Department of Health

Local Authority Health Scrutiny

A summary of consultation responses

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Local Authority Health Scrutiny

Response to the consultation

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Executive summary

1. The consultation on the future regulations governing local authority health scrutiny took place between 12th July 2012 and 7th September 2012. Respondents were able to submit their feedback via an online portal, by email or in hard copy.

2. A total of 239 written responses to the consultation were received. Of these, 205 were from organisations and 34 from individuals. A list of organisations who responded is at Annex A. Not all respondents replied to or commented on every question.

3. The largest category of respondents (27%) was Local Authority Health Overview and Scrutiny Committees (HOSCs).

4. This report provides a written summary and analysis of the responses received (and numerical analysis of responses to each question) and sets out the policy that the Department has now adopted.

5. Respondents were largely positive about the proposals put forward in the consultation:

   - The majority of respondents (77%) agreed that it was sensible to require those proposing and scrutinising changes to health services to publish clear timescales that will bring greater clarity and transparency to the process of reconfiguring services;

   - Around 62% of respondents agreed that the Department should provide indicative timescales in guidance to support the above;

   - Some 66% of all respondents agreed that financial considerations should be taken into account, but were clear that this should be done in conjunction with other factors such as patient outcomes, safety and access, so that the health scrutiny function would come to a balanced view on the proposals being considered

   - There was clear support for the proposal that the NHS Commissioning Board take on the informal, supportive role set out in the consultation document;

- Respondents agreed that the formation of joint health scrutiny arrangements should be made mandatory within regulations, for service reconfigurations which span more than one local authority area.

- Responses were mixed to the proposal that the full council should exercise the power of referral. Some were supportive, seeing this as formalising good practice currently operating in parts of the country. The majority opposed the proposal on the grounds it would undermine the independence of health scrutiny and risked politicising referrals. HOSCs in particular felt that only health scrutiny should be able to exercise the power to refer and should do so without reference to the full council. This is in essence a desire to maintain the current system.

- The Department recognises these concerns. Under changes made by the provisions of the Health & Social Care Act 2012 ("the 2012 Act") to the National Health Service Act 2006 ("the 2006 Act), it is the local authority that will hold the statutory powers. This recognises the importance of flexibility for local authorities to determine the appropriate arrangements for their local circumstances. The system of health scrutiny needs to change to reflect this.

6. Several additional themes emerged from the consultation, such as the need for greater clarity about the relationship between health scrutiny, local Healthwatch and health and wellbeing boards, mechanisms for effective scrutiny of foundation trusts, alignment with localism and the importance of early and continuous dialogue between health scrutiny and NHS commissioners and providers developing proposals for service change. We will address the majority of points raised through guidance.

7. Following the consultation, Ministers have agreed to proceed with preparing the new regulations. We intend these will be laid before Parliament in early 2013, and come into force from April 2013. We will also be issuing guidance to accompany the new regulations, as a result of comments received.

8. The Equalities Impact Screening that accompanied the consultation has been updated and amended to reflect additional sources of evidence identified by respondents. The impact assessment for the changes to scrutiny regulations, *'Increasing Local Democratic Legitimacy in Health'* (ref. 6032), is unchanged.

9. The Department wishes to thank all those who responded to the consultation.

Introduction

10. The overview and scrutiny of health is an important part of the Government's commitment to place patients and the public at the centre of health services. It is a fundamental way by which democratically elected community leaders may voice the views of their constituents and hold local NHS bodies and providers of NHS and public health services to account.

11. In broad terms, the main aim of Health Scrutiny is to act as a democratic lever to improve the health of local people. It is about looking at the wider local health economy, not just services provided, commissioned or managed by the NHS.

12. The Health and Social Care Act 2001 ("the 2001 Act") introduced provisions for local authorities to scrutinise the NHS. Regulations made under the 2001 Act gave overview and scrutiny committees of local authorities with social services responsibilities the statutory power to review any matter relating to the planning, provision and operation of health services in their area, and to make reports and recommendations to NHS bodies and local authorities. These powers are currently discharged through a HOSC.

13. Since the powers were introduced, NHS organisations, health services and local authorities have changed significantly. Further structural reforms are underway, arising from the 2012 Act. These will see the introduction of clinical commissioning groups (CCGs), health and wellbeing boards and local Healthwatch. Health and wellbeing boards represent an important opportunity to strengthen democratic input to health services from the very start of the strategic planning process. The NHS Commissioning Board was established in October 2012 to establish and support CCGs. It will have a role in the delivery of improvements in health outcomes. Healthwatch England also came into being in October 2012, as the new independent consumer champion created to gather and represent the views of the public.

14. The 2012 Act made provision to extend the scope of health scrutiny to include "relevant health service providers". This includes providers of NHS and public health services commissioned by the NHS Commissioning Board, CCGs and local authorities, including providers in the independent and third sectors. It also changed the regulation-making powers so that in future the health scrutiny powers would be conferred onto the local authority directly rather than a HOSC, but with powers to enable the authority to arrange for the functions to be discharged through a HOSC or other arrangement.

15. The Government recognised that the current arrangements for health scrutiny needed to be updated to reflect the wider changes brought about by the 2012 Act, ensuring that the new organisations are subject to appropriate scrutiny and that all NHS commissioners and providers continue to be held to account through local democratic structures.

16. On 12th July 2012, the Department of Health published a consultation paper on local authority health scrutiny. The consultation paper is available at www.dh.gov.uk/health/2012/07/health-scrutiny. The consultation ran until 7th September 2012.

17. This report provides a written summary and analysis of the responses received. The Department wishes to thank all those who responded to this consultation. Their views have informed the policy set out in this document and will inform the development of the new regulations and accompanying guidance.

Consultation process

How we consulted

18. The consultation document was published on the Department of Health's website and consultation hub, CitizenSpace. Respondents were able to submit their feedback online, by email or in hard copy.

