph (2)(d), a relevant body may not refuse to select a provider that meets the criteria established by the relevant body for the purposes of that decision, except where to do so would mean exceeding a limit set by the relevant body on the number of selected providers.

(7) In this regulation, a "framework agreement" means an agreement or other arrangement between one or more relevant bodies and one or more providers which establishes the terms under which the provider will enter into one or more contracts, for the provision of health care services for the purposes of the NHS, with a relevant body in the period during which the framework agreement applies.

(8) This regulation does not apply to the extent that any relevant criteria are laid down by or under any enactment.

Assistance or support for purchasing activities

8.—(1) This paragraph applies where a relevant body has arrangements for a person to assist or support the body in the exercise of its functions, in so far as those functions involve the commissioning of health care services for the purposes of the NHS.

(2) Where paragraph (1) applies, the relevant body must ensure that the person acts in accordance with the requirements in regulations 2, 3, 4(2) to (4), 5 to 7, 9 and 10, in so far as they apply in relation to an activity performed by that person.

Record of contracts awarded

9.—(1) A relevant body must maintain, and publish on the website maintained by the Board under regulation 4(1), a record of each contract it awards for the provision of health care services for the purposes of the NHS.

(2) Such a record must, in particular, include in relation to each contract awarded—

(a) the name of the provider and the address of its registered office or principal place of business,

(b) a description of the health care services to be provided,

(c) the total amount to be paid or, where the total amount is not known, the amounts payable to the provider under the contract,

(d) the dates between which the contract provides for the services to be provided, and

(e) a description of the process adopted for selecting the provider.

Anti-competitive behaviour

10.—(1) When commissioning health care services for the purposes of the NHS, a relevant body must not engage in anti-competitive behaviour(**a**), unless to do so is in the interests of people who use health care services for the purposes of the NHS which may include—

(a) by the services being provided in an integrated way (including with other health care services, health-related services, or social care services); or

(b) by co-operation between the persons who provide the services in order to improve the quality of the services.

(2) An arrangement for the provision of health care services for the purposes of the NHS must not include any term or condition restricting competition which is not necessary for the attainment of—

(a) intended outcomes which are beneficial for people who use such services; or

(b) the objective referred to in regulation 2.

Patient choice: primary medical services

11.—(1) The Board must not restrict the ability of an individual—

(a) to apply for inclusion in the list of patients of the practice of the individual's choice,

(b) to express a preference to receive services, from the practice in whose list of patients the individual is included, from a particular performer or class of performer either generally or in relation to any particular condition.

(2) Paragraph (1) does not apply to the inclusion in a contractor's contract of any term which provides for the contractor to refuse an application for inclusion in its list of patients, or not to agree to any preference expressed to receive services from a particular performer or class of performer, in accordance with—

(**a**) "Anti-competitive behaviour" is defined for the purposes of Part 3 of the 2012 Act in section 64(2) of that Act.

(a) Part 2 of Schedule 6 to the National Health Service (General Medical Services Contracts) Regulations 2004(**a**) (other contractual terms: patients),

(b) Part 2 of Schedule 5 to the National Health Service (Personal Medical Services Agreements) Regulations 2004(**b**) (other contractual terms: patients), or

(c) arrangements for the provision of primary medical services made under section 83(2) of the 2006 Act (primary medical services).

(3) In this regulation—

"contract" means, as the case may be—

(a) an arrangement for the provision of primary medical services made under section 83(2) of the 2006 Act, including any arrangements which are made in reliance on a combination of that provision and any other powers to arrange for the provision of health care services for the purposes of the NHS;

(b) a general medical services contract made under section 84(1) of the 2006 Act (general medical services contracts); or

(c) an agreement made in accordance with section 92 of the 2006 Act (arrangements by the Board for the provision of primary medical services);

"contractor" means a person who has entered into a contract with the Board;

"performer" means a medical practitioner included in a list prepared in accordance with regulations made under section 91(1) of the 2006 Act (persons performing primary medical services)(**c**); and

"practice" means the business operated by a contractor for the purposes of delivering primary medical services under Part 4 of the 2006 Act under a contract for the provision of such services.

Patient choice: choice of alternative provider

12. Where regulation 48 of the 2012 Regulations (duty to offer an alternative provider)(**d**) applies, a relevant body must offer a person a choice of alternative provider in accordance with regulation 48(4) of those Regulations.

PART 3

Investigations, declarations, directions and undertakings

Powers of Monitor to investigate

13.—(1) Monitor may investigate a complaint received by it that a relevant body has failed to comply with a requirement imposed by regulations 2 to 12, or by regulations 39(**e**), 42 or 43 of the 2012 Regulations (choice of health service provider)(**f**).

(2) Monitor may on its own initiative investigate whether a relevant body has failed to comply with a requirement imposed by regulation 10.

(**a**) S.I. 2004/291. Relevant amendments were made by S.I. 2007/3491 and 2012/970.
(**b**) S.I. 2004/627. Relevant amendments were made by S.I. 2007/3491 and 2012/970.
(**c**) *See* S.I. 2004/585, as amended by S.I. 2010/412.
(**d**) Regulation 48 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the 2012 Regulations") applies in the circumstances laid down in regulation 47 of, and is subject to regulation 49 of, the 2012 Regulations.
(**e**) Regulation 39 of the 2012 Regulations is subject to regulations 40 and 41 of the 2012 Regulations.
(**f**) Section 76(2) of the 2012 Act provides that Monitor may only investigate a complaint received by it where it is satisfied that the person making the complaint has sufficient interest in the arrangement to which the complaint relates.

(3) Monitor may not investigate a matter which is raised by a complaint under paragraph (1) where the person making the complaint has brought an action under the Public Contracts Regulations 2006(**a**) in relation to that matter.

(4) A relevant body must provide Monitor with such information in its possession as Monitor may specify for the purposes of an investigation carried out by virtue of paragraph (1) or (2).

(5) The power of Monitor under paragraph (4) includes—

(a) power to require the relevant body to provide an explanation of such information as it provides, and

(b) in relation to information kept by means of a computer, power to require the information in legible form.

Declaration of ineffectiveness

14.—(1) Monitor may declare that an arrangement for the provision of health care services for the purposes of the NHS is ineffective(**b**).

(2) Monitor may only make a declaration under paragraph (1) where it is satisfied that—

(a) in relation to that arrangement, a relevant body has failed to comply with a requirement imposed by regulation 2, 3(1) to (4), 4(2) and (3), 5 to 8 or 10(1), and

(b) the failure is sufficiently serious.

(3) Monitor may declare that a term or condition of an arrangement for the provision of health care services for the purposes of the NHS is ineffective where is it satisfied that—

(a) in relation to that term or condition, a relevant body has failed to comply with regulation 10(2), and

(b) the failure is sufficiently serious.

(4) On a declaration being made under paragraph (3), the term or condition is void; but that does not affect—

(a) the validity of anything done pursuant to the term or condition,

(b) any right acquired or liability incurred under the term or condition, or

(c) any proceedings or remedy in respect of such a right or liability.

