Health Scrutiny- A Short Guide

Written by Megan Ingle, Research and Project Officer, CfGS

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What is this guide about?

This is a comprehensive introductory guide that aims to provide an overview of the main facets of Health and Adult Services Scrutiny, giving a summary of some of the key tools and skills needed to improve and enhance health scrutiny in your authority.

As well as providing a general introduction to the key themes and issues, the guide looks at two specific substantive areas of policy where scrutineers might want to take work – support to older people, and health inequalities.

Because the rules around aspects of health scrutiny – in particular, the statutory power of referral to the Secretary of State – are changing, we expect to issue an update of this paper later in 2023.

We have produced a counterpart to this paper which explores scrutiny of children's services.

Who is it for?

Anyone working in or with Health-related Public Services is likely to come into contact with Health Scrutiny, but specifically the primary audience for this document is:

- Members of Health Scrutiny committees/commissions/panels, including Chairs and Vice-Chairs.
- Scrutiny officers
- Those in Senior Management, i.e Public Health Directors, Directors of Adult Services etc.
- Council leaders and other Cabinet members. This is because political leadership is crucial to effective Health Scrutiny. Commitments to supporting the Health Scrutiny function (this applies to the scrutiny function more generally) and recognizing the political dynamic within which it operates must come from the top.
- Those new to Health Scrutiny, whether this is officers or members.

Background

Here at CfGS we have twenty years of experience and are the leading experts in providing support and advice to local authorities on scrutiny and governance. We are committed to developing and promoting leading policy and practice in governance and scrutiny, and this particular guide seeks to bring together a number of our publications on the matter of Health Scrutiny. We have sought to repackage these publications from over the years into one concise guide for scrutineer practitioners. These publications include:

- Advising residents about health and social care complaints: a guide for councillors (June 2014, not available)
- A good place to grow older? Practice guide for Overview and Scrutiny Committees (January 2011, not available)
- Providing a lifeline: Effective scrutiny of local strategies to prevent or reduce suicide (October 2018, not available)
- Checking the Nation's Health: The Value of Council Scrutiny (February 2014, not available)
- 10 questions to ask if you're scrutinising local immunisation services (April 2016)
- Getting wiser about growing older
- Governance of Sustainability and Transformation Partnerships: the verdict so far (July 2017)
- Improving the scrutiny of integrated care systems and sustainability and transformation partnerships: A guide to good practice
- Governance and accountability for integrated health and care (January 2019)
- Peeling the onion: Learning, tips and tools from the Health Inequalities Scrutiny Programme
- Piecing it together: Effective scrutiny of health and social care integration (May 2015)
- Scrutinising the Transformation of Adult Social Care: Practice Guide
- Scrutiny and NHS Health Check Understanding data briefing (November 2013)
- Shared principles for redesigning the local health and care landscape
- Spanning the system: Broader horizons for council scrutiny
- Walk a mile in my shoes: Scrutiny of dignity and respect for individuals in health and social care services: a guide (November 2009)
- Winter Pressures: A Guide for Council Scrutiny (November 2015)

Since the publication of most of the above papers, there have been changes to health scrutiny powers, including new structural and legislative changes brought in by the Health and Care Act 2022, which we will now discuss in further detail.

The Health and Care Act 2022

CfGS recently published a briefing paper on the Act, which you can read here. We will also provide a summary of the Act and what it entails below.

The Health and Care Act 2022 received Royal Assent on 28th April 2022. Formal changes will be coming into force in the coming months – statutory Integrated Care Boards and Integrated Care Partnerships were introduced on 1 July 2022. New powers for the Secretary of State to intervene in local health services will begin in 2023, however the exact date for this has not been announced.

Substantial ongoing uncertainty on key elements of the new arrangements will make preparation a challenge, however, a suite of statutory guidance is expected; further guidance from NHS England is also forthcoming. When this is available, we will update this paper accordingly. As a result of the upcoming guidance, changes will be needed to the current Health Scrutiny Regulations. For comprehensive information on what remains the same following the new legislation for local authorities, the NHS and for patient and public involvement can be found here.