19. The consultation exercise was conducted in accordance with the Government's Code of Practice on Consultations. The consultation ran for 8 weeks, shorter than the normal period of 12 weeks recommended in the Code of Practice[1]. This was because of the extensive engagement undertaken during the passage of the 2012 Act through Parliament and an earlier consultation, Local Democratic Legitimacy in Health, carried out in conjunction with the Department for Communities and Local Government.

20. Communications were made via the Department of Health's 'The Week' bulletin to all NHS and local authority Chief Executives, and Directors of Adult Services and children's services. Notification of the consultation was published on a number of websites, including the Department of Health's website, the NHS Modernisation channel website and the Health and wellbeing board knowledge hub. We used a number of alerts and bulletins to bring the consultation to the notice of potential respondents, including NHS Networks bulletins, the NHS Commissioning Board's CCG bulletin, the Commissioning Zone newsletter, and the Primary Care Commissioning Zone newsletter, and bulletins to the Department of Health's Strategic Partner network. A number of organisations including local authorities, Help the Hospices, the Royal College of Nursing, the Centre for Public Scrutiny, the King's Fund, the National Skills Academy for Social Care and the UK Healthy Cities Network, featured the consultation on their own websites, to encourage wider responses. Wider engagement was undertaken with SHA Reconfiguration and Patient and Public Involvement leads, and a variety of scrutiny officers' networks.

21. Invitations to respond to the consultation were sent directly to the Chief Executives of a range of organisations, including the NHS Confederation, Foundation Trust Network, NHS Alliance, Local Government Association, the Centre for Public Scrutiny, National Voices, the independent Reconfiguration Panel, National Association of LINks Members, Monitor, Care Quality

[1] The Government announced a new approach to consultations on 17th July 2012, based on making the type and scale of engagement proportional to the potential impacts of the proposal. The Cabinet Office Code of Practice on Consultations was updated to allow Government departments to follow a range of timescales rather than defaulting to a 12-week period, particularly where extensive engagement has occurred before

Commission, English Community Care Association, Registered Nursing Home Association and the National Care Association.

22. The consultation posed 11 questions, which are listed in full at Annex B.

Breakdown of respondents

23. A total of 239 written responses were received: 115 via the consultation hub, 9 by letter and 115 by email. The following table contains a breakdown of responses received, by category.

Category of Responder	No. Responses	% of Total Responses
Academic/Professional Institution	1	0.4%
Charity/Voluntary Sector	11	4.6%
Clinician	1	0.4%
Commissioner/CCG	11	4.6%
HOSC	64	26.8%
Government	2	0.8%
Individual	34	14.3%
LINk/Local Healthwatch	7	3.0%
Local Authority	50	20.9%
NHS Foundation Trust	6	2.5%
NHS Trust	6	2.5%
None supplied	6	2.5%
Patient Group	4	1.7%
PCT	13	5.5%
Private Organisation	2	0.8%
Professional Body	16	6.8%
Regulatory Body	1	0.4%
SHA	1	0.4%
Think Tank	1	0.4%
Union	2	0.8%

24. Not all respondents replied to or commented on every question. Two respondents provided general comments, rather than answering the specific questions. A breakdown of responses by consultation question is shown at Annex C.

Responses to Consultation Questions

25. In this section, we have summarised the responses to each of the consultation questions. Not all respondents answered every question; some answered the consultation questions while others commented more broadly on the overall content of the consultation document.

26. We agree with the comments of many respondents that health scrutiny has, since its introduction, been an effective means of improving the quality of services and the experience of people who use them. It is, as East Sussex County Council's HOSC commented, "*one aspect of current structures for patient and public involvement and democratic accountability in health that works well*". Hackney Council's HOSC saw health scrutiny as "*a rare instance of a public accountability function designed that has genuine teeth. As such, this is a piece of scrutiny machinery that other similar functions…tend to look on with considerable envy*." It is clear that health scrutiny is highly valued and well-respected. CQC reported that "*evidence from scrutiny committees that relates to regulated services has been of a high quality and useful to our inspectors in making decisions about whether services comply with government standards of quality and safety*."

27. That we intend to retain and build on what is already in place in terms of health scrutiny was welcomed by many. While recognising that the proposals under consultation related primarily to service reconfiguration and the process of referrals, respondents felt it important to not lose sight of the overview role of health scrutiny in holding the NHS to account for the quality of the services they provide. The North East Regional Joint Health Scrutiny Committee, for example, wished to emphasise *"the more pro-active nature of health scrutiny activity including in-depth reviews of issues of local concern".* We agree, and fully support the continued scrutiny of broader system issues such as thematic reviews, pathways of care and wider access issues. This is an essential role of health scrutiny and will be fully preserved within the new system.

Consultation question 1

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

28. The majority of respondents (77%) agreed that this was a sensible proposal that could bring greater clarity and transparency to the process of making service reconfigurations and help with the forward planning of health scrutiny work programmes. As the NHS Confederation commented, "*The system proposed, whereby notification and a date must be provided to local authorities, who in turn communicate their own date of decision seems, we think, to be a helpful addition to the process*."

29. Other respondents highlighted the benefits that this change would bring, particularly around clarity, transparency and stakeholder engagement. One County Council commented that "*Such clear timescales enables both the local authority and NHS to plan for decisions and to understand how such actions link to any wider public and stakeholder consultation on the issue*". Guys & St Thomas' NHS Foundation Trust said that this would "*provide greater clarity to the process and enable more effective planning and management of service change, as well as the management of public uncertainty when substantial changes are proposed*".

30. Many respondents, including the Local Government Association and SOLACE were supportive on condition that there should be flexibility for timescales to be amended if circumstances warranted, for example so that local authorities were not forced into a referral decision simply to meet a published timescale. London Councils commented that *"…it is important that though a requirement to publish clear timescales is introduced, there should still be flexibility for that timescale to change should any unforeseen complexities arise*."

