At a meeting of the HEALTH AND WELL-BEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on WEDNESDAY, 8th DECEMBER, 2010 at 5.30 p.m.

Present:-
Councillor Walker in the Chair

Councillors Fletcher, Maddison, Padgett, Shattock, D. Smith and Snowdon.

Also in Attendance:-

Councillor Tate	-	Chairman of Management Scrutiny Committee
Councillor Morrissey	-	Observing
Karen Brown	-	Sunderland Council
Nonnie Crawford	-	Sunderland Teaching Primary Care Trust
Sharman Cummings	-	Northumberland Tyne and Wear NHS Trust
Anne Dingwall	-	Sunderland Council
Emma Hindmarsh	-	Sunderland Council
Ian Holliday	-	NHS South of Tyne and Wear
Norma Johnston	-	Sunderland Council
Alison O'Neill	-	Sunderland Council
Russell Patton	-	Northumberland Tyne and Wear NHS Trust
Tony Railton	-	Northumberland Tyne and Wear NHS Trust
Jim Usher	-	Sunderland Council

Apologies for Absence

Apologies for absence were received on behalf of Councillors Chamberlin, A. Hall. Old and N. Wright and on behalf of Mr. A. Patchett

Minutes of the last Meeting of the Committee held on 15th September, 2010

1. RESOLVED that the minutes of the meeting of the Committee held on 10th November, 2010 be confirmed and signed as correct record.

Declarations of Interest

There were no declarations of interest made.

Performance Report Quarter 2 (April – September 2010)

The Chief Executive submitted a report (copy circulated) to provide the Committee with a performance update relating to the period April to September 2010 to include:

- Progress in relation to the LAA targets and other national indicators.
- Progress in relation to the Home Care Provision Policy Review, Dementia Policy Review and Health Inequalities Policy Review Recommendations.
- Results of the annual MORI residents survey which took place during May to July 2010

(For copy report – see original minutes)

Ms. Sharon Lowes, Strategic Commissioning Manager presented the report in relation to adult social care, Dr. Nonnie Crawford commented on the health inequalities aspect and Ms. Johnston and Ms. O'Neill were in attendance to respond to any questions regarding environmental health and sport and leisure respectively.

With reference to health inequalities, Dr. Crawford reiterated comments she had previously made that the performance information did not place enough emphasis on children's health and there was too much focus on the adult model. She reminded the committee that within the headings of the Marmot Review 'giving every child the best start in life' was the highest priority recommendation and a life course perspective was central to the Review.

Councillor Shattock questioned what was being done in the city to ensure that those people who needed support to live independently were not left isolated.

Ms Lowes advised that it was very important to get the balance right when supporting people to live at home within the wider preventative agenda. Alongside the Telecare service, voluntary and community services were funded for such schemes as befriending and telephone companionship. Sunderland had a range of responses and services to meet the needs of its residents.

In response to a further question from Councillor Shattock regarding how services had coped during the recent bad weather, Ms. Lowes advised that the Business Continuity Plan had been successfully initiated.

With reference to Direct Payments, Councillor Shattock enquired whether individuals could still buy council services and was advised that there had been a prohibition on buying council services but it had now been lifted.

In relation to the statistics relating to satisfaction with Children's playgrounds, Councillor Smith questioned whether the statistics were gathered on a ward by ward basis. Ms. O'Neill agreed to find out and respond to Councillor Smith directly.

Councillor Shattock queried why the figures for alcohol related issues were increasing and was informed by Dr. Crawford that more services had been developed and consequently more people were being referred to those services. The four tier strategic framework reflected increasing intensities of intervention; enhanced services and more education work meant that the increase was not a bad news story on one level, however, the increase was only slight given the increase in services.

The Chairman noted that the number of pharmacies offering NHS Health checks would increase from 11 to 13 by the 1st of January 2011 and questioned whether there were any plans to roll this initiative out further.

Dr. Crawford advised that all GP's delivered health checks and those checks that were offered in pharmacies were in low uptake areas. There were further plans to also target these hard to reach groups effectively using other community locations such as supermarkets and Working Men's Clubs

Having thanked the officers for their contribution it was:

2. RESOLVED that the committee acknowledges the continued good progress made by the council and the Sunderland Partnership and those areas requiring further development to ensure that performance is actively managed.

Pride Project Update

The Chief Executive submitted a report (copy circulated) to provide members with the outcome of the Public Consultation seeking views on Options and Locations and the subsequent Option Evaluation process concerning PRIDE (Providing Improved Mental Health and Learning Disability Environments in Sunderland and South Tyneside.)

(For copy report – see original minutes)

The Chairman welcomed Tony Railton, Associate Director Northumberland Tyne and Wear NHS Trust and Ian Holliday, Commissioning Lead for Mental Health / Learning Disabilities NHS South of Tyne and Wear to the Committee and invited them to present the report.

Mr Railton reminded the Committee of the three potential sites that were identified for consultation and the four options for consideration. Mr Railton explained how the scoring process worked - a widely used method of weighted scoring endorsed in Government guidance. Measurement criteria defined as benefits, were allocated a value (weighting) out of a total value of 100 – the greater the defined or perceived value, the greater the weighting.

Mr. Railton advised that Option 3 had been ranked in first place.

Option 3 involved the following proposals:

Ryhope:	Sunderland adult and older people's functional illness services
Monkwearmouth:	Sunderland and South Tyneside older people's organic illness service
South Tyneside:	South Tyneside older people's functional illness

Looking at consultation alone, option 4 was ranked higher than option 3, however, the total sum of weighted scores for all other criteria was greater in option 3. Therefore, option 3 was ranked in first place overall.

Option 3 was duly considered and approved for business case preparation. Mr Railton advised that work was now underway to prepare a Business Case, which would be submitted for consideration to the Trust's Board of Directors in 2011.

In response to an enquiry from the Chairman regarding whether the project would be delivered on schedule, Mr Railton advised that the target to vacate the Cherry Knowle site by summer 2013 and move into the new facilities by January to March 2014 was realistic.

Councillor Shattock was very keen to see new facilities as soon as possible but expressed concerns regarding capacity and forecasting bed numbers. She cited the recent emphasis the Justice Secretary, Kenneth Clarke had placed on mental health and the justice system - the need to start diverting people with mental illness away from police stations, courts and prison. Councillor Shattock questioned whether this would result in a need for more bed numbers.

Mr. Russell Patton, Director of Adult Services, NTW NHS Trust advised that if the Green Paper advocated the transfer of prisoners with mental illness, they would be accommodated in a different type of facility to those currently provided by the Trust. Durham was well resourced in secure facilities, however if as an organisation the provision of low/medium secure facilities was a good business proposition then it could be considered in the future.

Mr Holliday stated that it was acknowledged within the model of mental health that people were spending too much time as inpatients. There needed to be reinvestment in supported accommodation as well as a focus on prevention so that in patient beds were used most effectively.

Councillor Tate welcomed the improvements.

3. RESOLVED that the contents of the report be received and noted and the Committee receive regular updates on progress.

Improvements to Out of Hours Provision within Sunderland

The Director of Health, Housing and Adult Services submitted a report (copy circulated) to update the Committee following a decision in February 2010 when the committee agreed 6 recommendations to improve access to Out of Hours (OOH) Provision within Sunderland, and to the creation of a Task & Finish Group to progress these. This report detailed;

- how these actions had been implemented
- how any remaining issues were to be progressed

(For copy report – see original minutes)

Mr. Jim Usher, General Manager, Health, Housing and Adult Services presented the report and outlined what improvements had been made to make access to OOH provision better. Mr Usher also detailed planned/ ongoing activity.

Councillor Maddison noted that additional emergency housing provision had been arranged with 2 Crash Beds being located within Salvation Army premises and questioned whether their use was monitored. Mr Usher advised that the beds had been used on three separate occasions and their availability was ongoing.

Councillor Shattock stated that the Local Authority and North Tyne and Wear NHS Trust had provided an excellent response to the issues raised to progress the recommendations from the Task and Finish Group. She enquired whether there had been a noticeable reduction in complaints.

Mr Usher advised that since the recommendations had been progressed there had been few if any complaints.

Councillor Shattock queried whether she would be able to attend the workshop that was being arranged to engage with all stakeholders. Mr Usher agreed to invite Councillor Shattock.

Councillor Shattock requested that an item on the new care management system was brought to a future meeting of the Committee. Ms. Lowes agreed to provide a report in the early part of 2011.

Mr Patton apologised for an error in the appendix to the report in relation to Crisis Resolution Service referral criteria which should read 'the resident does not need to be known by the team already'.

4. RESOLVED that the Health and Wellbeing Scrutiny Committee receive the report for information and agree that;

i) the Task and Finish Group has met its initial remit and should be discontinued
ii) Further analysis of OOH demand is undertaken periodically by HHAS / the Contact Centre – and a further report on this and any other OOH issues be provided to committee in 6 months time. This will determine the need for any further actions.

Pharmaceutical Needs Assessment

The Chief Executive submitted a report (copy circulated) to inform the Scrutiny Committee about a consultation on a Pharmaceutical Needs Assessment (PNA) for Sunderland.

(For copy report – see original minutes)

Ms. Brown advised that the full consultation document had previously been circulated to Members for their consideration.

The Chairman proposed that individual Members forward their comments to Karen Brown to enable her to compile a response on behalf of the Committee.

At the suggestion of Councillor Maddison, Ms. Emma Hindmarsh, Democratic Services Officer agreed to arrange for the consultation document to be placed on the Members Ward Bulletin Service.

5. RESOLVED that Members forward any comments on the Pharmaceutical Needs Assessment based on the questions outlined in paragraph 4.2 of the report to Karen Brown, Scrutiny Officer.

Forward Plan – Key Decisions for the Period 1st December, 2010 – 31st March, 2011

The Chief Executive submitted a report (copy circulated) to provide Members with an opportunity to consider the Executive's Forward Plan for the period 1st December, 2010 – 31st March, 2011.

(for copy report – see original minutes)

6. RESOLVED that the contents of the report be received and noted and additional information be provided to Members.

Annual Work Programme 2010 - 11

The Chief Executive submitted a report (copy circulated) for the Committee to receive an updated work programme for the 2010-11 Council year.

(for copy report – see original minutes)

7. RESOLVED that the Committee note the updated work programme.

The Chairman then closed the meeting having thanked Members and Officers for their attendance.

(Signed) P. WALKER,
Chairman.

HEALTH AND WELL-BEING SCRUTINY COMMITTEE

12 January 2011

PREVENTION ON SEXUALLY TRANSMITTED INFECTIONS AND PROMOTION OF GOOD SEXUAL HEALTH

Commissioning Lead for Sexual Health & Health Improvement Practitioner, Sunderland Teaching Primary Care Trust

1. Purpose of Report

1.1 The report will outline the current services and initiatives operating across the city of Sunderland to promote positive sexual health for young people. The report will provide information on the universal and targeted services including the Chlamydia screening programme.

2. Background

2.1 Sunderland currently has a teenage pregnancy rate of 51.8 as reported from the Q3 conception data for 2009. This is both above the national and regional average. Continued efforts along with a recent national support Visit for Teenage pregnancy are striving to make improvement to young people's sexual health and to reduce the number of teenage conceptions.

2.2 In relation to sexually transmitted infections (STI) Sunderland currently Chlamydia is the most common STI among young people under the age of 25. As a result of this consistently high rate a national screening programme for Chlamydia was launched in 2007/08 which lead to PCT's being asked to screen % of all 15-25 year olds in order to halt an increase on the rising figures of Chlamydia cases.

2.3 In addition to sexual health access to contraception is also a key element of young people's sexual health. Condom card schemes have been operating across the country since the beginning of the teenage pregnancy strategy 10 years ago. Sunderland currently has a condom scheme operating across the city known as the SHOWT card.

2.4 As well as access to condoms, Long acting reversible contraception is considered to be more affective with young people as the method does not rely on the young person remembering to take is as it is a long term contraceptive ranging from 3 months to 10 years, depending on the chosen method.

2.5 To ensure access to contraception is available City Hospitals Sunderland have been commissioned to provide a contraceptive and sexual health service to all people within Sunderland, but have also included a dedicated young people's service to target the provision.

3. Current Position

3.1 To ensure young people understand and practice good sexual health Sunderland currently has the following initiatives in place;

3.2 **Your Health:** is a universal health information initiative for young people within Sunderland. The youth health has a number of elements to the programme to ensure young people have one point of contact for health information including sexual health. The programme has involved the establishment of a website (www.yourhealthsunderland.com) which has provided two sections to date for young people 11-15 and 16-24 to access health information and knowledge of local services available to them.

3.3 In addition to the website a number of resources have been developed for our secondary schools including a display board that promotes the your health brand and website as well as holding the individual health leaflets that have been produced. These boards are in every secondary school and young people's services across the city. A year 7 pupil handbook and year 7 parent handbook have also been produced and given to every year 7 pupil in September 2010. There has also been a resource developed for the college settings.

3.4 The final element of the Your Health communication strategy is the rebranding of the sexual health services dedicated to young people. The long standing young people's service in Sunderland was known as Answers, and consultation with young people agreed to keep the name but to rebrand all young people's contraception and sexual health service provision as Answers.

3.5 **Answers:** is the young people's dedicated contraception and sexual health service in Sunderland. The service is commissioned to offer a full sexual health service to young people under the age of 25. the current intention is to have at least one Answers clinic in each of the 5 areas fo the city. Currently we have a clinic operating in 4 of the 5 areas with the 5 area to come on board Early 2011. The venues hosting the clinics include the royal hospital in Sunderland, Washington Primary care centre, Hylton College and Bede College. The remaining venue to come on board is within the Houghton area in the new primary care centre development.

3.6 The service has undergone a review to extend the provision into the 5 areas as well as communication plan to increase young people's knowledge about the service and what it offers. This is an ongoing strategy to continue to increase access to sexual health services among this age group.

3.7 **Showt Card:** is the current condom card scheme available for all young people in Sunderland 14-24 to access free condoms. The scheme has a number of outlets that have trained staff to support young people to access condoms and Chlamydia screening. The scheme currently operates a paper based system with little electronic data to record uptake and monitor effectiveness of outlets. Therefore a review of the current system has involved the sourcing of an electronic system to manage the scheme to give robust data on uptake and access as well as effectiveness of venues and stock control. The new system will be in place by March 31st, by when all staff and outlets will have been trained to use the new system.