The Act does make some substantial changes to the organisation of health and care functions across England. You can find general briefings about the Health and Care Act and its contents more broadly here:

- Government press release: https://www.gov.uk/government/news/health-andcare-bill-granted-royal-assent-in-milestone-for-healthcare-recovery-and-reform
- BMA briefing: https://www.bma.org.uk/advice-and-support/nhs-delivery-andworkforce/integration/the-health-and-care-act
- The King's Fund briefing: https://www.kingsfund.org.uk/blog/2022/05/health-andcare-act-2022-challenges-and-opportunities
- LGA briefing (based on the situation applying during consideration of Lords amendments at the end of March 2022): https://www.local.gov.uk/parliament/briefings-and-responses/health-and-carebill-consideration-lords-amendments-house
- NHS Confederation briefing: https://www.nhsconfed.org/publications/health-andcare-bill-five-influencing-successes

Structural changes

The main structural change in the Act is the abolition of CCGs and the development of Integrated Care Systems (ICSs). There are two bodies in particular that will come into fruition, which are:

- Integrated Care Boards (ICBs), new bodies with a range of duties around the commissioning of health services;
- Integrated Care Partnerships (ICPs), bodies comprised of ICBs and representatives of local authorities in the area, with a responsibility for jointly planning health and care services across an area.

More information on what the duties of ICBs and ICPs can be found in our briefing paper.

Changes to the powers of Health Scrutiny

There will be changes to the powers of Health Scrutiny, which we have set out below, however it must be noted though there is still uncertainty about which of these powers set out in the current regulations (which can be

found here) will remain, in light of the Secretary of State's new powers of intervention. We know that the Act designates the ICB as a "responsible person" for the purposes of the Regulations, and that therefore some of these critical powers will, indeed, persist.

The Secretary of State's new powers of intervention

The Secretary of State's (SOSs) new powers of intervention will involve the granting of significant discretion to the SOS to intervene in the operation of local health and care services. Previously, the SoS was only able to intervene after the referral from a local authority (usually, from a scrutiny committee) had taken place, the original provisions of the Bill were that he or she would be able to do so essentially unilaterally.

The power previously held by scrutiny to refer matters to the SoS is being removed and replaced by an obligation on the SoS to "consult". Consultation will still provide HOSCs with an opportunity to directly influence the SoS's decision, but it will remove a degree of proactivity from the arrangements.

These formal steps will need to be preceded by some form of engagement between scrutiny and the ICB itself. Its status as a statutory consultee should mean that – as has been the case with the referral power – scrutiny has, in theory, a degree of clout in the system and can expect early engagement with the ICB on change plans.

If a scrutiny committee is concerned about the adequacy of change plans, it could contact the SoS to ask that powers to intervene be exercised – but this request would have no formal status. It remains to be seen how the SoS proposes to develop the insights and data needed to be able to make accurate judgements as to where intervention might be necessary – again, it is likely that statutory guidance will make this clearer.

What is Health Scrutiny?

The primary aim of Health Scrutiny and Health Scrutiny Committees (HOSCs) is defined by the Government in its 'Local Authority Health Scrutiny Guidance: to support Local Authorities and their partners to deliver effective health scrutiny' (2014). It is designed to act as a lever to improve the health of local people, ensuring that their needs are considered as an integral part of the commissioning, delivery, and development of health services.[1]

Health scrutiny is an important function in which elected members represent the views of their constituents and hold relevant NHS bodies and health service providers to account. It is therefore vital that health scrutiny functions are undertaken in a transparent way, so that their constituents can easily access proceedings, in line with the transparency measures that were implemented in the Local Audit and Accountability Act 2014.[2]

HOSCs can examine and investigate any health-related issue in their locality and must invite interested parties when they choose to carry out such investigations. HOSCs make suggestions to local NHS bodies and have the right to require a response within 28 days. The scrutiny function can carry out investigations on its own initiative, or at the suggestion of Local HealthWatch. Where scrutiny finds issues around local health services, the HOSC now has the power to refer it to the Secretary of State (prior to the Health and Care Act 2022, the Council had to do this as opposed to the HOSC)[3]

In light of the Health and Care Act 2022, which we discussed above, under the new legislation, HOSCs will continue to play an essential role as the body responsible for scrutinising health services for their local area. The government advises that HOSCs will continue to retain their legal duties to review and scrutinise matters relating to the planning, provision, and operation of the health service in the area. Some local authority areas may have separate scrutiny committees for health and for adult social care, though they recommend that ICBs and ICPs should develop a trusting relationship with HOSCs to enable effective scrutiny[4].

