A toolkit for use by South-West region health scrutiny members and officers

Contents

Foreword

This brief guide to the scrutiny of health commissioning has been prepared by Andrew Lawrence and Shaun Gordon from the Centre for Public Scrutiny's Expert Advisory Team.

The purpose of this short guide is to raise awareness of the opportunities for health scrutiny committees to get involved in the scrutiny of health commissioning, with a particular focus on health inequalities. The guide has been prepared following the holding of six workshops across the South-West region in collaboration with NHS South-West and public health professionals in South-West primary care trusts.

We would like to thank Mark Woodcock, Pam Smith and Nicola Carmichael of NHS South-West, Jackie Beavington of NHS Bristol, Steven Brown of NHS Devon and Maggie Rae of NHS Wiltshire and Wiltshire Council for delivering excellent presentations and raising awareness of commissioning and health inequalities across the South West region.

1. Good public scrutiny and scrutiny of health commissioning

Public scrutiny processes must be conducted in ways which are open and transparent to everyone. The work of scrutineers should be purposefully focused on the needs and concerns of the public. Scrutineers should see themselves as conducting a dialogue with the public – ensuring that they adequately reflect and connect with the voice of the public who elected them.

Challenges to the executive should always be constructive and based on evidence. It is a challenge which will almost always come out of deliberation and discussion. Attention to the behaviours and processes will define the impact it makes.

The Centre for Public Scrutiny advocates four basic principles of public scrutiny. Good scrutiny:

1. Provides 'critical friend' challenge to executive policy-makers and decision-makers.
2. Enables the voice and concerns of the public.
3. Is carried out by 'independent minded governors' who lead and own the scrutiny process.
4. Drives improvement in public services.

Why is scrutiny of health commissioning important?

Local authority scrutiny of NHS commissioning is an essential part of the role of Overview and Scrutiny Committees. In parallel with the increasing emphasis on commissioning as the strategic driver of care quality and health resource allocation, there as been more emphasis on commissioning as the appropriate way in for overview and scrutiny committees to understand and assess their local health services and hold the NHS to account.

An advantage of scrutinising commissioning is that OSCs can assess the whole picture of local health issues. For example, perhaps there are concerns about access to an area of healthcare such as support for chronic obstructive pulmonary disease. By looking at how the service is commissioned as well as how it is delivered, OSCs can make recommendations covering the quality of design of the entire patient pathway, rather than simply looking at the quality of delivery at the end point of the pathway.

From a strategic perspective, scrutiny committees are in a strong position to ensure that commissioning plans and decisions reflect the needs and preferences of local communities and that they are integrated with the plans of other partners such as local authorities themselves. NHS commissioning is not yet functioning at a consistent high level in every area. OSCs are well placed to consider the effectiveness of commissioning and make recommendations from a local democratic perspective.

2. Commissioning for health and the World Class Commissioning programme – key stages in the commissioning cycle

What is commissioning?

The Department of Health defines commissioning in the NHS as "the process of ensuring that the health and care services provided effectively meet the needs of the population"

The split between commissioning and providing services in the NHS was introduced by the incoming Labour Government in 1997 to describe the functions previously called 'purchasing' and 'providing' by the outgoing Conservative Government which introduced the 'internal market' to the NHS. Most NHS patients and members of the public remain unclear about the distinction between these terms.

The NHS is structured so that all levels of healthcare need to be commissioned – primary and community care, secondary and tertiary care and specialist care. Commissioning currently occurs mainly at Primary Care Trust (PCT) level. Commissioners are responsible for 'buying' health services from providers. This can be from NHS trusts, NHS foundation trusts, the 'provider arm' of the PCT itself, GPs or from the private or voluntary and community sectors, including new types of social enterprises set up for the purpose.

Individual PCTs negotiate contracts with providers of healthcare and health services for their own area within certain parameters set by the Department of Health (DH).

