OVERVIEW AND SCRUTINY COMMITTEE
5 SEPTEMBER 2012
LOCAL AUTHORITY HEALTH SCRUTINY – PROPOSALS FOR CONSULTATION
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

To present the Department of Health's consultation on proposals for health scrutiny, following the changes brought about by the Health and Social Care Act 2012, for consideration and response.

2. Action required

The Committee is asked to consider the consultation proposals at Appendix 1 to this report and the draft responses to the questions at Appendix 2, and to approve them with or without amendments for forwarding to the Department of Health.

3. Background information

3.1 The Health and Social Care Act 2012 has introduced major changes to the how health services operate, including the creation of clinical commissioning groups, the NHS Commissioning Board, local Healthwatch and Health and Wellbeing Boards. The Government intends to publish regulations and statutory guidance to update the functions and powers of local authority health overview and scrutiny.

3.2 These particular consultation proposals relate to the power to refer unsupported proposals for changes to NHS services to the Secretary of State for Health. Such referrals are, in turn, considered by an Independent Reconfiguration Panel. Nottingham City Council has never exercised this power, but Nottinghamshire County Council has previously done so.

3.3 The proposals would require local authorities considering a referral to:

- determine a timescale within which a referral could be made;
- consider and take account of the financial implications of a referral;
- secure full Council approval to make a referral;
- form joint health scrutiny committees to consider cross-boundary NHS service changes; and
- go through an intermediate referral stage via the NHS Commissioning Board.

3.4 A draft response to the 11 questions posed in the consultation is attached at Appendix 2 for the Committee's consideration. The closing date for responses to the consultation is Friday 7 September 2012.The responses seek to convey the message that current joint scrutiny arrangements work well, that it is not desirable to require full Council approval of scrutiny decisions and that the overview and scrutiny function has neither the capacity nor expertise to work up alternative financial proposals when considering referral.

4. List of attached information

Consultation document and proposed response.

5. Background papers, other than published works or those disclosing exempt or confidential information

None.

6. Published documents referred to in compiling this report

Local Authority Health Scrutiny: Proposals for Consultation.

7. Wards affected

All.

8. Contact information

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Appendix 1

Local Authority Health Scrutiny

Proposals for consultation

Prepared by the Patient and Public Engagement and Experience Team
Local Authority Health Scrutiny

Contents

Introduction

1. This document sets out the Government's intentions to strengthen and streamline the regulations on local authority health scrutiny, following amendments to the National Health Service Act 2006[1] ("NHS Act 2006") by the Health and Social Care Act 2012[2] ("the 2012 Act"). These enable regulations to be made in relation to health scrutiny by local authorities.

2. The proposed changes to health scrutiny by local government will strengthen local democratic legitimacy in NHS and public health services, helping to ensure that the interests of patients and the public are at the heart of the planning, delivery, and reconfiguration of health services, as part of wider Government strategy to create a patient-centred NHS.

3. In this document, we will build on proposals set out in *Equity and Excellence: Liberating the NHS*[3], which set out a vision of increased accountability, and *Local Democratic legitimacy in health: a consultation on proposals*[4], which posed a number of questions around health overview and scrutiny in particular.

4. The Government recognises that health scrutiny has been an effective means in recent years of improving both the quality of services, as well as the experiences of people who use them. There is much that is good within the existing system on which to build.

5. Our aim is to strengthen and streamline health scrutiny, and enable it to be conducted effectively, as part of local government's wider responsibility in relation to health improvement and reducing health inequalities for their area and its inhabitants.

6. We are aware from engagement to date that there are a range of related matters on which the NHS and local authorities would welcome further clarification and advice that cannot be provided within regulations. We therefore intend to produce statutory guidance to accompany the new regulations that will address some of these issues.

7. Your views on the proposed revisions to health scrutiny are critical. Your participation in this consultation will help us to ensure that the new regulations and any associated

guidance will be successfully implemented.

[1] http://www.legislation.gov.uk/ukpga/2006/41/contents
[2] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm
[3] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
[4] http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586

8. The proposals in this document are being consulted on until 7th September 2012. The comments received will be analysed and will inform the development of new regulations for local authority health scrutiny.

9. We would welcome your comments on the proposals outlined in this document, your suggestions as to how to improve them, together with any general points you wish to make. The document sets out a number of questions on which we would particularly like your views. These are repeated as a single list at Annex A. Details of how to respond and have your say are set out on page 22.

10. Once we have considered your views, a summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm. It is our intention to bring the new Regulations into effect from April 2013.

11. The rationale for changes to the scrutiny regulations is set out in the impact assessment published alongside *Local Democratic Legitimacy in Health: a consultation on proposals*. This consultation document is published alongside an Equalities Screening that considers the impact on equalities. The Department welcomes any information or evidence that will help further analyse the impact of the proposals contained in this document.

