APPENDIX 2

AGENDA ITEM: 6

SCRUTINY AND THE NEW NHS BILL

TO: Chief Officer's Management Team

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1. The NHS Bill

1.1 Until its debate in the House of Lords last week, the Bill was on course to receive Royal Assent in this Parliament. The debate centred on the role of the Community Health Councils (CHCs) and more particularly their proposed abolition. There was a strong lobby in the House of Lords to retain them whereas the Minister, of course, wanted to get rid of them.

1.2 This is important for at least two reasons:

- It could affect what responsibilities are passed to local authorities to scrutinise health
- The retention of CHCs will affect the distribution of resources to support the new infrastructure that the Minister wishes to put in place.

1.3 My understanding is that Government still intends that the Bill will receive the Royal Assent in this Parliament.

2. The Content of the Bill

2.1 As we know from the presentation made by Hugh Carey to Cabinet, chapter 10 of the Bill contains a range of proposals to strengthen the patient and public involvement in the NHS. Paragraphs 10.25 to 10.27 set out proposals to give local authorities the power to scrutinise the NHS at a local level.

2.2 These new arrangements include the requirement for the chief executives of NHS organisations (the Area Health Authority, NHS and Primary Care Trusts, other trusts such as the Bucks Mental Health Trust) to attend the main local authority scrutiny committee at least twice annually if requested to do so. The plan also proposes that these committees will be able to refer contested major service reconfigurations to a new independent reconfiguration panel.

2.3 The Government clearly sees this as an extension of the powers that local authorities already have to scrutinise the local health economy. For example, the work already undertaken by the Partnership Select Committee is very much in line with the role that the Government sees for local authorities.

3. The Key Principles of Scrutiny

3.1 In undertaking these new responsibilities, Government has set out five key principles that they think should underlie successful arrangements for the overview and scrutiny of the NHS. These are:

- Flexibility. Flexibility should be used to determine the appropriate mechanisms to meet different local circumstances.

- Partnership. Scrutiny must be based on a constructive and informed dialogue between local government and the NHS underpinned by partnership working so as to avoid an adversarial approach.

- Comprehensive. Scrutiny will be most valuable where it looks at the broad spectrum of provision including NHS but also local government services as well.

- In context. Scrutiny will need to relate to the ways in which different organisations work and to the variety of performance management frameworks that operate both in local government and the health service.

- Resourced. Effective overview and scrutiny will need to be properly resourced with adequate officer support and information.

4. Who Should Do the Scrutinising?

4.1 The Bill proposes that councils with social service responsibilities should be responsible for overview and scrutiny of health. In two-tier areas, however, district councils must also have a role in this process. It is suggested that whilst it is probably more appropriate in two-tier areas for county councils to take the lead, it might be appropriate for district councils to take the lead in scrutinising PCT/Gs, especially where boundaries are co-terminous. This is in response to the pressure from the LGA to recognise the role of Districts.

4.2 Government sees it as essential that local councils and their health partners develop a scrutiny model which suits local circumstances. We would be able to co-opt (with full voting rights) members from other authorities onto an overview and scrutiny committee or we could delegate the function to another authority or to a joint committee of several authorities.

4.3 It is suggested that we should begin now a dialogue with surrounding councils and health partners how best to develop proposals to ensure that the new responsibilities are built in to our new political structure rather than bolted on at a later date.

5. What Form Should the Scrutiny Take?

5.1 The guidance from the LGA suggests that scrutiny should take place on two broad fronts:

- Firstly, to review the appropriateness of provision in relation to the health improvement programme and to the needs identified within our community strategy.

- The second relates to Health Authority performance. Bearing in mind the scale of what is being considered, the LGA advice is that the scrutiny arrangements should ensure that there is no undue focus on the performance of any one organisation. The scrutiny process should take a broader view on the cross-cutting issues across the whole health economy.

5.2 Clearly a lot of this will depend on the supporting framework within which scrutiny sits. For example, the patients' forums and the patients' advisory liaison service that has a co-ordinating function in this process. Whilst the Bill might result in better outcomes for patients, it would appear not to achieve anything in terms of reducing the bureaucracy required to achieve it.

6. The Style and Tone of Overview and Scrutiny

6.1 Again, strong emphasis is placed on achieving a partnership approach in carrying out the overview and scrutiny role. The guiding principle is that local authorities, as leaders of their communities, should ensure that local people's needs and aspirations are met, not to control all that happens within their boundaries. Equally, NHS organisations are extolled not to look at the process as unwarranted interference or intervention. In carrying out its task, any scrutiny committee would have to be careful to ensure that the process itself does not set back what are generally seen as positive joint working arrangements.

6.2 Helpfully the LGA, in conducting a recent survey, has identified what are seen as being a number of barriers to successful partnerships. These are:

- concern over funding arrangements for the new responsibilities
- lack of understanding of each others' roles, cultures, processes and languages
- lack of clarity on how the separate planning processes can be joined up.