Power to give directions

15.—(1) Monitor may direct a relevant body—

(a) to put in place measures for the purpose of preventing failures to comply with a requirement imposed by regulations 2 to 12, or by regulations 39, 42 or 43 of the 2012 Regulations;

(b) to put in place measures for the purpose of mitigating the effect of such failures;

(c) to vary or withdraw an invitation to tender for the provision of health care services for the purposes of the NHS to prevent or remedy a failure to comply with a requirement imposed by regulations 2 to 8 and 10;

(d) to vary an arrangement for the provision of health care services for the purposes of the NHS made in consequence of putting the provision of services out to tender to remedy a failure to comply with a requirement imposed by regulations 2 to 8;

(e) to vary an arrangement for the provision of health care services for the purposes of the NHS to remedy a failure to comply with regulation 10;

(**a**) S.I. 2006/5, as amended by S.I. 2007/3542, 2008/2256, 2008/2683, 2008/2848, 2009/1307, 2009/2992, 2010/976, 2011/1043, 2011/1848, 2011/2053, 2011/2581 and 2011/3058.

(**b**) Section 76(5) of the 2012 Act provides that where such a declaration is made the arrangement is void; but that does not affect: (a) the validity of anything done pursuant to the agreement, (b) any right acquired or liability incurred under the arrangement, or (c) any proceedings or remedy in respect of such a right or liability.

(f) to otherwise remedy a failure to comply with a requirement referred to in sub-paragraph (a).

(2) Monitor may not direct a relevant body under paragraph (1) to hold a competitive tender for a contract for the provision of health care services for the purposes of the NHS.

Undertakings

16. Monitor may accept an undertaking from a relevant body to take such action of a kind mentioned in regulation 15(1)(a) to (f)(**a**) as is specified in the undertaking within such period as is so specified.

Actions brought under the Public Contracts Regulations 2006

17. A person who has brought an action under the Public Contracts Regulations 2006 for loss or damage may not bring an action under section 76(7) of the Health and Social Care Act 2012(**b**) in respect of the whole or part of the same loss or damage.

Revocation of the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013

18. The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013(**c**) are revoked.

Signed by authority of the Secretary of State for Health.

Earl Howe
Parliamentary Under-Secretary of State,
Department of Health

6th March 2013

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations impose requirements on the National Health Service Commissioning Board ("the Board") and clinical commissioning groups ("CCGs") in order to ensure good practice in relation to the procurement of health care services for the purposes of the NHS, to ensure the protection of patients' rights to make choices regarding their NHS treatment and to prevent anti-competitive behaviour by commissioners with regard to such services.

Part 2 of the Regulations imposes requirements on the Board and CCGs (together referred to as "relevant bodies") in relation to procurement, patient choice and anti-competitive behaviour.

Regulation 2 lays down a general objective for relevant bodies when procuring health care services for the purposes of the NHS.

Regulation 3 lays down general requirements which are to apply to the procurement of health care services for the purposes of the NHS. This includes requirements for procurement to be carried out in a transparent and proportionate manner and for providers to be treated equally and in a non-discriminatory way.

(**a**) Section 77(3) to (5) and Schedule 9 of the 2012 Act make further provision in relation to any undertakings accepted by Monitor under these Regulations. In particular, Monitor may not continue with any investigation in relation to the matter in question, or make a declaration of ineffectiveness in relation to the arrangement in question.

(**b**) Section 76(7) of the 2012 Act provides that a failure to comply with a requirement imposed by regulations made under section 75 of that Act which causes loss or damage is actionable.

(**c**) S.I. 2013/257.

Regulations 4 and 5 provide for requirements relating to transparency in the award of contracts for the provision of health care services for the purposes of the NHS. Where a relevant body is advertising an intention to seek offers from providers to provide services it must publish a contract notice on a website to be maintained by the Board (regulation 4(1) and (2)). A relevant body need not advertise an intention to seek such offers where it is satisfied that the services are only capable of being provided by a particular provider (regulation 5).

Regulation 6 prohibits the award of a contract by a relevant body for the provision of NHS health care services where conflicts between the interests in commissioning the services and the interests in providing them affect, or appear to affect, the integrity of the award of the contract. Regulation 7 requires a relevant body to establish and apply transparent, proportionate and non-discriminatory criteria for the purposes of taking certain decisions in relation to the provision of health care services for the purposes of the NHS.

Regulation 9 requires relevant bodies to maintain and publish a record of all contracts entered into by them for the provision of health care services for the purposes of the NHS.

Regulation 10 lays down a general prohibition on anti-competitive behaviour by relevant bodies, except where it is in the interests of people who use NHS health care services.

Regulation 11 requires the Board not to restrict the ability of a person to apply for inclusion in the list of patients of a practice providing primary medical services, or to express a preference to receive such services from a particular medical practitioner or class of medical practitioner.

Regulation 12 places a requirement on relevant bodies to offer a choice of alternative provider in accordance with regulation 48(4) of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the 2012 Regulations"), in the circumstances laid down in regulation 47 of the 2012 Regulations.

Part 3 of the Regulations provides Monitor with powers to investigate and take enforcement action in relation to breaches of the requirements imposed on relevant bodies by these Regulations and regulations 39, 42 and 43 (choice of health service provider) of the 2012 Regulations. These include powers for Monitor to declare arrangements for the provision of health care services for the purposes of the NHS to be ineffective (regulation 14), to give directions to a relevant body (regulation 15), and to accept undertakings from a relevant body (regulation 16).

Regulation 17 provides that a person who has brought an action for loss or damages under the Public Contracts Regulations 2006 may not bring an action for the same loss or damage resulting from a breach of these Regulations or of regulation 39, 42 or 43 of the 2012 Regulations.

Regulation 18 revokes the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 (S.I. 2013/257), which are replaced by these Regulations.

An impact assessment of the effect these Regulations will have on the costs of the business and the voluntary sector is available from the Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS and at www.transparency.dh.gov.uk/category/transparency/ias/.

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STATUTORY INSTRUMENTS

2013 No. 500

NATIONAL HEALTH SERVICE, ENGLAND

PUBLIC PROCUREMENT, ENGLAND

The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

£5.75

E5986 03/2013 135986T 19585

Changes to the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013

Revised regulations - laid in Parliament on 11 March 2013 - put beyond doubt the Government's strong commitment that competition in the health service should always be used in the interests of patients.

The previous regulations went no further than the set of procurement guidelines issued in March 2010. However, concerns were raised about their precise wording. The Government has listened carefully to those concerns and have improved the drafting of the regulations so there can be no doubt about how they apply.

The changes to the regulations make clear that:

- The position remains the same as now - there is no requirement to put all contracts out to competitive tender. This means that commissioners are able to offer contracts to a single provider where only that provider is capable of providing the services.
- Monitor – the regulator - has no power to force the competitive tendering of services. Decisions about how and when to introduce competition to improve services are solely up to doctors and nurses in clinical commissioning groups.
- Competition should not trump integration - commissioners are free to use integration where it is in the interest of patients.

The changes to the regulations are as follows:

Regulation 2 states that the 'objective' of procurement is securing the needs of patients and improving quality and efficiency. We have made it clear that providing services in an integrated way is a way of achieving that objective.

Regulation 3(5) now requires commissioners to record how their awarding of a contract complies with the duties on them to secure integration.

