Introduction

1. The Health and Social Care Act 2001 provides explicit powers for local authority overview and scrutiny committees (OSCs) to scrutinise health services within the authority's area as part of their wider role in health improvement and in reducing health inequalities for their area and its inhabitants. The Act also identifies duties for the NHS within the scrutiny process to ensure its effective implementation,

2. Local authorities already have the legal power to promote the social, economic and environmental well-being of their areas. The new power of overview and scrutiny of health will add value to this by enabling committees to take an overview of health needs within their area and to scrutinise priority issues. These priorities may be thematic on issues of a public health nature, such as homelessness or services for older people which might impact upon the health of local people, or a specifically service oriented priority such as the provision of and access to chiropody services. The outcomes and recommendations of health scrutiny are also intended to contribute to policy development on matters affecting the health and well-being of communities.

3. A number- of duties are placed upon NHS bodies in relation to the overview and scrutiny committees. These range from providing information to overview and scrutiny committees to consulting on substantial developments or variations in services. in the case of a substantial variation or development of services, the overview and scrutiny committee will have the power to refer the issue to the Secretary of State for Health for consideration on the basis of inadequate consultation or the where it is not satisfied of the merits of the proposals for change.

Regulation-making power*

4. The Health and Social Care Act 2001 gives Ministers a number of regulation-making powers in relation to overview and scrutiny of health. Ministers do not intend to exercise all of these at present, but if and when new regulations are proposed, the public will be consulted on those proposals.

Timescale

5. Consultation on these regulations will run from 7 October 2002. Responses must reach the Department of Health before 18 November 2002. The consultation period will be 6 weeks. The new power will be implemented from 1 January 2003.

6. The consultation document has been published on the Internet, at www.doh.gov.uk/oscrecconsultation. Information about it has been sent to a wide variety of organisations, including strategic health authorities, Primary Care Trusts, NHS trusts, local authorities, Community Health Councils, ACHCEW and relevant voluntary organisations.

7. If alternative versions of the document are required, please write/ email to the address below.

8. All organisations and individuals with an interest on these issues are invited to submit their responses on this consultation document. Responses should be sent to

Overview and Scrutiny Listening Exercise
Department of Health
Room 608
Richmond House
79 Whitehall
London
SW1A 2NS

Email: mbhealthscrutiny@doh.gsi.gov.uk

9. In order to ensure that we are able to keep track of all the information you send us, would you please provide the following information:
   - your name;
   - your job/professional role and organisation (if applicable);
   - your comments on this document.

   Please note that we may not be able to reply to you personally, but all comments will be taken into account as appropriate in preparing the final version of the regulations.

10. You are welcome to pass this document (and the contact details for the consultation) on to interested colleagues, or to direct them to this web-site (www.doh.gov.uk/oscregconsultation) where they may download a copy.

11 Please note that all responses to this consultation may be made public unless you request that your response be kept confidential.

THE LOCAL AUTHORITY (OVERVIEW AND SCRUTINY COMMITTEES HEALTH SCRUTINY FUNCTIONS) REGULATIONS 2003

1. To be made under powers contained in the Health and Social Care Act 2001 and the NHS Reform and Health Care Professions Act 2002

CONSULTATION DOCUMENT

2. Comments are invited on all aspects of the proposed regulations. These will be drafted in the light of comments received.

Objectives

3. The functions of the committees and duties of the NHS bodies are set out in primary legislation. The aim of the consultation is not to discuss whether overview and scrutiny committees should have this additional power, or whether local NHS bodies should be subject to the duties, but to gauge public views on the content of the regulations. The regulations will set out the parameters within which these core responsibilities will be discharged.

KEY QUESTIONS

4. You are invited to submit your comments on the proposals for the regulations with particular reference to the questions identified within this document, and on any aspect which you feel needs to be clarified.

The Regulations

Citation, commencement, extent and interpretation

5. The Regulations apply to overview and scrutiny committees in England). In particular, the first part (see paras. 8-23 below) applies to committees of a county council, county borough council, the council of any district in an area for which there is no county council, London borough council, the Common Council of the City of London, and the Council of the Isles of Scilly; the second part applies as above but also includes any district council.

6. Where the Regulations refer to 'local NHS bodies', these mean a Health Authority, Strategic Health Authority, Primary Care Trust, or National Health Service Trust which provides, or arranges or performance manages the provision of services to people residing within the area of the overview and scrutiny committee's local authority.

Matters to be reviewed and scrutinised

7. The Regulations specify matters that the overview and scrutiny committees shall include in reviewing/scrutinising health matters:

   a) arrangements made by local NHS bodies to secure hospital and community health services to the inhabitants of the authority's area;

   b) the provision of such services to those inhabitants;

c) the provision of services under Part II of the 1977 Act or under arrangements made under section 28(c) of that Act;

d) the provision of piloted services under pilot schemes established under section 28 of the 2001 Act and of LP services under the LPS scheme established under Schedule 8A to the 1977 Act;

e) arrangements made by local NHS bodies for public health in the authority's area;

f) the planning of health services by local NHS bodies, including plans made in co-operation with local authorities setting out a strategy for improving both the health of the local population and the provision of health care to that population;

g) the arrangements made by local NHS bodies for consulting and involving patients and the public under the duty placed on them by section 11 of the 2001 Act; and

h) any matter referred to the Committee by a Patient's Forum by virtue of powers under the NHS Reform and Health care Professions Act 2002.