31. Those who disagreed with this proposal commented that the NHS is already generally open about sharing timescales with HOSCs as part of their on-going engagement around service reconfigurations. They saw this to be a matter of good practice, which could be dealt with through guidance rather than requiring additional regulation. As one Joint Scrutiny Committee commented, *"…we would expect guidance on good practice to suffice rather than a requirement to public clear timescales*". Nottingham City Council's HOSC felt that "*Consistent and ongoing engagement between local authorities/committees and the NHS during the reconfiguration process is the most effective means of avoiding the uncertainty this measure seems designed to prevent*."

32. While guidance can emphasise the importance of clarity for all concerned, including patients and the public, the Government believes that regulation is required to make this happen consistently across the country. Regulations will therefore require both the organisation proposing the service change, and in response, the local authority, to publish clear timescales for their decision-making. Regulations will not stipulate what those timescales will be, but will make provision that allows timescales to be amended.

Consultation question 2

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

33. Many respondents, including the Association of Democratic Services Officers, agreed that indicative timescales given in guidance would be helpful. Knowsley Metropolitan Borough Council commented that indicative timescales would, "*provide a basic framework for decision-making*" while Camden Council saw them has enabling Members and officers to "*remain focussed on responding to health proposals rather than negotiating process*". The RNIB envisaged indicative timescales in guidance being "*a beneficial tool in supporting commissioners and local authorities to decide upon an adequate timeframe*".

34. Some were supportive, providing that indicative timescales were put forward as guidelines subject to local context, rather than hard and fast rules which may be seen as de facto targets. As Help the Hospices said "*timescales should not be seen as definitive*". Hampshire Council's HOSC also warned of the risk that "*some organisations would view these as the expected timescales and would be resistant to derogation from them*". Southwark Council's HOSC thought that "*a timescale provided in guidance may become a bureaucratic hurdle to be got over, rather than a meaningful timescale that provides both time for local consideration and efficient working*".

35. A number of respondents suggested that one way to mitigate this risk would be for indicative timescales to be provided for a range of reconfiguration scenarios, to reflect the complexities of service reconfigurations locally.

36. The Government recognises that each reconfiguration scheme is different and will proceed at a different pace. Each will need to be considered fully by health scrutiny. However, these variations in scope notwithstanding, there are key decision points that are generally common to all service reconfigurations, and to the process of health scrutiny. We accept the view of the majority of respondents. We will work with key stakeholders to develop indicative

timescales that will help both the local authority and the organisation proposing the service change to develop realistic and feasible timescales, which would then be published in accordance with new regulations.

Consultation question 3

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

37. There was widespread support for this proposal. North Tees and Hartlepool NHS Foundation Trust commented that "*it reinforces the fact that every public body has a duty to secure economic efficiency and effectiveness*". The NHS Confederation continued, "*given the economic context facing the NHS, the legitimacy of HOSCs would be improved by requiring them to take local NHS finances into account in any decisions they make*." Others described a situation where health scrutiny did not consider financial issues to be "*naïve*", "*worrying*" and "*unrealistic*".

38. On the other hand respondents such as Middlesbrough Council's HOSC, Sandwell Metropolitan Borough Council and Stockton-on-Tees Borough Council commented that HOSCs already consider financial aspects of a proposed service change and that further regulation was unnecessary. A number of respondents felt that demonstrating financial sustainability is a task for the organisation who is proposing the service change, and that it should be set out in the business case put forward by them.

39. There was a broad consensus amongst all respondents that financial considerations are just one of a number of issues that HOSCs should take into account when making their deliberations. West Sussex County Council commented that financial considerations are a key element, but that "*other factors should also be taken into account in forming a balanced view of whether or not a service reconfiguration is in the best interests of the local health service and the people it serves*." Luton Borough Council's HOSC acknowledged that financial considerations could not be ignored, but along with St Helens Council and the HOSCs from Nottingham City Council and Darlington Borough Council, felt that they "*should not be the overwhelming driver*." This was echoed by many other respondents, who felt it would not be right to give financial considerations greater prominence than issues of patient safety, clinical outcomes, access, and patient experience. Clearly, no service reconfiguration which is financially unsustainable could be in the interests of the local community, but all issues should be given equal weight and consideration in the scrutiny process.

40. The Government acknowledges that it is for the organisation proposing to change services to demonstrate that the change is financially sustainable and delivers lasting clinical quality. Similarly, it is their responsibility to show how the proposal meets the Secretary of State's four tests for service reconfigurations. Given the current economic climate and the need for the NHS to deliver substantial efficiency savings in coming years, we remain of the view that there is merit in making the need to have regard to the financial sustainability of local health services explicit in guidance. It is right that health scrutiny take into account affordability as part of its wider assessment of the proposal. The existing powers of HOSCs to request information, and ask questions, will be retained, and will support the health scrutiny function in making their assessments.

41. The Government is also of the view that as the NHS should provide strong and robust evidence in support of a service reconfiguration, it is appropriate that local authorities should equally need to provide clear evidence in support of any referral they subsequently choose to make to the Secretary of State. We agree with respondents that many local authorities give full and detailed consideration to issues of safety, outcomes and access, and work proactively to address any concerns they may have with the local NHS first, with referral to the Secretary of State being seen as a last resort. However, where a referral is made, the Government will expect to see local authorities providing a very clear evidence-based justification that considers the full context within which the local NHS is operating, including financial sustainability and clinical quality, and demonstrates that all alternative courses of action have been explored. This is already good practice observed by many local authorities, and we intend to clarify this further in guidance. CCGs will be members of the health and wellbeing board and it is to be expected that any service reconfigurations proposed will support the local JSNA and JHWS. Local authorities will therefore need to set out clearly why they are referring a matter which is supported by the health and wellbeing board.

42. There was strong opposition to the suggestion in the consultation document that local authority health scrutiny should be required to provide financially sustainable alternative service reconfiguration options. This was seen as firmly outside the remit of health scrutiny, and would require a depth of expertise, clinical and financial knowledge that the majority of health scrutineers could not be expected to possess. The Government accepts this argument and will not pursue this proposal.

Consultation questions 4 - 6

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 stage referral to the NHS Commissioning Board?