Commissioning is not just about spending money. The DH describes commissioning as *"a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers".* The process is best thought of as a constantly repeated cycle which moves through a number of phases.

Why does commissioning matter?

In the NHS, commissioners act on behalf of the public, ensuring they have access to the services they need, not only today but also in the future. By commissioning the right kinds of care, including new ways of delivering care, commissioners are intended to influence the way care is provided to suit the needs of their populations. In theory, therefore, commissioning determines where the NHS's money goes and whether people's health needs are met, both in the short and long term.

PCTs distribute over 80% of the NHS revenue budget and have the main responsibility for planning to meet demographic changes and local health needs and to reduce health inequalities, working alongside partners such as local authorities. PCTs' ability to carry out this role effectively is vital to the

fair, equitable, efficient and effective distribution of resources for healthcare and to the quality of care.

World Class Commissioning – an overview

As the 'market' in healthcare has developed, the vision described of powerful commissioners shaping local healthcare systems (i.e. markets) through careful planning and contracting has been challenged by the reality.

To support the strategic objectives of the commissioning function and to strengthen the capacity of commissioners, the Department of Health launched, in December 2007, its World Class Commissioning programme. This is intended to provide a framework and practical support for a national approach to commissioning both health and social care services. There are four key elements to World Class Commissioning:

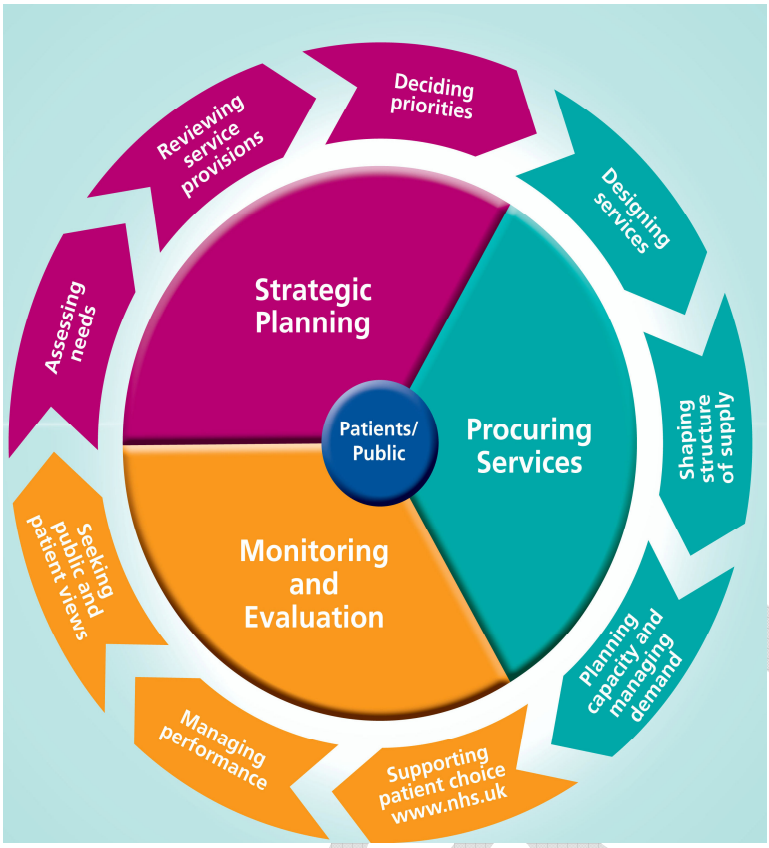
- A vision for world class commissioning.
- A set of world class commissioning 'competencies'.
- An assurance system.
- A support and development framework.

The first three elements of world class commissioning could provide an approach for Overview and Scrutiny Committees to scrutinise commissioning by their PCT. The fourth element provides useful information for scrutineers about the Department of Health's expectations of PCT commissioners.

The commissioning cycle

The diagram overleaf illustrates the main stages of the commissioning process and tasks to be addressed within each stage.