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107226/Local_authority_health_scrutiny.pdf
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107226/Local_authority_health_scrutiny.pdf
[3] https://www.local.gov.uk/sites/default/files/documents/11%2064_Scrutiny%20for%20councillors_03_1.pdf
[4] https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles

Important elements of Health Scrutiny

Below we will outline what we consider the important elements of health scrutiny to be:

A systems approach to understanding and collaboration

- A 'systems approach', in the context of health scrutiny, can be defined as 'a way of addressing health delivery challenges that recognises the multiplicity of elements interacting to impact an outcome of interest and implements processes or tools in a holistic way[5].' In simpler terms, it is about bringing together the voices and perspectives of all those involved, including: constituents, professionals in the Health Sector and Adult Services Sector etc. Following the abolition of CCG's, it is important that that there is close co-operation and dialogue between the local authorities and ICBs, ICPs. This is especially true in a Joint HOSCs, as it is arguably harder for HOSCs to operate over a larger geographical footprint covering multiple local authorities. This is because there may not be pre-existing relationships and the new committee may not work automatically together as a team.

Public process and public confidence

- Local authorities must work with the best interests of the constituents they serve in mind. The processes used within Health Scrutiny must be transparent and easily accessible (i.e. available on the council website) and constituents should be able to challenge and hold the council to account. Processes must be robust and in order to garner and maintain public confidence.

Community leadership role

- When undertaking Health Scrutiny, members must be mindful that they are undertaking outreach within their local area, so that they are aware of the needs of the local community. Councillors bring unique perspectives to the table regarding health scrutiny, that can bring to bear on the work that it does.

Builds on arrangements to 'hold the executive to account' and to 'review matters that effect the area'

- Holding the executive to account and reviewing matters that effect the area are important in the context of health scrutiny for several reasons. Firstly, it ensures that the executive is transparent and accountable for its decisions and actions, which can have significant impacts on the health and wellbeing of the constituency. By enacting thorough scrutiny, you will be able to identify any potential issues or concerns and therein address them in a timely manner. Secondly,

[5] https://bmjopen.bmj.com/content/11/1/e037667

health scrutiny can help to identify areas for improvements and provide recommendations for identified shortcomings, leading to better health outcomes for the local community.

The benefits of Health Scrutiny

Here we will outline what we consider the benefits of health scrutiny to be:

- Being able to put forward straightforward, powerful questions in a complex system. Elected members will likely not be experts in the health-field and nor are they expected to be. During health scrutiny, members have the opportunity to put ask questions that may have otherwise been overlooked by those in the field.

- Health scrutiny can undertake 'deep dives', test assumptions and review what is known/not known.

- Health scrutineers are able to link up system leadership around actions in order to achieve common goals.

- It is patient centred and gives the public a voice. Though it should be noted that whilst this is the case, professional judgement should also be respected.

- HOSC's can embed action to prevent poor health and maintain people's independence.

Challenges for health scrutiny

Now we have considered the benefits of health scrutiny, it is important to explore what challenges can arise:

- Health and care is complex with very high profile- As stated before, members involved in health scrutiny are not expected to be experts. However, it is important to know what the right questions are to ask and be confident in the information that is requested, due to the complex nature of health and care.

- Local actions are often nationally driven, due to a lack of financial sustainability- In terms of public health spending, the picture is more complex. Most of the local government spending on public health comes through a direct annual grant from DHSC which has been distributed every year since 2013/14, which is when public health functions were transferred from the NHS to local government[6]. The public health grant is becoming a less useful guide than it was in terms of understanding the landscape of local government public health spending.

[6] https://www.kingsfund.org.uk/blog/2022/03/local-government-public-health-funding

The King's Fund advises that DHSC needs to be clearer and consolidate its data, so that it can be seen how much money gets to local public health teams and how much is being spent.