3.8 In addition to the new electronic system the card will be re-branded to give a fresh and improved look to the scheme. The launch of the image will be in line with the new system.

3.9 **Chlamydia Screening Programme:** in Sunderland the Chlamydia screening programme is currently commissioned through Newcastle PCT until March 2011. The programme manages and co-ordinates the screening, providing treatment, partner notification and data analysis for all screening processed. The programme currently have a target to screen 35% of the total population of 15-24 years old in Sunderland equating to 13,195 screen between April 2010 to March 2011.

3.10 To promote the screening programme within Sunderland a number of marketing initiatives have been developed including a text service for a young person to request a kit, facebook advertising to promote awareness and giving a link to the regional Chlamydia screening website for a testing kit and further information. In addition to this a number of seasonal and holiday campaigns are used to cover key events such as Valentines Day, summer holidays and Christmas.

3.11 **Emergency Contraception Scheme:** access to emergency contraception is offered for free to any woman through pharmacies that have signed up to the local enhanced service. The service allows any young person to access emergency contraception up to 72 hours after unprotected sex. The list of current participating pharmacies is advertised within the Your Health website.

3.12 Although the service is available a branding or communication strategy is not in place to promote the scheme more widely. Although increase in use of emergency contraception is something to advocate, preventing an unwanted pregnancy is, and signposting young women to the service should also include information on other forms of contraception. It is proposed to brand the scheme and develop promotional materials to clearly outline which pharmacies are engaged in the scheme.

4. Conclusion

4.1 To conclude the report a number of actions will be carried out (as outlined within the report) to improve the current services available, and further guidance will be given in the new year around sexual health due to the current release of the Public Health White Paper: Healthy Lives Healthy People.

HEALTH AND WELL-BEING SCRUTINY COMMITTEE

12 January 2011

CANCER DRUGS FUND

REPORT OF CHIEF EXECUTIVE

1. Purpose of Report

1.1 For members to be aware of proposals for the Cancer Drugs Fund and other supporting measures around cancer services.

1.2 Dr Nonnie Crawford, Locality Director of Public Health, Sunderland Teaching Primary Care Trust will be in attendance at the meeting to take members through the consultation document.

2. Background

2.1 The Department for Health is consulting on proposals for establishment of a Cancer Drugs Fund. The consultation sets out the context and case for change, the objectives for the Fund, and the implications these have for the structure of the Fund.

3. Cancer Drugs Fund

3.1 The Fund is intended as a means of improving patient access to cancer drugs prior to the anticipated reform of arrangements for branded drug pricing on expiry of the current Pharmaceutical Price Regulation Scheme (PPRS) at the end of 2013.

3.2 Decisions on the implementation of the Cancer Drugs Fund will be taken following this consultation.

3.3 A copy of the Consultation is attached as Appendix A and is available at the link below:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_120931.pdf

4. Interim Cancer Drugs Fund

4.1 In July 2010 it was announced that an Interim Cancer Drugs Fund would start on 1October. The interim fund of £50 million runs until the end of March 2011 when the full Cancer Drugs Fund is introduced.

4.2 A report by National Cancer Director Professor Sir Mike Richards on international variations in drug usage shows the UK’s uptake of new drugs falls behind other European countries. The funding is for cancer patients to access drugs now to help extend life or improve quality of life, ahead of longer term plans to change the way the NHS pays for drugs. The interim measure precedes the Cancer Drugs Fund due to commence in April 2011. Doctors will be put in charge of deciding how the funding is spent for their patients locally based on the advice of cancer specialists.

5. Office for National Statistics data on cancer survival

5.1 On 7 September 2010 the Office for National Statistics published new data showing that cancer survival rates have improved, although there is still a North South divide.

5.2 The index has been designed for routine monitoring of the local effectiveness of cancer services. It is adjusted for differences between PCTs in the profile of their resident cancer patients by age, sex and type of cancer.

http://www.statistics.gov.uk/pdfdir/canpct0910.pdf

5.3 The figures show that:

- Overall, the one-year cancer survival index for England has increased during the period 1996–2006, from 61.8 per cent in 1996 to 65.0 per cent in 2006

- Geographic inequalities in cancer survival are persistent over time. In 1996, a clear North South gradient existed. This is still evident in 2006, but it is less marked

6. Signs & Symptons Campaign

6.1 On 27 September 2010 a signs and symptoms campaign was launched which will focus on breast, lung and bowel cancers alerting people to the early signs of cancer and encourage them to get checked out.

6.2 From January 2011 a range of local campaigns - 59 in total - will be launched, focusing on the three big killers: breast cancer, bowel cancer and lung cancer. Local areas have each been given a share of £9 million in funding for their campaigns. At the same time as running these local projects, the Department of Health will be trialling centrally-led campaign activity in two regions, to raise awareness of bowel cancer symptoms and encourage people to visit the doctor earlier.

6.3 The campaign will run alongside the Cancer Drug Fund and review of the Cancer Reform Strategy[1].

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[1] The Cancer Reform Strategy 2007 builds on the NHS Cancer Plan in 2000 and set a direction for cancer services for the next five years.

7. Conclusion

7.1 Members are asked to note the proposals around cancer services.

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The Cancer Drugs Fund

A consultation

DH INFORMATION READER BOX

Policy
HR / Workforce
Management
Planning /
Clinical
Estates
Commissioning
IM & T
Finance
Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	14909
Title	The Cancer Drugs Fund: A consultation
Author	Margaret Stanton, Department of Health
Publication Date	27 Oct 2010
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Patients, carers, cancer networks, the pharmaceutical industry and the general public
Circulation List	PCT PEC Chairs
Description	A consultation on proposals for the establishment of the Cancer Drug Fund from April 2011. The consultation sets out the context and case for change, the objectives for the Fund, the implications these have for the structure of the Fund and invites views on how we can ensure that the Fund delivers its objectives as well as possible.
Cross Ref	
Superseded Docs	
Action Required	For comment
Timing	**Responses to consultation by 19th January 2011**
Contact Details	Gillian Baker - Consultation Coordinator Cancer Drugs Fund, Room 5W12, Department of Health Quarry House, Quarry Hill, Leeds, West Yorkshire LS2 7UE http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120834
For Recipient's Use	

The Cancer Drugs Fund

A consultation

Ministerial foreword

In the White Paper *Liberating the NHS,* published in July, we described our ambition for the NHS to excel in the future. Achieving equity and excellence in the NHS will give the people of this country confidence in the quality of the healthcare they receive, in addition to their confidence in access to healthcare based on need, not ability to pay. The Government is committed to ensuring that the NHS is there for people when they need it most.

We know that patients and clinicians are frustrated and angry that they cannot access some effective cancer medicines on the NHS. This is why we made a commitment in the Coalition's Programme for Government to create a Cancer Drugs Fund to help patients access the cancer drugs their doctors think will help them. Access to cancer drugs is a key priority for the Government, as demonstrated by the extra £50 million we have already made available to the NHS this year for interim funding of additional NHS cancer drugs. This consultation document sets out how we plan to build on this early progress and establish the Cancer Drugs Fund from April 2011.

We want to empower clinicians, and to enable them to use the cancer drugs that they and their patients agree are needed to extend or improve life. In parallel, we are working to change the way the NHS pays for drugs in the longer term, so that patients get better access to treatments that will benefit them, pharmaceutical companies are rewarded for delivering benefits to patients and taxpayers get better value for money. In that context the Cancer Drugs Fund is a key part of our wider plans to improve access to effective medicines, as well as one element of our wider strategy to improve NHS cancer services.

The Government is fulfilling its commitment to establish the Cancer Drugs Fund, committing £200 million a year over the next three years to ensure its success. We need comments and suggestions from patients, clinicians and other interested groups to ensure that the Fund works as well as possible and delivers the greatest benefit to patients. I hope that you will want to respond to this consultation and give us your views.

Secretary of State for Health

Contents

The Cancer Drugs Fund: A Consultation

Section 1 - Introduction

1.1 The Government has set out its plans to establish a Cancer Drugs Fund from April 2011. The Fund will provide a means of improving patient access to cancer drugs prior to the anticipated reform of arrangements for branded drug pricing on expiry of the current Pharmaceutical Price Regulation Scheme (PPRS) at the end of 2013.

1.2 This document sets out proposals for the establishment of the Cancer Drugs Fund and seeks views on a number of key issues. The consultation will run for 12 weeks from 27 October 2010 to 19 January 2011. Information on the consultation process, including how you can respond to the consultation, is contained in Annex B. Alongside this public consultation, we will actively engage key stakeholders in developing the proposals for implementation.

1.3 Decisions on the implementation of the Cancer Drugs Fund will be taken following this consultation.

Section 2 - Context and Case for Change

The Cancer Drugs Fund – A Bridge to Value

2.1 The Government believes that there are significant failings within the current system for drug pricing and access. *The Coalition: our programme for government* outlined the Government's commitment to move to a system of value-based medicines pricing to provide NHS patients with better access to effective and innovative treatments at a price that secures value for the NHS. It will take time to implement these changes and the Government has set out its intention to work towards introduction of the new arrangements on expiry of the current PPRS agreement at the end of 2013.

2.2 *The Coalition: our programme for government* also confirmed the Government's commitment to the establishment of a Cancer Drugs Fund from April 2011. The Fund will address some of the most pressing access issues, enabling cancer patients to be treated with the cancer drugs their doctors think will help them. It will begin to make the connection to value by putting clinicians and cancer specialists in the driving seat to decide how the funding is best spent for patients. The Fund will bridge the gap until introduction of the new medicines pricing arrangements at the end of 2013, which will formalise the relationship between value and price. Both the Cancer Drugs Fund and value-based medicines pricing reflect our determination to give more power to clinicians to take decisions about treatments in discussion with patients.

2.3 As part of the transition to a new medicines pricing approach, consideration will need to be given to the position of drugs that have been funded through the Cancer Drugs Fund following a negative appraisal from the National Institute for Health and Clinical Excellence (NICE). The Government intends to consult shortly on its plans for introducing value-based pricing.

Why Cancer?

2.4 More than one in three people will develop cancer at some time in their lives and one in four will die of cancer. In England in 2007 (the latest year for which data is available) 245,300 people were diagnosed with cancer and 127,800 people died of cancer. Cancer accounted for 30 per cent of all deaths in males and 25 per cent in females.

2.5 The creation of the Cancer Drugs Fund recognises the particular issues around access in the UK to some newer cancer drugs. These issue were highlighted earlier this year in a report from Professor Sir Mike Richards, National Cancer Director, to the Secretary of State for Health. The *Extent and Causes of International Variations in Drug Usage* looked at international variations in the use of a number of medicines across a range of disease areas. The report clearly illustrates the UK's comparatively low usage of cancer drugs, in particular newer cancer drugs, by international standards.

2.6 Professor Richards' report concludes that a range of factors appear to influence the UK's level of drug usage, as compared with other countries. These encompass health, economic, organisational and cultural issues and are likely to vary according to the disease area. UK patterns of use are frequently driven by clinical preference, but it is undoubtedly the case that funding restrictions are a factor in some cases.

2.7 In 2009 NICE introduced new flexibilities in its appraisal of drugs for less common, end of life conditions. In addition, the 2009 PPRS sets out more flexible pricing options which drug companies can use to improve the value specific drugs offer the NHS. In combination, these measures have already helped to make more drugs for rarer cancers available to NHS patients, including: Sutent for renal cell carcinoma, Revlimid for multiple myeloma and Yondelis for soft tissue sarcoma. However, there remain cancer drugs which NICE has not felt able to recommend even with the application of a more flexible approach to decision-making, and which drug companies have been unwilling or unable to price at a level NICE would regard as cost-effective.

2.8 NICE guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and their guardian or carer. Clinicians have to make an independent clinical judgement, taking account of NICE's advice and the strength of evidence which lies behind it. This clinical freedom also applies in relation to those treatments on which no NICE guidance exists. The Cancer Drugs Fund is intended to ease the funding constraints which can prevent patients in such circumstances from accessing drugs which their doctors recommend for them at a time when some extra weeks or months of life may be particularly precious. The Fund should be seen as addressing a particular category of cases where NHS funding is not otherwise available. The role of NICE as an authoritative source of advice to clinicians remains undiminished.

2.9 The drugs NICE rejects generally combine high cost with a limited average extension of life and/or improved quality of life. These benefits can of course be of great importance to individual patients and their families, and it may be that current arrangements do not adequately reflect the value society places on ensuring that patients in such circumstances have access to drugs that can help them.

2.10 In response to the publication of Professor Richards' report, the Government announced additional funding of £50 million to improve access to cancer drugs in 2010-11. The funding was issued to Strategic Health Authorities (SHA) for allocation through regional clinically-led panels from October 2010.

Why Cancer Drugs?

2.11 The Cancer Drugs Fund is an interim measure until we can introduce a new value-based approach to medicines pricing. The purpose of the Fund is to mitigate the current problems of access and value that have been identified in relation to cancer drugs. In the medium-term, the Government plans to introduce value-based medicines pricing and make new medicines available to NHS patients at a price that represents their value.

2.12 Whilst the funding will therefore focus primarily on improving access to drugs, there may be other cancer treatments at the margins that clinicians consider it would be appropriate to provide out of the Fund. This issue is explored in paragraph 4.11.

2.13 The Cancer Drugs Fund is also an important part of the Government's wider plans to improve cancer services. The Government is currently reviewing the Cancer Reform Strategy (CRS) to set the direction for cancer services for the next 5 years and ensure we have the right strategy to deliver what is most important to patients and their families – cancer outcomes.

2.14 Improving cancer survival rates is key. It is now generally agreed that the most important reasons for lower survival rates in England, compared with other European countries are low public awareness of the signs and symptoms of cancer, delays in people presenting to their GPs, and patients having more advanced disease at diagnosis. By bringing survival rates in England in line with the best performing European nations through earlier diagnosis, as well as improving treatment and after care, it is estimated that up to 10,000 cancer patients' lives could be saved each year. On 21 September, the Government announced that a new campaign to alert people to the early signs of cancer and encourage them to see their doctor quickly will be launched in January next year. The campaign will consist of 59 local initiatives focussing on the three big killers - breast, bowel and lung cancer. At the same time, the Department will be trialling, in two regions, centrally-led campaign activity to raise awareness of bowel cancer symptoms and to encourage early presentation. Subject to evaluation, the campaign will be introduced nationally.