7. What Will Happen to the Outcomes of Reviews?

7.1 The outcomes of reviews will in the normal way be presented both to the cabinet and possibly to the council. Scrutiny committees will of course have no powers to ensure that recommendations are implemented. However this does not mean that they are powerless in terms of the influence they can bring. It is envisaged that the scrutiny committees will draw on the expertise of those involved in the new patients' forums, the patients' advocacy and liaison service and others to ensure that the arguments behind their recommendations are strong and well reasoned.

7.2 The reports of the overview and scrutiny committees will be presented to all relevant partners for their consideration. Accountability arrangements within the Health Service mean that NHS organisations cannot be required to implement those recommendations. However they can be called to account to explain why they have chosen not to do so.

8. Support for the New Scrutiny Arrangements

8.1 Whilst it is still unclear as to what resources, if any, Government propose to make available to support the new arrangements, advice is clear that overview and scrutiny will need to be adequately supported if it is to be effective. It may be for example, that arrangements might involve secondment of officers from health partners to the local authority. It may also be that joint funding arrangements for the support and training of members might be considered in some areas. Equally there is a lot of skill and expertise in the current CHCs which should be harnessed and not lost. Also there may be ways in which the cost of supporting scrutiny arrangements can be shared, depending on the model best suited to local need.

9. Questions to be Considered

9.1 In their submission to the Minister, the LGA is taking a very positive view of the local authorities' roles and responsibilities in holding the NHS to account. They have taken the lead in arguing the case for including district councils in the overview and scrutiny process and would appear, in part at least, to have won that argument. The LGA has

suggested that there are at least three different types of arrangement that might be appropriate for local councils and health partners. The models they are advocating are:

9.1.1 Model One - Joint Overview and Scrutiny Committees

This would entail the creation of a joint overview and scrutiny committee between any combination of authorities involved, ie county council, district councils, unitary council. It might be appropriate, for example, where there is a regional or national resource in a county area, such as Stoke Mandeville, where interests range beyond the boundaries of the lead authority.

9.1.2 Model Two – Delegation to District Councils

This model is more relevant to scrutiny at the local level of PCTs/PCGs, especially where they are co-terminous with district boundaries. The LGA supports their argument for this in terms of the strength of the relationships which have already been established between PCTs/PCGs at the local level. It is also seen as a way of reducing the resource burden that might be placed on a county council in scrutinising the work of a significant number of trusts.

9.1.3 Model Three – Co-option onto the County Scrutiny Committee

Under this arrangement the county council would lead the scrutiny process but co-opt members from relevant district councils onto their scrutiny committee – with voting rights.

Clearly combinations of these options are also possible and a factor for us particularly would be to think about the relationship with Milton Keynes bearing in mind the current boundaries of the Health Authority.

From conversations which have taken place previously at the County and District Leaders' meeting, I am quite clear that the Districts would want to have an involvement. At one stage it was suggested that the scrutiny committee might comprise the leaders of the County and District Councils. However, the current guidance would rule that out in as members of local authority executives cannot participate in the scrutiny process.

10. Resourcing the New Arrangements

10.1 Originally I was told that since the new arrangements would actually increase the number of organisations holding the NHS to account, there would be no resources released by the abolition of the CHCs which could be diverted to local authorities. However, last week I had an e-mail from a colleague at the LGA who is involved in discussions with the DOH. Under the current proposals in the Bill, in each locality there will be established a patient's forum for each NHS body in the area. From these forums there will be a local patients' council comprising one member from each forum.

10.2 It has not been decided what area these councils will cover, whether it will correspond to a health authority area or to a local authority area. The issue has been raised therefore as to how these bodies will be supported in staffing terms and there is a proposal from the DOH that local authorities be asked to employ these staff with the resources being made available direct by the DOH.

10.3 The intention would be that they would operate as a distinct unit, probably at arm's length from the council, probably accountable to a senior officer responsible for scrutiny. They would provide the secretariat for the local patients' forum and the patients' council and would be able to provide advice/support to the local council's overview and scrutiny committee. The LGA see this as a real opportunity for local authorities to exercise their community leadership role and to that extent I have indicated that we would support discussing this proposal further.

10.4 However the key question for us to consider is whether these additional responsibilities can be absorbed within the existing scrutiny process. In our model the work would most closely fit to that of the Partnership Select Committee but there are obviously clear links with the Personal Care Select Committee and possibly Lifelong Learning. In my view these new responsibilities are additional to the work that we might envisage the current select committees undertaking and our response should be seen in that context.

11. Next Steps

11.1 Whether or not the Bill received Royal Assent in this session of Parliament, we clearly ought to be discussing how the authority is going to respond and we should initiate a dialogue with our district and health partners at the earliest opportunity. The next logical step would be to set up a meeting internally, perhaps between Hugh Carey, David Jones, Trevor Fowler and myself, to clarify our thinking. Once we have done that and made a joint report to Cabinet, we ought to start discussing the detail much more closely with Jackie Haynes and her Chairman and Chris might also want to raise the issue with CADEX and put an item on the agenda of the next County and District Leaders' meeting.

G Batchelor
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