In 2019/20 Councils received 23% of their funding from government grants, however local authority 'spending power' has fallen 16% since 2010. This is largely because of reductions in the central government grants, which have been the most sharply cut component of local government revenue since 09/10[7]. Whilst social care is a statutory responsibility and has protected spending within this area, it is often at the 'expense' of other services, including the public health budget. Of course, COVID has hit council budgets hard, especially health and care budgets, of which all councils are still recovering.

- A lack of resources to support a balanced work programme- health scrutiny, and scrutiny in general is often poorly resourced, this is usually due to budget constraints. CfGS believes that, where possible, there should be assigned officers to scrutiny committees in order to assist with health scrutiny.

[7] https://www.instituteforgovernment.org.uk/explainers/local-government-funding-england

Scrutiny of substantive topics

This section goes into more detail on two particular areas that health scrutiny might investigate, derived from CfGS's research over the past decade. In doing so we hope both to provide practical advice on these two areas, and to stimulate thinking about connected matters where some of the questions and issues below might be salient.

- Our ageing population, how it impacts the health and care system, and how the system can support older people's needs – including the need to engage with and learn from older people better;
- Winter pressures in the health services;
- Health inequalities, and how we can better understand the determinants of good health in how we support local people

Aging population

The most recent Office of National Statistics Census 2021 confirmed that there are more people than ever before in older age groups. Over 11 million people – 18.6% of the total population – were aged 65 years or older, compared with 16.4% at the time of the previous census in 2011.

Whilst of course aging and living longer is something to be celebrated and presents many opportunities, it also has implications for the economy, services, and society[8]. Population aging is causing significant concerns about the increasing need for healthcare and care services. With insufficient funding, rising demand, rising costs, and a 40% cut to local government budgets since 2010, councils are struggling to decide which care services they can offer[9]. The older demographic are as diverse a group of people as any other section of the population, which will affect health outcomes as one size will not fit all[10].

Pensioners and older people are one of the demographics that is being hit the hardest by the cost-of-living crisis, as they may be on fixed incomes and have higher household bills, which will need to be accounted for when planning.

Health scrutiny and HOSCs have an important role to play with regards to older people. HOSCs may already have experience and expertise in

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8 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/voicesofourageingpopulation/livinglongerlives#:~:text=The%20population%20of%20England%20and,the%20previous%20census%20in%202011.

9 https://www.local.gov.uk/sites/default/files/documents/ageing-silver-lining-oppo-1cd.pdf

10 https://www.local.gov.uk/sites/default/files/documents/ageing-silver-lining-oppo-1cd.pdf

reviewing strategies and services for older people, CfGS have seen evidence that this is a popular topic for review.

A number of factors, including the current economic situation and lack of capacity within LA's, mean that many councils have not undertaken reviews of this nature in some time. The publication of national policies, such as the Health and Care Act and the proposed adult social care charging reforms may provide the opportunity for councils to update and refresh their local strategies regarding the older cohort. Here ate CfGS we provide services such as scrutiny improvement reviews (SIRs) which we can undertake to aid you in assessing your health scrutiny function, more information can be found here.

HOSCs are also well-placed to involve HealthWatch, older people's forums and older people in their work. Many HOSCs co-opt members of voluntary organisations, service users and older people's representatives onto review panels. You may also choose to invite them to become expert advisers to a panel or committee and to participate by providing written evidence or talking to the panel in person.

There are several areas that HOSCs need to ensure that they are incorporating when scrutinising health and care of older people. We believe these are:

Setting strategy and developing partnerships

In light of the cross-cutting nature of the delivery of services to older people, and associated financial constraints, HOSCs must ensure when they are undertaking scrutiny on this matter, that there is strong leadership at chief officer level – not just in adult social care but across all departments – in understanding the impact of ageing on the way that the council does business generally.

HOSCs should be aware that it is important that individual departments and organisations are engaged in 'age-proofing' the services for which they are responsible. This means ensuring that older people have equal access to universal services, through auditing and refreshing them based on the views of older people. This is not about forcing some complicated process of redesign – it is more about reframing how those planning services think about how people will use them.