Innovation Pass and the Cancer Drugs Fund

2.15 The Innovation Pass was an initiative announced in the previous Government's Office for Life Sciences (OLS) blueprint. The Innovation Pass was intended to provide funding to innovative new medicines for small patient populations that had the potential to offer valuable benefits, but which would be unlikely to receive a positive NICE appraisal. In developing proposals for the Cancer Drugs Fund, it became apparent that there is a high degree of potential overlap between drugs potentially covered by the Fund and possible candidates for the Innovation Pass. It is important that we are able to look at our plans to improve patient access to innovative medicines as a whole, avoiding duplication between the Pass and the Fund, and, in view of this, the Innovation Pass was suspended in July. We have no plans to reinstate the Pass at this time, but our plans for the Cancer Drugs Fund recognise the vital role the pharmaceutical industry plays in developing new drugs that deliver benefit to patients.

Section 3 - Cancer Drugs Fund – Outline for Implementation

Objectives for the Fund

3.1 There are a number of objectives that the Cancer Drugs Fund should address. We consider the most important of these are that the Fund should:

- provide maximum support to NHS patients;
- put clinicians and cancer specialists at the heart of decision-making, consistent with the Government's wider policy of empowering health professionals and enabling them to use their professional judgement about what is right for patients; and
- act as an effective bridge to the Government's aim of introducing a value-based pricing system for branded drugs in 2014.

Implications for the Structure of the Fund

3.2 A range of options for structuring the Fund has been considered, from complete devolution to complete central control, with each offering a different balance of risks and benefits:

- **Complete devolution of decision-making**: this is immediately attractive as it places decisions on use of the funding firmly in the hands of the doctors treating patients. However, if clinicians take decisions in isolation this may lead to greater variations in patient access with decision-making lacking structure and investment lacking focus. It would be very difficult to guarantee that resources allocated for the Fund were used for the intended purposes;

- **Central control**: this should lead to greater consistency in decision-making but there is a danger that a national approach may be unresponsive to particular patient needs and to the experience of treating clinicians. The NHS White Paper sets out our wider plan to empower NHS clinicians to do the best for their patients. We want decisions about the use of drugs to be taken by the clinicians who treat cancer patients, and not by politicians in Whitehall;

- **Regionally based coordination**: this would build on the approach taken to managing the additional £50 million funding for cancer drugs in 2010-11. Organising the Fund regionally would provide a clear structure for decision-making and should prevent funding running into the sand. A regionally based approach would provide good opportunities for co-operation and information sharing between relevant parties, including clinicians, NHS commissioners, patient groups and industry, and should help to guard against unjustified variations in patient access to drugs.

3.3 A key objective for the Cancer Drugs Fund is that it should put clinicians at the heart of decision-making. There is of course a potential conflict between ensuring clinical ownership of decision-making and providing uniformity of decisions. A national model would in theory allow a high degree of consistency, but decision-making would be less likely to have local clinical ownership and would be less able to respond to particular patient needs. While a regional model could introduce greater scope for variation, it would deliver much stronger clinical ownership and be significantly more responsive to the needs of patients. We believe that there are ways in which the risks associated with a regional model could be mitigated, and these are described further.

3.4 There will be a need to manage priorities to ensure the greatest benefit within the funding available. A regional model offers obvious attractions if it properly engages clinicians in the decision-making process. A national approach would inevitably be more bureaucratic in bringing together the specialisms within cancer treatment. It would also be further removed from knowledge of the local circumstances and individual cases. A national approach would require the introduction of central controls to manage financial risk and comply with legal requirements in Government procurement, such as limiting the funding any one drug could receive and possibly restricting use of the Fund to specific named treatments. We feel such an approach would be inconsistent with our drive to empower front-line clinicians and their patients.

3.5 We want to ensure that the Cancer Drugs Fund secures the best possible deal for the NHS. A national approach to the Fund would not appear to add anything to what companies are already able to offer in the context of the NICE appraisal process. A regional approach could open up greater flexibilities than may be available at national level for the NHS to reach agreements with manufacturers for supply of individual drugs, as happens now in some cases.

3.6 On the balance of the risks and benefits, we have concluded that by far the best way of delivering our objectives for the Fund would be through a regional fund, balancing local ownership of decision making with sufficient traction to ensure the Fund is deployed to good effect. A regionally based process will allow real clinical engagement with the opinion leaders in local cancer services.

3.7 This approach can usefully build on the regional arrangements established for allocation of the additional £50 million funding in 2010-11. In response to the challenge set in 2010-11, SHAs have worked closely with Cancer Networks, and with each other, to develop appropriate arrangements for allocation of the additional funding. As part of the implementation arrangements for the Cancer Drugs Fund, the regional committees will need to consider arrangements for patients who have received drugs through the additional funding provided in 2010-11. The committees will need to determine, on the basis of clinical advice, the appropriate transitional arrangements for such patients.

3.8 Over the period of the consultation, we will work with those involved in developing and operating the current arrangements to ensure that any learning is fed into the implementation of the Cancer Drugs Fund.

3.9 A regional approach is of course not without its challenges. Section 4 invites views on how we can ensure that the Fund delivers its objectives as well as possible.

Section 4 – Key Issues and Questions for Consultation

Consistency with NHS White Paper

4.1 The NHS White Paper: *Equity and Excellence: Liberating the NHS* sets out the Government's plans to delayer and simplify the architecture of the health system and liberate the NHS from excessive bureaucratic and political control. It is therefore important that the structure of the Cancer Drugs Fund can be adjusted to enable it to keep pace with the evolution of the NHS.

4.2 In the first instance, we envisage implementation being overseen by SHAs. However, given that SHAs will be abolished once the NHS Commissioning Board is fully established as a Non-Departmental Public Body (NDPB) from April 2012, further consideration will need to be given to what adjustments need to be made to the Cancer Drugs Fund to reflect these changes. We would expect the NHS Commissioning Board to be guided by the principles outlined in this document and the outcome of the consultation in taking any decisions on the future format of the Cancer Drugs Fund.

Resourcing

4.3 The Spending Review outcome reaffirmed the Government's commitment to protect funding for the NHS, despite the very tough fiscal climate, and to ensure that the NHS is there for patients when they most need it. Therefore, we will ensure that £200 million is available for each of the three years of Fund operation, beginning in 2011/12. Analysis of the "Extent and causes of international variations in drug usage" report[1] makes clear that, if the UK were to provide newer (less than 5 years old) cancer medicines in line with European average levels, this would cost an additional £225m a year. For England, this would represent less than £200m. This accords with work done by the Rarer Cancers Foundation and is in line with expectations, based on estimates of resources available, prior to the election. The Fund will bridge the gap until the introduction of new pricing arrangements for medicines from the start of 2014, which will establish a clear link between the value of a drug and the price the NHS pays for it. The Cancer Drugs Fund will therefore finish at the end of 2013.

4.4 The level of annual funding available will remain constant over the three-year life of the Fund, and "underspends" from one year will not be available for carry-forward into the next. Clinically-led panels will need to manage the available funding in a way that enables them to respond to the changing profile of available treatments over that period, and potential fluctuations in the numbers of patients presenting for specific treatments.

1. **How can clinically-led panels ensure they are able to respond to the changing nature of available technologies and patient demand over the life of the fund?**

4.5 Additional in-year funding to support improved access to cancer drugs was issued to SHAs for allocation through regional clinically-led panels from October 2010. The allocations to each SHA were determined on the basis of the weighed capitation formula. We have considered options for resource allocation for the Cancer Drugs Fund

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[1] IMS Health, Issues Bulletin: New Insights into the extent and causes of international variations in drug usage, October 2010

and do not believe there are strong arguments for taking a different approach from 2010-11. We therefore propose that SHA shares of the funding are calculated on the basis of the national weighted capitation formula. This formula is used to inform allocations to the NHS and takes account of such factors as the age distribution of the population and additional need in determining the appropriate allocation of funding.

2. **Do you agree that the national weighted capitation formula is the best way of determining each SHA's share of the Fund?**

Operation of the Fund

4.6 We have set out the Government's rationale for proposing a regional approach to operation of the Cancer Drugs Fund. It will however be useful to set out ground rules for operation of the Fund and there will be areas on which it would be helpful for national guidance to be developed.

3. **What should the national role be in terms of providing guidance? Are there particular issues that national guidance should address?**

4.7 We believe that regional variations could be minimised by encouraging regional bodies to work collaboratively in assessing individual drugs, pooling expertise and avoiding unnecessary duplication of effort. For example, we could encourage individual regional panels to take the lead in evidence assessment for specific cancers.

4. **Do you agree that it would make sense for different regions to take the lead in considering the evidence on drugs for different cancers, to minimise variation, reduce duplication and make the best use of scarce expertise?**

4.8 As part of the NICE technology appraisal process, Patient Access Schemes can be put forward by a manufacturer to increase the value offered by specific drugs, but there is no scope for national price negotiation. The Cancer Drugs Fund will operate within the framework of the existing PPRS, but a regional approach could open up greater flexibilities than may be available at national level for the NHS to reach agreements with manufacturers for supply of individual drugs which enhance patient access and reflect value.

5. **Is there anything further that could be done to ensure the Fund operates in a way that encourages drug companies to put forward improved value propositions to the NHS?**

Scope

4.9 The Fund is intended to give patients access to cancer drugs that would not otherwise be available on the NHS. This may include:

- drugs appraised by NICE and not recommended on the basis of cost effectiveness, or where the recommendations materially restrict access to the treatment beyond the specifications set out in the marketing authorisation (an 'optimised' recommendation); and
- drugs not, or not yet, appraised by NICE.

4.10 Where NICE has not carried out an appraisal, the available evidence may make it hard for PCTs to agree funding, for example use of cancer drugs outside their licensed indications (so called “off-label” use). In some individual cases, clinicians may judge that the use of an “off-label” drug is in the patient’s best interest and local management of the fund would allow clinicians greater flexibility in deciding whether to use such treatments in the best interests of patients.

4.11 The funding is intended to be additional to that already included in PCT allocations and to be used to provide treatments where there is no appropriate alternative that the NHS would otherwise fund. It is therefore important that existing PCT processes are adequately explored before a call is made on the Fund. This includes PCT consideration of Individual Funding Requests (IFR), where appropriate. It will be important to ensure that PCT level considerations are timely and do not result in delays to patients accessing drugs from the Fund. The regionally based panel should monitor these arrangements to ensure that cases are being handled appropriately.

6. **How else can we ensure the Fund is focused on providing new drug treatments, and does not subsidise treatments that would otherwise have been funded by PCTs?**

4.12 We have set out the reasons why the Fund is focussed on access to cancer drugs. There may however be treatments at the margins that may not be considered to be conventional drugs, but which clinicians feel it would be appropriate to provide from the Fund, particularly where the evidence on a treatment is not yet sufficiently developed for it to be routinely funded in the NHS. The obvious example is of radiopharmaceuticals, drugs combined with radiation therapy, including treatments such as Selective Internal Radiation Therapy (SIRT).

7. **Should the NHS have some flexibility in application of the Fund to cover, for example, the funding of radiopharmaceuticals for Cancer?**

4.13 We believe that decisions on competing priorities should be managed with the involvement of treating clinicians, and that we should not put central restrictions on the cancer drugs that are eligible for the Fund. It will be important for the composition of the clinical panels to allow for the broadest consideration of cancer drugs, including drugs for rarer cancers, and panels will wish to ensure there is the facility to obtain further expert input where appropriate. This may be particularly important for some rare or very rare cancers where there may be limited published evidence of effectiveness, and a decision taken solely on the strength of such evidence may leave patients with these conditions at a disadvantage. Conversely, there could be a case for issuing guidance to panels on the need to avoid a scenario where just one or two drugs consume a disproportionate share of the Fund.

8. **Do you agree that the Fund should be available for use on any cancer drugs that would not otherwise be funded by the NHS, and not be restricted to a national list of eligible drugs?**

9. Should guidance be issued on prioritising the Fund application, for example to rarer cancers, or should these be issues left for local resolution within the available funds?

10. What advice can we give the panels on the specific challenge posed by rarity, or single drugs that have the potential to consume a large proportion of the Fund?

4.14 To enable the funding to go as far as possible, the Fund will be focussed on the cost of the drug and PCTs will be expected to meet the associated service costs related to provision of these medicines. It may be that molecular diagnostic tests, such as those for KRAS or EGFR mutations, would help target the drugs patients are most likely to benefit from. It could therefore be argued that it would be useful to provide these tests out of the Fund.

11. Should the Fund be restricted to treatments or should the NHS be able to spend some of the Fund on molecular diagnostic tests to help target the drugs patients are most likely to benefit from?

4.15 It is of course imperative that patients receive the drugs they need in a timely fashion and are not delayed in accessing treatment as a result of overly bureaucratic processes. We would therefore encourage regional panels to develop funding policies for groups of patients wherever possible. This will support timeliness, consistency of decision-making and effective management of the resources available. It will be necessary for the panels to have the facility to consider individual requests where these would not be appropriate for a population-based approach, for example if the drug in question is for treatment of a very rare tumour or if exceptional circumstances apply in particular cases. In cases where the treatment relates to a very rare tumour, the panels will need to ensure that they have access to the appropriate clinical expertise to make an informed decision.

4.16 Panels will need to put in place a mechanism for considering appeals against funding decisions and should ensure that these processes support timely consideration.

Evidence, Information and the Role of NICE

4.17 NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. As set out in the NHS White Paper, NICE remains at the heart of the Government's plans for the NHS. It will continue to play a vital role in offering advice to the NHS on the clinical and cost effectiveness of new medicines.

4.18 Even if NICE does not recommend a drug through its appraisal process, its thorough assessment of the evidence on clinical effectiveness will be of considerable use to clinicians and patients looking for the best treatment option. We believe it is important that NICE should continue to appraise new cancer drugs by default and that companies should continue to have an incentive to engage with that process. We therefore consider it would be appropriate for the regionally based panels to decide not to fund drugs that have not been subject to NICE appraisal because the manufacturer refused to supply information to NICE.

4.19 In addition, by continuing to appraise the great majority of new cancer drugs NICE will ensure pharmaceutical companies will have an incentive to offer prices that represent value rather than relying on the Cancer Drugs Fund to pick up new drugs.