There are generally three main phases, and opportunities for scrutiny in relation to each of these phases.



Source: The Health and Social Care Information Centre.
The interactive version of this diagram can be seen at **http://tiny.cc/Uh9yR**

Strategic Planning – identifying the needs of local populations, establishing priorities for healthcare, understanding the local health economy (i.e. which providers of healthcare exist locally and whether they are providing the right services in the right way) and configuring local health service delivery so that it is 'fit for purpose'.

Procuring Services – identifying appropriate care settings for the relevant population, which providers commissioners want to contract with, specifying the services to be provided, developing the contracts and incentives that will provide the best services and the most value for money.

Monitoring and Evaluation – ensuring that contracts are met as specified, monitoring quality, working with patients and the public to ensure that they are satisfied with services and feeding back into the planning process to develop and improve services.

Issues for scrutiny to consider when examining the commissioning cycle

- At what stage in the commissioning cycle might you focus your scrutiny activities?
- And why?
- What might you learn?

- Where might you add value?

3. Scrutinising commissioning with a focus on health equalities

There are specific national targets to reduce health inequalities and this is a major theme in all national health policy and in the recent national review of the social determinants of health *"Fair Society, Healthy Lives"* led by Sir Michael Marmot.

The aim of the 'Marmot review' was to propose an evidence based strategy for reducing health inequalities from 2010. The strategy includes policies and interventions that address the social determinants of health inequalities. The Review had four tasks:

a. Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action.

b. Show how this evidence could be translated into practice.

c. Advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy.

d. Publish a report of the review's work that will contribute to the development of a post-2010 health inequalities strategy.

The Marmot review generated nine key messages; details OF which may be found in the Executive Summary document.
http://www.ucl.ac.uk/gheg/marmotreview/FairSocietyHealthyLivesExecSummary

Key messages 3, 7 and 9 may be of particular interest to overview and scrutiny issues when formulating work programmes with the aim of impacting upon health inequalities.

"3. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health."

"7. Reducing health inequalities will require action on six policy objectives:

- *Give every child the best start in life.*
- *Enable all children young people and adults to maximise their capabilities and have control over their lives.*
- *Create fair employment and good work for all.*
- *Ensure healthy standard of living for all*
- *Create and develop healthy and sustainable places and communities*
- *Strengthen the role and impact of ill health prevention."*

"9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities."

PCTs should have explicit strategies to reduce health inequalities in their own areas, through their commissioning; and should be working with their local authorities on joint strategies to tackle the social and economic determinants

of health which contribute most to inequalities.

In addition to asking commissioners, *Are health inequalities and the wider determinants of health being addressed?* Members may also wish to ask:

- Is there a common understanding between commissioners and other Local Strategic Partnership partners of the major factors that contribute to health inequalities?

- Is this understanding reflected in the Local Area Agreement, the area's Sustainable Community Strategy and the Joint Strategic Needs Assessment?

- Does the commissioning strategy address these issues effectively, including specific measures to tackle inequalities for particular disadvantaged groups?

- Is there a programme budget linked to the Joint Strategic Needs Assessment (JSNA) that shows how resources are being directed towards reducing inequalities (a budget that describes objectives, outputs and expected results as well as costs)?

- How well integrated into budgeting systems is the public health and prevention activities of commissioners?

4. Lessons learned at the South–West region events in November 2009 and February / March 2010 in relation to health commissioning and health inequalities

November 2009 - World Class Commissioning

- The world class commissioning assurance process assesses PCTs against four elements: Outcomes, competencies. Governance and potential for improvement.

- PCTs assess themselves against defined competencies (including how well they engage with local communities) using evidence from stakeholder surveys, staff surveys and performance against set targets. Data is analysed by an independent panel chaired by the SHA director.

- In 2008/9 NHS South West came second out of the ten SHAs nationwide.

- The process has helped to provide a focus on what a good commissioning organisation comprises.

- It has been recognised that effective engagement with local stakeholders helps to drive improvements in delivery across the local system.