In understanding the need in this area, population and demographic data is essential – it helps policymakers (including commissioners) to understand where and how interventions need to be targeted.

For certain areas, older people may form a large proportion of the population – this will impact on plans too.

While the overall trend across the UK sees an increase in the older population, the rate of change and the composition of the local population

will vary according to a range of factors such as current age and disability profiles, 'urban flight' issues, BAME populations, and deprivation. Thus, council areas will be affected in different ways and demographic profiling is fundamental for effective planning.

Possible questions that scrutineers may pose when considering strategy and partnerships:

- Have local partners developed any ways in which they are able to keep track of their progress on the later life agenda? Do these focus on outcomes that are valued by older people? If so, what progress is being made?
- Is it clear which agencies are responsible for activity relating to each outcome?

Involving older people

Local authorities need to think about how older people are involved in decisions that are made pertaining to their health and wellbeing.

Beyond thinking about older people are merely "hard to reach", councils need to think about barriers which might make it more difficult for them to be listened to. Assumptions about older people's capability (for example, the assumption that they may not be technologically literate) may be increasingly erroneous – however, there may be other barriers (cultural, social and financial) that council officers may not have thought about.

There is a particular need to think about the unique challenges of listening to those who may not be "part of" the wider community – such as those living in residential care.

Commissioning, and financial management, requires understanding older people's needs and preferences by hearing from them directly. This will allow costs, and their outcomes, to be properly understood based on an accurate sense of the contribution they make to quality of life.

An integrated approach to working with the NHS is important and there should be an increasingly concerted emphasis on the health/care interface. HOSCs will likely be a key player in ensuring that this emphasis is maintained, especially in the light of the creation of integrated care partnerships (ICP) which will bring together strategic thinking on this point.

Possible questions scrutineers may wish to look at when involving older people:

- To what extent are older people involved in governance and decision-making structures, including but not confined to

Health and Wellbeing Boards? What evidence is there that strategic and policy decisions have been influenced by the views of older people?
- How do the council and partners support and engage with older people's voluntary and community organisations and umbrella organisations which bring them together?

Achieving cost effective services

As councils are well aware, the ageing population produces a significant financial cost. In 20/21 gross expenditure on adult social care by local authorities in England was £21.2 billion[11]. The cost of social care is on the rise due to two main factors: an increase in demand for these services and the increasing costs of providing them.

The population requiring social care has grown in recent years, though this has not always been reflected in the number of people utilising care services. Last year, 1.9 million people requested assistance from their council, a jump of more than 100,000 since 2015/2016. This increase can be partially attributed to demographic shifts, as people are living longer and may have multiple or complex needs that require short or long-term social care[12].

Achieving the most cost effective ways of providing support has always been a pressure, but with the economic downturn, and billions of pounds' worth of savings expected from the public sector in the coming years, it is an imperative.

Possible questions scrutiny may wish to consider when examining cost-effectiveness:

- Do strategies and implementation plans show the link between local population trends, demand forecasts, evidence-based interventions and budget efficiencies?
- Has the medium-term financial strategy been updated to take into account the impact of the ageing population?
- What evidence is there that the council is taking a holistic approach to funding to achieve quality of life outcomes for older people, rather than considering budgets within departmental silos?

Diversity, dignity and equality

[11] https://digital.nhs.uk/news/2021/latest-key-statistics-on-adult-social-care-include-council-spending-in-2020-21
[12] https://www.kingsfund.org.uk/audio-video/key-facts-figures-adult-social-care

Ageing affects individuals differently and at different times. Every older person belongs to many other groups depending on their interests and other aspects that make up their identity, including their gender, ethnicity, and sexual orientation. This is one of the reasons why the focus is now so much on 'personalised services', as individuals can shape these to suit their own circumstances. Combating stereotypes and unfounded assumptions about what older people are like, either as individuals or as groups, is an important aspect of promoting dignity and equality.

Unfortunately, issues relating to dignity and respect are common amongst older people, this is mainly attributed to the fact of the examples where older people have been treated badly, particularly in health or care settings. Loss of dignity and lack of respect for individuals can also lead to abuse.