12. **Is there a role for NICE, in the context of the Fund, in signalling the technologies that are potentially of significant clinical value (albeit they were unable to recommend them as cost effective)?**

13. **Do you agree that it would be appropriate for the regionally based panels to decide not to fund drugs where a manufacturer has refused to cooperate with the NICE appraisal process?**

14. **What more could be done to deter pharmaceutical companies from charging higher prices for new drugs in expectation these will be met by the Cancer Drugs Fund?**

4.20 We will also need to consider the information needs of patients. Patients will need appropriate information on the available options to support them in making informed decisions. Treating clinicians will remain responsible for helping patients to make informed choices, taking account of their individual circumstances and the likely benefits and risks of the treatment in question.

15. **How can we support patients with appropriate information on the options available to them?**

4.21 The Government is also considering what more can be done to provide the NHS with reliable assessments of the available evidence on “off-label” uses of medicines.

4.22 We believe that it will be important for clinicians to provide audit data (including clinical audit data) on their use of drugs paid for from the Fund. At a local level, this information will be valuable in managing allocation and prioritisation of the funding. At a national level, it may be helpful to monitor the arrangements to ensure the Fund is fully and appropriately utilised. And over time it will help to improve the available evidence on how these drugs perform in real-world clinical practice.

16. **Should there be a national specification or standards for data collection, to promote consistency?**

17. **What audit data would it be most valuable to collect and at what level (local or national) should the collection be done?**

18. **Should the clinical panels be able to decide to use a small proportion of the funding (say 0.5-1%) to audit medicines use at a regional level?**

Section 5 - Cancer Drugs Fund – Summary of Questions for Consultation

Following the consultation, we will consider the responses to these questions before publishing final plans for the implementation of the Cancer Drugs Fund from April 2011.

1. **How can clinically-led panels ensure they are able to respond to the changing nature of available technologies and patient demand over the life of the fund?**

2. **Do you agree that the national weighted capitation formula is the best way of determining each SHA's share of the Fund?**

3. **What should the national role be in terms of providing guidance? Are there particular issues that national guidance should address?**

4. **Do you agree that it would make sense for different regions to take the lead in considering the evidence on drugs for different cancers, to minimise variation, reduce duplication and make the best use of scarce expertise?**

5. **Is there anything further that could be done to ensure the Fund operates in a way that encourages drug companies to put forward improved value propositions to the NHS?**

6. **How else can we ensure the Fund is focused on providing new drug treatments, and does not subsidise treatments that would otherwise have been funded by PCTs?**

7. **Should the NHS have some flexibility in application of the Fund to cover, for example, the funding of radiopharmaceuticals for Cancer?**

8. **Do you agree that the Fund should be available for use on any cancer drugs that would not otherwise be funded by the NHS, and not be restricted to a national list of eligible drugs?**

9. **Should guidance be issued on prioritising the Fund application, for example to rarer cancers, or should these be issues left for local resolution within the available funds?**

10. **What advice can we give the panels on the specific challenge posed by rarity, or single drugs that have the potential to consume a large proportion of the Fund?**

11. **Should the Fund be restricted to treatments or should the NHS be able to spend some of the Fund on molecular diagnostic tests to help target the drugs patients are most likely to benefit from?**

12. **Is there a role for NICE, in the context of the Fund, in signalling the technologies that are potentially of significant clinical value (albeit they were unable to recommend them as cost effective)?**

13. **Do you agree that it would be appropriate for the regional panels to decide not to fund drugs where a manufacturer has refused to cooperate with the NICE appraisal process?**

14. **What more could be done to deter pharmaceutical companies from charging higher prices for new drugs in expectation these will be met by the Cancer Drugs Fund?**

15. **How can we support patients with appropriate information on the options available to them?**

16. **Should there be a national specification or standards for data collection, to promote consistency?**

17. **What audit data would it be most valuable to collect and at what level (local or national) should the collection be done?**

18. **Should the clinical panels be able to decide to use a small proportion of the funding (say 0.5-1%) to audit medicines use at a regional level?**

19. **Are there any other comments or information you wish to share?**

Annex A - Glossary

EGFR (epidermal growth factor receptor) - Mutations affecting EGFR expression or activity could result in cancer

KRAS (Kirsten rat sarcoma) – the mutation of a KRAS gene is an essential step in the development of many cancers

Both KRAS and EGFR tests help to define groups of patients who are more or less likely to benefit from drugs (for colorectal and lung cancer respectively). By doing these tests, clinicians can recommend drugs to those who are most likely to benefit from them and can spare others from treatment, which will almost certainly not be active against the cancer but could have unpleasant side effects.

National Institute for Health and Clinical Excellence (NICE) – NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

Pharmaceutical Price Regulation Scheme (PPRS) – a voluntary agreement between the Department of Health (on behalf of the UK health departments) and the branded pharmaceutical industry (represented by the Association of the British Pharmaceutical Industry) which aims to ensure that the NHS has access to good quality branded medicines at reasonable prices, and promotes a healthy, competitive pharmaceutical industry.

Annex B- The Consultation Process

Responding to the consultation

You can respond to the consultation by completing the response form available at http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120834 and either emailing it to cancerdrugsfund@dh.gsi.gov.uk or posting it to:

Cancer Drugs Fund,
Gillian Baker - Consultation Coordinator,
Department of Health,
5W12 Quarry House,
Quarry Hill,
Leeds LS2 7UE

Comments should be received by 19 January 2011.

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

Link to consultation Code of Practice

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's **Information Charter.**

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

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HEALTH & WELL-BEING SCRUTINY COMMITTEE

12 January 2011

SUNDERLAND'S CHILD AND FAMILY POVERTY STRATEGY AND ACTION PLAN 2010-11 PHASE 2

REPORT OF THE EXECUTIVE DIRECTOR OF CHILDREN'S SERVICES

1. Purpose of Report

1.1 The purpose of the report is to update the Scrutiny Committee on the progress and achievements of Phase 1 of the Sunderland Model in reducing Child and Family Poverty and seek approval to progress to Phase 2 with a revised and focussed strategy based on the outcomes of the consultation process and the needs assessment.

2. Introduction

2.1 There was a duty on the Council and its Partners to carry out a Child and Family Poverty Needs Assessment by October 2010 and to produce a Local Child and Family Poverty Strategy by April 2011. The Coalition Government has decided not to issue formal statutory guidance in relation to this duty on the Council and its Partners or laying regulations detailing requirements of local Child and Family Poverty Needs Assessments.

2.2 The Child and Family Poverty Strategy consultation process has been completed. An extensive range of partners, officers across the Council and Elected Members participated in the process and the outcome will be set out further in the report.

2.3 The first phase of the Child and Family Poverty Needs Assessment has been completed, once again with a wide range of partners participating and the next steps are considered further in this report.

2.4 The Coalition Government has introduced a new NI116 Child Poverty measure and HMRC has produced a national dataset which relate to families below 60% of median income. This has established the level of Child and Family Poverty in Sunderland at 25.4%

3. Progress Update

3.1 The progress of the first phase of Sunderland's strategic approach to reducing Child and Family Poverty has produced the following products:

- A Sunderland three phased model to tackling child and family poverty
- A Governance structure in place with the Local Strategic Partnership (LSP) as lead, supported by the Child and Family Poverty Board.
- Committed 'buy-in' from all strategic partners
- A greater level of understanding of child and family poverty issues in Sunderland
- A Child and Family Poverty Strategy that was developed in partnership, with a wide range of partners actively engaged and then consulted

- Engagement of young people in the planning process (including the development of a DVD)
- An initial high-level Action Plan which covered the scope of the actions across the partnership to tackle child and family poverty
- Senior Management support within the Council and Partners
- A Child and Family Poverty Needs Assessment completed
- A regional profile on an innovative and progressive approach
- A national profile with the Child Poverty Unit (CPU) visit and health task team reports
- Progress on reducing Child and Family Poverty without access to substantial additional resources as was the case with neighbouring Authorities.
- Performance Framework in place with Partners signed up

3.2 The progress in the first year of developing Sunderland's approach and the products achieved is fully compliant with the non-statutory guidance, ahead of schedule.

4. Child and Family Poverty Consultation

4.1 In June 2010 the draft Sunderland Child and Family Poverty Strategy document was formally shared with key partners for consultation. Partners were given the opportunity to feedback on the strategy between June and September 2010, either by post or email. One interpretation of the limited number of responses received is that partners are satisfied with the content of the strategy and this is largely due to the engagement of partners in the strategy development process. In addition, suggestions and key intelligence was highlighted as result of various presentations to LSP Delivery Partnerships, Area Committees, the Children, Young People and Learning Scrutiny Committee and one to one meetings will also be integrated into the revised strategy.

4.2 Sunderland's Independent Advisory Groups (IAGs), established to represent disability, race, gender, faith, older people, younger people and lesbian, gay and bisexual people, will be invited to share their views on Child and Family Poverty and influence the actions that form the Child and Family Poverty Action Plan. The process of requesting the involvement of the IAGs has commenced, in line with the agreed protocol.

5. Needs Assessment

5.1 Following the Child and Family Poverty Board's approval to a Needs Assessment specification, a project brief was issued to all Directorates and Partners to carry out this assessment. The objective of the task was to ensure that Sunderland Child and Family Poverty Strategy and Action Plan is rooted in sound, up to date analysis of the needs and characterisations of children and families living, or at risk of living, in poverty in Sunderland.

5.2 The Needs Assessment was completed and is now the subject of detailed consultation and discussion with Partners. The Needs Assessment is attached as **Appendix 1** together with a highlight report (**Appendix 2**) summarising the key points for the Committee's consideration. A development event was held on 10 November 2010 to engage Partners in refining and agreeing the Needs Assessment.

6. Regional Developments

6.1 The North East Child and Family Poverty Advisory Group is currently drafting a North East Declaration on Child and Family Poverty which will be aimed at local businesses and the Community and Voluntary Sector. Authorities were consulted to tie-in the Declaration to a Regional European Event held on 13 November 2010. Sunderland children were represented at this event showcasing their work in producing the Child and Family Poverty DVD.

7. Recent Policy Developments Relevant to the Supporting Child and Family Poverty Agenda

7.1 The work on Child and Family Poverty and the associated draft strategy was developed under the previous government. As anticipated the change of government has had a significant impact on the policy, operational and economic environment and this will continue apace into the future. There are many policy developments that will fundamentally change the environment within which families and support services operate, in particular changes in the social welfare system will impact on the circumstances of many families that are living in poverty.

7.2 The change of government is also impacting on how the Council and its partners operate in the future. The emergence of policy drivers such as the localism agenda and the Big Society, amongst others, provide the basis on which local services can be developed to provide an increasingly focused approach to service delivery. The move towards personalised service delivery that is responsive to an informed understanding of need is at the core of the service review activities that are emerging through the Sunderland Way of Working (SWOW). This approach should provide the basis on which the factors that contribute to Child and Family Poverty can be mitigated. Of course we also need to ensure that the service developments that are emerging from the review process do not disadvantage those in our communities who are already subject to inequalities.

7.3 In addition, several research reports that are relevant to the Child and Family Poverty agenda have been published since we embarked on the development of the strategy and these provide supporting evidence for the approach that is being developed in the city.

- The Marmot Review concluded that reducing health inequalities is a matter of fairness and social justice. Health inequalities result from social inequalities so actions must be universal but with a scale and intensity that is proportionate to the level of disadvantage (proportionate universalism).
- Alan Milburn’s report on Unleashing Aspiration recognises that while prosperity has grown for most in our country, poverty remains an entrenched way of life for too many people. The report advocates targeted help so that the most disadvantaged, children especially, get a fair chance to compete to succeed.
- Frank Field’s Independent Review of Poverty and Life Chances was published on 3 December 2010. As expected it focuses on what happens during the early years of a child’s development that so impacts on a child’s lifetime opportunities and outline an ‘index of life opportunities’ to open a new phase in the anti-poverty strategy.

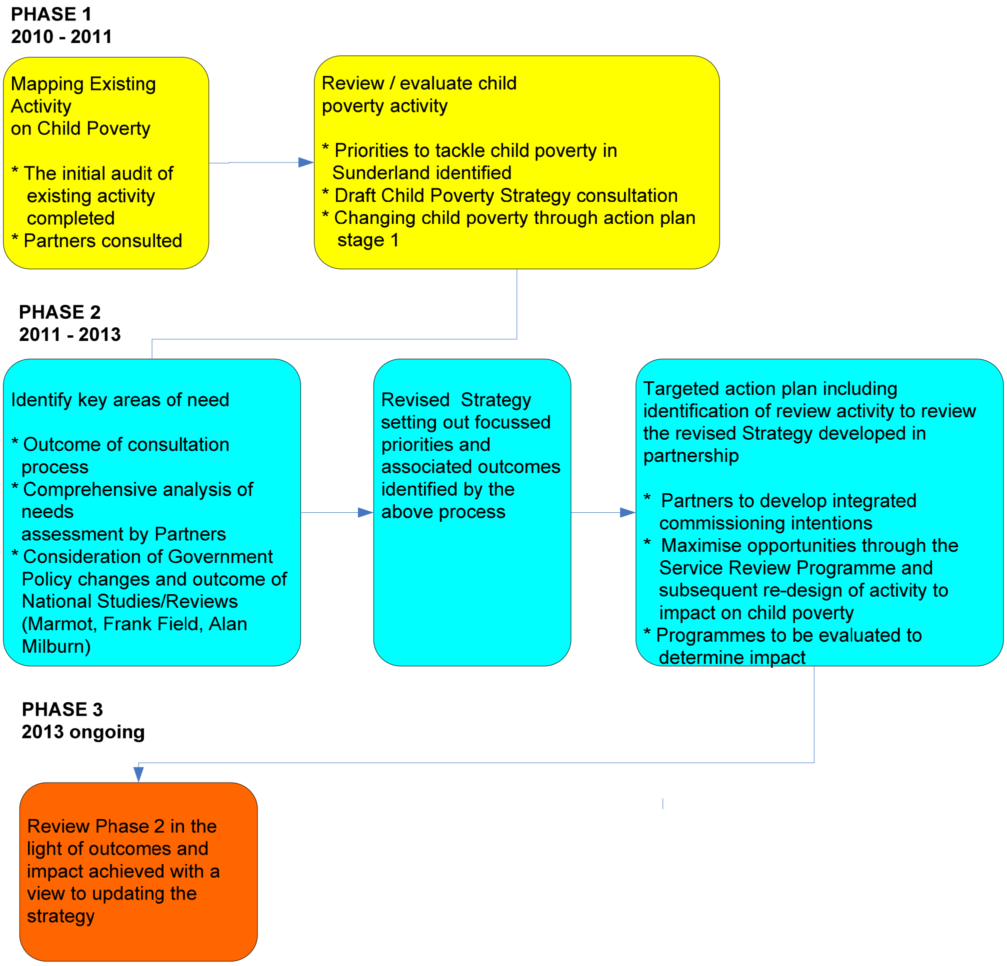
7.4 The developments outlined above demonstrate the need to reconsider the strategy in order that it is fit for purpose going forward.