Increasing Local Democratic Legitimacy in Health

12. *Equity and Excellence: Liberating the NHS* set out the Government's ambition to achieve significant improvements in health outcomes and the quality of patient care. These ambitions will be delivered through a new clinically-led commissioning system and a more autonomous provider sector. Underpinning the White Paper reforms is a commitment to increasing accountability by ensuring a strong local voice for patients and local communities and putting their views and experiences at the heart of care.

13. Strengthening health scrutiny is one of the mechanisms proposed to increase accountability and enhance public voice in health. In addition, health and wellbeing boards are being established within local authorities. Through health and wellbeing boards, local authorities, the NHS and local communities will work together to improve health and care services, joining them up around the needs of local people and improving the health and wellbeing of local people. By including elected representatives and patient representatives, health and wellbeing boards will significantly strengthen the local democratic legitimacy of local commissioning and will provide a forum for the involvement of local people. Overview and scrutiny committees of the local authority will be able to scrutinise the decisions and actions of the health and wellbeing board, and make reports and recommendations to the authority or its executive.

14. Health and wellbeing boards will consist of elected representatives, representatives from

clinical commissioning groups (CCGs), local authority commissioners and patient and public representatives. A primary responsibility of health and wellbeing boards is to develop a comprehensive analysis of the current and future health and social care needs of local communities through Joint Strategic Needs Assessments (JSNAs). These will be translated into action through Joint Health and Wellbeing Strategies (JHWSs) as well as through CCGs' own commissioning plans for health, public health and social care, based on the priorities agreed in JHWSs. The involvement of local communities will be critical to this process and to the work of the health and wellbeing board. It will provide on-going dialogue with local people and communities, ensuring that their needs are understood, are reflected in JSNAs and JHWSs, and that priorities reflect what matters most to them as far as possible.

15. From April 2013, local authorities will also commission local Healthwatch organisations – the new consumer champion for local health and social care services. Local Healthwatch will help to ensure that the voice of local people is heard and has influence in the setting of health priorities through its statutory seat on the health and wellbeing board.

16. *Local Democratic legitimacy in health,* a joint consultation between the Department of Health and the Department of Communities and Local Government, proposed an Local Authority Health Scrutiny enhanced role for local authorities and asked a number of questions about how the commitment to strengthen public voice in health could be delivered. It aimed to find ways to strengthen partnership working between NHS commissioners and local authorities so that the planning and delivery of services is integrated across health, public health and social care.

17. In the light of responses to that consultation, the Government decided to expand and adapt its proposals for legislation around local democratic legitimacy. *Liberating the NHS: Legislative Framework and Next Steps*[5] proposed extending the scope of scrutiny to include any private providers of certain NHS and public health services as well as NHS commissioners. It also accepted that its original proposition to confer health scrutiny powers onto health and wellbeing boards was flawed. It instead proposed conferring scrutiny functions on local authorities rather than on Health Overview and Scrutiny Committees (HOSCs) directly, giving them greater freedom and flexibility to discharge their health scrutiny functions in the way they deem to be most suitable. These intentions are encompassed within changes made by the 2012 Act to the health scrutiny provisions in the NHS Act 2006.

Aim of Health Overview and Scrutiny

18. This consultation document deals exclusively with health scrutiny. This is an essential mechanism to ensure that health services remain effective and are held to account. The main aims of health scrutiny are to identify whether:

- the planning and delivery of healthcare reflects the views and aspirations of local communities;
- all sections of a local community have equal access to health services;
- all sections of a local community have an equal chance of a successful outcome from health services; and
- proposals for substantial service change are in the best interests of local health services

The History of Health Scrutiny

19. The Local Government Act 2000[6] established the basis for the arrangements that are still in place today, where there are two groups of councillors in most local authorities;

The Executive (sometimes called the Cabinet), responsible for implementing council policy; and

[5] http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624
[6] http://www.legislation.gov.uk/ukpga/2000/22/contents

The Overview and Scrutiny Committees (sometimes called Panels or Select Committees), responsible for holding the Executive to account and scrutinising matters that affect the local area.

20. This Act established that, for the first time, democratically-elected community leaders were able to voice the views of their local constituents, and require local NHS bodies to respond, as part of the council's wider responsibilities to reduce health inequalities and support health improvement.

21. The Health and Social Care Act 2001[7] subsequently amended the Local Government Act, to require local authorities to ensure that their overview and scrutiny committee or committees (OSC) had the power to scrutinise matters relating to health service. The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002[8] ("the 2002 Regulations") required NHS bodies to consult formally with the HOSC on any proposals for substantial variations or developments to local services.

22. The 2002 Regulations also set out the health scrutiny functions of such committees and the other duties placed on NHS bodies. These regulations are still in force today. They:

a. enable HOSCs to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area;

b. require NHS bodies to provide information to and attend (through officers) before meetings of the committee;

c. enable HOSCs to make reports and recommendations to local NHS bodies and to the local authority on any health matters that it scrutinises;

d. to require NHS bodies to respond within a fixed timescale to the HOSC's reports or recommendations, where the HOSC requests a response;

e. require NHS bodies to consult HOSCs on proposals for substantial developments or variations to the local health service; and

f. enable local authorities to appoint joint HOSCs;

g. enable HOSCs to refer proposals for substantial developments or variations to the Secretary of State where they have not been adequately consulted, or believe that the proposals are not in the best interests of the local health service.