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

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

43. Responses were mixed on the Government's proposal to require an intermediate referral to the NHS Commissioning Board before a referral could be made to the Secretary of State. Around one-third of respondents supported the introduction of a formal role for the NHS Commissioning Board, including Oxfordshire's joint Overview and Scrutiny Committee, who thought this would "*reflect the move to greater local decision making*". Knowsley Metropolitan Borough Council saw the NHS Commissioning Board as "*ideally placed*" to support local resolution as they "*may have an understanding of the cultural, political and social issues within an area*" that could aid agreement on the way forward.

44. Nearly half of all respondents did not agree that the NHS Commissioning Board should act as an intermediate point of referral. Many acknowledged the potential drawbacks highlighted in the consultation document, emphasising concerns that this would add another layer of bureaucracy. They suggested that this could increase the length of time taken to reconfigure services, and thus deliver the intended benefits to local people, if health scrutiny subsequently pursued a referral to the Secretary of State. A particular issue for HOSC respondents was the perceived impartiality of the NHS Commissioning Board, with some commenting it was unlikely a CCG would bring forward proposals for substantial service change without already having secured their backing and that health scrutiny would be unlikely to accept the judgement of a body with a clear interest and involvement in the proposed change. Another significant concern highlighted by some respondents was that the proposal had the effect of establishing a more complex referral process, whereby some reconfigurations were referred to the Board and others directly to Secretary of State. On balance, the majority of respondents were against the Board taking on this formal role.

45. There was stronger support amongst all respondents for the NHS Commissioning Board to take on the informal role outlined, whereby they would work with local authorities and CCGs in order to facilitate local agreement and resolve immediate concerns. Some, including Guys & St Thomas' NHS Foundation Trust saw this as formalising "*what has to date been an informal role of the strategic health authority*". A large number of respondents suggested that the NHS Commissioning Board could facilitate the engagement of all parties from the earliest stage of proposals being developed. This would, it was felt, enable the development of solutions that were mutually acceptable to the NHS and local authorities, avoiding the need for referrals. A number of respondents commented that the Independent Reconfiguration Panel already provide the local facilitation role envisaged in the consultation document, an arrangement that the Panel have signalled will continue. Bracknell Forest and Norfolk Councils, amongst others, envisaged that the health and wellbeing board could also play a valuable role in resolving local disputes.

46. The Government agrees with the majority of respondents that a formal, intermediate referral of proposals to the NHS Commissioning Board should not be introduced through the new regulations. We will instead ask the NHS Commissioning Board to fulfil a more supportive role with a focus on facilitating engagement and local agreement on the way forward, as appropriate. The NHS Commissioning Board will provide further detail of how this support may be provided as part of its operating model. The Mandate[2] between the Department of Health and the NHS Commissioning Board calls for "better informed local decision-making about services, in which the public are fully consulted and involved". It sets the NHS Commissioning Board an objective to ensure that proposed changes to services meet four tests: (i) strong public and patient engagement; ii) consistency with current and prospective need for patient choice; iii) a clear clinical evidence base; and iv) support for proposals from clinical commissioners. This is in addition to its role as a facilitator of change outlined above.

47. We intend that the regulations will retain powers of direction and that new powers will enable the Secretary of State, on a case-by-case basis and once a referral has been made by a local authority, to direct the Board to take certain steps to resolve the matter referred where it relates to a service that the Board commissions. New powers will enable the Board to direct CCGs to consult or to resolve matters in other ways.

Consultation question 7

[2] https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf

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

48. There was a mixed response to this consultation question. Some 25% of respondents supported the proposal that the power of referral should be exercised by the full council, believing this would increase the legitimacy of those decisions. One County Council commented that *"The full council, as the highest democratically accountable local body, should be given the opportunity to debate the merits of a potential referral, having regard to a wide range of views on the matter."* The London Borough of Bexley's HOSC recognised *"that with health scrutiny powers now being conferred on local authorities rather than an OSC specifically, there needs to be a different process for referring a service reconfiguration to the Secretary of State for Health which reflects this."* Worcestershire County Council's HOSC suggested that *"A sensible process would be for the overview and scrutiny committee to first consider the proposed service change and to then make a report to Council if it felt that a referral was warranted".* This was supported by North East Lincolnshire Council, who agreed that the full council should make the referral *"following a recommendation from the health scrutiny function".*

49. A number of local authorities commented that this is a matter of good practice to seek the endorsement of full council for key decisions, and that they already had mechanisms in place to require their HOSC to bring referral recommendations before the full council. Stockton-on-Tees Borough Council reported that *"as part of the working arrangements at Stockton Council, consultation submissions and referrals in relation to substantial changes to local services are already endorsed by full council"* and that this *"has the benefit of adding to the democratic legitimacy behind such submissions"*.

50. One local authority said during an engagement event that bringing referral recommendations before full council was a useful rehearsal of the arguments that would be set out in the referral documentation sent to the Secretary of State. A number of HOSCs commented that they already had powers to refer their recommendations to full council for support where they felt that was warranted.

51. The majority of respondents, however, did not support the proposal. Some had misinterpreted the consultation as suggesting that the full council should not be able to delegate the *process* of health scrutiny, rather than the power of referral, and disagreed with the proposal on that basis. It has never been the Department's intention that the full council of a local authority should not be able to delegate the functions of health scrutiny. Our proposal suggested only that the full council should exercise the power of referrals, in response to

recommendations received from its health scrutiny function, however that latter function was discharged.

52. There was opposition to the proposal from HOSCs in particular, who felt this potentially undermined the independence of health scrutiny. Others commented that members of the council can make their views known to health scrutiny through their usual deliberative processes, and that a further measure to sight members on the activity of health scrutiny was not only unnecessary but risked politicising the process if voting went along party lines. A number questioned whether a full council would be able to make a fully-informed decision, as it would be challenging in the time that a full council meeting allowed for health scrutiny to bring council members fully up-to-speed with all of the background information and evidence that had been considered. The majority of HOSCs felt that the statutory power to refer matters to the Secretary of State should remain in their hands, and that they should be able to exercise this without reference to the full council. This represents, in essence, a desire to maintain the current system.