8. Moving to Phase 2 of the Sunderland Child and Family Poverty Model – The Process

8.1 The previous sections of this report have identified that considerable progress has been made in establishing Child and Family Poverty as a priority, put in place a robust governance structure and a greater understanding that ‘Reducing Child and Family Poverty in Sunderland is Everybody’s Business’. This completes Phase 1 of the Sunderland model.

8.2 However, the position has fundamentally changed since we first drafted the City's Strategy twelve months ago. It is now time to revise this draft to reflect the outcome of the consultation, the findings of the Child and Family Poverty Needs Assessment, the change in policies from the Coalition Government and the impact of the Comprehensive Spending Review.

It is proposed to move the Phase 2 in accordance with the following process:



8.3 The process outlined above is in accordance with the adopted Sunderland model for tackling Child and Family Poverty and is also consistent with the established principle of moving to Outcomes Based Commissioning as set out in the following model:

9. Sunderland Child and Family Poverty Strategy – Way Forward

9.1 The findings of the Sunderland Child and Family Poverty Needs Assessment 2010 provide the basis of the revised Sunderland Child and Family Poverty Strategy. The Phase 2 Strategy also takes into account the outcome of the consultation process, the national evidence base and a Development Workshop held on 10 November 2010. This timely review will enable Partners to take account of the Strategy's Priorities in the re-shaping of services following the Comprehensive Spending Review.

9.2 Initial consideration by the Child and Family Poverty Board and Working Group has identified the following priorities for consideration:

- **Employment:** focussing on the long-term unemployed, training opportunities and engaging local businesses in the agenda
- **Children's Services and Education**: focussing on access to childcare and Children's Centres by our poorest families, narrowing the attainment gap and reducing the number of NEETS
- **Health and Quality of Life:** a focus on reducing teenage conceptions, child obesity, mental health, drug and alcohol abuse, smoking related disease, improved lifestyles through physical activity and safer communities.
- **Housing**: with a focus on supporting the socially excluded, the provision for homeless families, improvements to unfit housing and tackling fuel poverty
- **Financial Inclusion:** focussing on increasing financial capability, improved advice and reducing indebtedness.

9.3 A key feature of the strategy in taking forward these actions was considered to be through the development of a localised/neighbourhood model of tackling poverty based on the Whole Life Inclusive City aim of the Economic Masterplan (including the development of the city villages concept), and a greater understanding of local/community needs linked to mapping systems such as the Geographical Information System (GIS).

9.4 As noted above, a Development Workshop was held on 10 November 2010 to consider the five existing, agreed priorities, the neighbourhood model and the Needs Assessment

9.4.1 At the development workshop there was agreement amongst practitioners that in order to make difference, we need to take a different approach. From discussions, a two pronged approach emerged:

9.5 Firstly, embedding action on the existing child and family poverty priorities into the day to day practice and the service plans and strategies of those organisations which form the Sunderland Partnership. The overarching priority for the child and family poverty strategy in Sunderland would therefore be to:

- **Make child and family poverty everybody's business through adopting an approach to 'child and family poverty proof' Strategic Plans of all Partners as routine practice.**

9.6 Secondly, a focus on a more defined service area which could engage the contributions of a range of partners and agencies, may be more likely to make a real impact

9.6.1 The second priority would be:

- **To develop integrated neighbourhood models of service to retarget and deliver Early Years and Early Intervention.**

10. Draft Outline of the Revised Child and Family Poverty Strategy

10.1 In the light of the changes and progress identified in this report, the Scrutiny Committee is requested to consider whether the current model and proposed direction of Phase 2 is consistent with the Sunderland Way of Working and the Council's (and its Partners) expectations.

10.2 If the Committee is mindful to support continuation with the current model, the following structure to the revised Strategy is proposed:

- Policy background
- Review and achievements of Phase 1
- Endorsement of Sunderland Model and outlining Phase 2
- Highlighting the evidence base (Marmot Report etc)
- Needs Assessment outcomes
- Consultation feedback
- Links to other Strategies
- Revised priorities (as highlighted above)
- Process for engaging Partners in developing the revised Action Plan (December-March)

11. Timetable for the Production of the Revised Strategy

11.1 The timeline is as follows:

Meeting	Date of Meeting
Child and Family Poverty Needs Analysis and Strategy Review Workshop	10/11/10
Delivery Improvement Board	10/11/10
Children & Young People's Scrutiny Committee	11/11/10
Local Strategic Partnership	16/11/10
Cabinet (to approve Strategy)	01/12/10
Children's Trust	January 2011
Cabinet (to approve Action Plan)	01/03/11

12. Recommendations

12.1 The Scrutiny Committee is recommended to:

12.1.1 Note the progress and the products from Phase 1 of the Sunderland Model to reduce Child and Family Poverty in Sunderland.

12.1.2 Consider and comment on the move to Phase 2 with a revised Strategy reflecting the Consultation and Needs Assessment outcomes.
12.1.3 Consider and comment on the structure of the revised Strategy and priorities as set out.

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE

12 January 2011

HEALTHY LIVES, HEALTHY PEOPLE: PUBLIC HEALTH WHITE PAPER

REPORT OF CHIEF EXECUTIVE

1. Purpose of Report

1.1 To provide a briefing to the Scrutiny Committee about the Public Health White Paper, Healthy Lives, Healthy People: the strategy for public health in England, published on 30 November. This expands on the proposals for public health originally set out in Equity and Excellence: Liberating the NHS.

2. Background

2.1 The Public Health White Paper outlines considerable public health challenges. It supports Professor Sir Michael Marmot's recommended 'life course' approach to improving health and addressing health inequalities, which focuses on health and wellbeing throughout life to ensure that everyone is supported to make healthier choices. It also emphasises the importance of addressing the wider determinants of health such as employment, educational achievement, environmental, social and cultural factors, as well as housing.

2.2 It highlights the need to improve wellbeing – mental and physical – as well as treating sickness, and highlights the lead role that local government has in addressing this agenda. Furthermore, the White Paper emphasises the importance of tackling inequalities in health.

3. Summary of key proposals

3.1 The White Paper: Healthy Lives, Healthy People talks about a "radical new approach that will empower communities, enable professional freedoms and unleash new ideas based on the evidence of what works, while ensuring that the country remains resilient to and mitigates against current and future health threats". It talks about a shift from centralised, top down approaches.

3.2 Councils and their local communities will have the freedoms, powers and resources to make a real impact on health and wellbeing. The White Paper announces "It is time to free up local government and local communities to decide how best to improve the health and wellbeing of their citizens, deciding what actions to take locally with the NHS and other key partners".

4. The Main Proposals

A focus on outcomes

4.1 A national outcomes framework for public health will set the broad public health and health inequalities outcomes for all areas and organisations to address.

Transferring public health

4.2 From 2013, public health responsibilities currently undertaken by Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) will be divided between Public Health England (PHE) and local councils. The Directors of Public Health (DsPH) will move to local authorities and will be jointly appointed by councils and PHE.

Funding and rewards

4.3 From 2013, upper-tier councils will receive a ring-fenced public health grant to improve the health of the population and to reduce health inequalities. A new 'payment by results' system will reward Councils for making progress in improving health outcomes and reducing health inequalities.

Public Health England

4.4 The White Paper announces the creation of a dedicated and professional public health service, known as Public Health England (PHE), within the Department of Health. PHE will be charged with "bringing together a fragmented system, it will do nationally what needs to be done; it will have a new protected public health budget; and it will support local action through funding and the provision of evidence, data and professional leadership". PHE will be accountable to the Secretary of State for Health, who will have new powers to protect the population's health. PHE will have a close relationship with the NHS, social care, business and voluntary sector partners, and with the NHS Commissioning Board.

4.5 It will incorporate the current functions of the Health Protection Agency, the National Treatment Agency, the Regional DsPH, the Public Health Observatories and cancer registries. At local level, Directors of Public Health (DsPH) will develop relationships with GP commissioning consortia, through Health and Wellbeing Boards (HWBs). PHE are likely to hold responsibility for the ring-fenced public health funding which comes from the overall NHS budget. Early estimates suggest that current spend on the areas that are likely to be responsibility of PHE could be approximately £4 billion.

4.6 Public Health England's role will include:

- Providing public heath advice, evidence and expertise to the Secretary of State and the wider system;
- Delivering effective health protection services;
- Commissioning or providing national-level improvement services, including appropriate information and behaviour change campaigns;
- Jointly appointing DsPH and supporting them through professional accountability arrangements;
- Allocating ring-fenced funding to local government and rewarding them for progress made against elements of the proposed public health outcomes framework;
- Commissioning some public health services from the NHS;
- Contributing internationally-leading science to the UK and globally. PHE will be responsible for funding and commissioning of health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child health promotion (including health visiting and school nursing) and some elements of GP contract such as immunisation, contraception, dental public health.

Director of Public Health and transfer of public health staff

4.7 All upper-tier and unitary authority will be required to have a DPH, though they can be shared with other councils. DsPH will be employed by local government and jointly appointed with PHE, and will be "the strategic leader for public health in local communities, deploying the local ring-fenced budget to achieve the best possible public health outcomes across the whole local population".

4.8 DsPH will be public health professionals with a support team with specific public health and commissioning expertise. Critical tasks for DsPH are:

- Promoting health and wellbeing within local government and advising on health inequalities and developing local strategies to reduce them;
- Providing and using evidence relating to health and wellbeing and leading public health through membership;
- Advising and supporting GP consortia;
- Developing an approach to improve health and wellbeing locally;
- Working with PHE health protection units to provide health protection as directed by Secretary of State;
- Collaborating with local partners – i.e. GP consortia, other local DsPH, local business.

4.9 Professional accountability for DsPH will be to the Chief Medical Officer. Both the council and the Secretary of State for Health will have the power to dismiss DsPH, which distinguishes them from other senior council officers.

The role of the NHS in public health

4.10 The NHS will continue to play an important role in public health. PHE will commission NHSCB to undertake screening, including cancer screening, some aspects of emergency preparedness, childhood immunisations and public health aspects of primary care contracts, through the Secretary of State's mandate to the NHSCB.

4.11 Other health professionals, including GPs, dentists, pharmacists, health visitors (who will be employed by PHE) dieticians, speech therapists all have an important role to play in improving health and addressing health inequalities. GPs in particular, will be incentivised – both as primary care professionals and commissioners – to focus on prevention and early intervention. Locally, GP consortia and DsPH will work with councils, the voluntary and community sectors and the business sectors through HWBs to ensure that services and commissioners are maximising their effectiveness on health improvement and reducing inequalities. To incentivise GP practices, the Quality and Outcomes Framework (QOF) will focus far more on primary and secondary prevention, with funding for this work coming from the PHE budget. GPs will continue to provide a range of public health services such as childhood immunisations, contraceptive services, cervical screening etc but in the future PHE may wish to change how services are commissioned and delivered.

Addressing health and wellbeing throughout life

4.12 The White Paper takes a 'life course' approach to health improvement outlined in Prof. Sir Michael Marmot's report encompassing:

- Starting well – focusing on maternal and child health and breaking the intergenerational cycle of ill-health and inequalities. There will be a particular focus on children who are at risk of poor outcomes. Details of a new health visitor workforce of 4,200 to improve child health will be published in 2011, though the document does highlight the role of Health and Wellbeing Boards (HWBs) in ensuring that they join up with existing services and plans for early years.
- Developing well – focus on child and adolescent wellbeing, including mental wellbeing and self esteem. Schools have an important part to play in delivering better health outcomes for children and young people in promoting physical activity, providing high quality personal, social and health education, improving self-esteem and mental wellbeing through a range of existing and new programmes.

- Living well – encompasses all factors which contribute to health and wellbeing, including housing, planning, the natural environment, access to active transit etc. The White Paper lists a range of new and existing schemes to support people to make healthier choices in relation to eating, physical activity, environmental sustainability and use of alcohol. It highlights many ways that councils can influence health through their housing, planning, environmental, licensing, community development and regulatory functions.
- Working well – promoting good physical and mental health at work. This section focuses on the importance of work in promoting health and wellbeing and the intention of the Government to support people with long term health conditions to get back into the world of work.
- Ageing well – supporting older people to remain active, health and independent within their own homes. It summarises a wide range of universal benefits and more targeted support that enable older people to maintain their health, wellbeing and capacity. A crucial component is the Vision for Social Care published on 16 November 2010.
- There is a focus on mental health and wellbeing throughout life, with a particular emphasis on mental wellbeing of children and adolescents.

<u>Health protections and emergency planning</u>

4.13 New arrangements for emergency preparedness and health protection in which PHE will bring together the health protection and emergency planning functions of the Health Protection Agency with the public health functions of PCTs and SHAs. At local level, DsPH will have a leading role in emergency planning.

<u>Role of business, the voluntary sector and other partners</u>

4.15 The report highlights the role of business and the voluntary sector through the Public Health Responsibility Deal with five networks on food, alcohol, physical activity, health at work and behaviour change. The Responsibility Deal will be launched with further details in 2011. It is expected to include undertakings from retailers on more socially responsible selling of alcohol. Individuals will be encouraged to make healthy choices by the provision of subsidised sporting activities.

4.16 More details will be available in 2011 but so far, there are plans for a ‘Great Swapathon’ which will make available £250 million worth of business sponsored vouchers for physical activity sessions.

5. Next Steps

5.1 The Government’s proposals will be set out in the Health and Social Care Bill which will be introduced to parliament early in the New Year.

Subject to the passage of the Health and Social Care Bill, the Government plans to:

- enable the creation of Public Health England, which will take on full responsibilities from 2012, including the formal transfer of functions and powers from the Health Protection Agency (HPA) and the National Treatment Agency for Substance Misuse (NTA);
- transfer local health improvement functions to local government, with ring-fenced funding allocated to local government from April 2013; and
- give local government new functions to increase local accountability and support integration and partnership working across social care, the NHS and public health.

5.2 The transition to Public Health England will be developed in alignment with changes to primary care trusts (PCTs) and strategic health authorities (SHAs), and the creation of the NHS Commissioning Board (NHSCB). The detailed arrangements will be set out in a series of planning letters throughout the course of 2011.