[7] http://www.legislation.gov.uk/ukpga/2001/15/contents
[8] http://www.legislation.gov.uk/uksi/2002/3048/contents/made

Benefits

23. The current health scrutiny functions support the accountability and transparency of public services. They provide a means for councillors to engage with commissioners, providers and local people across primary, secondary and tertiary care.

24. HOSCs set their own priorities for scrutiny to reflect the interests of the people they serve. Councillors on HOSCs have a unique democratic mandate to act across the whole health economy, using pathways of care to hear views from across the system and examining priorities and funding decisions across an area to help tackle inequalities and identify opportunities for integrating services.

25. By creating a relationship with NHS commissioners, health scrutiny can provide valuable insight into the experiences of patients and service users, and help to monitor the quality and outcomes of commissioned services. It can also provide important insight that will contribute to the process of developing JSNAs and JHWSs, on which future commissioning plans will be based.

26. Where relationships between the NHS and HOSCs are mature, health scrutiny adds value by building local support for service changes. Some HOSCs also advise the NHS on appropriate forms of public engagement, including alternatives to full public consultation, thus saving NHS resources. These effective relationships are usually a result of early engagement between the NHS and the HOSC, where there is co-operation on proposals for consultation and potential areas of dispute are surfaced and solutions agreed as part of wider consultation.

Proposals for Consultation

Why are we looking at this?

27. The current reform programme is underpinned by a commitment to increasing local democratic legitimacy in health. Strengthening health scrutiny is one element of this.

28. These important reforms are taking place against a backdrop of a very challenging financial environment for public services. The need to deliver improved quality and outcomes in this economic context will be a significant challenge for both NHS commissioners and local authorities. Commissioners will need to focus on achieving the very best outcomes for every pound of health spend, meaning that complex decisions over the current and future shape of services are likely to be required. In a tax-funded system, it is important that such decisions are grounded with effective local accountability and discussed across local health economies. The role and importance of effective health scrutiny will therefore become more prominent.

29. Since the scrutiny provisions were implemented in 2003, NHS organisations, health services and local authorities have changed substantially. The 2012 Act will bring about further structural reforms with the introduction of the NHS Commissioning Board, CCGs, health and wellbeing boards and Healthwatch.

30. The Government recognises that the current arrangements for health scrutiny need to be updated to ensure the scrutiny provisions reflect the new structure and are appropriate to the new system. It is important that the new NHS bodies are made subject to effective

scrutiny and held to account.

31. In updating the scrutiny regulations, we propose to retain the best of the existing system but take this opportunity to address some of the challenges that have been experienced by both local authorities and NHS bodies since 2003.

32. The 2012 Act has made changes to the regulation-making powers in the 2006 Act around health scrutiny. In future, regulations will:

a. confer health scrutiny functions on the local authority itself, rather than on an overview and scrutiny committee specifically. This will give local authorities greater flexibility and freedom over the way they exercise these functions in future, in line with the localism agenda. Local authorities will no longer be obliged to have an overview and scrutiny committee through which to discharge their health scrutiny functions, but will be able to discharge these functions in different ways through suitable alternative arrangements, including through overview and scrutiny committees. It will be for the full council of each local authority to determine which arrangement is adopted;

b. extend the scope of health scrutiny to "relevant NHS bodies" and "relevant health service providers". This includes the NHS Commissioning Board, CCGs and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and the local authority, including independent sector providers.

33. These important changes to health scrutiny regulations were consulted upon widely through the White Paper, *Liberating the NHS,* and throughout the passage of the 2012 Act in Parliament. This document does not consult further upon the merits of these changes.

34. The Government recognises that the existing health scrutiny regulations have, on the whole, served the system well. Some elements of the regulations, for example around the provision of information and attendance at scrutiny meetings, are fundamental to the effective operation of health scrutiny, and will need to be retained. We propose therefore to preserve those provisions which:

a. enable health scrutiny functions to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area;

b. require NHS bodies to provide information to and attend (through officers) before meetings of the committee to answer questions necessary for the discharge of health scrutiny functions;

c. enable health scrutiny functions to make reports and recommendations to local NHS bodies and to the local authority on any health matters that they scrutinise;

d. require NHS bodies to respond within a fixed timescale to the HOSC's reports or recommendations;

e. require NHS bodies to consult health scrutiny on proposals for substantial developments or variations to the local health service;

35. The provisions will be modified in accordance with amendments to the 2006 Act by the 2012 Act so, for example, they will apply in relation to the NHS Commissioning Board, CCGs and providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and local authorities, in line with paragraph 32 b) above.