In **Regulation 5**, we have removed the words that inadvertently created the impression that there were only very narrow circumstances in which commissioners could award a contract without a competition. Monitor's guidance on the regulations will make clear that we are continuing the same approach as now under the Principles and Rules for Cooperation and Competition.

Regulation 10 prohibits anti-competitive behaviour unless it is in the interests of patients. We have amended the regulation to make clear that 'behaviour in the interests of patients' may include services being provided in an integrated way or co-operation between providers in order to improve the quality of services. This reflects the Government's firm view that competition is a means to improving services and not an end in itself.

Regulation 10(2) has also been amended to make clear that its scope relates only to 'terms or conditions' that restrict competition. The purpose of this is to provide extra clarity on the policy intention and consistency of the wording with regulation 14. We have also amended regulation 10(2) to make clear that these questions of anti-competitive terms or conditions would not be considered in isolation from the objective of improving quality and efficiency, and securing the needs of patients.

Regulation 15 has been amended to clarify, for the avoidance of doubt, that Monitor does not have the power to direct a commissioner to hold a competitive tender.

EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (PROCUREMENT, PATIENT CHOICE AND COMPETITION) (No.2) REGULATIONS 2013

2013 No. 500

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 These Regulations impose requirements on the NHS Commissioning Board and clinical commissioning groups to ensure good practice when procuring health care services for the purposes of the NHS, to protect patients' rights to make choices and to prevent anti-competitive behaviour. The Regulations provide scope for complaints to, and enforcement by Monitor, an independent health regulator, as an alternative to challenging decisions in the courts.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None.

4. Legislative Context

4.1 The Regulations are made under section 75 of the Health and Social Care Act 2012 (the 2012 Act). They set certain requirements on commissioners of NHS health care services to be enforced by Monitor.

4.2 During the passage of the 2012 Act the Government responded to concerns about the future application of choice and competition in the health service by committing to retain the existing non-statutory administrative rules (The Principles and Rules for Cooperation and Competition), that concern procuring for clinical services, and place them on a firmer, statutory footing (see the Government response to the NHS Future Forum report, CM 8113)[1].

4.3 The Regulations, therefore, are being used as the vehicle to deliver the Government's commitment and continue sector specific rules, building on the Principles and Rules for Cooperation and Competition, in the new health system.

4.4 These Regulations will apply alongside the Public Contracts Regulations 2006 and do not affect their application.

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[1] Earl Howe also "committed to retaining [the Principles and Rules] and giving a firmer statutory underpinning through Monitor's sectoral powers" during the Lords Debate on the Health and Social Care Bill on 13 December 2011 (Hansard, Column 1188, to be found at http://www.publications.parliament.uk/pa/ld201011/ldhansrd/text/111213-0002.htm#11121377000740)

4.5 These Regulations will revoke and replace the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013.

5. Territorial Extent and Application

5.1 This instrument applies to England.

6. European Convention on Human Rights

As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

- **What is being done and why**

7.1 The 2012 Act makes changes to how NHS health care is commissioned in England. The 2012 Act establishes a new NHS Commissioning Board and clinical commissioning groups who will commission the majority of NHS health care in England and between them will be responsible for over £80 billion of annual public expenditure.

7.2 The Regulations build on the existing administrative rules, The Principles and Rules for Cooperation and Competition, first established by the Government in 2007 to protect patients' interests, and reviewed in 2010 to ensure they remain consistent with the White Paper: Equity and Excellence: Liberating the NHS[2]. The Regulations are necessary, however, because the administrative rules will not apply to the commissioners established under the 2012 Act who have greater autonomy within that legislative framework. The Secretary of State will no longer have extensive general powers to intervene in the NHS; these are replaced with specific and limited powers. The Regulations, therefore, provide for important safeguards to protect patients' interests.

7.3 Part 2 of the Regulations places requirements on these new bodies to improve the quality and efficiency of services, including through services being provided in an integrated way, by procuring from the providers most capable of meeting that objective and delivering best value for money. In doing so commissioners are required to always act transparently, proportionately, without discrimination and consider where more integration, patient choice and competition would be appropriate means to achieving their aims. The overarching intention is to ensure that patients have access to the highest quality services and that best value is achieved for the taxpayer. The Regulations are intended to cover all actions and decisions taken by commissioners in relation to the procurement of healthcare services.

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[2] The revised Principles and Rules for Cooperation and Competition, published by the Department of Health on 30 July 2010. The document can be accessed at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118221

7.4 The Regulations place further requirements on commissioners to ensure accountability and transparency in their expenditure. In particular:

- to record the rationale for their decisions and how they have met their duties as to quality, effectiveness and the promotion of integration;
- to publish details of the contracts that they have awarded;
- to not award contracts where conflicts or potential conflicts of interest have, or appear, to affect the integrity of the decision; and
- not to engage in anti-competitive behaviour unless to do so is in the interest of patients. Regulation 10 makes clear that behaviour in the interests of patients may include services being provided in an integrated way or co-operation between providers in order to improve the quality of services. This reflects the Government's firm view that competition is a means to improving services and not an end in itself.

7.5 Regulation 5 provides for commissioners to award a new contract without a competition where there is only one capable provider. There has been no change in policy from the requirements of the Principles and Rules for Cooperation and Competition and the supporting procurement guidance. Monitor's guidance on the regulations will make this clear.

7.6 The 2012 Act has established Monitor as an independent regulator for the health care sector with a duty to protect and promote the interests of people who use health care services. Part 3 of the Regulations provide for Monitor to investigate potential breaches of the requirements and to take action to ensure that patients' interests are protected. It provides for complaints to Monitor, a regulator with specific knowledge of the health sector, as an alternative to bringing actions through the courts for breaches of the Public Contract Regulations 2006 (in so far as they apply to health care services).

7.7 Part 2 of the Regulations also place a requirement on the NHS Commissioning Board not to restrict patients' rights of choice of GP practice, or the choice of practitioner within the practice. The Regulations also provide for Monitor to protect those rights and the other rights to choice that patients have under the NHS Constitution, including the right to exercise choice at referral to secondary elective care services as required under Part 8 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. There is evidence that these rights have been frustrated in the past[3] and therefore Monitor will seek to ensure that they continue to be protected.

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[3] "Review of the Operation of 'Any Willing Provider' for the provision of routine elective care" was published by the Cooperation and Competition Panel on 28 July 2011. The Report can be accessed at: http://www.ccpanel.org.uk/content/cases/Operation_of_any_willing_provider_for_the_provision_of_routine_elective_care_under_free_choice/280711_AWP_Review_Final_Report.pdf

7.8 The Regulations provide for Monitor to direct a commissioner to prevent or mitigate a failure to comply with the requirements, or remedy a failure to comply. Alternatively, Monitor has the power to accept an undertaking from a commissioner in lieu of a direction. The Regulations provide for Monitor to set aside a contract that a commissioner has entered into where there has been a sufficiently serious breach of the Regulations.

7.9 The Regulations do not give Monitor the power to direct where or when commissioners should introduce competition or patient choice of provider. In particular, the regulations provide that Monitor may not direct a commissioner to hold a competitive tender for a contract for the provision of health care services. Monitor's role is to investigate whether commissioners have respected due process, considered the full range of options and followed the requirements in the Regulations when procuring health care services.