8. The above includes health services provided from a body outside the area of the local authority to inhabitants within it.

Question: are there any other matfers which must be reviewed or scrufinised that should be identified within the regulation?

Reports and recommendations

9.A committee may make reports and recommendations to local NHS bodies (and the local authority) on any matter reviewed or scrutinised by virtue of the Health and Social Care Act 2000. The reports made must include the following:

(a) an explanation of the issues addressed;

(b) a summary of the information considered;

(c) a list of the participants involved in the review or scrutiny; and

(d) any recommendations on the matters considered.

10 Copies of the report should be widely circulated and made publicly available.

11 .Reports should not generally be made or be forwarded to the Secretary of State for Health. The regulations make provisions for reporting to the Secretary of State only for when an issue is being referred for his consideration on the grounds of inadequate consultation or where the overview and scrutiny committee questions the merits of the proposal.

Consultation of committees by local NHS bodies

12. It shall be the duty of every local NHS body to consult the appropriate overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the local authority, or on any proposal to make any substantial variation in the provision of such service(s). The consultation shall commence at least three months before a decision on a proposal is made.

13.The Regulation will not define 'substantial variation or development' but the associated guidance, outlined in Appendix A as draft support information, will

assist the committee(s) and NHS bodies in identifying whether an issue is substantial or not within the local context.

14. The requirement for consultation shall not apply with respect to any proposal to establish or dissolve an NHS Trust or Primary Care Trust unless that establishment or dissolution represents a substantial variation or development. Likewise, the requirement for consultation will not apply to any proposals for pilot schemes within the meaning of section 4 of the National Health Service (Primary Care) Act 1997.

15. The requirement for consultation will not apply to any proposals on which the local NHS body concerned is satisfied that, in the interest of the public's health, a decision has to be taken without allowing time for consultation. in any such case, the local NHS body shall notify the committee immediately of the decision taken and the reason why no consultation has taken place.

16. A local NHS body may specify the date by which comments on any proposals referred to are to be made by the committee(s) which it is consulting.

17. Where the committee is not satisfied:

a) that sufficient time has been allowed under paragraph (4); or

b) that consultation on any proposal referred to in paragraph (1) has been adequate; or

c) of the merits of any proposal

it shall notify the Secretary of State in writing, who may require the local NHS body concerned to carry out such further consultation with the committee as he considers appropriate. Where further consultation has been required by the Secretary of State, the local NHS body shall, having regard to the outcome of such further consultation, reconsider any decision it has taken in relation to the proposal in question.

Question: do you have any comments on the issue of consultation of commiffees by NHS bodies?

information to be provided by local NHS bodies

18. It shall be the duty of each local NHS body to provide the local committee(s) with such information about the planning, provision and operation of health services within the area of the committee(s) as they may reasonably require in order to discharge their health scrutiny functions under the legislation. However, nothing shall require the provision by a local NHS body of:

a) confidential information which relates to and identifies an individual,

b) any information the disclosure of which is prohibited by or under any enactment.

19. This is unless the information is disclosed in a form in which the identity of any individuals cannot be ascertained, or an individual consents to the information being disclosed. In a situation where the disclosure of information is prohibited in this way, a committee may require the person holding the information to anonymise it in order for it to be disclosed. In every case the committee will have to be able to explain why the information is necessary for the execution of its health scrutiny functions.

Qoesfion: do you have any comments* on *the* issue information *to be provided by NHS bodies?

Obtaining information and explanations

20. In conducting a review or scrutiny, a committee or person authorised by it in writing, may require any officer of a local NHS body to attend before the committee to answer questions that the committee, or authorised person consider necessary for the review or scrutiny. The committee will be required to give the officer reasonable notice of its request and the intended date of attendance.

21. An 'officer' of a local NHS body includes the Chief Executive of that body.

22. The committee will no? have the power to require the officer to provide any information that is identifiable to an individual or that he/she would be entitled to refuse to answer in or for the purposes of proceedings in a court in England.

Quesfion: do you have any comments on the issue of obtaining information and explanations from NHS bodies?

Joint Committees

23. Two or more local authorities may appoint a committee (a "joint committee") of those authorities and arrange for relevant functions in relation to any (or all) of those authorities to be exercisable by the joint committee. Where it appears to the appointing authorities that the joint committee has completed the exercise of relevant functions for which it was appointed, or that it is not adequately performing those functions, those authorities may jointly terminate the appointment.

24. A joint committee appointed in this way, is to be treated as a body to which section 15 of the Local Government and Housing Act 1989 (duty to allocate seats to political groups) applies. In this way, the proportional allocation of the appointing authorities is reflected in the composition of the joint committee.

25. A joint committee is only able to discharge the functions for which it has been established.

Question: do you have any comments on the issue of joint overview and scrutiny committees?