53. The Department recognises the concerns expressed by those who opposed this proposal. However, under the changes made by the 2012 Act it is the local authority that will hold the statutory powers of health scrutiny and they will determine how those functions are discharged. This is consistent with the principles of localism. While they may choose to retain an HOSC arrangement, there will be no obligation to do so and the authority may choose to undertake health scrutiny through another committee or other suitable arrangement. The current system, therefore, need to change to reflect this.

54. The Department takes the view that, as the holder of the statutory health scrutiny powers, the local authority is accountable for decisions over how those powers are exercised. As local authorities will be able to determine the arrangements for discharging their health scrutiny functions, the Department recognises that this should be reflected in the arrangements for referrals.

55. The power of referral is a function of the full council, as are other health scrutiny functions under changes made by the 2012 Act. Where a local authority chooses to retain a HOSC as the means of discharging their health scrutiny functions under the new regulations, they will not be prevented from delegating the power of referral to that HOSC should they choose to do so. They may similarly delegate the power of referral to a joint scrutiny arrangement. Where an authority discharges health scrutiny functions through an arrangement other than a HOSC or joint scrutiny arrangement, only the full council will be able to exercise the power of referral.

56. The Department believes that, in a delegated arrangement, it is right and proper that the full council should be fully sighted on how the powers for which it is accountable are being exercised. While the power of delegation will not be conditional upon this point, it would be prudent for local authorities to consider whether to set in place additional safeguards or processes to achieve this, for example requiring the HOSC to notify the full council of an intention to refer a matter to the Secretary of State, before that referral is made. This will give the full council the opportunity to debate that intention, if they so wish.

Consultation question 8

Do you agree that the formation of joint 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?

57. There was widespread support for this proposal, with many respondents acknowledging the value and effectiveness of joint scrutiny. Wakefield Council and Luton Borough Council's HOSC both welcomed the formalisation in regulations of the existing arrangements, while the London Borough of Havering and Northumberland County Council reported that they had been successfully operating such arrangements for many years. Others highlighted the benefits of joint scrutiny, in ensuring consistency, avoiding duplication of effort and better utilisation of resources. CQC commented that "*From the regulator's perspective, it can be very important to hear from joint committees about issues of care relating to large service providers.*" Those against the proposal felt that it should be left to local determination whether to form joint scrutiny arrangements, as this was felt to be more in line with the localism agenda.

58. The Government agrees with the view that joint scrutiny has been an effective means of examining proposals that span more than one area. The new regulations will therefore require the formation of joint scrutiny arrangements where the change proposer consults more than one local authority. This will formalise the existing arrangements within regulations. We will, in response to requests from respondents, provide further advice in guidance about the formation of joint scrutiny arrangements in relation to nationally or regionally commissioned services.

59. A number of local authority and HOSC respondents wanted the ability to not participate in a joint scrutiny arrangement, but at the same time to retain the ability to scrutinise proposals and make separate recommendations to the organising proposing the service change. Brent Council's Health Partnerships

Overview and Scrutiny Committee felt that "*it is unrealistic to expect local health overview and scrutiny committees to not comment on major service changes that could take place in their area, even where a JOSC exists*." The Government recognises the importance of health scrutiny being able to review and comment on changes, but would argue that it is burdensome and a poor use of resources for any organisation proposing change to be required to attend before multiple scrutiny committees. As Gloucestershire County Council's HOSC said "*it would be a more practical and efficient use of resources if NHS commissioners were required to attend a single committee rather than multiple committees*". There may be unintended consequences, as one individual respondent pointed out: "*the difficult arises where two OSCs try to work independently on the same proposals, sometimes making conflicting recommendations or actions, which then cause confusion within the service change process*". This is borne out by East Sussex County Council and their HOSC, who commented that "*the alternative (consultation with potentially numerous individual HOSCs) is not desirable*"

60. If a health scrutiny function wishes to comment on major service changes, the Government sees no reason why they should not do so through the joint scrutiny arrangement, the report of which should reflect the views and opinions of all participating authorities, thus allows participating authorities to reflect the views of their local population. Currently Directions provide that only the joint scrutiny arrangement can request information, require officers to attend before them to answer questions or make comments on the proposal. The Government intends to continue this provision within the new regulations. Regulations will also retain the flexibility for local authorities to delegate their health scrutiny functions to a joint scrutiny arrangement in other circumstances or to an overview and scrutiny committee of another local authority, where they feel this is the best approach locally.

Consultation question 9

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

61. A small number including the Centre for Public Scrutiny, the National LGB&T Partnership and Opus Training and Development Ltd highlighted additional sources of evidence for inclusion in the equalities screening document that accompanied the consultation. We have updated this screening document to include these additional references, and this is republished alongside this summary report.

62. Other respondents were concerned that while the proposals may not cause disadvantage to equalities groups, their implementation may. To address this, the Government will emphasise in guidance the Public Sector Equality Duty, with which all public bodies must comply. Guidance will also reiterate the importance of involving all sections of a community in the planning, delivery and reconfiguration of health services. Health scrutiny should continue to take account of the views of local people in their work.

63. A greater number of respondents commented on equalities issues more broadly in relation to health scrutiny, with some commenting that extending the scope of health scrutiny to relevant health service providers in addition to NHS bodies should offer greater opportunities for transparency and accountability for all groups, and that increased flexibility and autonomy around health scrutiny will mean local areas are better able to ensure equalities are considered.

Consultation question 10

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?

64. The majority of respondents (82%) did not offer any alternative approaches or additional reasons other than those set out in their responses to the consultation questions above.