5.3 Forthcoming consultation documents will set out the proposed public health outcomes framework, and funding and commissioning arrangements for public health responsibilities.

6. Recommendation

6.1 Members are asked to note the proposals in the White Paper.

7. Background Papers

Healthy Lives, Healthy People: the strategy for public health in England, 30 November 2010 Department of Health

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE

12 January 2011

REVIEW OF THE MANAGEMENT OF MALNUTRITION AND DEHYDRATION IN HOSPITALS

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 To provide evidence to the Scrutiny Committee about the Age UK campaign ‘Hungry to be Heard’ as part of the review of malnutrition and dehydration in hospitals.

2. Background

2.1 The Scrutiny Committee has been pursuing a review of the management of malnutrition and dehydration in hospitals.

2.2 Aim of the Review

To review strategies to support the decision-making of health professionals involved in the provision of food and fluids, nutritional support and public health advice/interventions for Sunderland hospital inpatients in order to manage avoidable malnutrition and dehydration.

2.3 Terms of Reference

- To consider the whole process for providing hospital meals: menu/nutritional planning; preparation; meal time; monitoring [who is eating their meal]; and clear-up;
- To explore issues around the identification of patients who are admitted to hospital malnourished and whether that status has changed on discharge;
- To explore reasons why patients are not eating their meals;
- To establish how patients who find it difficult to feed themselves are supported to do so;
- To evaluate the effectiveness of management, treatment and education/training programmes relevant to malnutrition and dehydration;
- To explore what happens to monitoring information and how it is used to ensure all people receive the nutrition they require.

3. Age UK Campaign

3.1 The review was selected following a number of national research studies highlighting the risks including the national Age Concern campaign.

3.2 In 2006 Age Concern published Hungry to be Heard, a report into malnourished older people in hospital that argued for a change in culture and practice. It recommends seven steps that hospitals should take to end the malnourishment of older people.

3.3 The campaign aimed for every ward in every hospital to implement seven steps to end malnutrition in hospital:

Step 1 - Listen to us
We must be consulted about hospital menus, our meal requirements and our preferences, and hospital staff must respond to what we tell them.

Step 2 - All ward staff must become 'food aware'
Ward staff need to take responsibility for our food needs in hospital.

Step 3 - Hospital staff must follow professional codes
Hospital staff must follow their own professional codes and guidance from other bodies.

Step 4 - Assess us for malnourishment
As many of us are malnourished on admission to hospital, we should all be weighed and our height measured on admission.

Step 5 - Introduce protected mealtimes
Protected mealtimes will ensure we are given appropriate assistance to eat meals when needed and sufficient time to eat our meals.

Step 6 - Use a red tray system
Those of us who need help with eating should be identified on admission and our meal placed on a red tray to signal the need for help.

Step 7 - Use mealtime volunteers
Where appropriate, hospital should use trained volunteers to provide additional help and support to us at mealtimes.

3.4 In August 2010 Age UK published Still Hungry to be Heard which follows the campaigning report Hungry to be Heard, published four years earlier.

3.5 The report recognises that there are examples of good practice across the country, but not enough has changed since the original report in 2006 to change outcomes. The report is critical about the way malnutrition is tackled among older people in hospitals.

3.6 Age UK Sunderland recently carried out a Hospital Meals Survey in support of the national Hungry to be Heard campaign. The results of the survey are attached for members' information as Appendix 1.

4. Conclusion

4.1 The Committee is asked to receive evidence at the meeting about the campaign and the implementation of the seven steps to end malnutrition in hospitals and consider how the campaign issues are complementary with the review.

5. Background Papers

Health & Well Being Scrutiny Committee Reports
- Work Programme and Policy Review Report 9 June 2010
- Evidence from City Hospitals Sunderland 10 November 2010

Age Concern ‘Hungry to be Heard’
Age UK ‘Still Hungry to be Heard’

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Sunderland
age UK

Hospital Meals Survey

Age UK Sunderland has been supporting the national ‘Hungry to be Heard’ campaign for several years. During that time we have worked with City Hospitals Sunderland NHS Foundation Trust to address some of the issues we face locally around nutrition for patients in hospital.

During the summer we undertook a survey of 104 patients after they had been discharged from hospital as they accessed our Hospital Discharge Support Service.

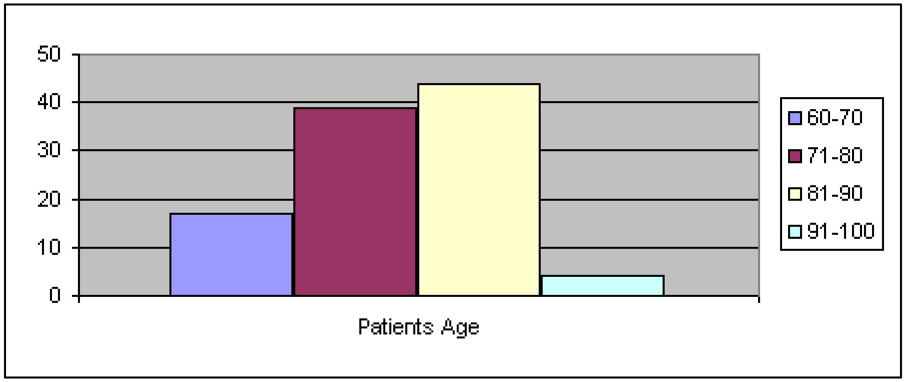
This service is aimed at people aged over 60 years who do not have a social care assessment and who either live alone or have an older person caring for them. The service provides short term support to ensure the older person settles back home and any longer term support needs are identified. The service often makes referrals to health and social care colleagues and to other services offered by Age UK Sunderland and other voluntary sector organisations. Thus, the service prevents hospital re-admissions.

The people taking the survey, although vulnerable through illness would not be regarded as the most vulnerable because they do not have an assessed need.

Sunderland Royal Hospital - Meals Survey

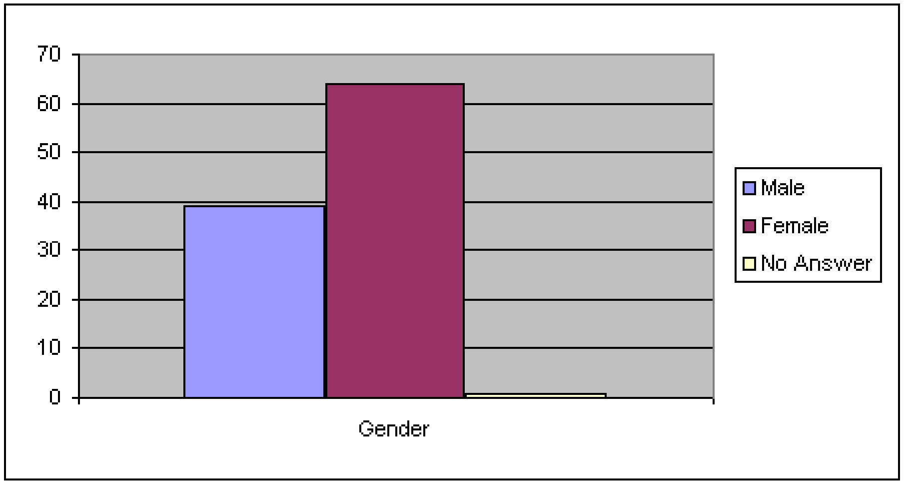
Q1. Patients Age

60-70	17
71-80	39
81-90	44
91-100	4
Total	**104**



Q2. Gender

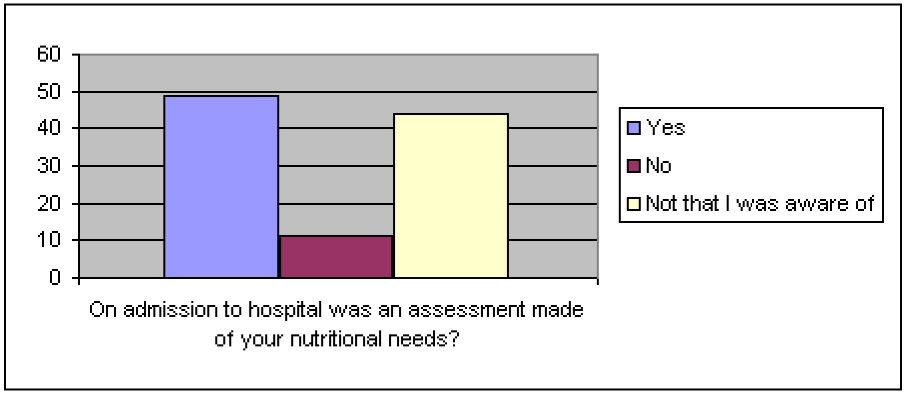
Male	39
Female	64
No Answer	1
Total	**104**



Questions 1 & 2. Show the demographic of the survey participants.

Q3. On admission to hospital was an assessment made of your nutritional needs?

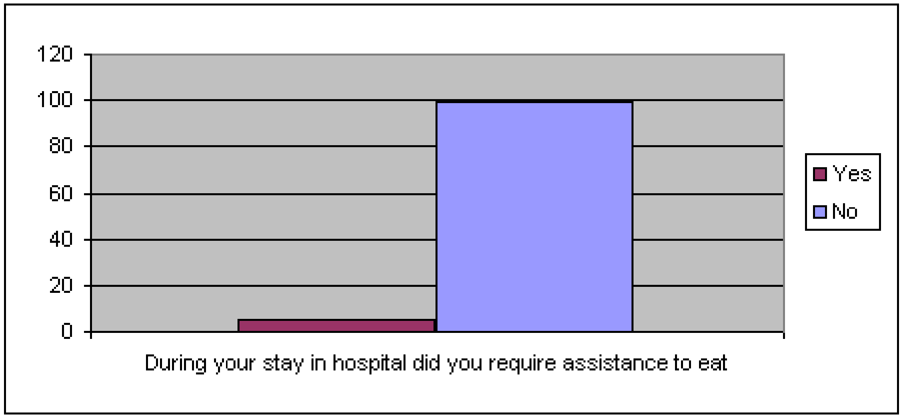
Yes	49
No	11
Not that I was aware of	44
Total	**104**



Question 3. Shows that in just over half the replies the person either did not have a nutritional assessment done or they were not aware one had been done. The likelihood is that an assessment may have been done in most cases but it was done in such a way as that the person was unaware of the fact that an assessment was being done was not emphasised.

Q4. During your stay in hospital did you require assistance to eat?

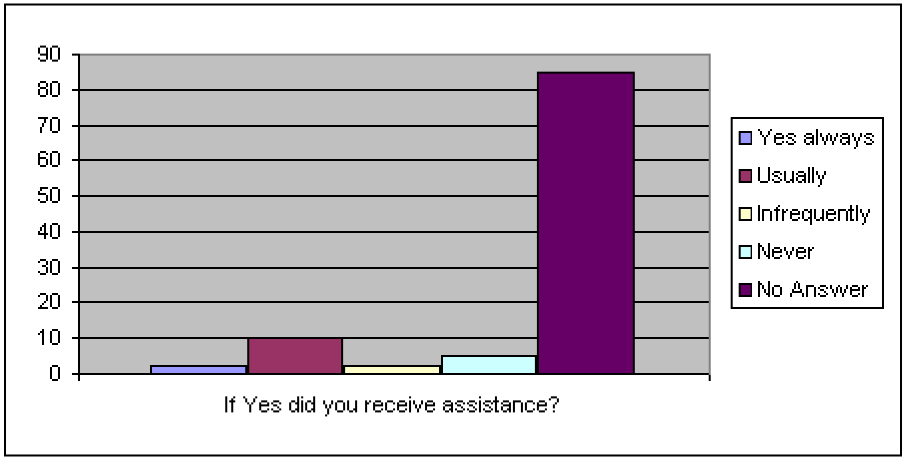
Yes	5
No	99
Total	**104**



Question 4. In line with the fact this group does not have an assessed need almost all report they did not require assistance to eat.

Q5. If Yes did you receive assistance?

Yes always	2
Usually	10
Infrequently	2
Never	5
No Answer	85
Total	**104**



Question 5. The findings here are slightly at odds with the previous questions as more people report receiving assistance than those who identified they needed assistance. This could be down to helpful hospital staff providing assistance. Interestingly, 5 people in the previous question required assistance and here 5 people say they never got help.

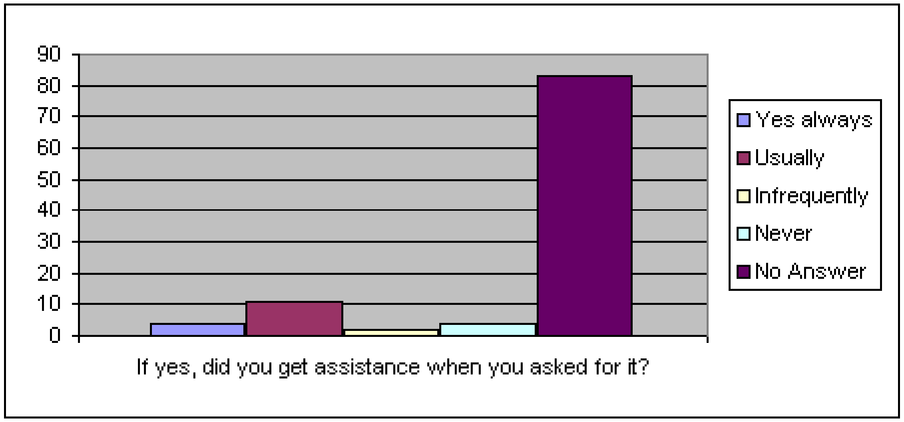
Q6. Did you ask for assistance to eat?

Yes	9
No	94
No Answer	1
Total	**104**

Question 6. Less than 10% of respondents asked for assistance to eat.

Q7. If yes, did you get assistance when you asked for it?

Yes always	4
Usually	11
Infrequently	2
Never	4
No Answer	83
Total	**104**



Question 7. The results here speak for themselves with mixed reporting of staff responses to requests for assistance to eat.