Delegated Scrutiny

26. A local authority may arrange for relevant functions in relation to that authority to be exercisable by a committee of another local authority. The regulations enable this to take place when a local authority, in agreement with another local authority, believes that another authority would be better placed to undertake a particular scrutiny. Delegation may be from a local authority with social services responsibilities to a district council.

27. This regulation prevents delegation from taking place when the committee is being consulted in issues of substantia! variation or substantial development.

28. A committee to which relevant functions have been delegated under this regulation may not discharge any functions other than those functions agreed for delegation.

Quesfion: ***do you have any comments on delegation.***

Co-option

29. A county council for any area may arrange for one or more of the members of a committee of the council for a district comprised in that area to be appointed as—

a) a member of a committee of the county council or another local authority, for the purposes of relevant functions of the committee in relation to the county council, or

b) a member of a committee of the county council, for the purposes of relevant functions of the committee in relation to another local authority.

30. A county council making an arrangement for an appointment may specify that the appointment is—

i) for the life of the committee, or

ii) until such time as it decides to terminate the appointment, or

iii) for a particular review or scrutiny

31. In this regulation, references to a committee of a county council include references to a joint committee of the council and another local authority.

Question: ***do you have any comments on the issue of co-option onto committees?;***

Directions

32. The Secretary of State may direct local authorities to make any specific arrangements and to comply with such requirements in connection with the arrangements as he may direct.

33. With regard to the overview and scrutiny of NHS bodies with a regional or national remit, it is the intention that directions will be made to ensure the most effective use of the new powers and duties, balancing the needs of patients and the public with the practicalities of impact on NHS resources. The options being considered are:

1) all local authorities receiving services from an NHS body providing services national or regional services (e.g. ambulance trust, teaching hospital, regional cancer services, Great Ormond Street Hospital), delegate their functions to the local authority where the administrative head quarters of the body is based for the purpose of scrutiny (other than substantial variation or development); or

2) the local authority where the administrative base of the NHS body providing national or regional service (e.g. ambulance trust, teaching hospital, regional cancer services, Great Ormond Street Hospital) is located, takes responsibility for establishing a joint committee for the purposes of undertaking scrutiny of that body (or collaborative). In these circumstances, local authorities may delegate their responsibilities to another, for example it may be agreed that across a strategic health authority area one local authority may represent all others.

Question: ***which (if any) of these proposed models do you consider to be most appropriate for the overview and scrutiny of national or regional specialities, ambulance trusts or collaboratives, or can you propose any other?***

Application of section 22 of the 2000 Act

34. The final regulation provides that the arrangements outlined above will be applicable to all arrangements made under section 21 of the Local Government Act 2000 and also to those local authorities operating alternative arrangements.

Annex A

Support **information • proposals for the effective implementation of local authority overview and scrutiny of health**

I. Background

1.1 This support information has been written to help local authorities and NHS bodies to develop and implement health overview and scrutiny effectively. The purpose of the document is to assist local authorities, NHS bodies and other stakeholders in understanding the implementation of the new powers and duties. it provides the basis for the guidance which will be published in December 2002 to coincide with the finalisation and laying of Regulations. The final guidance will provide practical information about how the new powers and duties will complement the existing powers of local authorities to promote social, economic and environmental well-being. Your comments on this document will inform the preparation of the final guidance.

1.2 Both the process and outcomes of scrutiny are intended to be outward looking, strengthening and invigorating the representative role of councillors. The NHS Plan introduced the idea of local authority scrutiny of health by stating: *'Local authorities are an important democratically elected tier of government. As they modernise, they will become more effective channels for the* views of *local people.'* Although many councils have already undertaken scrutiny reviews of external issues, they have had no power to require input from external organisations (although in practice, most have been willing to co-operate). The Health and Social Care Act 2001 and the associated regulations grant local authority overview and scrutiny committees formal powers in relation to, and place duties upon, local NHS bodies.

2. Aims and structure of this support information

2.1 This document is primarily for local authorities and NHS bodies. lt will however be useful for Patients Forums and other organisations. It aims to offer clarity about the primary and secondary legislation that provides local authority overview and scrutiny committees with the power to scrutinise health services. It also clarifies the duties placed upon the NHS.

3. Introduction

3.1 Health scrutiny is both a challenge and an opportunity for local authorities and the NHS. Its primary aim is to act as a lever to improve the health of local people. Its focus should be on health improvement in the widest sense, building on the powers of local authorities to promote social, environmental and economic well-being as well as the power to scrutinise local services provided and commissioned by the NHS. This will be achieved by addressing issues around health inequalities between different groups and working with NHS and other partners to secure the continuous improvement of health services and services that impact upon health.

3.2 If scrutiny is to have meaningful, effective and positive impact, those involved need to focus on two key success factors:

. giving careful and early consideration to the objectives and context **for** scrutiny; and

- taking a constructive but challenging approach to the role, aimed at bringing together evidence and experience to address problems and drive improvement.