36. The Health Act 2009[9] introduced the Unsustainable Providers Regime for NHS trusts and NHS foundation trusts. The purpose of this regime is to deliver a swift resolution in the unlikely event that an NHS provider is unsustainable, to ensure patients are not put at risk. Parliament accepted the principle that under these exceptional circumstances, public consultation and local authority scrutiny should be restricted to a truncated 30-working day consultation period. Therefore, the provisions in the 2002 Regulations on consultation of HOSC and referrals by them, and on provision of information to them and attendance before them, do not apply in relation to a Trust Special Administrator's report.

[9] http://www.legislation.gov.uk/ukpga/2009/21/contents

37. The 2012 Act introduced a framework to secure continued access to NHS services, which included a modified and improved version of the 2009 Act failure regime for NHS foundation trusts. We intend to retain the exemption from the need to consult local authority scrutiny functions on proposals contained in a Trust Special Administrator's report and the other exceptions mentioned above. In line with paragraph 32 b) above, we also intend to extend this exemption to Health Special Administration[10] proposals, which will provide equivalent continuity of service protection to patients receiving NHS care from corporate providers in the unlikely event that one such provider becomes insolvent.

Proposals under consultation

The current position on service reconfiguration and referrals

38. Throughout its history, the NHS has changed to meet new health challenges, take advantage of new technologies and new medicines, improve safety, and modernise facilities. The redesign and reconfiguration of services is an important way of delivering improvements in the quality, safety and effectiveness of healthcare.

39. The Government's policy is that service reconfigurations should be locally-led, clinically driven and with decisions made in the best interest of patients. The spirit of 'no decision about me, without me' should apply, with patients and local communities having a genuine opportunity to participate in the decision-making process.

40. Reconfigurations should also demonstrate robust evidence against the Secretary of State's four tests for major service change[11]. This means all proposals should be able to demonstrate evidence against the following criteria.

- a clear clinical evidence base, which focuses on improved outcomes for patients;
- support for proposals from the commissioners of local services;
- strengthened arrangements for patient and public engagement, including consultation with local authorities; and
- support for the development of patient choice.

41. Effective patient and public engagement is at the heart of any successful reconfiguration. NHS bodies have a legal duty to make arrangements that secure the involvement of patients and the public in the planning of service provision, the development and consideration of proposals for changes in the way services are provided and decisions to be made affecting the operation of those services.

[10] Chapter 5 of Part 3 of the 2012 Act
[11] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_118085.pdf

42. Under the current system, NHS bodies must consult the HOSC on any proposals for "a substantial variation" in the provision of the health service or "a substantial development" of the health service. The existing health scrutiny regulations do not define what constitutes 'substantial'. The Government's view, taking into account previous consultation on this issue, is that this is a matter on which NHS bodies should aim to reach a local understanding or definition with their HOSC.

43. It is normal for local stakeholders and communities to have different views on how best to reorganise and reshape services to best meet patient needs within available resources. In the majority of cases, these differences of opinion are reconciled locally through effective partnership working and engagement.

44. However, there may be occasions where a local authority scrutiny body does not feel able to support a particular set of proposals for service change or feels that consultation has been inadequate. Under the 2002 Regulations, a HOSC or a joint HOSC can refer proposals to the Secretary of State if they:

a. do not feel that they have been adequately consulted by the NHS body proposing the service change, or

b. do not believe that the changes being proposed are in the interests of the local health service

45. Upon receiving a referral, the Secretary of State will then usually approach the Independent Reconfiguration Panel (IRP) for advice. The IRP is an independent, advisory non-departmental public body that was established in 2003 to provide Ministers with expert advice on proposed reconfigurations. In providing advice, the IRP will consider whether the proposals will provide safe, sustainable and accessible services for the local population.

Proposed changes

46. The Government is aware through conversations with stakeholders from the NHS, local government and patient groups that existing dispute resolution and referral mechanisms do not always work in the best interests of improving services for patients. Moreover, the current referral process was developed in 2002, which pre-dates considerably the current raft of reforms and structural changes underway across the health and social care system. It is essential that the system changes so that local conversations on service reconfiguration are embedded into commissioning and local accountability mechanisms.

47. More integrated working between clinical commissioners, local authorities and local patient representatives will help to move the focus of discussions about future health services much earlier in the planning process, strengthening local engagement and helping build consensus on the case for any change.

48. The introduction of health and wellbeing boards will significantly improve joint working and planning between local authorities and the NHS across health services, social care and public health. Whilst the 2012 Act is very clear that health scrutiny remains a separate function of the local authority (and cannot be delegated to health and wellbeing boards), health and wellbeing boards provide a forum for local commissioners (NHS and local authority) to explain and discuss how they are involving patients and the public in the

design of care pathways and development of their commissioning plans.

49. It is sensible, therefore, that we look further at how a balance can continue to be struck between allowing services to change and providing proportionate democratic challenge that ensures those changes are in the best interests of local people.