In the government's Care and Support Statutory Guidance, it stipulates that wellbeing is a broad concept, but that personal dignity (including treatment of the individual with respect) comprises one of the nine areas of wellbeing and that there is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round. When making decisions regarding health and social care, HOSCs therefore need to factor in how age equality is addressed within their authority.

Possible questions when considering diversity dignity and equality:

- What action are the council and its partners undertaking to prepare for the implementation of age discrimination in health and social care?
- Do the local adult safeguarding board's policy and procedures and annual report demonstrate an effective approach, giving equal weight to safeguarding people of all ages from abuse, and ensuring this is reflected in the allocation of resources for safeguarding?
- Does your council have a dignity policy which specifically addresses the concerns of older people and covers areas beyond social care? What evidence is there that dignity issues are being actively addressed?
- Does your authority understand the experiences and aspirations of different groups of older people within the population? How does it take their views into account in planning and designing services?

Being prepared for later life

Effective planning and preparation can have a huge impact on the quality of later life, for example, making sure that people have the financial security and social support networks they need to make the most of their time. Supporting people to prepare and make provisions for later life is particularly important for local authorities, at a time when finances are very stretched and when a number of national policy changes are taking place

that will affect people's retirement, pensions and benefits. The amount of support available locally – through services like Citizens Advice Bureaux – is likely to be diminished from the position some years ago.

Local authorities and their partners provide an important local arm for information, including the opportunity for face-to-face contact. Good quality, timely information and advice can help people prepare as much as possible. It is also important for the provision of care directed by older people themselves.

Since some councils may be actively working on their information and advice systems, this could be a helpful time for HOSCs to have oversight of progress. HOSCs will be able to flag where current information and advice services are often cobbled together from a 'multiplicity of separate initiatives' rather than being part of a coherent strategy.

In terms of finance in later life, local authorities have an important role in providing information and support to help people plan for and supplement their income in later life. The largest source of income for people of pension age is state benefit income. Average incomes conceal considerable variations between poorer and richer pensioners, and it is estimated that that £1.7 billion of unclaimed Pension Credit is available for around a third of eligible pensioners, or one million people. Councils need to work with the third sector partners and grass roots organisations to assist in tackling pension poverty.

Possible questions:

- How well is the council working with partners such as the Department of Work and Pensions, the citizens advice bureaux and local Age UK to signpost residents to sources of help and advice in their financial planning and management? For example, are social care staff aware that they can refer older people to the Pensions Service for social security benefits? Does the website have easily-found appropriate links? Does the council participate in a multi-agency one-stop shop?
- What are the council and partners doing to promote take-up of benefits including one off grants such as smart cards for leisure and travel and grants for insulation and/or central heating?

Personalised health and social care for older people

This section covers some of the aspects of social care that are particularly relevant to older people.

Dementia Care

Dementia currently affects 900,000 people in the UK and this is projected to rise to 1.6 million by 2040[13]. Dementia costs the UK economy £25 billion a year[14], and by 2050 years the cost is expected to double to nearly £50 billion[15]. About one third of people with dementia live in their own homes in the community, either alone or with family carers, often their frail older spouses[16].

The Health and Social Care Committee published their report 'Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report' (2022) which welcomed a Government decision to publish a standalone dementia strategy, however warned that extra investment in social care services will not be enough. You can read the full government response to the report here.

Local authorities have a hard task in assisting those with dementia and those that care for them, due to the current 'unfair and confusing' social care system, the decline in timely diagnosis, the cost implications and because of this (amongst other factors) those that suffer with dementia often live in their own homes, requiring carers.

Examples of good practice in dementia care that those within health scrutiny may wish to explore:

- Holistic multi-disciplinary assessments resulting in personalised care plans
- Using assistive technology as part of the intervention and prevention process
- Developing dignity policies for people with dementia and appointing dignity leads for dementia care
- Including people with dementia in falls prevention services.
- Life story, memory and reminiscence work with people with dementia and their carers

Possible questions:

- How well developed are local strategies and partnerships?
- How good are local awareness, early identification and diagnosis?