3.3 It is important to be clear from the outset what health scrutiny is aiming to achieve. If scrutiny concentrates on developing solutions to issues and problems that really matter to local people, it will also capture members' interest and engage local NHS bodies. Authorities could start by identifying some positive outcomes for scrutiny -for example, breaking logjams that prevent vulnerable people from accessing the services they need, co-ordinating public consultation on health issues across agencies or attracting greater resources for health promotion.

3.4 Councils will be scrutinising a health system or economy, not just services provided, commissioned or managed by the NHS. Therefore, local authority's power to scrutinise health should be seen in the context of their role in community leadership and local strategic partnerships. Acting in isolation, committees cannot deliver improvements in the health of the local population or of the quality of services they receive. Neither will they achieve progress by merely criticising other local agencies. While the decision on what and how to scrutinise is *one* for local authorities, NHS bodies and other local stakeholders should be involved in discussions about the purpose and scope of the role.

3.5 The field of NHS regulation is a crowded one. The purpose of local authority scrutiny role should be to fill the gap in existing arrangements, not to duplicate them. In particular, the work of committees should focus on issues of local concern, where objective review by elected lay representatives will help progress to be made. Scrutiny is one part of wider developments in public and patient involvement in the NHS. To ensure an integrated approach locally, committees, strategic health authorities and patient groups need to set up clear lines of communication and information exchange.

3.6 A constructive approach -based on mutual understanding between the committee, the local authority executive function and local NHS bodies will be a prerequisite for success. Where inter-agency relationships are currently poor, steps should be taken to build an understanding between partners to ensure effective scrutiny. Scrutiny should always be challenging and will sometimes be uncomfortable for those on the receiving end. But if the process is aggressive, or relies on opinion rather than evidence, it is unlikely to lead to positive improvement. Committees should aim to use constructive criticism, while health bodies need to respond honestly to questioning and provide convincing explanations for why they do not take up scrutiny recommendations.

3.7 Getting scrutiny right is difficult, and health is a complex area for scrutiny to address. Committees should plan ahead and be realistic about what can be achieved in the early days of the new role. They will also need to be aware of the demands on external agencies, working jointly with neighbouring authorities when necessary.

3.8 Committee members need to have, or develop, a basic understanding of how the NHS works and of the key issues within the local health economy. Local NHS bodies may be able to support this by providing

briefings for committee members. However, the role of overview and scrutiny committees is not to become experts, but to ask challenging questions as elected lay representatives of their communities. The approach to individual health scrutiny reviews should depend upon the topic being addressed and the desired outcome. There is a good case for early reviews to focus on topics that are not technically complex and suit a developmental approach, helping to build knowledge and develop trust between agencies.

3.9 Committees will not make decisions – their role is to raise local concerns, challenge the rationale for decisions and propose alternative solutions. For scrutiny to achieve positive impact, therefore, it needs to be persuasive but critical and assertive. If members take an aggressive approach; or make assertions that are not supported by evidence, this will provoke a defensive reaction on the part of the NHS and make it difficult for scrutiny to add value.

3.10 Committees must take steps to avoid any potential conflicts of interest arising from members' involvement in the bodies or decisions that they are scrutinising. This is especially important for those councillors that are also Non-Executive Directors of NHS trusts or PCTs. Counciiiors who are also Non-executive Directors of NHS Trusts and PCTs are not excluded from membership of OSCs, but they must follow the usual guidance regarding participation where there is a risk of conflict of interest.

3.11 The health scrutiny power needs to be applied both robustly and responsibly. Scrutiny should be probing and incisive, but always aimed at supporting improvement. Asking the 'obvious question' can be very revealing, but committees must also recognise that the most difficult problems facing the NHS have no simple, or universally popular solution Local NHS bodies have to make complex trade-offs between competing service demands and any changes will have to be made within a national framework of policies and standards. There will sometimes be tensions between the wishes of local people and what is affordable and/or clinically effective.

3.12 The local authority scrutiny role in health will be as successful as local stakeholders want it to be. The aim of the legislation is that this function can play a key role in improving local health, provided that local agencies work together in a systematic way and a culture of openness. Councillors' credibility will come from their ability to 'stand on the outside' and speak on behalf of local people who need and use health services. However, success will not be easy or automatic. Actions are required on the part of local authorities, local NHS bodies and all other stakeholders with an interest in health.

4. Application **of new powers and duties**

4.1 The Regulations apply to overview and scrutiny committees of a county council; county borough council, the council of any district in an area for which there is no county council, London borough council, the Common Council of the City of London, and the Council of the Isles of Scilly.

4.2 Although the new powers are not provided to district councils in two-tier systems, there are opportunities for them to become involved in joint committees or to be delegated powers as explained in sections 10 and 11 below.

4.3 Where the Reguiations refer to 'local NHS bodies', these mean a Health Authority, Strategic Health Authority, Primary Care Trust, or National Health Service Trust which provides, or arranges or performance manages the provision of services to peopie residing within the area of the overview and scrutiny committee's local authority.