50. We are proposing a number of changes around service reconfiguration and referral which are designed to clarify and streamline the process in the future. Our proposals on referrals break down into four main areas:

a. requiring local authorities to publish a timescale for making a decision on whether a proposal will be referred;

b. requiring local authorities to take account of financial considerations when considering a referral;

c. introducing a new intermediate referral stage for referral to the NHS Commissioning Board for some service reconfigurations;

d. requiring the full council of a local authority to discharge the function of making a referral.

Publication of timescales

51. Under the 2002 Regulations, an HOSC can decide to refer a reconfiguration proposal at any point during the planning or development of that proposal. The 2002 Regulations do not specify a time by which an HOSC must make this decision. Most referrals are done at the point where the NHS has concluded its engagement and consultation and decided on the preferred option to deliver the proposal. Where referrals have been made earlier in the process, the IRP have usually advised the Secretary of State against a full review and advised that the NHS and HOSC should maintain an on-going dialogue as options are developed.

52. We are aware from feedback from both the NHS and local authorities, that the absence of clear locally agreed timetables can lead to considerable uncertainty about when key decisions will be taken during the lifetime of a reconfiguration programme. Some have expressed a view that timescales should be specified in regulations but we believe that imposing fixed timescales in this way would be of limited value. Each reconfiguration scheme is different and it is right to allow local flexibility for the adoption of timetables that are appropriate to the nature and complexity of any change.

53. We therefore propose introducing a requirement in regulations that, in relation to proposals on which the local authority scrutiny function must be consulted, the NHS commissioner or provider must publish the date by which it believes it will be in a position to take a decision on the proposal, and notify the local authority accordingly. We propose that on receipt of that notification, local authorities must notify the NHS commissioner or provider of the date by which they intend to make a decision as to whether to refer the proposal.

54. If the timescales subsequently need to change – for example, where additional complexity emerges as part of the planning process – then it would be for the NHS body proposing the change to notify the local authority of revised dates as may be necessary, and

for the local authority to notify the NHS organisation of any consequential change in the date by which it will decide whether to refer the proposal. The regulations will provide that the NHS commissioner or provider should provide a definitive decision point against which the local authority can commence any decisions on referral.

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons

Q2 Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?

Financial sustainability of services

55. Under present regulations, an HOSC can make a referral if it considers the proposal would not be in the best interest of the local health service. The regulations do not define what constitutes 'best interest' but evidence from previous referrals indicates that local authorities interpret this in terms of the perceived quality and accessibility of services that will be made available to patients, users and the public under the new proposals.

56. The Government protected the NHS in the Spending Review settlement with health spending rising in real terms. However, this does not mean that the NHS is exempt from delivering efficiency improvements - it will need to play its part alongside the rest of the public services. Delivery of these efficiencies will be essential if the NHS is to deliver improved health outcomes while continuing to meet rapidly rising demands.

57. As local authorities and the NHS will increasingly work together to identify opportunities to improve services, we believe it is right that health scrutiny be asked to consider whether proposals will be financially sustainable, as part of its deliberations on whether to support or refer a proposed service change.

58. It would not be right for a local authority to refer a reconfiguration proposal to the Secretary of State without considering whether the proposal is both clinically and financially sustainable, within the existing resources available locally. We believe health scrutiny would be improved in it was specifically asked to look at the opportunities the change offered to save money for use elsewhere in improving health services.

59. We therefore propose that in considering whether a proposal is in the best interests of the local health service, the local authority has to have regard to financial and resource considerations. Local authorities will need support and information to make this assessment and the regulations will enable them to require relevant information be provided by NHS bodies and relevant service providers. We will address this further in guidance.

60. Where local authorities are not assured that plans are in the best interests of the local health services, and believe that alternative proposals should be considered that are viable within the same financial envelope as available to local commissioners, they should offer alternatives to the NHS. They should also indicate how they have undertaken this engagement to support any subsequent referral. This will be set out in guidance rather than in regulations.

Q3. Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your views.

Referral to the NHS Commissioning Board

61. The 2012 Act ensures the Secretary of State's duty to promote a comprehensive health service remains unchanged in legislation, as it has since the founding NHS Act 1946. The NHS Commissioning Board has a parallel duty. The 2012 Act also makes clear that the Secretary of State remains ultimately accountable for the health service. However, the Secretary of State will no longer have general powers to direct the NHS. Instead, NHS bodies and the Secretary of State will have specific powers that are defined in legislation, enabling proper transparency and accountability. For example, Ministers will be responsible, not for direct operational management, but for overseeing and holding to account the national bodies in the system, backed by extensive powers of intervention in the event of significant failure. The NHS Commissioning Board and CCGs will have direct responsibility for commissioning services. The NHS Commissioning Board will help develop and support CCGs, and hold them to account for improving outcomes for patients and obtaining the best value for money from the public's investment.

62. We believe that where service reconfiguration proposals concern services commissioned by CCGs, the NHS Commissioning Board can play an important role in supporting resolution of any disputes over a proposal between the proposer of the change and the local authority, particularly where the local authority is considering a referral.