8. Consultation outcome

8.1 Proposals setting out draft requirements were the subject of a formal consultation exercise which ran from 15 August to 26 October 2012. The Department worked closely with the NHS Commissioning Board and Monitor in developing the proposals. In addition to consulting with individuals working in the commissioning and provision of NHS services, over 80 responses to the consultation were received. Responses were received from a wide range of organisations including commissioners, providers, trade unions, professional and representative organisations.

8.2 Overall, stakeholders responded favourably with broad support for the approach being proposed, in particular:

- there was broad support for the proposed approach to use the regulations to set principles of good procurement rather than more prescriptive rules in order to retain flexibility for commissioners;
- almost all respondents agreed that the rights of patients to make choices as enshrined in the NHS Constitution should be protected;
- there was also broad support for the approach proposed whereby restrictions on competition would be balanced against patient benefits.

8.3 Of concern to many respondents was that there should be sufficient support and guidance published for commissioners to accompany the Regulations.

8.4 A full analysis of the responses to the consultation is available from the Department's website: www.dh.gov.uk

9. Guidance

9.1 Section 78 of the 2012 Act places a duty on Monitor to publish guidance for commissioners on compliance with the Regulations and how it intends to exercise its enforcement powers. Monitor must consult and must obtain the approval of the Secretary of State before the guidance is published.

The NHS Commissioning Board will also publish guidance in early 2013 to help clinical commissioning groups understand and work within the Regulations, including in relation to conflicts of interest. The NHS Commissioning Board and Monitor are working closely together so that their guidance is consistent and will bring the guidance together through a resource for the NHS called the Choice and Competition Framework.

10. Impact

10.1 The direct impact on business, charities or voluntary bodies is negligible.

10.2 The direct costs on the public sector is negligible. There could be indirect costs associated with commissioners' compliance with statutory regulations instead of non-statutory rules. This is difficult to estimate and could be negligible given the regulations are consistent with EU and UK procurement law with which commissioners are already required to comply.

10.3 An Impact Assessment is available from the Department of Health's website: http://transparency.dh.gov.uk/category/transparency/ias/

11. Regulating small business

11.1 The legislation does not apply to small businesses.

12. Monitoring & review

12.1 Monitor will monitor commissioners' compliance with the Regulations as part of its responsibilities under the Regulations. The Department of Health will keep Monitor's performance under review through quarterly financial and accountability stocktakes. The operation of the Regulations will be kept under review and updated as required. In addition, the Department of Health will be commissioning an independent evaluation programme of the impact of its policies on the NHS.

13. Contact

Matthew Henry, Sector Regulation Unit at the Department of Health.
Telephone: 0207 210 5268, or email matthew.henry@dh.gsi.gov.uk

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON SAFEGAURDING ADULTS BOARD		
DATE OF DECISION:		21 March 2013		
REPORT OF:		HEAD OF COMMUNITIES, CHANGE AND PARTNERSHIPS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Caronwen Rees**	**Tel:**	**023 80832524**
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Director	**Name:**	**John Tunney**	**Tel:**	**023 80917713**
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STATEMENT OF CONFIDENTIALITY

None.

BRIEF SUMMARY

This paper provides an introduction to the Southampton Safeguarding Adults Board.

RECOMMENDATIONS:

(I) To note the contents of the paper at appendix 1 and receive an update on the Southampton Adults Safeguarding Board.

REASONS FOR REPORT RECOMMENDATIONS

1. To provide background information to enable member to scrutinise the SSAB Annual Report at a later date.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. At the HOSP meeting on 29 November 2013 the Panel agreed that in future the SSAB annual report would be presented to the panel for discussion. This agenda item is intended to provide an introduction to the Southampton Safeguarding Adults Board and their plans for the future to enable the Panel to scrutinise the annual report in the future.

4. Southampton Safeguarding Adults Board (SSAB) provides the key mechanism for agreeing how relevant local organisations cooperate to safeguard and promote the welfare of adults at risk. SSAB's principal mission is to prevent, identify and respond effectively to any abuse and neglect affecting adults at risk. The coalition government published its Statement of Government Policy on Adult Safeguarding in 2011, outlining its intention to place Safeguarding Adult Boards on a new statutory footing. This was one of the recommendations from the Law Commission.

5. The SSAB has recently appointed independent Chair, Carol Tozer. The report at appendix 1 is the inaugural report from the Independent Chair's results from her induction meetings with several SSAB members. The report sets out a series of actions designed to help the Board fully maximise its effectiveness and impact in safeguarding adults at risk in Southampton. The suggested actions are based on SSAB Board members' shared observations about the SSAB's current ways of working and frequently mentioned priorities for the Board.

6. Carol Tozer and Carol Valentine, Head of Personalisation and Safeguarding, will attend the panel meeting to present the background to the SSAB an update on progress to date.

RESOURCE IMPLICATIONS

Capital/Revenue

7. None.

Property/Other

8. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

9. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

10. None.

POLICY FRAMEWORK IMPLICATIONS

11. None

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1. **Independent Chair's Report**

Documents In Members' Rooms

1. None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents
Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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Subject:	**Independent Chair's Report**		
Links to other relevant document:		**Executive Summary** **This inaugural report from the Independent Chairs results from her induction meetings with several SSAB members. The report sets out a series of actions designed to help the Board fully maximise its effectiveness and impact in safeguarding adults at risk in Southampton. The suggested actions are based on SSAB Board members' shared observations about the SSAB's current ways of working and frequently mentioned priorities for the Board**.	
Date:	1 November 2012	**Author:**	Dr C L Tozer
Action:	Agreement of SSAB to implement the incoming Independent Chair's proposals set out in detail in section 2 pertaining to: • real life agenda item • annual joint meeting with Southampton Local Safeguarding Children Board • annual SSAB development day • annual case file audit of practice • annual SSAB conference • development and implementation of inter agency performance scorecard • engagement in peer review process • biannual report by Independent Chair to Southampton Health and Wellbeing Board and Overview and Scrutiny Committee • proactive communication strategy • review of SSAB budget.		

1. Introduction

1.1 Southampton Safeguarding Adults Board (SSAB) provides the key mechanism for agreeing how relevant local organisations cooperate to safeguard and promote the welfare of adults at risk. SSAB's principal mission is to prevent, identify and respond effectively to any abuse and neglect affecting adults at risk. To do this well, partners must ensure that local policies, procedures and practice are robust and enacted to consistently high standards, hold each other to account, ensure that safeguarding adults remains high on the agenda across the partnership area, monitor performance and promote

improvements where necessary and engage proactively with adults at risk, carers and frontline professionals. A learning culture, therefore, must underpin all of the SSAB's work

1.2 As the incoming Independent Chair, I have spent several days meeting SSAB members, agency senior executives and elected members in order to gain an understanding of the Board's existing strengths and areas to improve. Additionally, I have attended safeguarding training in order to acquaint myself better with local policies and procedures and to meet frontline staff engaged in safeguarding adults at risk across different agencies. This paper results from these activities and reflects people's views in my proposals that the SSAB is asked to agree or refine in order to further strengthen its profile, performance and impact. These

2. Key Points

2.1 Real Life Agenda Item

2.1.1 Several SSAB members have informed me that a development priority is to ensure that the Board is fully grounded in the quality of, and issues revealed by, frontline professional practice in safeguarding adults at risk. In response, I propose that the first agenda item of every SSAB comprises the "Real Life" agenda item. Appendix 1 provides the draft template that each agency will distribute amongst its staff and managers in order to ensure the selection of suitable cases and guidance to staff in how to prepare for their presentation to the SSAB.