65. A small number of local authority and HOSC responses called upon the Government to maintain the status quo for health scrutiny, seeing no need for change. Northumberland County Council said that "*The Council can see no logical reason for the power to be granted instead to the wider authority. In addition to that, we cannot see a realistic alternative for local authorities to carry out health scrutiny, other than how it does now, with non-executive councillors in a panel/committee type environment*." This was echoed by Middlesbrough Council's HOSC and a number of other authorities in the North East. The Royal College of Nurses were concerned that transferring the statutory powers to local authorities may lead to variations in practice across the country or, worse, reduce levels and quality of health scrutiny undertaken.

66. We agree that the HOSC model is a strong one, which, as Wakefield Council said, "*has generally proved to be effective*." However, maintaining the status quo is not an option. The 2012 Act has already changed the regulation-making powers around health scrutiny and from April 2013, the holder of the statutory powers will be the local authority. They will have the flexibility to discharge these powers through a HOSC or other suitable arrangement.

Regulations need to change to reflect this. Regulations will enable a local authority to continue with a HOSC if they choose to have one, but this will no longer be required of them.

67. Linked to the issue of publishing clear timescales for decision-making, a number of respondents proposed that there should be an upper time limit for making referrals to Secretary of State, outside of which referral is not possible. The King's Fund highlighted their previous recommendation that "*maximum timescales should be set for the scrutiny function*" while Walsall Council's HOSC suggested that "*there could for instance be a standard time period following the outcome of any consultation where there is an opportunity for an HOSC to make a referral*". The purpose of this would be to ensure that uncertainty for all parties does not continue for an indefinite period, and the benefits of the service change for patients are achieved at the earliest opportunity.

68. While we recognise that continued uncertainty is not desirable for anyone, the Government believes that setting a maximum time period within which referrals must be made could act as a significant barrier to effective scrutiny, particularly in the case of complex service reconfigurations. We believe also that this step is unnecessary given that regulations will require both the proposer of the change and the local authority to set out clear timescales for their decision-making.

69. Although this was not specifically asked in the consultation document, a number of respondents called for the decisions of joint scrutiny functions to be binding on all participant local authorities. The Government, while recognising the merits of this suggestion, remains of the view that it is essential that the ability of individual authorities to refer proposals to the Secretary of State is preserved. We will not, therefore, remove the right of individual participating authorities to refer proposals to the Secretary of State, where scrutiny has been undertaken through a joint arrangement.

Consultation question 11

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?

70. Several themes emerged from respondents comments. Comments regarding the need for clarity on the relationship between health scrutiny, Healthwatch and health and wellbeing boards were the most prevalent. There were also a large number of comments suggesting that guidance should emphasise the need for continuous and on-going dialogue between commissioners/providers

and health scrutiny, to build effective relationships and create open and transparent debate about the future of health services locally.

71. An effective relationship between health and wellbeing boards, Healthwatch and health scrutiny will be essential to ensuring high-quality and effective services are commissioned and delivered.

72. Under changes made by the 2012 Act, every local authority in England will have a duty to commission a local healthwatch organisation. They will begin their work on 1st April 2013. Local Healthwatch organisations will involve people of all ages and from all sections of a local community, ensuring that everyone has a voice. They will develop a picture of the experiences of people using local health services, and use this to influence the way services are designed and delivered. Local Healthwatch organisations will be a valuable source of intelligence for health scrutiny on the views, aspirations and experiences of local people with regard to local health services. The evidence that local Healthwatch can provide will be useful to health scrutiny, whether undertaking a proactive review of particular services, or scrutinising proposals for service change. Local Healthwatch organisations will, like Local Involvement Networks can now, be able to refer matters of concern about local health services to health scrutiny for consideration. Where a local Healthwatch organisation makes such a referral, health scrutiny will be under a duty to acknowledge receipt of the referral within 20 working days and keep the referrer informed of any action it intends to take.

73. As a committee of the local authority exercising particular functions, health and wellbeing boards would be subject to overview and scrutiny. We expect that overview and scrutiny arrangements will want to review and scrutinise the decisions and actions of health and wellbeing boards, and make reports and recommendations to the authority or its executive. Separately, health scrutiny is an important way that the local authority (and through it, local people) can hold some health and wellbeing board members to account for their role in the delivery of health services, or consider how the JSNA and JHWS process is used by them to plan services.

74. A number of respondents commented that NHS foundation trusts were not mentioned specifically in the consultation document. The current arrangements for scrutiny of NHS foundation trusts are different to those of other NHS bodies in some respects.

75. The Health & Social Care (Community Health and Standards) Act 2003 (Supplementary and Consequential provision) (NHS Foundation Trusts) Order 2004 amended the 2002 scrutiny regulations to allow HOSCs to refer proposals that would result in substantial changes to services at an NHS

foundation trust to Monitor, formerly known as the Independent Regulator of NHS Foundation Trusts. This allows Monitor to take a view as to whether the changes are in line with the foundation trust's terms of authorisation.

76. The 2012 Act has changed the role of Monitor to be the Sector Regulator for all providers of NHS care. The Act has also replaced NHS foundation trusts' terms of authorisation with a licence for providers of NHS care. The Government considers that retaining the power of referral to Monitor is not appropriate. The Government intends, therefore, to remove the existing power of health scrutiny to refer service change proposals to Monitor. Local authorities will, under new regulations, refer contested proposals that would result in substantial changes to services at an NHS foundation trust to the Secretary of State. This will bring NHS foundation trusts under the same scrutiny regime as other NHS bodies and relevant health service providers.

77. This does not mean that NHS foundation trusts will have total freedom to make changes to NHS services that people need - there have been checks and balances built into the new system to ensure continuity of services. The 2012 Act requires Monitor to design and publish guidance on complying with the continuity of service licence conditions. Monitor must carry out an on-going assessment of risk to continuity of NHS services. Monitor's proposals[3] are that commissioners and providers would work together to assess whether withdrawing a particular service would have a significant adverse impact on the health of users of health care and/or on health inequalities, in the absence of alternatives. If the commissioners' and providers' assessment is that there would be significant impact then the service would be defined as "Commissioner Requested Services" and subject to continuity of service licence conditions. Monitor's proposed continuity of service licence conditions[4] would not allow NHS foundation trusts to make changes to essential services without having the support of the relevant commissioners.