4.4 Impact of new powers on local authority constitutions

4.5 Local authority overview and scrutiny committees are bound to have regard to statutory guidance under the Local Government Act 2000. The Local Government Act 2000 (Constitutions)(England) Direction 2000 states that scrutiny arrangements should be set out in local authority constitutions. Arrangements for the overview and scrutiny of health should be set out clearly in the executive arrangements as part of the constitution. To ensure it is clear which committees are responsible for overseeing which functions and policy areas, the remit and terms of reference for each committee must also be set out. Details of how overview and scrutiny of health will be implemented should include explaining the roles of any joint arrangements with or delegated to other local authorities. This must include the terms of reference and functions of joint arrangements with or delegated to other local authorities, the membership of any joint committees or subcommittees, and rules governing proceedings of joint committees or sub committees.

5. Matters to be reviewed and scrotinised

5.1 The Regulations specify matters that the overview and scrutiny committees may include:

a) arrangements made by local NHS bodies to secure hospital and community health services to the inhabitants of the authority's area;

b) the provision of such services to those inhabitants;

c) the provision of services under Part II of the 1977 Act or under arrangements made under section 28(c) of that Act;

d) the provision of piloted services under pilot schemes established under section 28 of the 2001 Act and of LP services under the LPS scheme established under Schedule 8A to the 1977 Act;

e) arrangements made by local NHS bodies for public health in the authority's area;

f) the planning of health services by local NHS bodies, including plans made in co-operation with local authorities setting out a strategy for improving both the health of the local population and the provision of health care to that population;

g) the arrangements made by local NHS bodies for consulting and involving patients and the public under the duty placed on them by section 11 of the 2001 Act; and

h) any matter referred to the Committee by a Patient's Forum by virtue of powers under the NHS Reform and Heaith care Professions Act 2002.

The above includes health services provided from a body outside the area of the local authority to inhabitants within it.

5.2 It is recommended that committees produce an annual overview and scrutiny plan that has been discussed and shared with local health bodies. The plan should identify priority issues for a given period (more detail for the first year of the plan and identifying issues for a further two years). It should also build in capacity for the committee to respond to consultations on service reconfigurations that may arise or to issues raised by the local Patients' Forums. Reports and recommendations to NHS bodies should take account of and identify informatidn and evidence that was presented during the scrutiny process. To ensure that scrutiny complements existing initiatives and makes effective use of existing resources, early discussions of local priorities should be informed by available documents. For example:

- work of the Local Strategic Partnership (LSP)
- the local community strategy or plan
- the Health Improvement and Modernisaiion Plan (HImP)
- the most recent report of the local Director of Public Health
- recommendations from inspection or audit reports (in the public domain following a public meeting of the trust board)
- patients survey and prospectus
- reports from local Patient Advice and Liaison Service (PALS)
- information from Community Health Councils, whilst they still exist
- information from Patients' Forums within the local authority area (co-ordinated by the PCT Patients' forum) when they have been established
- reports by local voluntary and community organisations which focus on health issues
- local transport plans
- crime and disorder reduction strategies
- housing needs surveys
- local neighbourhood renewal plans
- completed best value reviews
- completed health or environmental impact assessments
- issues arising from modernisation and partnership boards within or in partnership with local NHS bodies

5.2 It is recommended that advice should be sought from other agencies and individuals including discussion with local NHS bodies. Criteria for identifying priorities might include:

- the ability to make a distinct and positive impact through the scrutiny function;

- topics that are timely and relevant, but not already under review elsewhere; and
- maintaining a balance between health improvement and health services (and between acute services and primary and community care).

5.3 **How overview and scrutiny of health relates to other aspects of the new patient and public involvement agenda**

5.4 The NHS Plan proposed substantial organisational changes to the involvement and representation of patients and the public in health services. The primary aim was to ensure that services were developed with patients needs at the centre. The Health and Social Care Act 2001 and the National Health Service Reform and Health Care Professions Act 2002 provide the legislative framework to enable the majority of the changes to be implemented.

5.5 The new system for public and patient involvement in health may be summarised as follows:

- Patients' forums attached to but independent from every trust and PCT, made up of patients and other members of the local community, with power to inspect all aspects of the work of trusts, and the power to refer issues of concern to different agencies including overview and scrutiny committees. PCT Patient Forums to have extra responsibilities, including to promote involvement of the public in decisions and consultations on matters affecting their health. and to monitor how well the local NHS is meeting its duty to involve and consult the public;
- Independent complaints advocacy services (ICAS) - provided or commissioned by PCT Patient Forums to provide support to patients and carers if they wish to make a formal complaint about NHS services;
- Patient Advice and Liaison Services (PALS) - provided by each trust and PCT to support patients and carers, who have problems or issues that are not formal complaints, and find speedy solutions;
- National Commission for Patient and Public Involvement in Health (CPPIH) -to set standards and ensure consistency in the involvement system as a whole; to raise the concerns of patients at a national level: and, to provide funding, staff and performance management for the patient forums and ICAS.
- New duty on the NHS under section 11 of the Health and Social Care Act'2001, to make arrangements to consult and involve the public. NHS trusts, PCTs and Strategic Heaith Authorities will make arrangements to involve and consult patients and the public in planning of service provision, involvement in the development of changes, and involvement in decisions about changes to the operation of services.