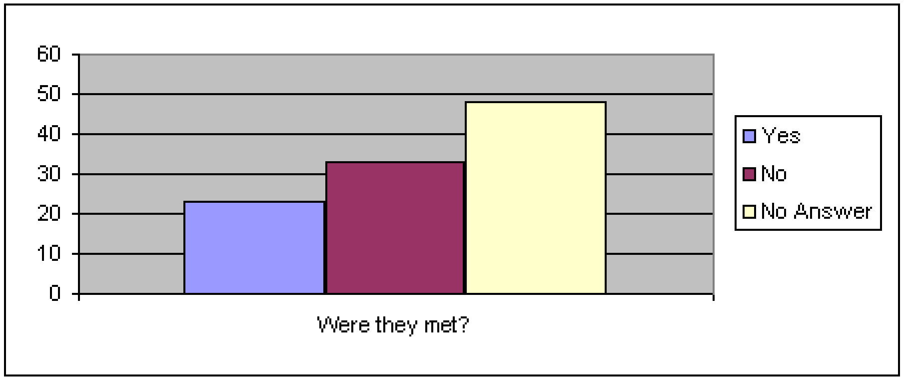
Q8. Do you have any specific dietary needs?

Yes	22
No	82
No Answer	0
Total	**104**

Question 8. The majority of respondents did not have any dietary needs but 22 reported that they did.

Q9. Were they met?

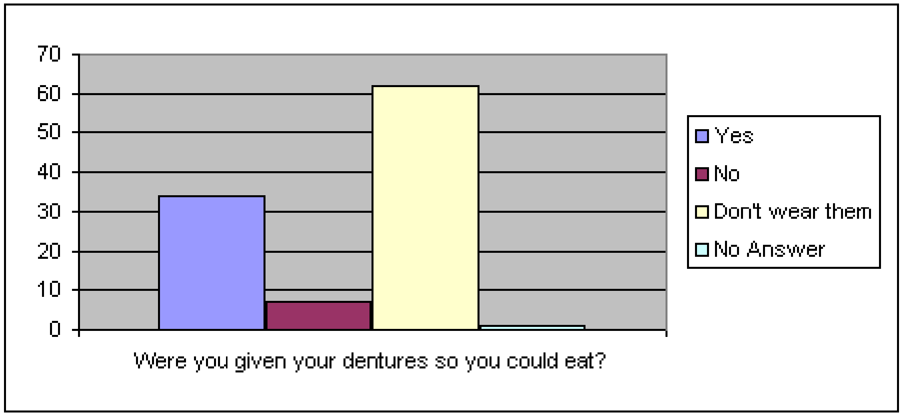
Yes	23
No	33
No Answer	48
Total	**104**



Question 9. There is an inconsistency in responses here with 33 people reporting their dietary needs were not met. This may be more about food choices rather than dietary needs.

Q10. Were you given your dentures so you could eat?

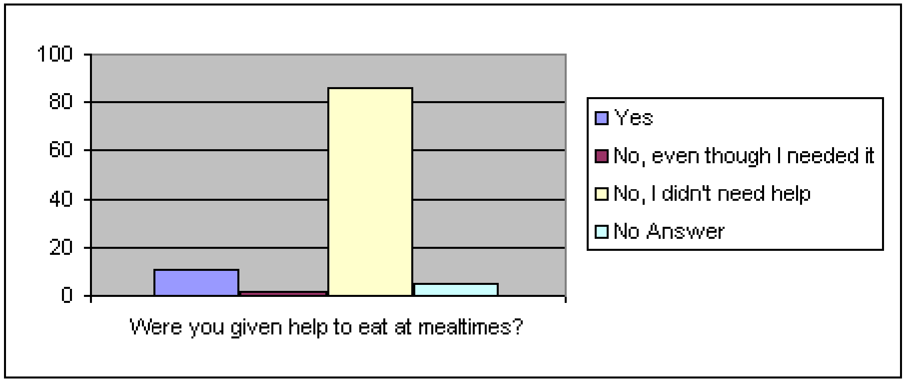
Yes	34
No	7
Don't wear them	62
No Answer	1
Total	**104**



Question 10. Most people who wear dentures were given them so they could eat but 7 reported they weren't and this is a known factor in cases of malnutrition.

Q11. Were you given help to eat at mealtimes?

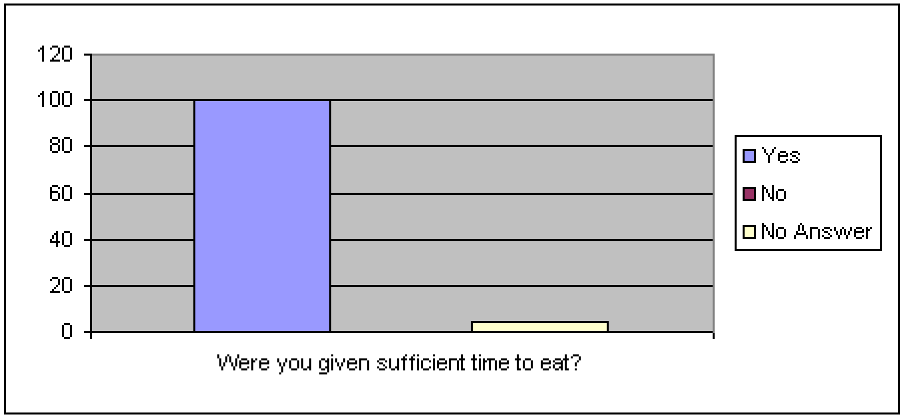
Yes	11
No, even though I needed it	2
No, I didn't need help	86
No Answer	5
Total	**104**



Question 11. A small minority reported they were not given help to eat even though they needed it with 11 reporting they got the help they required.

Q12. Were you given sufficient time to eat?

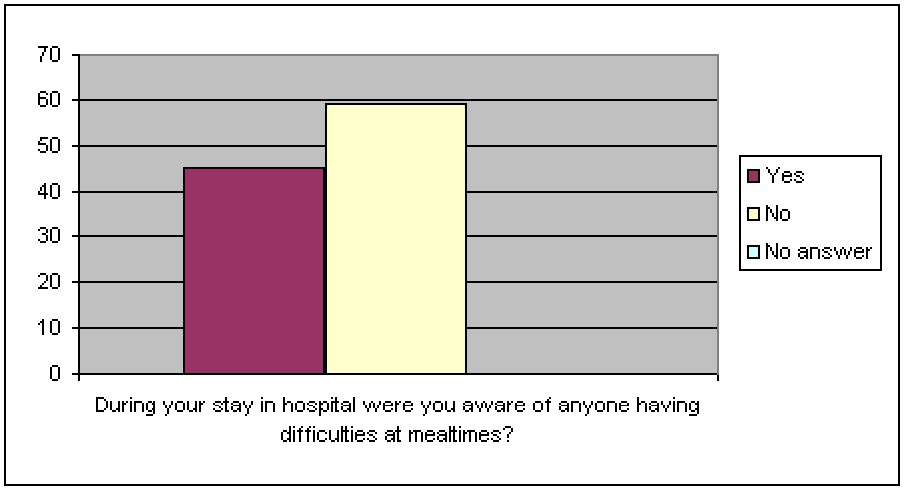
Yes	100
No	0
No Answer	4
Total	**104**



Question 12. All respondents answering this question said they were given sufficient time to eat.

Q13. During your stay in hospital were you aware of anyone having difficulties at mealtimes?

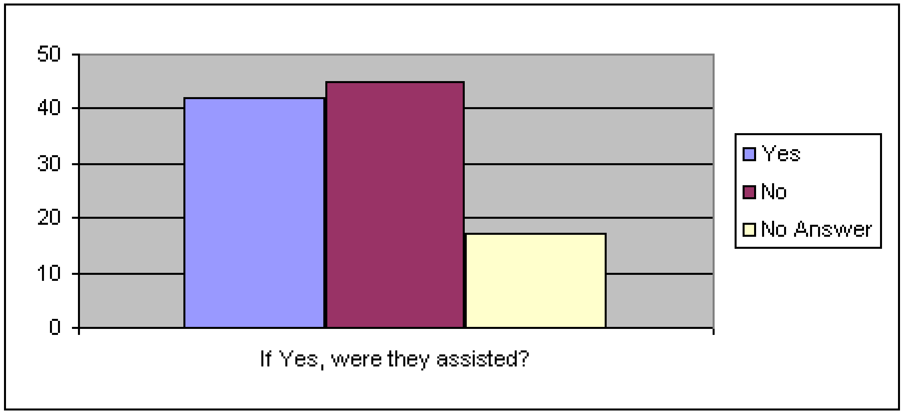
Yes	45
No	59
No Answer	0
Total	**104**



Question 13. As this group were more able bodied we asked if they were aware of anyone having difficulties at mealtimes and 45 (almost half) replied Yes.

Q14. If Yes, were they assisted?

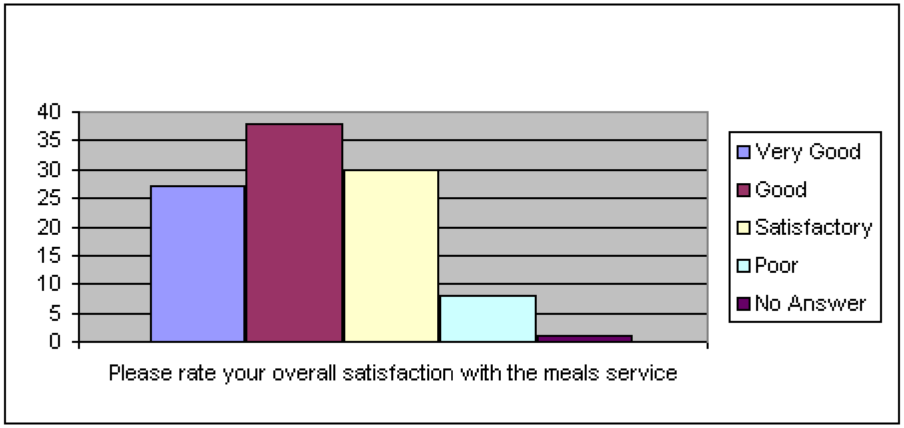
Yes	42
No	45
No Answer	17
Total	**104**



Question 14. When asked if the person they had seen having difficulties over half reported that no assistance was provided. No explanation or narrative was asked for but this area raises a concern and is worthy or further investigation.

Q15. Please rate your overall satisfaction with the meals service

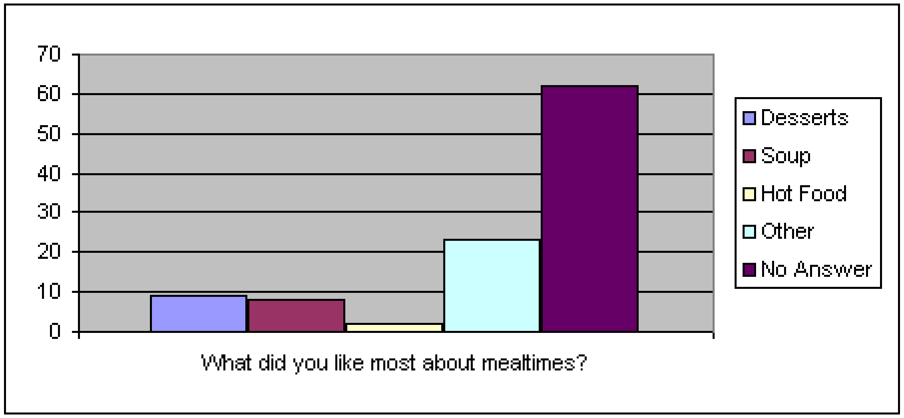
Very Good	27
Good	38
Satisfactory	30
Poor	8
No Answer	1
Total	**104**



Question 15. The vast majority of respondents reported the food satisfactory, good or very good meals service. City Hospitals are to be congratulated for this achievement.

Q16. What did you like most about mealtimes?

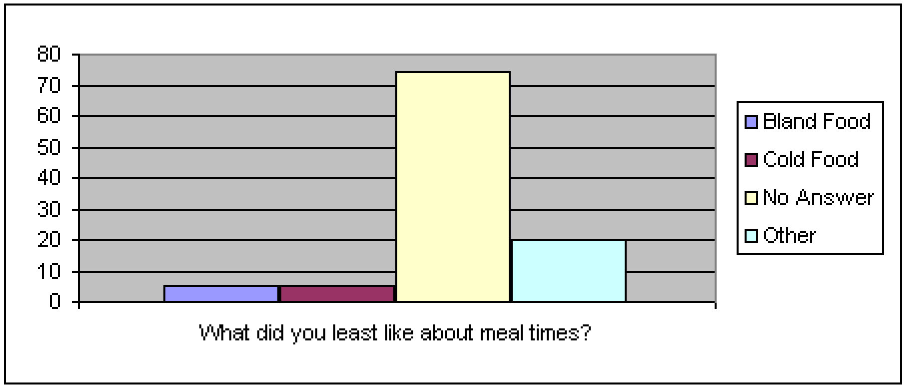
Desserts	9
Soup	8
Hot Food	2
Other	23
No Answer	62
Total	**104**



Question 16. Respondents here identify which elements of the meal they enjoyed most.

Q17. What did you least like about meal times?

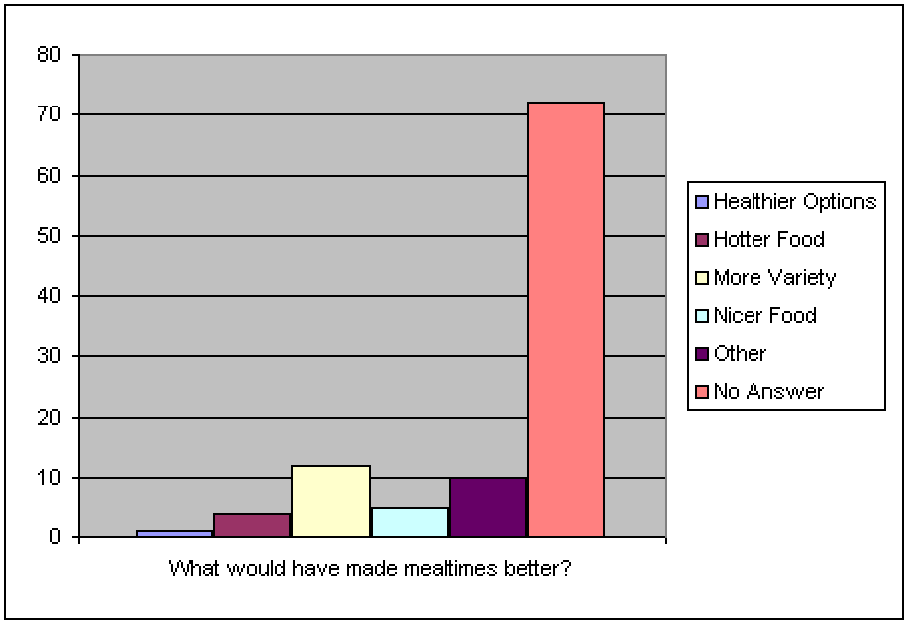
Bland Food	5
Cold Food	5
No Answer	74
Other	20
Total	**104**



Question 17. Respondents here identify what they least liked with the majority failing to answer.