[13] https://www.alzheimers.org.uk/blog/how-many-people-have-dementia-uk
[14] https://www.dementiastatistics.org/statistics/cost-and-projections-in-the-uk-and-globally-3/
[15] https://www.dementiastatistics.org/statistics/cost-and-projections-in-the-uk-and-globally-3/
[16] https://www.alzheimers.org.uk/about-us/policy-and-influencing/what-we-think/dementia-living-alone#:~:text=About%20one%2Dthird%20of%20all,Mirando%2DCostillo%2C%202010).

- How are people with dementia supported in living at home?
- What is the quality of life for people with dementia in care homes?
- How are people with dementia involved in their communities and civil society?

End of life care

End of life care helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

End of life care is a particular concern for older people (although it can also be a need for a small but significant minority of younger people). Around half a million people die in England each year, of whom almost two thirds are aged over 75. Most deaths follow a period of chronic illness and most (58 per cent) occur in NHS hospitals, with around 18 per cent occurring at home, 17 per cent in care homes, four per cent in hospices and three per cent elsewhere. Around 70 per cent of people express a wish to die at home.

End of life care, or care for individuals nearing the end of their lives, has been a focus in healthcare legislation and policy for some years and has become an important part of broader policy. The Care Act 2014 legally requires councils with social care responsibilities to support individuals, families, and carers during this time. The first national end of life care program and strategy were established in 2004 and 2008, respectively, and there has been a continued focus on improving end of life care since then[17].

The initial 2008 strategy outlines a 'care pathway' with good quality care required at each of the following stages:

- Discussions as the end of life approaches
- Assessment, care planning and review
- Co-ordination of care
- Delivery of high quality services in different settings
- Care in the last days of life
- Care after death

The Ambitions Partnership, a multi-agency partnership comprising various statutory bodies, voluntary sector agencies, national charities, and professional bodies, offers the most comprehensive policy approach for palliative and end-of-life care. Local government representation in

17 https://www.local.gov.uk/sites/default/files/documents/22.53%20End%20of%20life%20care%20guide%20for%20councils%20WEB.pdf

this partnership is provided by the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA)[18].

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help.

Below are some points to consider when scrutinising end of life care:

- Thinking outside the box- End of life care is not solely about hospice care or care for people with cancer, and most of us want to die in our own homes. We all die and want good care whatever our condition.
- End of life care is a vast and cross cutting area- It affects virtually all conditions and places of care. In view of this, you may wish to focus on one aspect at a time, such as support for carers at the end of life, or end of life care for people with dementia.
- Medical practitioners- It is important not to overlook the key role played by GPs and community nurses, who are the first point of call for most people. Therefore, scrutinisers need to be engaging with these key stakeholders.

Possible questions:

- What evidence is there that people approaching the end of life are being offered greater choice and better quality of care at the end of their lives?
- Is there a joint commissioning strategy for end of life care, which includes a care pathway approach and support for carers?
- How well is end of life care co-ordinated across sectors, including out of hours care?

18 https://www.local.gov.uk/sites/default/files/documents/22.53%20End%20of%20life%20care%20guide%20for%20councils%20WEB.pdf

Winter pressures

The winter months can represent the most challenging times for local health and care systems and the additional pressures can result in poor outcomes for many people, especially within the current climate, with longer waits for urgent care/accident and emergency services, cancelled operations or delays in being discharged from hospital.

At the same time, the NHS in England is in crisis. Huge pressures over the winter show no signs of abating. Ongoing strike action has called attention to the fragile state of the health and care system – at A&E and in the ambulance service, where problems are perhaps most visible, but also in social care, whose lack of capacity and resilience many consider to be the root cause of many of the challenges the system now faces.

This is not new, of course; although the pandemic has exacerbated the weaknesses in the health service, the knock-on impacts of poor health and social care integration has been understood for many years (and are in fact one of the core justifications for the current system reforms). Successive Governments have, however, been coy about the issue – either ploughing more funding unstrategically into acute services (where people failed by the care system end up, further exacerbating pressures) or assuming that minor, time-limited funding boosts will somehow "resolve" a crisis in social care that is systemic, and that has been well over a decade in the making.