6. **Reports and recommendations**

6.1 A committee mav make reports and recommendations to local NHS **bodies on** any matter reviewed or scrutinised under section 7 of the Health and Social Care Act 2000. The reports may include the following:

(a) an explanation of the issue addressed;

(b) a summary of the information considered;

(c) a list of the participants involved in the review or scrutiny; and

(d) any recommendations on the matters considered.

6.2 Overview and scrutiny committees have no power to make decisions or to require that others act upon their suggestions.

6.3 The strength of scrutiny is its independence and ability to take on board differing perspectives. To be effective, committees must balance 'expert opinion and public concerns where these conflict – for example in the case of service reconfignrations. To ensure credibility, committee should consider all views and evidence before iinaiising recommendations. Reports should incorporate the views and information received and, where possible, clear recommendations should be made.

6.4 Once the committee has completed its scrutiny and produced its report, it will need to send copies to each NHS body considered by the review, Reports may also be made to local authorities. The Regulations will require the NHS bodies concerned to respond to the committee, in wriiing, within an accepiabie time-frame. The regulations will not specify the maximum time for the response to be received by the committee. However, a response should be received within 8 weeks, with no more than 12 weeks elapsing if there is a good reason that is provided in writing. The reply should set out the views of the body on the recommendations, proposed action to implement the recommendations or any reasons for inaction to the recommendations made. The NHS response should be copied to key stakeholders which may include:

- the full Council of the committee's local authority
- Local MP(s)
- the Strategic Health Authority
- relevant Patient Forum(s)
- local voluntary organisaiions with an interest
- other NHS trusts and PCTs
- other local authorities, for example district councils or neighbouring authorities

6.5 It should also be made available within local libraries, community venues and on websites.

7. **Consultation of committees by NHS bodies**

7.1 The Regulations oblige every local NHS body to consult the appropriate overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the local authority, or on any proposal to make any substantial variation in the provision of such service(s). The consultation shall commence at least three months before a decision on a proposal is made.

7.2 The requirement for consultation shall not apply with respect to any proposal to establish or dissolve an NHS Trust or Primary Care Trust unless that establishment or dissolution represents a substantial variation or

development. Likewise, the requirement for consultation will not apply to any proposals for pilot schemes within the meaning of section 4 of the National Health Service (Primary Care) Act 1997(1 j.

7.3 The requirement for consultation will not apply to any proposals on which the local NHS body concerned is satisfied that, in the interest of the public's health, a decision has to be taken without allowing time for consultation. In any such case; the local NHS body shall notify the committee immediately of the decision taken and the reason why no consultation has taken place.

7.4 A local NHS body may specify the date by which comments on any proposals referred to are to be made by the committee(s) which it is consulting.

7.5 Where the committee is not satisfied:

a) that sufficient time has been allowed; or

b) that consultation on any proposal has been adequate; or

c) of the merits of any proposal

it may report to the Secretary of State in writing, who may require the local NHS body concerned to carry out such further consultation with the committee as he considers appropriate. Where further consultation has been required by the Secretary of State, the local NHS body shall, having regard to the outcome of such further consultation, reconsider any decision it has taken in relation to the proposal ***in*** question.

7.6 Understanding 'substantial variation and substantial development'

7.7 The Regulations do not define 'substantial' within this context, and NHS bodies should aim to reach a local understanding or definition with their local overview and scrutiny committee(s) on any local proposals. This process should be informed by discussions with other key stakeholders including Patients Forums. In considering the issues, they should take into account

a) ***changes*** **in** ***accessibility of services,*** **for example** both **reductions** and increases on a particular site or changes in opening times for a particular clinic. Communities attach considerable importance to the local provision of services, and local accessibility can be a key factor in improving population health, especially for disadvantaged and minority groups. At the same time, development in medical practice and in the effective organisation of health care services may call for reorganisation including relocation of services. Thus there should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location (other than to any part of the same operational site).

b) ***impact of*** **proposal** ***on the*** **wider** ***community and other services,*** including economic impact, transport, regeneration.

c) ***patients affected,*** changes may affect the whole population (such as changes to A&E), or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example, renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial.

d) *methods of* service *delivery*, altering the way a service is delivered may be a substantiai change - for example moving a particular service into community settings rather than being entirely hospital-based. The views of patients and the Patients Forum will be helpful in such cases.

7.8 It is clear that the primary focus for identifying whether a change should be considered as substantial, is the impact upon patients, carers and the public who use or have the potential to use a service. For example; a PCT dissolution would not necessarily be such if it were as a result of a merger or the establishment of a Care Trust; but it might be if a service currently being provided was to be lost as a result.

7.9 Where committees do not consider that local people have had sufficient opportunity to have their say, or where the merit of change is contested, they can refer the issue to the Secretary of State for Health who will be required to review matters for a final decision. This action should only occur when local resolution and negotiation of issues has not been achieved. The OSC and NHS bodies should make every effort to reach a shared conclusion and referral should happen only as a last *resort*

7.10 Where a substantial service reconfiguration is proposed, the Secretary of State may ask the Independent Reconfiguration Panel to advise on the matter referred

8. **Information provided by NHS bodies**

8.1 It shall be the duty of each local NHS bodv to provide the local committee(s) with such information about the planning, 'provision and operation of health services within the area of the committee(s) as they may reasonably require in order to discharge their health scrutiny functions under the legislation. However, nothing shall require the provision by a local NHS body of:

a) confidential information which relates to and identifies an individual;

b) any information the disclosure of which is prohibited by or under any enactment.