November 2009 - The commissioning cycle and where overview and scrutiny committees can engage

- The commissioning cycle consists of three key stages:
    1. Strategic planning – Assess needs (through the Joint Strategic Needs Assessment), Review service provision, Decide priorities.
    2. Procuring services – Design services, shape the structure of supply, plan capacity and manage demand.
    3. Monitoring and evaluation – support patient choice, manage performance, seek public and patient views.

- HOSCs should have an on-going dialogue with the NHS throughout the cycle with more formal consultation at key decision stages (Deciding priorities and plans, evaluating performance).

- More formal consultation is required on substantial variations or service transformation.

November 2009 - What makes for a good working relationship between an overview and scrutiny committee and NHS organisations?

- Critical friend role – challenging but realistic. HOSC is not an inspection agency.

- Understand each other's culture and develop mutual respect.

- Regular and open communication – regular exchange of intelligence and briefings particularly on plans and work programmes.

- No surprises.

- Recognition that councillors operate in a political environment. Their close contact with local communities should be a source of strength to improve services.

February / March 2010 - Developing a scrutiny toolkit

- Focus should be on identifying the issues that are particularly relevant to the South West region.

- Explore opportunities for the scrutiny of commissioning relating to health inequalities through examination of the 'Marmot review'.

February / March 2010 - What Health inequalities have been identified in plans and strategies?

- Public Health Directors' and SW Public Health Observatory statistics illustrate that throughout the South West region most health indicators have been improving overall but the gap between prosperous and deprived areas has been widening. The reasons for this are related to wider determinants of health including lifestyle choice, income and employment, socio economic status, housing conditions and education.

- Members need to acknowledge, or not, that addressing health inequalities is to be a priority for further investigations in their area. Public health professionals should provide further explanations on what the health indicators data means and what opportunities might exist for scrutiny involvement.

February / March 2010 - How can members access reliable statistical information about health inequalities?

- At a national level statistics are compiled by the Office of National Statistics (ONS). Most Local authorities have a Research and Information (R&I) unit with officers who are knowledgeable about data sources. Members are advised to contact these officers as a first port of call. Advice and information is also available from the regional Public Health Observatory or from Directors of Public Health.

- When developing their plans for a scrutiny review HOSCs might find it useful to seek advice from their R&I units about the data that they would like to inform their review. This may include published data sources, data compiled for management or operational reasons and special one-off surveys. This should be considered at an early stage in any review as data collection and analysis can be very time consuming.

- Sometimes reviews discover that reliable data is just not available to allow for in-depth investigation of an issue. In such cases an outcome of the review may be to recommend the establishment of an information system or data sharing protocol that will provide better information in the future.

February / March 2010 – Approaches to scrutinising health inequalities

- Members may focus their scrutiny enquiries on one, two or all three phases in the cycle, though necessarily, a scrutiny review is likely to take longer if more than one phase is examined.

- Members agreed that there are opportunities to scrutinise health inequalities at any stage in the commissioning cycle.

- The NHS Information Centre weblink will take members to an interactive 'commissioning cycle' graphic. More information on data sources which might influence each phase may be found through following the weblink and exploring the commissioning cycle in more detail.

- Make comparative studies of how services are delivered in different areas. Are different approaches used in the more deprived areas where health conditions are worst? Are these approaches tailored to the characteristics of the area so that they address underlying issues rather than scratch the surface?

- Members agreed that the 'social gradient', set out in 'Marmot' is helpful in focusing where their key lines of enquiry might start, such as on individuals, groups or communities whose life experiences were worse than others.. Measures to illustrate this include mortality ratios, life expectancy charts and deprivation mapping, amongst other sources.

- Members agreed that there are many sources of information and that cross-referencing, and seeking advice and guidance from commissioners and service users is part of the process of scoping a review focused on commissioning in relation to health inequalities.