63. We are seeking views on how the NHS Commissioning Board could provide this support and help with dispute resolution. One option is to introduce an intermediate referral stage, where local authorities make an initial referral application to the NHS Commissioning Board. Upon receiving a referral, the NHS Commissioning Board could be required by regulations to take certain steps, which could include working with local commissioners to resolve the concerns raised by the local authority. The NHS Commissioning Board would be required to respond to the local authority setting out its response and any action that it had taken or proposed to take.

64. If the local authority was not content with the response from the NHS Commissioning Board, it would continue to have the option to refer the proposal to the Secretary of State for a decision, setting out in support of its application where the NHS Commissioning Board's response fell short in addressing the concerns of the authority.

65. The exception to this referral intermediate stage would be where the reconfiguration proposals relate to services commissioned directly by the NHS Commissioning Board. In such a case, any referral would be made directly to the Secretary of State.

66. The Government believes this option holds most true to the spirit of a more autonomous clinical commissioning system, strengthening independence from Ministers, and putting further emphasis on local dispute resolution. However, we are aware through testing this option with NHS and local authority groups that it is not without complexities. It may be difficult for the NHS Commissioning Board to both support CCGs with the early development of reconfiguration proposals (where CCGs request this support) and also to be able to act sufficiently independently if asked at a later date by a local authority to review those same plans. Furthermore, this additional stage could lengthen the decisionmaking timetable for service change, which could delay higher quality services to patients coming on stream.

67. An alternative approach would be for the NHS Commissioning Board to play a more informal role, helping CCGs (and through them, providers) and the local authority to maintain an on-going and constructive dialogue. Local authorities would be able to raise their concerns about a CCG's reconfiguration proposals with the NHS Commissioning Board and seek advice. However, that would be at the local authority's discretion rather than a formal step in advance of referral to the Secretary of State.

68. If a local authority chose to engage the NHS Commissioning Board in this way, the Board would need to determine whether it was able to facilitate further discussion and resolution, and respond to the CCG and local authority accordingly. If following the Board's intervention the local authority's concerns remained, the local authority would continue to have the option as under current regulations to refer the proposal to the Secretary of State for review.

69. The Government does not have a preference between the formal and informal methods set out above, and would welcome comments from interested stakeholders on the advantages and disadvantages of both approaches. Irrespective of the referral route any informal dispute resolution process that may be put in place, we do not propose to fundamentally remove a local authority's power of referral to the Secretary of State. This ability to refer to Secretary of State is unique within local authority scrutiny and provides a very strong power for local authorities within the new landscape, where the Secretary of State will have fewer powers to direct NHS commissioners and providers.

Q4. Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?

Q5. Would there be any additional benefits or drawbacks of establishing this intermediate referral?

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?

Full council agreement for referrals

70. Under existing regulations, it is for the HOSC to determine whether to make a referral to the Secretary of State for Health. A referral to the Secretary of State in many ways represents the break down in the dialogue between local authorities and the NHS. It should be regarded as a last resort and the decision itself should be open to debate.

71. Given the enhanced leadership role for local authorities in health and social care, we believe it is right that the full council should support any decision to refer a proposed service change, either to the NHS Commissioning Board or to Secretary of State. We propose that referrals are not something that the full council should be able to delegate to a committee, and that the referral function should be exercised only by the full council.

72. This will enhance the democratic legitimacy of any referral and assure the council that all attempts at local resolution have been exhausted. It is potentially undesirable for one part of the council (the health and wellbeing board) to play a part in providing the over-arching strategic framework for the commissioning of health and social care services and then for another part of the council to have a power to refer to the Secretary of State.

73. This change would mean scrutiny functions would need to assemble a full suite of evidence to support any referral recommendation. It is important that all councillors should be able to contribute their views, to allow them to safeguard the interests of their constituents. This will also bring health oversight and scrutiny functions in line with other local authority scrutiny functions, which also require the agreement of a full council. The Government believes that this additional assurance would help encourage local resolution, and further support closer working and integration across the NHS and local government.

Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

Joint Overview and Scrutiny

74. There are many occasions when scrutiny functions from more than one local authority area will need to work together to ensure an effective scrutiny process. Joint scrutiny is an important aspect of existing health scrutiny practice, and has been very successful in a number of places. Some regions have established standing joint OSCs, or robust arrangements for introducing joint OSCs on specific regional issues. Joint scrutiny arrangements are important in that they enable scrutineers to hear the full range of views about a consultation, and not just those of one geographical area.

75. The Government is aware from its engagement with patients and the public, the NHS and with local authorities, that there are differences of opinion as to when a joint scrutiny arrangement should be formed. The current regulations enable the formation of joint scrutiny arrangements, but do not require them to be formed. We propose to make further provision within the regulations on this issue.