Q18. What would have made mealtimes better?

Healthier Options	1
Hotter Food	4
More Variety	12
Nicer Food	5
Other	10
No Answer	72
Total	**104**



Question 18. Asked what would have made mealtimes better some mixed responses were received with the majority failing to answer.

Conclusions

This research provides a snapshot from more ‘able bodied’ older people of their nutritional experiences whilst in hospital.

Overall, it appears that City Hospitals NHS Trust is performing well in most areas but more can still be done to improve the situation, especially in the following areas:-

1. The findings in relation to other people seen to be requiring assistance and not receiving it is an area of concern that could be usefully addressed by the Trust.

2. By ensuring nutritional assessments are completed upon admission and discharge to hospital and importantly communicated to patients so that they have an awareness of their assessments and any associated action required.

No one underestimates the scale, complexity and difficulty any hospital faces to ensue that patients receive the food and drink they need to prevent malnutrition and dehydration and aid their recovery.

HEALTH AND WELL-BEING SCRUTINY COMMITTEE

12 January 2011

POLICY REVIEW: FOOD IN HOSPITALS – SERVICE USER ENGAGEMENT

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 To provide a progress report to the Scrutiny Committee about the involvement of service users as part of the review of malnutrition and dehydration in hospitals.

2. Background

2.1 The Scrutiny Committee has been pursuing a review of the management of malnutrition and dehydration in hospitals. The review was selected following national studies highlighting the risks in hospitals across the country.

2.2 The scope of the review is to study the evidence in City Hospitals Sunderland set against those national studies and best practice guidance.

2.3 The Scrutiny Committee has taken evidence from City Hospitals Sunderland and will now take the views of service users.

3. Service User Consultation

3.1 A written consultation is currently taking place with service users asking for their views on various aspects of the hospital food service including:

- Satisfaction with hospital food including choice and quality
- Reasons for not eating / missing a meal
- Options and alternatives to cater for individual appetites
- Help with eating

3.2 This consultation is being achieved with the help and support of Links, Age UK, Health, Housing & Adult Services and Sunderland Teaching Primary Care Trust.

3.3 If there is sufficient interest from service users to be further involved in providing evidence to the review, a consultant will be engaged to carry out depth interviews. A project brief will be devised which will include the cost of the one-to-one engagement. This type of consultation could be achieved within the Committee's budget.

4. National research

4.1 Since the review began taking evidence new research and findings have been published including:

National Audit of Dementia (Care in General Hospitals) December 2010 Royal College of Psychiatrists'

4.2 Key findings of this national study included

- Nutritional assessments had not been recorded in almost a third of the audited casenotes;
- Of casenotes with an assessment, a minority contained no recording of the patient's weight.

National Inpatient Survey Results 2009

4.3 This report is the seventh survey of adult inpatients in NHS trusts in England. It shows how each trust scored for each question in the survey, compared with national average results. The report should be used to understand the trust's performance, and to identify areas where it needs to improve.

National Results

4.4 Over 69,000 adult patients from 162 acute and specialist NHS trusts in England responded to the survey, a response rate of 52%. Of those respondents who had hospital food, a fifth (20%) rated it as "very good," no change from 2008 but an increase from 18% in 2002. Just over a third (35%) described the food as "good", a decrease of one percentage point since 2008; 30% of respondents thought it was "fair". There has been a statistically significant increase, of less than one percentage point, from 2008 in the proportion of respondents who rated the food as poor (14%).

4.5 Overall, 78% of respondents reported that they were "always" offered a choice of food, no change from the previous survey, while another 16% said they were offered a choice "sometimes". Six percent of respondents said they were not offered a choice of food. However, this question showed differences related to how long respondents had been in hospital for: 13% of respondents who only stayed overnight said they were not offered a choice of food compared with four percent of those who stayed more than one night.

4.6 The tables below show the national results for the adult inpatient surveys carried out between 2002 and 2009.

How would you rate the hospital food?

	Survey Year						Significant change between 08 and 09	Significant change between 02 and 09
	2002	2005	2006	2007	2008	2009		
Very good	18%	18%	18%	19%	21%	20%		↑
Good	35%	36%	35%	36%	36%	35%	↓	
Fair	31%	31%	31%	31%	30%	30%		↓
Poor	16%	15%	15%	15%	14%	14%	↑	↓
Number of respondents	89304	76133	76046	72073	68842	65527		

Answered by all who had hospital food

Were you offered a choice of food?

	Survey Year				Significant change between 08 and 09
	2006	2007	2008	2009	
Yes, always	79%	77%	78%	78%	
Yes, sometimes	16%	16%	16%	16%	
No	6%	7%	6%	6%	
Number of respondents	75283	72868	70501	67366	

Answered by all

Did you get enough help from staff to eat your meals?

	Survey Year						Significant change between 08 and 09	Significant change between 02 and 09
	2002	2005	2006	2007	2008	2009		
Yes, always	58%	62%	58%	60%	63%	63%		↑
Yes, sometimes	24%	21%	21%	20%	19%	19%		↓
No	18%	18%	20%	20%	18%	18%		
Number of respondents	19049	19982	19041	20709	21079	20364		

Answered by all who needed help from hospital staff to eat their meals

Local Results

4.7 Locally the survey included 850 patients discharged during the month of June 2008.

4.8 The Trust is given a score for each question in the survey, which can be compared with national average results. Three questions around hospital food show that there are aspects of the food service that continue to be of concern for some patients at City Hospitals Sunderland NHS Foundation Trust, particularly the issue about patients not being offered a choice of food since this was also a low scoring question in the 2008 survey.

4.9 The Care Quality Commission has published a summative set of tables and charts showing Trust scores based on patients' responses to the survey. This highlights how these compare with other Trusts as either 'worse', 'about the same', or 'better'.

4.10 City Hospitals Sunderland NHS Foundation Trust Scores for Hospital Food are set out in Table 1:

Table 1.

4.6/10	**Quality of food** for describing the hospital **food** as **good**	WORSE	**ABOUT THE SAME**	BETTER
7.5/10	**Choice of food** for having been offered a **choice of food**	**WORSE**	ABOUT THE SAME	BETTER
6.8/10	**Help with eating** being given **enough help** from staff to **eat their meals**, if they needed it	WORSE	**ABOUT THE SAME**	BETTER

About the scores: The scores received are out of 10 based on the responses given by patients'. A higher score is better. The results from each trust take into account the age and sex of respondents, and whether their admission to hospital was planned or an emergency, compared with the age, sex and method of admission (planned or emergency) of all people across England that returned the questionnaire.

5. Further evidence

5.1 The next stage of the evidence gathering will include benchmarking performance with other hospitals and patients views of services elsewhere.

5.2 The Committee will also consider the community aspect of malnutrition and the nutritional status, particularly of older people on admittance and on discharge from hospital.

6. Recommendation

6.1 The Committee is asked to receive this progress report in relation to the involvement of service users in the policy review.

7. Background Papers

Health & Well Being Scrutiny Committee Reports
- Work Programme and Policy Review Report 9 June 2010
- Evidence from City Hospitals Sunderland 10 November 2010

National Audit of Dementia (Care in General Hospitals) December 2010 Royal College of Psychiatrists'

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HEALTH & WELL-BEING SCRUTINY COMMITTEE

12th January 2011

FORWARD PLAN – KEY DECISIONS FOR THE 1 JANUARY – 30 APRIL 2011 PERIOD

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of the Report

1.1 To provide Members with an opportunity to consider the Executive's Forward Plan for the period 1 January – 30 April 2011.

2. Background Information

2.1 The Council's Forward Plan contains matters which are likely to be the subject of a key decision to be taken by the Executive. The Plan covers a four month period and is prepared and updated on a monthly basis.

2.2 Holding the Executive to account is one of the main functions of scrutiny. One of the ways that this can be achieved is by considering the forthcoming decisions of the Executive (as outlined in the Forward Plan) and deciding whether scrutiny can add value in advance of the decision being made. This does not negate Non-Executive Members ability to call-in a decision after it has been made.

2.3 In considering the Forward Plan, members are asked to consider only those issues which are under the remit of the Scrutiny Committee. These are as follows:-

General Scope: To consider issues relating to health and adult social care services

Remit: Social Care (Adults); Welfare Rights; Relationships and scrutiny of health services; Healthy life and lifestyle choices for adults and children; Public Health; Citizenship (Adults); and External inspections (Adult Services)

3. Current Position

3.1 The relevant extract from the Forward Plan is attached.

3.2 In the event of members having any queries that cannot be dealt with directly in the meeting, a response will be sought from the relevant Directorate.

4. Recommendations

4.1 To consider the Executive's Forward Plan for the current period.

5. Background Papers

Forward Plan 1 January – 30 April 2011

Contact Officer : Karen Brown, Scrutiny Officer
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Forward Plan - Key Decisions for the period 01/Jan/2011 to 30/Apr/2011

Sunderland
City Council

E Waugh,
Head of Law and Governance,
Sunderland City Council.

14 December 2010

Forward Plan: Key Decisions from - 01/Jan/2011 to 30/Apr/2011

No.	Description of Decision	Decision Taker	Anticipated Date of Decision	Principal Consultees	Means of Consultation	When and how to make representations and appropriate Scrutiny Committee	Documents to be considered	Contact Officer	Tel No
01471	To consider the results of the Care Quality Commission Ratings.	Cabinet	17/Jan/2011	Cabinet, Service Users and Ward Members, Portfolio Holders	Briefings and /or meetings with interested parties	Via the Contact Officer by 20 December - Health and Wellbeing Scrutiny Committee	Report	Graham King	5661894
01438	To agree the Social Care Contributions Policy for Personalisation	Cabinet	09/Mar/2011	Cabinet, Service Users and Ward Members, Portfolio Holders	Briefings and/or meetings with interested parties	via the Contact Officer by 21 February - Health and Wellbeing Scrutiny Committee	Report	Neil Revely	5661880
01436	To agree for the Council to assist with and facilitate the transfer of NTW's learning disability homes to a Registered Social Landlord.	Cabinet	09/Mar/2011	Cabinet, Service Users and Carer Groups, Portfolio Holder, Adult Services Staff, Health Partners	Briefings and/or meetings with interested parties.	Via the Contact Officer by 21 February - Health and Wellbeing Scrutiny Committee	Report	John Fisher	5661876

HEALTH & WELL-BEING SCRUTINY COMMITTEE

12th January 2011

ANNUAL WORK PROGRAMME 2010-11

REPORT OF THE CHIEF EXECUTIVE

1. Purpose of Report

1.1 For the Committee to receive an updated work programme for 2010-11.

2. Background

2.1 The Scrutiny Committee is responsible for setting its own work programme within the following remit:

> *Social Care (Adults); Welfare Rights; Relationships and scrutiny of health services; Healthy life and lifestyle choices for adults and children; Public Health; Citizenship (Adults); and External inspections (Adult Services)*

2.2 The work programme can be amended during the year and any Member of the Committee can add an item of business.

3. Current Position

3.1 In addition to the items taken at the scheduled meetings the following activities have taken place since the last meeting.

3.2 The Regional Review of the Health Needs of the Ex-Service Community has nearly reached its conclusion and a final report is being prepared. The Regional Review was part of the Health Inequalities Scrutiny Programme supported and funded by the CfPS.

3.3 The CfPS is capturing Action Learning from the Scrutiny Programme, which involved 10 Scrutiny Development Areas, and an event took place in November to capture what has been learned about scrutiny from the project. The event was an opportunity to pool learning from across the country. The Scrutiny Programme had used a number of creative ways to gather evidence to help understand the impact of health inequalities in their communities.

3.4 All of the learning captured from the event, together with that from each of the reviews will be brought together in to a guide to help other areas to carry out scrutiny reviews of their health inequalities. The guide will point to best practice, how to overcome obstacles and in depth information from each of the areas experiences. The guide is to be launched on the 17th February 2011.

4. Conclusion & Recommendation

4.1 That Members note the updated work programme.

5. Background Papers

None

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HEALTH AND WELL-BEING SCRUTINY COMMITTEE WORK PROGRAMME 2010-11

	JUNE 09.06.10	JULY 07.07.10	SEPTEMBER 15.09.10	OCTOBER 13.10.10	NOVEMBER 10.11.10	DECEMBER 08.12.10	JANUARY 12.01.11	FEBRUARY 09.02.11	MARCH 09.03.11	APRIL 06.04.11
Cabinet Referrals & Responses	Article 4: Food Law Enforcement Service Plan. (NJ)	CQC Service Inspection of Safeguarding Adults & Choice & Control for Older People	CQC Service Inspection – Action Plan Response to 'Tackling Health Inequalities in Sunderland' Review			Response to Health Inequalities / Home Care & Dementia Reviews		LSP Delivery Report		
Policy Review	Proposals for policy reviews (KJB) Ex-Service Personnel Review (KJB) Regional Health Protocol (KJB)	Scope of review – Malnutrition in Hospitals (KJB)	Appointment of Coopted Member Ex-Service Personnel Review Progress (KJB)		Evidence Gathering – City Hospitals Sunderland		Hungry to be Heard – Age Uk (AP) Service User Engagement	Evidence Gathering Ex-Service Personnel Review – Final Report	Final Draft Report	Final Report
Performance			Performance & VfM Annual Report (GK)			Performance Q2 (GK)				Performance Q3 (GK)
Scrutiny	Mid-Staffordshire NHS hospitals Foundation Trust – Francis Report (CH) Internal Service Development (CW) CfPS Conference attendance (KJB)	TeleCare Services (PF) Total Place (LC) Social Care for Adults with LD (JF)	CAMHS Review (PCT) NHS White Paper Consultation CfPS Conference Feedback	Transforming Community Services NHS White Paper update Wearvmouth View Improvements		Pride Project (IH/TR) PNA Consultation Out of Hours Provision (JU)	Public Health White Paper Young People's Sexual Health Child Poverty (RS) Cancer Drugs Fund	NHS White Paper update Personalised Care (inc Re-enablement/discharge) (SL)	NHS White Paper update	Annual Report (KB)
CCfA/Members items/Petitions										

At every meeting: Forward Plan items within the remit of this committee / Work Programme update