2.1.2 The Real Life agenda item will be limited to 20 minutes and will comprise a multiagency presentation by frontline colleagues/managers from across the relevant agencies working with the adult concerned. A single agency will be responsible for co-ordinating the presentation – but in doing so they will liaise with the other agencies supporting the adult and ensure that the presentation provides a comprehensive overview of: how safeguarding issues were prevented or identified; the issues facing the adult at risk; the response given by the different agencies; what has worked well professionally (including partnership working); and what has worked less well (including partnership working). Of key importance to the Board, the presentation will conclude with practitioners'/managers' assessment of any key issues they need help from the Board in resolving. The Board will then be charged with responsibility to provide a prompt response to these issues.

2.1.3 In terms of which agencies should be responsible for co-ordinating the Real Life agenda item, I propose that these are: adult social care; health; police; housing; the voluntary and community sector; and the independent sector. Discussion is needed as to whether the health community should be asked to provide separate presentations as led by the CCG, the hospital and Solent Healthcare.

2.1.4 Introduced from the first SSAB meeting in 2013, I propose that the first Real Life agenda item is led by adult social care. Thereafter, the identity of the agency co-ordinating the next Real Life agenda item can be decided at each SSAB at the conclusion of the Real Life agenda item.

Recommendations:

i. **To commence the Real Life agenda throughout all SSAB meetings in 2013.**
ii. **To approve the Real Life Agency Template at Appendix 1 and for all SSAB members to take responsibility for explanation and distribution throughout their agency.**
iii. **That adult social care co-ordinate the first Real Life agenda item at the next SSAB**

2.2 **Annual Joint Meeting with Southampton Local Safeguarding Children Board (SLSCB)**

2.2.1 Safeguarding adults at risk is not a mirror image of safeguarding children. There are key differentiating factors such as the fact that only adults at risk (as defined in guidance) are subject to adult safeguarding arrangements – whereas children's safeguarding covers all those children aged under 18. Moreover, unless they "lack capacity", adults at risk have the right to take decisions/adopt lifestyles despite any safeguarding implications – children are assumed to always "lack capacity" in this regard. Finally, adult safeguarding plans often focus on the management of safeguarding risks because the adult concerned is prepared to live with these risks – whereas in children's safeguarding the imperative is to ensure that the child is safe at all times.
2.2.2 Differences notwithstanding, there are well established links and several similarities between child and adult safeguarding. Many serious case reviews have revealed that children who have experienced significant harm have parents or carers who are adults at risk – that is to say, parents/carers with substance misuse problems, mental health problems, experience domestic abuse or who have learning disabilities. The mechanics of adult and children safeguarding policies, procedures and practices are predicated on partnership arrangements and, as with LSCBs, Safeguarding Adults Board are about to be placed on a statutory footing – with the accompanying duty to co-operate placed on all agencies who work with adults at risk. The SSAB, like the SLSCB for children, must ensure that staff across all agencies who work with adults at risk are trained to prevent, identify and respond to safeguarding needs. The SSAB, like the SLSCB on behalf of children, must ensure that there is a good awareness among the wider public in preventing, identifying and responding to the safeguarding needs of adults at risk. When an adult at risk experiences significant harm, the SSAB must commission, learn from and respond to Serious Case Reviews – in exactly the same ways as the SLSCB where a child experiences significant harm. Equally, the SSAB, like the SLSCB, must monitor safeguarding performance across all agencies – supporting and challenging all agencies to achieve the highest professional standards and good safeguarding outcomes. Finally here, several SSAB members have reminded me that they are also SLSCB members – and that they would like the Independent Chairs to develop joint working in order to improve efficiency and systematically share best practice across the Boards.
2.2.3 An annual joint meeting between the SSAB and SLSCB could usefully focus on issues of mutual concern and interest to both Boards such as: how to engage with the public and the media in promoting wider awareness of safeguarding children and adults at risk; the delivery of effective governance through safeguarding boards; how to embed safeguarding in commissioning practice; relating to the Health and Wellbeing Board and working with Overview and Scrutiny; and monitoring progress in implementing the action plans of serious case reviews where children and adult services are both involved.

Recommendations

iv. **To invite the SLSCB to convene an annual meeting with the SSAB**

v. **The agenda for the meeting to be agreed by the SSAB and SLSCB Independent Chairs and arranged by the Safeguarding Board managers**

2.3 Annual SSAB Development Day

2.3.1 It is widely accepted that SABs have 3 primary roles: to establish safeguarding policies and procedures; to make significant and strategic decisions in the delivery of safeguarding arrangements by all agencies working with adults at risk; and to evaluate the effectiveness of safeguarding activity. If a SAB is to execute its roles well, it must aspire to, and be characterised by, effective governance. After all, it is governance that determines the Board's focus, behaviours and structures.

2.3.2 Several SSAB members have informed me that they want the SSAB to measure its effectiveness against best practice from elsewhere, build in routine and regular reviews of how well the Board is working, agree practical steps for ongoing improvement and provide an assured and timely response to external forces (such as financial austerity and national guidance). Board members have also stressed that participation in sector led improvement activities (such as the peer review process currently endorsed by the LGA and ADASS) as equally important in helping the SSAB to constantly update and improve its work.

2.3.3 An annual SSAB development day, therefore, will allow the SSAB to be efficient and effective in its work to safeguard adults at risk.

Recommendations

vi. **That all SSAB members participate in an annual development day – in June 2013 and annually thereafter.**

vii. **To agree the agenda at the SSAB meeting immediately prior to the Development Day**

2.4 Annual case file audit of practice

2.4.1 The SSAB exists to ensure that adults at risk are safe in their own homes and communities, safe from abusive relationships and safe from neglectful or abusive care and support. And no matter how comprehensive adult safeguarding policies and procedures are, it is the quality of practice that determines safeguarding outcomes for adults at risk. Accordingly, the SSAB must be vigilant – if not obsessed – about the quality and consistency of practice. Individual agencies are directly responsible for the quality of practice as enacted by their staff – and must ensure that their staff work appropriately and assuredly in partnership with other agencies who have safeguarding responsibilities towards adults at risk. Accordingly, the SSAB must receive reports from individual agencies detailing the results of internal quality assurance exercises – and these reports should also be reported to agencies' leadership teams, Boards and, in the case of local authorities, Elected Members.

2.4.2 But I believe that the SSAB must be more proactive in examining the quality and impact of professional practice – it is not good enough that the SSAB simply receives quality assurance reports from agencies. Rather, the SSAB should role model the behaviour it expects of all its members agencies. For this reason, I propose that the SSAB undertakes an annual audit of practice.