78. A proportion of respondents raised the issue of defining what is, or is not, a "substantial" variation or development of services. While respondents recognised that the Government currently has no plans to define this, many did suggest that further clarity would be helpful over the sorts of impacts that should be considered when forming a view on whether a proposed change is substantial. We agree, and will provide further advice on the issues to be taken into account when considering whether a change is substantial in guidance. Some commentators said that that locally-agreed protocols had

[3] Monitor consultation on guidance on Commissioner Requested Services: http://www.monitor-nhsft.gov.uk/sites/default/files/Consultation%20on%20guidance%20for%20commissioners%20+%20annex%20-%20final%20150812.pdf

[4] Monitor consultation on provider licence http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/consultations/consultations-and-engagement-monito-0

been helpful to them in considering this issue and forming a consensus view between the NHS and the HOSC. We would encourage those using such mechanisms to share these protocols, to support the spread of best practice.

79. Some district council respondents felt that there was insufficient recognition within the consultation of the role that they play in health scrutiny. The Government fully acknowledges the valuable contribution and active involvement of district councils in two-tier areas. The arrangements for the possibility of district council representation in upper-tier scrutiny arrangements will continue unchanged. Regulations will continue to enable district council membership on health scrutiny committees in upper-tier authorities. We will preserve the ability of upper-tier authorities to delegate health scrutiny to a district council, where they consider that the district council is better placed to undertake the function, for example where matters affect a specific locality represented by that district council..

80. A small proportion of respondents foresaw an important role for the Directors of Public Health in local authorities in being able to provide objective advice to health scrutiny on how health services impact on population health and how proposed changes may impact population health in the future. Others called for greater recognition of public health within the new regulations.

81. The Government recognises the important public health responsibilities that will be delivered by local authorities and, in some instances, by the NHS Commissioning Board. Health scrutiny will be able to hold to account a local authority as a commissioner of public health services, and the scope of health scrutiny will extend to providers of public health services commissioned by them. Public health services commissioned by the NHS Commissioning Board will be subject to scrutiny on the same basis as other health services and the referral process outlined above will apply.

Next Steps

82. Following the consultation, Ministers have agreed to proceed with preparing the new regulations. We intend that these will be laid before Parliament in early 2013, and come into force from 1st April 2013. We will issue guidance to accompany the new regulations.

Annex A – List of Responding Organisations[5]

- Airedale Wharfedale and Craven Clinical Commissioning Group
- Association of County Chief Executives
- Association of Democratic Services Officers
- Association of North East Councils
- Barnsley Metropolitan Borough Council
- Barts Health NHS Trust
- Bath & North East Somerset Council
- Bedford Borough Council
- Borough of Poole Council
- Bournemouth Borough Council
- Bracknell Forest Council
- Bradford City Clinical Commissioning Group
- Bradford District Clinical Commissioning Group
- Brent Council Health Partnerships Overview and Scrutiny Committee
- Bristol Council Health and Adult Social Care Committee
- British Dental Association
- British Geriatric Society
- British Medical Association
- Buckinghamshire County Council Health Overview and Scrutiny Committee
- Calderdale Council Adults Health and Social Care Scrutiny Panel
- Cambridgeshire County Council, Adult Wellbeing and Health Overview and Scrutiny Committee
- Camden Council
- Capsticks
- Care Quality Commission
- Central Bedfordshire Council Health Scrutiny Committee
- Centre for Public Scrutiny
- Cheshire East Council
- Cheshire West and Chester Council
- Chesterfield Borough Council
- Chiltern District Council
- City of Bradford Metropolitan District Council
- City of York Council Health Overview and Scrutiny Committee
- Cornwall Council
- Council of the Isles of Scilly Health Overview and Scrutiny Committee
- County Councils Network
- Darlington Borough Council Overview and Scrutiny Committee
- Denby Dale Centre
- Derby City Council Health Overview and Scrutiny Committee
- Derbyshire Community Health Services NHS Trust
- Derbyshire County Council Health Overview and Scrutiny Committee
- Devon County Council Health and Wellbeing Scrutiny Committee
- Devon Health and Social Care Forum
- Doncaster Metropolitan Borough Council

[5] This list excludes those organisations who wished not to be named in this summary report

- Dorset County Council Health Overview and Scrutiny Committee
- Dudley Public Health
- Durham County Council
- East Herts Council
- East Sussex County Council
- East Sussex County Council Health Overview and Scrutiny Committee
- East Sussex Healthcare NHS Trust
- Enfield Council
- English Community Care Association
- Essex County Council
- Foundation Trust Network
- Gateshead Council
- Gateshead Voluntary Organisations Council
- Gloucestershire County Council Health Overview and Scrutiny Committee
- Gloucestershire LINk
- Guy's & St Thomas' NHS Foundation Trust
- Hackney Council Overview and Scrutiny Team
- Hampshire Council Health Overview and Scrutiny Committee
- Hartlepool Borough Council Health Overview and Scrutiny Committee
- Help the Hospices
- Herefordshire Council Health Overview and Scrutiny Committee
- Hertfordshire County Council
- Hertfordshire County Council Scrutiny Officers
- Hertfordshire Partnerships NHS Foundation Trust
- Independent Reconfiguration Panel
- Ipswich Borough Council
- Joint Scrutiny Committee (Bury, Manchester, Oldham and Rochdale)
- Kent County Council
- Kirklees Council
- Knowsley Metropolitan Borough Council
- Lancashire County Council Health Overview and Scrutiny Committee
- Leeds City Council's Scrutiny Board (Health and Wellbeing and Adult Social Care)
- Leeds Community Healthcare NHS Trust
- Leeds West Clinical Commissioning Group
- Lincolnshire County Council Health Overview and Scrutiny Committee
- Local Government Association & Society of Local Authority Chief Executives and Senior Managers
- London Borough of Barking & Dagenham Health Overview and Scrutiny Committee
- London Borough of Bexley Health Overview and Scrutiny Committee
- London Borough of Havering
- London Borough of Lambeth Health Overview and Scrutiny Committee
- London Borough of Lewisham Health Overview and Scrutiny Committee
- London Borough of Merton Overview and Scrutiny Committee
- London Borough of Newham
- London Borough of Sutton Health Overview and Scrutiny Committee