8.2 This is unless the information is disclosed in a form in which the identity of any individuals cannot be ascertained, or an individual consents to the information being disclosed. in a situation where the disclosure of information is prohibited in this way, a committee may require the person holding the information to anonymise it in order for it to be disclosed. In every case, the committee will have to be able to justify why the information is necessary for the execution of its functions.

8.3 it is expected that health bodies will develop a co-operative working reiationship with their local committee about the types of information and frequency with it which it is required. if a local NHS body refuses to disclose information that is not prohibited by regulation, the committee may alert the performance managing organisation, i.e. the Strategic Health Authority for PCTs and Trusts and the Directorate of Health and Social Care for Strategic Health Authorities.

9. **Obtaining information and explanations from NHS bodies**

9.1 In conducting a review or scrutiny, a committee or person authorised by it in writing, may require any officer of a local NHS body to attend before the committee to answer questions that the committee, or authorised

person consider necessary for the review or scrutiny. The committee will be required to give the officer reasonable notice of the intended date of attendance.

9.2 'An officer of the NHS body' includes the Chief Executive or any other officer. The committee should provide sufficient time for the Chief Executive or officer to prepare prior to the meeting, and clarity should be provided about the issues being discussed and the areas that the questions will focus on. The functions of the committee do not include issues of individual performance of NHS employees and it will not be the purpose of regulations to require officers to attend committee meetings to be personally called to account. invitations to attend an overview and scrutiny committee should be processed via the office of the NHS organisations' Chief Executive.

9.3 Where an NHS body receives an invitation for an officer to attend an overview and scrutiny committee, it must send an appropriate officer. A committee may also invite the Chair or Non-Executive Directors to participate in a scrutiny process. They, however, are not required to attend.

9.4 **independent and private health care providers**

9.5 There may be times when a scrutiny process needs to consider health care provided by the private and independent sectors on behalf of the NHS. This is more likely as the health economy becomes increasingly mixed. In these circumstances: the committee can require the Chief Executive or officers from the local NHS body responsible for commissioning services from the private or independent sector to provide information to, or answer questions from, the committee. The legislation does not provide the committee with the powers to require attendance from representatives from private or independent health care providers. it is good practice that NHS bodies should build clauses into their contracts with the private and independent providers to ensure that they are able to provide any information requested by the committee and to attend meetings in conjunction with an officer from the NHS body.

9.6 Committees will need to be aware that they do not have the power to require individual General Practitioners (GPs) to attend a committee for the purposes of scrutiny. it should be recognised that GPs are not employees of a PCT or NHS body. Of course local GPs may very well be willing to participate at the request of the PCT. However, if a committee considers that a view from general practice would be helpful, an alternative source for information might be the Local Medical Committee. The same approach will be required for scrutiny of services provided by dentists, pharmacists and opticians

10. Joint committees

10.1 Two or more local authorities may appoint a committee (a "joint committee") of those authorities and arrange for relevant functions in relation to any (or ail) of those authorities to be exercisable by the joint committee. Where it appears to the appointing authorities that the joint committee has completed the exercise of relevant functions for which it was appointed, or that it is not adequately performing those functions, those authorities may jointly terminate the appointment.

10.2 A joint committee appointed in this way, is to be treated as a body to which section 15 of the Local Government and Housing Act 1989 (duty to allocate

seats to political groups) applies. In this way, the proportional allocation of the appointing authorities is reflected in the composition of the joint committee.

10.3 A joint committee is only able to discharge the functions for which it has been established.

10.4 In a number of circumstances, committees from more than one authority will need to work together to ensure an efficient scrutiny process. The Regulations will therefore allow joint committees to be formed by two or more local authorities, to carry out health scrutiny in relation to any or all of those authorities. For example, where one NHS body provides services to patients living or working within a number of local authority areas, or where a service relates to more than one local authority. The Regulations will ensure the maximum flexibility for local authorities to make the most of suitable arrangements to meet local circumstances whilst ensuring that NHS bodies are not burdened by multiple scrutiny exercises in one year. However, with flexibility comes responsibility. Whilst the legisiation will enable local authorities to identify the best approach to suit their area, they must give thought to the effectiveness of the process to be followed and work together across organisational boundaries.

10.5 **Issues specific to London**

10.6 The responsibilities for health overview and scrutiny within London lie with the 32 London boroughs and the Council of the City of London. it may be appropriate for these local authorities to establish a pan London joint committee to look at London wide services. This committee might also involve the Greater London Assembly which, whilst not having the legal power of health scrutiny as outlined in the Health and Social Care Act 2001, has the duty to promote the health of the people of London and also to scrutinise pan London health issues.

