Agenda Item No: **6**

Special Advisory Group
21 October 2014
Standards Committee
23 October 2014

Report title	Health Scrutiny Arrangements	
Cabinet member with lead responsibility	Councillor Roger Lawrence Leader of the Council	
Wards affected	All	
Accountable director	Keith Ireland, Delivery	
Originating service	Policy	
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Report to be/has been considered by	Special Advisory Group Standards Committee Council	21 October 2014 23 October 2014 5 November 2014

Recommendation(s) for action or decision:

The Special Advisory Group and Standards Committee are recommended to propose to Full Council that:

1. It discharge its Health Scrutiny powers as follows:
   (a) Health Scrutiny be delegated to the Health Scrutiny Panel
   (b) Responses to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals be delegated to the Health Scrutiny Panel
   (c) Referral of NHS substantial reconfiguration proposals to the Secretary of State be retained by Full Council

2. The composition of the Health Scrutiny Panel be increased to include three co-opted members from Wolverhampton HealthWatch and that they be accorded full voting rights

3. Should a joint health scrutiny committee with another local authority be required the arrangements for this be constituted by Full Council on a need-by-need basis

4. The process for Wolverhampton HealthWatch or HealthWatch contractors to refer a matter to the local authority be as follows:

   (a) All referrals should to be sent to the Scrutiny Team
   (b) All referrals to be acknowledged by the Scrutiny Team within 20 working days
   (c) The referral be considered by the next available Health Scrutiny Panel
   (d) A response to the referral be given to HealthWatch or HealthWatch contractors within five working days after consideration by the Health Scrutiny Panel.

1.0 Purpose

1.1 To explain the powers of health scrutiny held by the City Council and to propose how these powers will be discharged.

1.2 To amend the constitution accordingly.

2.0 Background

2.1 Health scrutiny is a statutory process which was introduced by the Health and Social Care Act 2001. This Act gave the following powers directly to individual local authority scrutiny committees:

- Day-to-day health scrutiny
- To respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:
  (1) The consultation has been inadequate in relation to the content or the amount of time allowed.
  (2) The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
  (3) A proposal would not be in the interests of the health service in its area.

Where changes to the health service crossed local authority boundaries, joint health scrutiny committees could be established with a decision being taken as to whether such committees could respond jointly to consultations and make any necessary referral to the Secretary of State for Health.

2.2 The Health and Social Care Act 2012 and Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 revoked the 2001 Act and conferred health scrutiny functions on the local authority rather than the scrutiny function of the local authority and in doing so required Full Council to decide how to discharge these functions. This has now been explained more fully in the associated guidance which was published in June 2014.

2.3 The scope of health scrutiny (as outlined in the guidance) includes services commissioned and/or provided by the NHS as well as public health services commissioned by local authorities. This includes services provided to the NHS by external non-NHS providers, including local authorities. Additionally, health scrutiny will need to review the role of the Health and Wellbeing Board Health and other agencies involved in the health care of local people. Health scrutiny also needs to focus on:

- health improvement
- prevention
- tackling health inequalities
- wider social determinants of health
- the health system
- the local health economy

3.0 Key messages from the Guidance

3.1 The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function.

3.2 Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration - and in making recommendations about how it could be improved.

3.3 At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service ("relevant NHS bodies and relevant health service providers") and in testing this information by drawing on different sources of intelligence.

3.4 Health scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

3.5 Effective health scrutiny requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local HealthWatch.

3.6 In the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although health scrutiny functions are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends.

3.7 Furthermore in the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local HealthWatch.

3.8 Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.

3.9 Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible. If external

support is needed, informal help is freely available from the Independent Reconfiguration Panel (IRP) and/or the Centre for Public Scrutiny. If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals.

3.10 In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.

3.11 Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny. Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings. This will be in line with the new transparency measure in the Local Audit and Accountability Act 2014 and will allow local people, particularly those who are not present at scrutiny hearing-meetings, to have the opportunity to see or hear the proceedings. This approach is reflected in the Council's own protocol on filming and social media, which is part of the Constitution.

4.0 Role of Health Scrutiny

The following roles of health scrutiny (conferred on Full Council to delegate as it decides) relates to the scrutiny of both commissioners and providers of health services:

4.1 Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services.

4.2 Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.

4.3 Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.

4.4 Make reports and recommendations to certain NHS bodies and expect a response within 28 days.

4.5 Where necessary, establish joint health scrutiny committees with other local authorities.

4.6 To respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals.

4.7 Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:

(1) The consultation has been inadequate in relation to the content or the amount of time allowed.
(2) The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
(3) A proposal would not be in the interests of the health service in its area.

4.8 Have a mechanism in place to deal with referrals made by HealthWatch or HealthWatch contractors.

5.0 Co-opted members

5.1 The Local Government Act 2000 allows local authorities to include co-opted members in their scrutiny arrangements. Many local authorities have chosen to do this, particularly within health scrutiny arrangements. Given this and 3.7 above, it is proposed to include three co-opted members from Wolverhampton HealthWatch in the membership of the Health Scrutiny Panel.

4.0 Financial implications

4.1 There are no financial implications arising from the recommendations in this report.
[GE/17102014/W] Special Advisory Group
[GE/17102014/U] Standards Committee

5.0 Legal implications

5.1 The relevant powers are contained in the following legislation and guidance:

Local Government Act 2000 (as amended by the Localism Act 2011)
Health and Social Care Act 2012
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
Local Authority Health Scrutiny; Guidance to support Local Authorities and their partners deliver effective health scrutiny; Department of Health; June 2014

5.2 The guidance document outlines how health scrutiny functions should be carried out in a transparent manner in line with the new transparency measure in the Local Audit and Accountability Act 2014.

[RB/17102014/Q]

6.0 Equalities implications

6.1 There are no equality implications arising from this report.

7.0 Environmental implications

7.1 There are no environmental implications arising from this report.

8.0 Corporate Landlord implications

8.1 There are no corporate landlord implications arising from this report.

9.0 Schedule of background papers

9.1 Local Authority Health Scrutiny; Guidance to support Local Authorities and their partners deliver effective health scrutiny; Department of Health; June 2014