2.4.3 The annual audit should be undertaken by SSAB members, working as pairs, and comprise a randomly selected sample of cases where adult safeguarding concerns have been raised in the previous 12 months. The detailed audit methodology and audit tool will be developed over the next three months and brought to the first SSAB meeting in January 2013 for approval. This will necessitate the SSAB establishing a task and finish group who will work to the following guidelines: the audit should encompass practice across all of the relevant agencies; confidentiality must be maintained; the audit should take place over one working day; the results of the audit will be written up by the task and finish group and reported to the SSAB, the Health and Wellbeing Board, Overview and Scrutiny Committee (and made available to any peer review or inspection); and an action plan will be developed in response to the findings. of

Recommendations

viii. To agree to undertake a SSAB annual audit of practice

ix. To identify SSAB members who will comprise the task and finish group designing the annual audit day and methodology

x. **To receive a report from the task and finish group at the first SSAB meeting in 2013 detailing the proposed methodology and date of the annual audit.**

2.5 Annual SSAB Conference

2.5.1 A key function of the SSAB is to raise awareness of the safeguarding needs of adults at risk in Southampton and to explain how agencies are responding to those needs. The SSAB needs to have a high public profile and have the full confidence of adults at risk and their families, agencies who work with adults at risk staff, members of the public and the media. The work of the SAB is already made public through such mechanisms as its annual report, the results of peer review and any inspections – and this will continue. Several SSAB members, however, expressed the view that the SSAB could further heighten its profile – and in doing so engage more directly with adults at risk, carers, frontline staff and those people charged with corporate governance duties and responsibilities (e.g., Non Executive Directors, Trustees or Elected Members).
2.5.2 An annual SSAB conference would provide a useful vehicle by which to heighten the profile of the work of the SSAB, raise awareness about the safeguarding needs of adults at risk in Southampton and provide assurance and insight into how well agencies are responding to those needs. An annual conference could also usefully focus on a contemporary national or local issue of importance (e.g., the implications of the Winterbourne View Hospital scandal) and be used as a wider learning opportunity across agencies and members of the public.
2.5.3 An annual conference could also be timed to coincide with a major national event designed to better safeguard adults at risk (e.g., action against elder abuse week) and be related to SSAB efforts to engage the local media (see below).

Recommendations

xi. To implement a SSAB annual conference – inviting speakers of national reputation and local senior leaders in addressing the safeguarding needs of adults at risk in Southampton

xii. To agree to share the costs of the annual conference across the City Council the NHS and the Police.

xiii. **To request that the safeguarding learning and development leads within the City Council, NHS and Police work together and bring a proposal for an annual conference in September 2013 to the spring meeting of the SSAB**

2.6 Development and implementation of inter agency performance scorecard

2.6.1 The effective scrutiny of the quality of professional practice and delivery of successful safeguarding outcomes – as described by relevant performance information – is a key function of the SSAB. A key observation made by the majority of SSAB members I have spoken is that the Board needs to further develop its performance management function. In particular, SSAB members have pointed out that the Board's review of performance is generally isolated to process and output measures of the City Council's safeguarding team – and that the examination of safeguarding outcomes is generally conspicuous by its absence.
2.6.2 The Board has recently prompted the implementation of improved performance monitoring arrangements such as tracking safeguarding alerts and referrals by provider (as well as by individual) – thereby enabling better identification of those services where there are unusually high levels of safeguarding alerts.
2.6.3 Such improvements notwithstanding, an inter agency performance scorecard needs to be developed and implemented. After all, all agencies working with adults at risk will have a duty to co-operate with the SSAB and the Board needs to have better performance information across all agencies in order to perform its performance management role.
2.6.4 I have asked the SSAB members I have met whether they would be prepared to identify three or four key performance indicators that they can or will use to assure themselves about the quality and impact of safeguarding within their organisations on a quarterly basis. Members has assured me that they would welcome bringing these data to the SSAB, together with an initial explanation of why they have been selected. The safeguarding office will combine these data into a single, interagency performance report. At each SSAB meeting the relevant agency lead will present their agency's performance data.

Recommendations

xiv That each SSAB agency, by January 2013, identify a maximum of 4 key performance indicators detailing the quality of safeguarding practice and safeguarding outcomes that it will present to each SSAB meeting.

xv. **That the SSAB receives a performance report that includes all additional PIs from its second meeting in 2013.**

2.7 SSAB Engagement in peer review process

2.7.1 Sector led reform is proving to be a powerful mechanism in improving outcomes for adults at risk, placing responsibility for that improvement on peer support and challenge. Regionally, the peer review process of adult safeguarding arrangements has already commenced with feedback being that it has been very helpful to SABs and individual agencies in identifying areas of strengths and areas for improvement. The peer review methodology has been formally agreed by the LGA, ADASS, SOLACE and other agencies.
2.7.2 The peer review methodology sets out that the SAB participates fully in the peer review process, receives the peer review report and develops and implements an action plan in response to any recommendations.

2.7.3 SSAB members I have spoken to welcome the prospect of a peer review but want to ensure that the timing is such that the Board can adequately evidence the progress and impact it has made in improving safeguarding systems and practice. In particular, members have stressed to me that there is a lot of activity currently underway in response to the Mr A Serious Case Review.
2.7.4 Accordingly, I propose that the SSAB asks the Director of Adult Social Care to liaise with her regional colleagues in requesting a peer review of Southampton's safeguarding adults arrangements in May 2013. This will allow the results of the review to systematically inform the SSAB development day as described above.

Recommendations:

- xvi. **The Director of Adult Social Care liaises with regional colleagues to secure a peer review of Southampton's safeguarding adults arrangements as near as possible to May 2013.**
- xvii. **That SSAB members and agencies participate fully in the peer review process and work together to implement any recommendations arising from the peer review**

2.8 Annual report by Independent Chair to the Southampton Health and Wellbeing Board and the Southampton Health Overview and Scrutiny Committee

2.8.1 The Southampton Health and Wellbeing Board provides the focal point for all commissioning decisions being taken across health and social care. It has a duty to improve the wellbeing of local people and this specifically includes the safeguarding needs of adults at risk. Equally, elected members have a duty to scrutinise the decisions, actions and impacts of all NHS organisations serving the people of Southampton – and this also includes NHS safeguarding arrangements.
2.8.2 The role of the SSAB Independent Chair is to support and challenge the safeguarding arrangements of all agencies working with adults at risk – and to do so from an informed and independent perspective so that the focus of the work of SSAB is fixed squarely on the needs and interests of adult at risk and their loved ones, not organisational interests.
2.8.3 Elected members I have met since my appointment have suggested that the Health and Wellbeing Board and Overview and Scrutiny Committee would welcome a formal annual report from the Independent Chair setting out the strengths and areas for improvement around safeguarding arrangements in Southampton, the activity and impact of the SSAB and the performance of agencies working to safeguard adults at risk. Elected members explained that they would be asking officers for similar information – but wanted independent advice on these matters from the SSAB Independent Chair.