Local authority scrutiny functions find themselves in an invidious position with regard to these issues. On the one hand, the idea of looking at system pressures, and understanding the impact they have on local people, is a no-brainer – an obvious thing for scrutiny to look at. The impact of A&E waits, stretched primary care services and serious worry for people with acute and chronic conditions demand some kind of intervention and understanding from council scrutiny functions.

What could scrutiny recommend that would provide solutions? The answer may lie in finding small solutions to small, but pivotal, problems. The wider situation is overwhelming, seemingly unresolvable. But the way that the consequences of this national crisis hit home at local level may be something we can do something about – even if that "something" is small in the scheme of things. Scrutiny may be able to look at the resilience and capacity of local care providers, or the impacts of the pressures on those with complex needs who may be especially worried about what is happening in secondary and tertiary care. Scrutiny might listen to people who have had recent, poor experiences – not to magically find solutions but to find ways to at least mitigate the worst of these problems. Scrutiny can, of course, help to raise public understanding – and the understanding of councillors themselves – of the link between health and social care, and that "social care" isn't something that is just "provided" to the physically infirm and elderly.

Building system resilience can help overcome potential difficulties and, although winter presents particular challenges, council scrutiny can review system resilience throughout the year, not just at wintertime. Contextual demographic or structural factors may vary from area to area - for example where there are diverse or dispersed populations or increased visitors at certain times of year.

Council scrutiny can ask questions about the local context of system resilience, within the overarching principle that a whole system approach to identifying and tackling potential risks is important.

Here are some issues that health scrutiny may wish to consider when planning for the winter months and for more long-term strategy:

- Early discharge planning- In elective care, planning should begin before admission. In emergency/unscheduled care situations, robust systems need to be in place to identify and develop plans for management and discharge and to allow an expected date of discharge to be set within 48 hours.
- Systems to monitor patient flow- Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.
- Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector- Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients.
- Home first/discharge to assess- providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home mean that people need no longer wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.
- Seven-day services: Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.
- Trusted assessors- Using trusted assessors to carry out a holistic assessment of needs avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.
- Focus on patient choice: Early engagement with patients, family and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

- Enhancing health in care homes- Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Public Health and Health Inequalities

Public health has its primary focus on the health of populations rather than, as is the case for a GP say, on the health of an individual patient. So Directors of Public Health look at how measures of health and well-being, disability and disease are distributed in the population they have responsibility for.

Knowing the distribution patterns of health and well-being, public health next looks at what are the likely causes of those patterns. Of course, it is individuals who become ill and among the causes of ill health are matters of genetic inheritance and of individual choice and behaviour

Local government and local communities need to be at the heart of improving health and well-being for their populations and tackling health inequalities. Local government is central to this endeavour because:

- The full range of local authority functions have an impact on the health of the local population.
- Many of the necessary interventions to address health inequalities require various statutory and voluntary sector organisations to work in partnership, and it is to the local authority that the various partners look for leadership.

Scrutiny can make a unique contribution to a council's strategic approach to health inequalities. In many places, health scrutiny members and Directors of Public Health work well together on a range of specific health inequalities issues and in future this should become normal good practice everywhere. The perspectives that the public health professionals and members bring to health inequalities are complementary – each has much to learn from the other, with members bringing a different but equally valuable perspective.

Contrasting and comparing professional perspectives with that of lay members who know their communities well can enrich the inquiry, yielding insights and identifying possible ways of proceeding that either alone would possibly not have identified.

With regards to what impact and engagement scrutiny can have on public health and health inequalities is detailed below:

- Help public health professionals to engage with the council and other agencies to tackle health inequalities.
- Make a contribution to a council's strategic approach to health inequalities.
- Bring together different professions and perspectives – enriching the outcome.
- Make effective use of local elected members with their knowledge and insight in to communities.

- Strike the balance by involving professionals and lay people.
- Be a very effective means of focusing the attention of outside agencies on health inequalities – strengthening the case for investment.
- Use its investigative mode to really dig under the surface and gain a greater understanding of the issues that communities face – and the assets that they have.
- Provide an independent arena to focus on issues that are sensitive or contentious.
- Confer authority and status in engaging and influencing decisionmakers