- Interview service users to see whether services really meet their needs, non-users who might benefit from the services and front-line staff.
- In areas of multiple deprivation individuals and families may require a range of different services so it is important to probe whether services are joined up or managed in separate compartments.

- Make sure that training and development in effective questioning is available for members (particularly new members).

- Probe the extent to which different agencies understand and take responsibility for how wider determinants affect health outcomes. Do Local Strategic Partnerships have clear plans and strategies that address these wider issues in order to improve health outcomes?

- Probe the connections between different policy areas (e.g. Does the local Community Safety Partnership recognise the impact of crime and anti-social behaviour on health? And remember it works the other way round too).

February / March 2010 - Formulating conclusions and drafting recommendations

- Evidence should be gathered in support of agreed key lines of enquiry and may include analysis of quantitative (for example, population or mortality data) and qualitative (for example, discourse or narrative) data.

- Tangible evidence should drive the formulation of conclusions. It is helpful to link the conclusions directly to evidence, so the reader is clear about data sources.

- Recommendations should be informed by review conclusions.

- Recommendations should be SMART, that is
    - **S** – Specific
    - **M** – Measureable
    - **A** – Achievable
    - **R** – Realistic
    - **T** – Time-framed

- Members should give serious consideration to the number and detail of the recommendations. Often minor issues are given parity with major issues, and this may lesson the focus on what really matters in terms of improving outcomes through the scrutiny of commissioning.

- Recommendations, from time to time, may be framed against PCT and Council strategies, plans and policies in order to emphasise the strategic focus. This may include commissioning plans and refer to the commissioning cycle, or parts of the cycle.

5. 11 key questions to ask when scrutinising commissioning

The following issues will be relevant to many reviews of commissioning, whether a review of a service from a commissioning perspective, or a review of the quality of commissioning itself. It is not likely that all of these issues would be considered as part of any single scrutiny review, rather a small number would be used, dependent on the scope of the review. More detailed information underpinning these research questions may be found in the CfPS Commissioning for Health guide http://www.cfps.org.uk/what-we-do/publications/cfps-health/?id=120

Use of information

1. Do commissioners have the right information and use it effectively?

Commissioning levels

2. Is commissioning being done at the right level?

Leadership and governance

3. Is there strong leadership and are appropriate governance arrangements in place?

Partnership working

4. Are commissioners engaged with the right partners and stakeholders?

Patient and public involvement

5. Have patients and the public been appropriately engaged?

Commissioning skills

6. Do commissioners have the right skills and tools for strategic commissioning?

Comparative evaluation

7. Is benchmarking being used effectively by commissioners?

Value for money

8. Is commissioning obtaining value for money?

Working with providers

9. Do commissioners work effectively with providers and potential providers?

Early intervention and prevention

10. Are commissioners focusing on early intervention and prevention?

Health inequalities

11. Are health inequalities and the wider social determinants of health being addressed?

6. Examples of good practice across the South-West region

<<for SW councils to insert weblinks to examples of good public scrutiny relating to health commissioning>>

7. Links to the CfPS / IDeA Health Inequalities scrutiny programme and developing a health inequalities resource kit

Led by Su Turner at the Centre for Public Scrutiny and the Improvement and Development Agency, the CfPS' Health Inequalities Scrutiny programme is a two-year programme to raise the profile of overview and scrutiny as a tool to promote community well-being and help councils and their partners in addressing health inequalities within their local community**.**

This programme has been commissioned by the Healthy Communities Team at the Improvement and Development Agency, and is in response to the increasing need to develop and strengthen the role of Local Government in tackling Health Inequalities.

A key element of the programme has been to identify Scrutiny Development Areas (SDA) to help to develop the role of overview and scrutiny in tackling health inequalities.