Recommendations

- xviii. **The Independent Chair provides a report to the Southampton Health and Wellbeing Board and Southampton Overview and Scrutiny Committee in June 2013 and annually thereafter.**

2.9 Proactive SSAB communication strategy

2.9.1 The SSAB has a key responsibility to raise public awareness in identifying and responding to any abuse or neglect experienced by adults at risk – and systematically promote and be seem to help lead safer communities initiatives such as reducing hate

crime. In order to fulfill this responsibility, the SSAB requires a proactive communications strategy.
2.9.2 First, the SSAB needs to engage positively and confidently with the media. We can be sure that the media will be assertive in contacting the SSAB in certain circumstances – e.g., when commissioning, receiving or responding to a Serious Case Review or poor safeguarding inspection. Media relations in such circumstances can be challenging and the SSAB needs to ensure that its key messages to reassure the public are delivered clearly and that the understandable media preoccupation with accountability is balanced with statements from the SSAB that focus on how the lessons learned are being applied and improvements being monitored. Equally, however, the SSAB needs to engage the media in promoting its work to the people of Southampton.
2.9.3 Second, the SSAB needs to ensure that there are good adult safeguarding promotional materials used by all agencies and posted in the right community outlets in order to help people identify and respond to any abuse or neglect experienced by adults at risk. Many SSABs have used adults at risk and their carers to help design these materials.
2.9.4 Third, in helping to explain to the wider public the importance of adult safeguarding work, the SSAB could think about orchestrating a series of interviews with frontline colleagues and managers working with adults at risk, the safeguarding team, and SSAB members. The idea would be to have a series of articles published/interviews transmitted over a predetermined period (e.g., to coincide with national action against elder abuse week) – establishing the shared commitment and responsibility across all SSAB agencies to safeguard adults at risk as well as the considerable efforts invested in ensuring that safeguarding practice is consistently high quality.

Recommendations

- **xiv. To request that the City Council, NHS and Police press/communications officers work together to develop a SSAB communications strategy. This could include consideration of the suggestions above as well as any other ideas arising from their expert knowledge.**
- **xv. To present the proposed strategy to the next SSAB meeting for consideration and approval.**

2.10 Review of SSAB Budget

2.10.1 All SSAB members I have spoken to have stressed the high priority placed on safeguarding adults well within their individual agencies. An organisational priority is inevitably accompanied by a clear identification of the resources necessary to fulfil that priority – because without such resource allocation (whether cash or kind) a priority is not realised.
2.10.2 If the SSAB is to achieve all of the suggestions set out above, resources (again, cash and/or kind) must be identified in order to take the work forward.
2.10.3 Currently, with the exception of the costs of the Board's Independent Chair (one day a month at £425 per day) which are shared, I have been informed that the City Council bears the full costs of safeguarding adult training, the costs of independent authorship and co-ordination of serious case reviews and all activities associated with the Board. My meetings with senior officers in the Council have revealed that this is a situation they wish to review.
2.10.4 The Council acknowledges its lead agency status for adult safeguarding and fully expects to continue to bear the majority of costs associated with the SSAB.
2.10.5 With the forthcoming statutory status of the Board and other agencies' duty to co-operate with local safeguarding adults arrangements, I propose that this is the right time to

undertake a review of the SSAB's expenditure plans, especially as all agencies are now developing their detailed proposals for 2013/14.

2.10.6 National guidance already exists for the multiagency funding of local safeguarding children board arrangements and associated activities. This guidance might provide a useful starting point to a review.

Recommendations

- **xvi. To request that senior officers from the City Council, the CCG, the Police and the Fire and Rescue Service establish a SSAB budget working group – working with the safeguarding manager to establish proposals for the SSAB 2013/14 budget**
- **xvii. To bring the budget proposals to the next meeting of the SSAB. .**

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY COMMITTEE		
SUBJECT:		PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL - RECOMMENDATIONS		
DATE OF DECISION:		21 March 2013		
REPORT OF:		HEAD OF COMMUNITIES, CHANGE AND PARTNERSHIPS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Caronwen Rees**	**Tel:**	**023 80832524**
	E-mail:	**Caronwen.rees@southampton.gov.uk**		
Director	**Name:**	**John Tunney**	**Tel:**	**023 80917713**
	E-mail:	**John.Tunney@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

This seeks the Panel's agreement of the draft recommendations from the review of Public and Sustainable Transport Provision to Southampton General Hospital.

RECOMMENDATIONS:

(I) The panel consider discuss, amend and agree the draft recommendations in relation to the review of Public and Sustainable Transport Provision to Southampton General Hospital attached at Appendix 1.

(ii) That, to enable the comments made by Scrutiny Panel members at the meeting to be incorporated into the final report, authority be delegated to the Head of Corporate Policy and Performance to amend the final report, following consultation with the Chair of HOSP.

(iii) That the Chair of HOSP presents the final report to the Overview and Scrutiny Management Committee on 16 May.

REASONS FOR REPORT RECOMMENDATIONS

1. The Panel agreed to undertake a review into public and sustainable transport provision to Southampton general hospital.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. At their meeting on 29 November the panel agreed to undertake a short review into public and sustainable transport provision to Southampton general hospital. The issue was also discuss on 31 January 2013 and the Panel held an additional meeting on 28 February to gather evidence from partners and stakeholders.

4. Following the meeting on 28 draft recommendations have been developed incorporating written feedback received from Panel members. These are attached as Appendix 1.

5. Members are asked to consider and comment on the draft recommendations. Given that this is the last meeting of the Panel in 2012/13 members are also asked to delegate authority to amend and finalised the report of the review of Public and Sustainable Transport Provision to Southampton General Hospital Head of Communities, Change and Partnerships in consultation with the Chair of HOSP. members electronically for comments before being presented to the OSMC on 16th May. The final report will be circulated to all relevant partners and presented to Cabinet for consideration.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None.

Property/Other

7. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

9. None.

POLICY FRAMEWORK IMPLICATIONS

10. None

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	Draft recommendations.

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL – DRAFT RECOMMENDATIONS

The Panel recommend:

Informing and listening to Customers

1. Further work has to be undertaken to ensure that staff, visitors and patients are aware of the public transport routes to and from the general hospital.
    a. UHS to review, improve and evidence the information provided to staff, visitors and patients in relation to travel to the hospital – including in patient appointment letters and the website;
    b. SCC to develop leaflets to publicise transport options to the general hospital from various parts of the city for distribution at relevant places included the hospital and GP surgeries and the information provided on the my journey website.
2. A customer group be established for public transport in Southampton including providers (buses and trains) transport users and councillor representation. The group should meet at least twice a year with scope for extra meeting if required and minutes available publically.
3. UHS ensure there is early engagement, allowing time to consult with the customer group mentioned in recommendation 2 where possible, with public transport providers over services changes that are likely to affect staff and patient travel – including the proposed extension of working hours at the hospital.
4. Bus drivers to be encouraged to share information with passengers – for example that it is quicker to wait and get the next bus, as a matter of course, particularly for vulnerable and elderly passengers and for this to be included in mandatory training.

Improving Physical Infrastructure

5. SCC to work with bus companies, network rail and red funnel to improve signposting to public transport, including to the general hospital, linking into legible city work.
6. SCC and UHS to work together to improve signposting to bus stops and cycle routes in and around the hospital including consideration of the potential route through the cemetery.
7. Consideration is given to the development of a bus hub within the general hospital site and how SCC may be able to work with the hospital to facilitate this.
8. SCC to improve bus stops around the general hospital site to ensure time tables and real-time information are available.
9. SCC to review lighting on Tremona Rd and Dale Rd Junction around bus stops.
10. Bus departure boards in hospital to be updated and sign posted.
11. All bus companies to implement accurate real time information systems.