76. Under the 2003 Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions)[12] where a local NHS body consults more than one HOSC on any proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such service, local authorities of those HOSCs must appoint a joint HOSC for the purposes of the consultation. Only that joint HOSC may make comments on the proposal, require information from the NHS body, require an officer of that NHS body to attend before the joint HOSC to answer questions and produce a single set of comments in relation to the proposals put before them. This is fundamental to the effective operation of joint scrutiny and we propose that it should be incorporated into the new regulations.

Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?

77. The ability of individual local authorities to refer proposals to the Secretary of State for review has been an important enabler of local democratic legitimacy. It is important that this ability to refer is preserved, where a joint health scrutiny arrangement is formed. Should a local authority participating in a joint health scrutiny arrangement wish separately to refer a proposal either to the NHS Commissioning Board or to the Secretary of State, they will still be required to secure the backing of their full council in order to make the referral.

[12] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4006257

78. There are a range of circumstances beyond service variation or development in which two or more local authorities may wish to come together to scrutinise health matters, for example where a CCG or NHS foundation trust spans two local authority boundaries. In such circumstances, the formation of a joint scrutiny arrangement would be discretionary.

Responding to this consultation

79. The Government is proposing a number of measures to strengthen and improve health scrutiny.

80. The Government wants to hear your views on the questions posed in this document, to help inform the development of the health overview and scrutiny regulations. We are also seeking your views on the following questions:

Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

Deadline for comments

81. This document asks for your views on various questions surrounding the issue of local authority health overview and scrutiny.

82. This is an 8 week consultation, running from 12th July 2012 to 7th September 2012 and building on earlier consultation on *Liberating the NHS, Local Democratic Legitimacy in Health*. In order for them to be considered, all comments must be received by 7th September 2012. Your comments may be shared with colleagues in the Department of Health, and/or be published in a summary of responses. Unless you specifically indicate otherwise in your response, we will assume that you consent to this and that your consent overrides any confidentiality notice generated by your organisation's email system.

83. There is a full list of the questions we are asking in this consultation on page 25. You can respond online at http://consultations.dh.gov.uk/public-patient-engagementexperience/http-consultations-dh-gov-uk-ppe-local-authority/consult_view by email to scrutiny.consultation@dh.gsi.gov.uk or by post to:
Scrutiny Consultation
Room 5E62
Quarry House
Local Authority Health Scrutiny
23
Quarry Hill
Leeds LS2 7UE

84. When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear whom the organisation represents and, where applicable, how the views of the members were assembled.

85. It will help us to analyse the responses if respondents fill in the questionnaire, but responses that do not follow the structure of the questionnaire will be considered equally. It would also help if responses were sent in Word format, rather than pdf.

Criteria for consultation

86. This consultation follows the Cabinet Office Code of Practice for Consultations. In particular, we aim to:

formally consult at a stage where there is scope to influence the policy outcome;

follow as closely as possible the recommendation duration of a consultation which is at least 12 weeks (with consideration given to longer timescales where feasible and sensible) but in some instances may be shorter. In this case, it is 8-weeks in light of previous consultation referred to in paragraph 82 above and engagement undertaken by the Department throughout passage of the 2012 Act.

be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;

ensure the consultation exercise is designed to be accessible to, and clearly targeted at those people it is intended to reach;

keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' "buy-in" to the process;

analyse responses carefully and give clear feedback to participants following the consultation;

ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

87. The full text of the code of practice is on the Better Regulation website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

88. If you have any concerns or comments which you would like to make relating specifically to the consultation process itself, please contact

Consultations Coordinator
Department of Health
Room 3E48
Quarry House
Local Authority Health Scrutiny
24
Quarry Hill
Leeds LS2 7UE
Email: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address

Confidentiality of information

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

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

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

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

After the consultation

93. Once the consultation period is complete, the Department will consider the comments that it has received, and the response will be published in the Autumn

94. The consultation and public engagement process will help inform Ministers of the public opinion, enabling them to make their final decision on the content of the health scrutiny regulations.

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

Annex A - Consultation Questions

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons

Q2 Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?

Q3. Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your view.

Q4. Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?

Q5. Would there be any additional benefits and drawbacks of establishing this intermediate referral?

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?

Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?

Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

Local Authority Health Scrutiny Consultation Response

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons.

A. No. Flexibility is required to account for the types and complexity of re-configuration proposals, and to address concerns brought to the Health Overview and Scrutiny Committee's (HOSC) attention at any point within the process. Consistent and ongoing engagement between local authorities/committees and the NHS during a reconfiguration process is the most effective means of avoiding the uncertainty this measure seems designed to prevent.

Q2. **Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?**

A. Yes, on the basis that it would provide all parties (the NHS, local authorities, patients and the public) with a timeline by which a reconfiguration process should be completed. Such an inclusion would:

- help HOSCs to programme their work,
- help hold the NHS to account in delivering timely reconfiguration while indicating, but not prescribing, when a referral to the Secretary of State was likely to take place,
- provide parameters for patients and the public to understand how a reconfiguration was progressing, and
- help service users plan for potential changes to services.

However, it must be clear that, if circumstances dictate, such timescales are not obligatory.