11. Delegation of scrutiny powers

11.1 A local authority may arrange for relevant functions in relation to that authority to be exercisable by a committee of another local authority. For example, when a local authority, in agreement with another local authority, believes that another authority would be better placed to undertake a particular scrutiny, Delegation may also be from a local authority with social services responsibilities to a district council.

11.2 This regulation prevents delegation from taking place when the committee is being consulted on issues of substantial variation or substantial development. In such circumstances, it is likely to be more appropriate for district council representation to be co-opted onto a committee than for it to undertake scrutiny on behalf of the county council.

11.3 A committee to which relevant Functions have been delegated under this regulation may not discharge any functions other than those functions agreed for delegation.

11.4 The regulation enabies the deiegation of scrutiny powers between local authorities that have the power of overview and scrutiny of health, and also from county councils to district councils. This reflects the recognition that there may be some health priorities which would be more effectively scrutinised at a district level. For cieiegation to be effective, there must be

clear terms of reference agreed with the delegated committee, and clarity about the scope and methods of scrutiny which might be used. In common with the regulation relating to joint scrutiny, delegation may be used for ongoing scrutiny or for 'short term' (i.e. single issue) scrutiny.

12. Co-options

12.1 A county council for any area may arrange for one or more of the members of a committee of the council for a district comprised in that area to be appointed as—

a) a member of a committee of the county council or another local authority, for the purposes of relevant functions of the committee in relation to the county council, or

b) a member of a committee of the county council, for the purposes of relevant functions of the committee in relation to another local authority.

12.2 A county council making an arrangement for an appointment may specify that the appointment is—

i) for the life of the committee, or

ii) until such time as it decides to terminate the appointment, or

iii) for a particular review or scrutinise

In this regulation, references to a committee of a county council include references to a joint committee of the council and another local authority.

12.3 The Local Government Act 2000 establishes clear mechanisms for co-options. The draft of the Local Government Bill includes an amendment to these to allow the grant of voting rights to co-opted members. For the purposes of overview and scrutiny of health, the Health and Social Care Act 2001 and its Regulations enable members of district council overview and scrutiny committees to be co-opted as voting members onto the committees of responsible authorities. This does not exclude the co-option of non-voting members from other organisations and groups, such as Patient Forums or voluntary organisations.

12.4 It is important to consider the value of co-option in relation to the value of involvement in other ways. Likewise, it is important to consider how a scrutiny process may be undertaken. Scrutiny must take place in public except where exempt issues are under consideration. The civic centre may not always be the best location for scrutiny, particularly since the process should strive to reflect the perspectives of 'ordinary people'. Elected members will need to go out and meet service users in places that are convenient and comfortable for them.

12.5 It is clear that co-opting people on to the committee may not be as important, or effective as involving stakeholders, including patients forums in specific scrutiny activities. In many circumstances, it may be more appropriate for external stakeholders to participate in working groups or as advisors to the committee rather than co-opting members of committees of the county council/another local authorities.

12. Directions

12.1 The Secretary of State may direct local authorities to make any specific arrangement< in relation to joint committees, delegation and co-option, and to comply with such requirements in connection with the arrangements as he may direct. it is our intention that directions will be made to ensure the most effective use of the new powers and duties, balancing the needs of patients and the public with the practicalities of impact on NHS resources in relation to the overview and scrutiny of NHS bodies or coliaboratives with a regional or national remit. The options being considered through the consultation process are:

1) all local authorities receiving services from an NHS body providing services national or regional services (e.g. ambulance trust, teaching hospital, regional cancer services, Great Ormond Street Hospital), delegate their functions to tine local authority where the administrative head quarters of the body is based for the purpose of scrutiny (other than substantial variation or development); or

2) the local authority where the administrative base of the NHS body providing national or regional service (e.g. ambulance trust, teaching hospital, regional cancer services, Great Ormond Street Hospital) is located, takes responsibility for establishing a joint committee for the purposes of undertaking scrutiny of that body (or collaborative). in these circumstances, local authorities may delegate their responsibilities to another, for example it may be agreed that across a strategic health authority area one local authority

12.2 The final guidance document will provide support information to enable the process of joint scrutiny of national, regional NHS bodies to be undertaken effectively. The consultation exercise asked for your comments on the options, or to identify other models that might be implemented.

Acknowledgements

This document has been produced by officials at the Department of Health with close involvement of the Overview and Scrutiny of Health Reference Group. We would like to give our thanks to the external members of the groups, and their organisations, for all their support, advice and hard work. In particular, we would like to thank the Audit Commission for their agreement for this support information to make extensive use of their management paper *A Healthy Outlook: local authority* overview *and scrutiny of health.*

We would also like to thank all the local authorities, NHS bodies, Community Health Councils and other key stakeholders that commented on the draft policy document which was consulted upon earlier in the year. These comments and subsequent discussions with officials have informed the development of the Regulations and support information.

External Membership of the Overview and Scrutiny of Health Reference Group includes representatives from:

Association of Community Health Councils for England and Wales

Barnsley Council

Bedfordshire County Council

Democratic Health Network

Health Development Agency

improvement and Development Agency (IDeA)

Local Government Association

London Borough of Lewisham

NHS Confederation

Office of the Deputy Prime Minister

Peterborough City Council