Further research

12. SCC, UHSFT, Southampton University, S-LINk and Bus Companies to work together to explore options for undertaking a survey to establish how patients and visitors travel to and from the general hospital and the results used are to inform future service planning and reliability.
13. HOSP to consider the Patient Transport Service and other dedicated modes of patient transport in more detail at a future meeting/s in order to better understand how the services are managed, publicised to patients and concerns with the current service. Commissioners and Providers, including the voluntary sector, of the service to be invited.
14. SCC to review to the effects of the bus subsidy cuts on transport to the general hospital in 6 months and report to HOSP.

Other

15. UHS to be asked to consider reviewing the zones used in relation to parking permits to consider areas where there is a direct bus route which falls outside of the inner zone but provides transport to the hospital within 30 minutes. This may help improve sustainability of bus services and encourage sustainable transport use.
16. Bus companies are encouraged to work together to develop a cross company bus ticket for use within Southampton to enable easier travel from the City to the hospital and then university and vice versa. This should be priced competitively with existing day ticket – e.g. first day ticket rather than the Solent travel card with covers a great area and is therefore more expensive. Consideration to also be given to how they can work better with train providers on this issue.
17. UHS to share their forthcoming travel plan with the HOSP and ensure that the plan details clear lines of accountability for actions and is refreshed yearly and fully updated every three years. SCC officers to support UHS to complete the implementation of the travel plan. UHS should ensure they share and learn from best practice on travel planning including with Southampton University.
18. Chair of HOSP to write to all partners with recommendations, seeking a response on what they accept and detailing an additional resources they are willing to provide.

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY COMMITTEE			
SUBJECT:	HEALTH SCRUTINY 2012/13 – REVIEW			
DATE OF DECISION:	21 March 2013			
REPORT OF:	HEAD OF COMMUNITIES, CHANGE AND PARTNERSHIPS			
CONTACT DETAILS				
AUTHOR:	**Name:**	**Caronwen Rees**	**Tel:**	**023 80832524**
	E-mail:	**Caronwen.Rees@southampton.gov.uk**		
Director	**Name:**	**John Tunney**	**Tel:**	**023 80917713**
	E-mail:	**John.Tunney@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

None.

BRIEF SUMMARY

The Overview and Scrutiny Management Committee is required to submit a report summarising scrutiny activities over the past twelve months to Full Council each year. This paper seeks agreement of the Panel for the HOSP contribution to the annual report and updates member on proposals of health scrutiny in 2013/14.

RECOMMENDATIONS:

(I) The Panel agrees the content for the HOSP contribution to the Scrutiny Annual Report due to be presented to OSMC on 11 April and Full Council on 15 May.

(ii) The Panel note the proposed changes to Health Scrutiny for 2013/14.

REASONS FOR REPORT RECOMMENDATIONS

1. The Annual Report is submitted for information in line with the requirements of the constitution.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. The Council's overview and scrutiny procedure rules require an annual report to be made to the Council on the overview and scrutiny function. It aims to provide a succinct summary of the main scrutiny activities and inquiries undertaken during the course of the year including Health Scrutiny. Members are asked to agree the following highlights of Health Scrutiny undertaken during 2012/13 are included in the Report.

4. **Responding to Government Consultations**

The Panel scrutinised several of the changes proposed nationally including:

- **Health Scrutiny:** The Panel responded to the Department of Health's consultation on proposals for local authority health scrutiny. Amongst their points the Panel raised concerns about the need for health scrutiny to remain non political and the role of the National Commissioning Board in relation to health scrutiny.
- **Draft Care and Support Bill: T**he Panel scrutinised and responded to the draft Care and Support Bill highlighting that uncertainty over the future funding arrangements weakens and undermines the true effectiveness of those good ideas which are contained in the draft Bill.

The Panel also scrutinised the local implementation of the Health and Social Care Act 2012 including progress with Healthwatch, the Health and Well-Being Board and new Commissioning Structures.

5. **Vascular Services Review**

The Panel continued to work closely with Southampton LINk to scrutinise changes to vascular services in the South Central region. There has regular engagement with both providers and commissioners and Panel members have attended external events including a meeting organised by the SHIP Cluster, which included national experts, and a Health Scrutiny meeting in Portsmouth. The Panel are continuing to scrutinise this issue and are very pleased that progress is being made towards the implementation of a sustainable solution.

6. **Joint Health and Wellbeing Strategy**

The Health Overview and Scrutiny Panel considered the draft strategy at a workshop session and fed back a number of detailed comments in response to the draft strategy document. These included making the strategy more focused with a smaller number of actions being required where impact and improvements could be measured and compared with other local authorities; improving the quality of the information cited from the and adopting innovative. The Panel were pleased to note that most of their recommendations had been adopted in the final version of the strategy.

7. **Health Service Pressures**

Budget pressures and increasing patient numbers have resulted in strain on local health services. The Panel continue to work closely with providers and commissioners to ensure local services are provided safely. The panel jointly scrutinised all local providers and commissioners in relation to the Emergency Care Intensive Support Team report on the South West Hants Unscheduled Care System and will continue to work with them to ensure all recommendations are implemented.

Recognising the links between the issues, the Panel also scrutinised the University Hospital NHS Foundation Trust over their recent Care Quality Commission inspection report at the same meeting. The Panel have asked for updates on progress against the implementation of the resulting action plan.

8. **Public And Sustainable Transport Provision To Southampton General**

Hospital Review

At the request of the Cabinet Member for Environment and Transport the panel agreed to undertake a short review into public and sustainable transport provision to Southampton general hospital. As part of the review evidence was gathered from several partners and stakeholders including University Hospitals Southampton NHS Foundation Trust, bus service providers, staff and patient representatives and Council transport officers.

The Panel provided early feedback to the Council's 2013/14 budget consultation. They have since made several recommendations, many of which can be quickly implemented to improve services for public transport users and look forward to hearing the response to thses from partners in due course.

9. **Health Scrutiny in 2013/14**

The local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations) 2013 amend the current health scrutiny legislation to confer the power to undertake health scrutiny on the Council rather than directly to a Health Scrutiny Committee. As a result in order for health scrutiny to continue to be carried out by the existing Health Overview and Scrutiny Panel (HOSP) the Council are required to delegate responsibility to OSMC and subsequently the Panel. A recommendation on this is due to be made to full council on 20th March 2013.

The legislation as drafted and existing guidance is not clear as to whether the power to refer to the Secretary of State can also be delegated to the HOSP or remains a function of the Council. Further guidance is expected before the end of March and the position will be clarified at Annual Council.

The Chair of the Panel is currently in discussion with the Chair of OSMC in relation to any further changes required next year for example in relation to clarity of responsibilities relating to social care, the autonomy of HOSP to undertake reviews and the need to formalise the relationship between the HOSP, the Health and Wellbeing Board, and Healthwatch.

RESOURCE IMPLICATIONS

Capital/Revenue

9. None.

Property/Other

10. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public

Involvement in Health Act 2007.

Other Legal Implications:

12. None.

POLICY FRAMEWORK IMPLICATIONS

13. None

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1. None	