Q3. **Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your views?**

A. While financial considerations may well inform a decision on whether or not to refer a reconfiguration proposal, it would not be appropriate for financial considerations to be an overwhelming factor for HOSCs. Similarly, it is inappropriate for HOSCs to be expected to develop evidence-based viable counter proposals 'within the same financial envelope as available to local commissioners' (paragraph 60 of the consultation document) – this would seem to go well beyond what is commonly understood to be scrutiny.

Central to the role of health scrutiny is helping ensure that proposals meet the views, aspirations and needs of local communities in providing equality of access to services, successful outcomes and being in the best interests of local health services. Reflecting the public concern, and referring those concerns to the Secretary of State where these persist following consultation and engagement, should not be dependent upon HOSCs effectively taking on the role of NHS clinicians and commissioners in drawing up alternative reconfiguration proposals. One of the values of the Health Scrutiny process lies in its ability to represent the views of the public to the decision takers within the NHS.

Its members have neither the capacity nor the expertise to produce fully costed proposals.

Q4. **Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board.**

A. On balance, no. An intermediate referral stage might well help resolve issues without the need for onward referral to the Secretary of State. However, the NHS Commissioning Board is not likely to be seen as an impartial arbiter in respect of concerns about reconfiguration proposals, calling into question the 'currency' of the Board's decisions.

Q5. **Would there be any additional benefits or drawbacks of establishing this intermediate referral?**

A. Interim referral might lead to a more timely resolution of issues, where the Board is perceived on all sides as an interested, expert and dispassionate facilitator. This, in turn, could help limit uncertainties for all parties.

The drawbacks of intermediate referral include the slowing down of the overall process, and the danger of the perception arising that the Board is partial, especially when it finds in favour of those proposing change in the face of popular opinion locally. This could be seen as an unnecessary and out-of-touch additional layer of bureaucracy which flies in the face of the localism agenda.

Referral to and consideration by the Secretary of State is on a case-by-case basis. As a record of the Board's involvement and decisions builds over time, there is a danger both of the Board allowing precedent to pre-determine outcomes, and of further wrangling where the Board's findings appear at odds with its previous decisions in similar circumstances.

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasize the local resolution of disputes?

A. While the response to Question 5 above is sceptical about the benefits of a formal intermediate referral stage in the process, informal working arrangements involving HOSCs, the CCG and the Board might help smooth out concerns over reconfiguration proposals.

Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

A. On balance, no. The endorsement of full Council could be seen to lend weight to a referral in that it signifies major concerns from the Authority as a whole rather than a single committee. Councils now do have an enhanced leadership role in health and social care through health and wellbeing boards, and greater co-operation and dialogue between boards (ie the Executive) and the overview and scrutiny function is desirable.

However, this proposal both politicises and undermines the independence of health scrutiny. The overview and scrutiny function does not take the issue of referral to the Secretary of State lightly – any such decision would be informed by expert legal advice, and would draw upon the accumulated knowledge and expertise of those councillors involved in health scrutiny issues.

The independent, politically neutral decisions of HOSCs should not be undermined by subjecting them to potential reversal at full Council – to do so calls into question the value of health scrutiny itself.

The proposal also creates blurred lines of accountability, whereby Executive councillors involved in taking decisions within one forum (the Health and Wellbeing Board) are then involved in the decision to refer issues to the Secretary of State at full Council.

Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?

A. No. The formation of joint committees should be left to local determination. The Joint Committee with Nottingham City and Nottinghamshire County works well. This is because the Joint Committee's focus is on the impact of proposals on the conurbation. If the intention is to require the establishment of standing regional Health Committees, depending on the reconfiguration being proposed, that would seem to be unwieldy.

It is also more likely that in constituting wider joint committees, there are winner and loser authorities arising from service reconfigurations, making consensus at regional level difficult to achieve, and increasing the risk of the 'local voice' being lost.

The proposal that referrals should be endorsed by full Council would seem to bring particular issues with it for Joint Committees. It is unclear what would happen if one full council referred and another did not.

Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

A. The point is made in the response to Q8 that in requiring joint committees at the regional level there is a strong risk of losing sight of the impact on local minority communities, especially when those communities are disproportionately affected by the changes.

Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

A. The response to Q7 makes clear that we do not support the proposal to have referrals made by the full Council, and want to maintain the independence and political neutrality of the overview and scrutiny function.

In view of the enhanced leadership role for local authorities in health and social care, it is suggested that a Notice of Intent to Refer, or similar, be submitted for information and, if

necessary, discussion by the Health and Wellbeing Board. This would provide an avenue for the strategic leadership to give the HOSC ‘pause for thought’ before proceeding with referral.

Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn’t?

A. There is a perception that significant reconfiguration of services could be achieved by stealth through the cumulative impact of a series of smaller planned changes over time which, of themselves, do not amount to significant changes. It might be useful to have guidance to help local determination of whether and when significant reconfiguration is slipping ‘under the radar’.