Following an application process, nine areas have been selected. The lead Councils are:

- Blackpool Council
- Cheshire West and Chester Council
- Chesterfield Borough Council
- Dorset County Council
- London Borough of Hammersmith and Fulham
- Newcastle City Council - North East Region
- Portsmouth City Council
- Sefton Metropolitan Borough Council
- Warwickshire County Council

The role of the SDAs will be to help develop and test a Scrutiny Resource Kit. The resource kit is designed to provide Councils with help, support and advice so as to encourage them to undertake scrutiny reviews of Health Inequalities. The kit will include:

- Information about the different Health Inequalities, tips on how to find out what they are in an area and practical applications of scrutiny;
- How scrutiny can assist in tackling Health inequalities;
- Several models that have been developed to undertake such reviews;
- A knowledge section – containing training resources

The resource kit does not exist at the moment. There is a framework that has been developed following consultation, this framework is essentially the contents list, with some case studies of different models of scrutiny that have been developed to date.

The SDA's will be used as live scrutiny case studies to enhance the impact of the resource kit. Officers have also asked for information on "what didn't

work" – as this sometimes is more important in helping areas when working on their reviews.

The resource kit will aim to include information on:

- Different types of health inequalities and tips on how to identify inequalities in your area.
- Advice on how scrutiny can help in tackling health inequalities.
- Descriptions of different models of scrutiny of health inequalities.
- Advice on working with communities and partners.
- A knowledge section containing training resources.
- Future challenges for Overview and Scrutiny Committees, for example, working with Joint Strategic Needs Assessments, Local Strategic Partnerships, the Comprehensive Area Assessment, Individual (personal) health budgets and Total Place.

8. Sources of further information and advice

Centre for Public Scrutiny

The Good Scrutiny Guide
http://www.cfps.org.uk/scrutiny-exchange/wiki/?id=19

CfPS Commissioning for health guide a guide for overview and scrutiny committees on NHS commissioning and the world class commissioning programme
http://www.cfps.org.uk/what-we-do/publications/cfps-health/?id=120

An extract from the IDeA Report, *The social determinants of health and the role of local government – Chapter 14 Using scrutiny to improve health and reduce health inequalities*, by Su Turner, CfPS Health Inequalities Programme Manager
http://www.idea.gov.uk/idk/aio/17422948

Improvement and Development Agency (IDeA)

Report: *The social determinants of health and the role of local government*
http://www.idea.gov.uk/idk/core/page.do?pageId=17415112

Department of Health

DH World Class Commissioning
http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH_083204

DH World class commissioning of primary care and community services
http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Policyguidanceandtoolkits/index.htm

Lord Darzi. Next Stage Review. 2008
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

NHS 2010 - 2015: from good to great. Preventative, people-centred, productive. Policy report.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109876

DH Transforming Community Services
http://www.dh.gov.uk/en/Healthcare/Primarycare/TCS/index.htm

Dr Foster Intelligence – a joint venture between the NHS and Dr Foster

The Intelligent Board 2009: Commissioning to reduce inequalities
http://www.drfosterhealth.co.uk/features/commissioning-to-reduce-inequalities

Glossary

Commissioning – the process of planning and procuring health and healthcare services at a strategic level to meet the needs of whole groups of service users or whole populations.

Primary care – the collective term for services which people receive at their first point of contact with the NHS. Usually refers to GP services, but also to other forms of care, such as nursing care, that take place within the community.

Procurement – the process of organizing the purchase of goods and services as determined by commissioning strategies; includes the technical side of specifying goods and services for contracts, negotiating and managing contracts, as well as influencing the design of services and monitoring capacity on the supply side.

Secondary care – The collective term for services to which a person is referred after first point of contact. Usually this refers to hospitals in the NHS offering specialized medical services and care (outpatient and inpatient services).

Social enterprise – the Department of Health is encouraging the creation of new non-profit organizations, described as social enterprises, set up specifically to contract with commissioners to provide health services. They can be formed from an existing health or social care service, an existing social enterprise or third sector organizations or a partnership of both.

Tertiary care – healthcare provided in specialist centres, usually on referral from primary or secondary care professionals.