- London Councils
- Luton Borough Council, Scrutiny: Health and Social Care Review Group
- Manchester City Council Health Scrutiny Committee
- Medway Council Health Overview and Scrutiny Committee
- Mid Devon District Council
- Mid Staffordshire NHS Foundation Trust
- Mid Yorkshire Hospitals NHS Trust
- Middlesbrough Council Health Scrutiny Panel
- National AIDS Trust
- National Council of Women of Great Britain
- National LGB&T Partnership
- Newcastle City Council Health Overview and Scrutiny Committee
- NHS Airedale, Bradford & Leeds
- NHS Bournemouth and Poole and NHS Dorset cluster
- NHS Bradford and Airedale
- NHS Cambridgeshire
- NHS Confederation
- NHS County Durham and Darlington
- NHS Enfield PCT & NHS Enfield Clinical Commissioning Group
- NHS Gloucestershire and NHS Swindon PCT Cluster
- NHS North West
- NHS South Gloucestershire
- NHS Wakefield District Public Health
- NHS Walsall
- Norfolk Health Overview and Scrutiny Committee
- Norfolk LINk
- North East Lincolnshire Council
- North East Regional Joint Health Scrutiny Committee
- North Tees and Hartlepool NHS Foundation Trust
- North Tyneside Council's Adult Social Care, Health and Wellbeing Sub-Committee
- North Yorkshire County Council
- Northamptonshire County Council's Health & Social Care Scrutiny Committee
- Northumberland County Council
- Northumberland, Tyne and Wear NHS Foundation Trust
- Nottingham City Council Health Overview and Scrutiny Committee
- Nottinghamshire County Council
- Nottinghamshire County LINk
- Oldham Council Health Overview and Scrutiny Committee
- Optical Confederation
- Oxfordshire Joint Overview and Scrutiny Committee
- Peterborough City Council, Scrutiny Commission for Health Issues
- Plymouth City Council Health Overview and Scrutiny Committee
- Plymouth LINk
- Portsmouth Link
- Redcar and Cleveland Borough Council Health Overview and Scrutiny Committee

- RNIB
- Rochdale Metropolitan Borough Council
- Rossendale Borough Council
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nursing
- Rugby Borough Council
- Salford City Council
- Sandwell Metropolitan Borough Council
- Sefton Metropolitan Borough Council
- Sheffield City Council Health Scrutiny Committee
- SHIP PCT Cluster
- Slough Borough Council Health Scrutiny Panel
- Solihull Metropolitan Borough Council Health Overview and Scrutiny Committee
- South Devon and Torbay Shadow Clinical Commissioning Group
- South East Coast Regional HOSC Network
- South Tyneside Council, Overview and Scrutiny Co-ordinating & Call In Committee
- Southampton Health Overview and Scrutiny Committee
- Southend-on-sea Borough Council
- Southwark Council Health Scrutiny Committee
- Specialised Services PPE Steering Group
- St Helens Council
- Stockport Metropolitan Borough Council Health Scrutiny Committee
- Stockton-on-Tees Borough Council
- Stoke on Trent City Council - Adult and Neighbourhoods Overview and Scrutiny Committee
- Suffolk Coastal & Waveney District Councils
- Suffolk County Council Health Overview and Scrutiny Committee
- Suffolk LINk
- Surrey County Council Health Scrutiny Committee
- The King's Fund
- The London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea, and the City of Westminster Joint Health Overview and Scrutiny Committee
- Torbay Council
- Trafford Council Health Overview and Scrutiny Committee
- UK Faculty of Public Health
- Unite the Union
- University Hospitals Bristol NHS Foundation Trust
- Wakefield Council
- Walsall Council Health Scrutiny Panel
- Warwickshire County Council
- West Berkshire Council
- West Sussex County Council
- Worcestershire County Council Health Overview and Scrutiny Committee
- Worcestershire LINk

Annex B – Consultation Questions

Q1 Do you consider it would be helpful for regulations to place a requirement on the NHS and LAs to publish clear timescales?

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 LA referrals?

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

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 autonomy in the new commissioning system and emphasise local resolution of disputes?

Q7 Do you consider it would be helpful for referrals to have to be made by the full council?

Q8 Do you agree that the formation of joint scrutiny arrangements should be mandatory for substantial service change?

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

Q10 For each proposal, can you provide additional reasons that support the proposed approach or current position? Have you suggestions for an alternative approach?

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

Annex C – Breakdown of responses by consultation question

Consultation Question	Number of responses (Yes/No/Don't know)	Number of textual comments
Do you consider it would be helpful for regulations to place a requirement on the NHS and LAs to publish clear timescales?	226	214
Would you welcome indicative timescales being provided in guidance?	217	186
What would be the likely benefits and disadvantages of this?	-	109
Do you consider it appropriate that financial considerations should form part of LA referrals?	221	214
Given the new system landscape and the proposed role of the NHSCB, do you consider it would be helpful that there should be a first stage referral to the NHSCB?	219	203
Would there be any additional benefits and drawbacks of establishing this intermediate referral?	-	162
In what other ways might the referral process be made to more accurately reflect autonomy in the new commissioning system and emphasise local resolution of disputes?	-	157
Do you consider it would be helpful for referrals to have to be made by the full council?	221	208
Do you agree that the formation of joint scrutiny arrangements should be mandatory for substantial service change?	217	177
Are there are additional equalities issues with these proposals that we have not identified. Will any groups be at a disadvantage?		159
For each proposal, can you provide additional reasons that support the proposed approach or current position? Have you suggestions for an alternative approach?		134
What other issues relevant to these proposals should we be considering as part of this consultation? Is there anything that should be included that isn't?		151
Comments made in addition, ie by covering letter		47

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