# Carlisle City Council

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| **Report to:-** | **Overview & Scrutiny Management Committee** | | |
| **Date of Meeting:-** | 14 March 2002 | **Agenda Item No:-** | |
| **Public** | **Policy/Operational/Information** | **Delegated Yes** | |
| | | | |

| **Accompanying Comments and Statements** | **Required** | **Included** |
|---|---|---|
| Tenant Consultation: | | |
| Environmental Impact Statement: | | |
| Corporate Management Team Comments: | | |
| City Treasurers Comments: | | |
| City Solicitor & Secretary Comments: | | |
| Head of Personnel Services Comments: | | |
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| **Title:-** | **Developing the Health Scrutiny Role: Consultation** |
| **Report of:-** | **Director of Housing** |
| **Report reference:-** | **H.023/02** |


## Summary:-

This report summarises the proposals for local authority scrutiny of health, outlined in the consultation document, *Local Authority Health Overview and Scrutiny*, published recently by the Department of Health. The deadline is 16 April 2002.


## Recommendation:-

The Overview & Scrutiny Committee are requested to endorse the views of the LGIU & Democratic Health Network as set out in 7.1 and the additional comments of the Council, in an addendum *(to be dispatched separately)* of this report

and recommend to the Executive Committee that a formal response is sent directly to the Department of Health by 16th April and incorporate our endorsement of views with partners in the Democratic Health Network by 1st April.

**Contact Officer:** Laurie Brewis **Ext:** 7301

**H023/02**

**To the Chairman & Members of**

**The Overview & Scrutiny Management Committee**

## Developing the Health Scrutiny Role: Consultation

1. **Introduction**

   The new consultation document *Local Authority Health Overview and Scrutiny* outlines the government's proposals for local government scrutiny of health which was first proposed in the NHS Plan – the stated intention of which is to make the NHS a "patient-centred organisation". The consultation document summarises the provisions of two major pieces of legislation, which give councils the power of health scrutiny. They are:
2. **The Local Government Act 2000:** This requires all councils to establish Overview and Scrutiny committees, which in addition to holding the executive to account, can also scrutinise and report on 'matters which affect the authority's area or the inhabitants of that area'. This could include health issues. The Act also gives a general power to the council to do anything to promote or improve the economic, social or environmental well being of the area. Each council must develop (with consultation) a community strategy, which sets out how the economic, social and environmental well being of the area will be promoted. The quality of health services and the capacity for health improvement are clearly issues that affect the economic, social or environmental well being of local areas.
3. **The Health and Social Care Act 2001:** This introduces a more general power for scrutiny committees of social services authorities to scrutinise health services. The Act includes powers for the Secretary of State for Health to issue regulations on how this should be done. The new consultation document will contribute to the development of these regulations.

4. **Aim of health scrutiny**

   The consultation document defines the aim of health scrutiny, including scrutiny of the NHS, as: "To act as a lever to improve the health of local people. This will be achieved by addressing issues around health inequalities between different groups and working with NHS and other partners to secure the continuous improvement of health services and services that impact upon health."

## 5. Content of the consultation document

1. The document discusses issues under the following headings:

   - **Function of health scrutiny committees:** includes a definition of councils that will have the health scrutiny power, which includes county, metropolitan, unitary and London boroughs, but not district councils.

   - **Operation of scrutiny of the NHS:** lists the framework of health services to be scrutinised, indicates that health scrutiny committees must meet in public except in certain cases, lists bodies to receive health scrutiny committee reports.

   - **Duties and responsibilities of NHS bodies:** indicates that NHS bodies will be required to supply certain information to health scrutiny committees; lists NHS officers and board members who will be required and who will be likely to attend scrutiny committees; outlines circumstances in which NHS bodies will be required to consult health scrutiny committees; and sets out a timetable for NHS responses to health scrutiny reports.

   - **Right of Referral to Secretary of State:** indicates that regulations will give scrutiny committees the power to make referrals to the Secretary of State for Health on grounds of merit or inadequate consultation, for example on NHS proposals to make major changes such as hospital closures.

   - **Independent Reconfiguration Panel:** notifies the government's intention to set up a panel to advise on contested major service change in the NHS.

   - **Planning health overview and scrutiny:** discusses the type of health-related issue that scrutiny committees might choose as the subject of a scrutiny exercise; how they might plan a forward programme of scrutiny; possible co-opted membership of health scrutiny committees; and councillors' eligibility for taking part in health scrutiny committees (where they are NHS employees, for example).

   - **Making use of local expertise and sources of information:** discusses existing resources and new patient structures that might provide information and support to health scrutiny committees.

   - **Joint Overview and Scrutiny Committees:** outlines the different possible permutations for setting up joint scrutiny committees and options for involving district councils in the health scrutiny function.

1. The report also explains how to take part in the consultation, and sets out a timetable for implementation of scrutiny arrangements and other plans for patient representation. The timetable is for consultation until 16 April, consultation on draft Regulations and Guidance in summer 2002, final draft Guidance in winter 2002, and scrutiny power to come into force in January

2003.

1. **Timetable and mechanisms for consultation**

   The Department of Health is seeking responses to the consultation paper **by Tuesday 16 April 2002.** There will be a series of "road-shows" to discuss the proposals throughout February and March. Details of these will be given on the Department's consultation website, www.doh.gov.uk/healthscrutinyconsultation as they are arranged. Copies of the consultation document may also be downloaded from this website.

   Councils are encouraged to take part in this consultation. Comments on the document may be sent to the Department's email address:

   Mbhealthscrutinyconsultation@doh.gsi.gov.uk or sent by post to:

   Health Scrutiny Consultation
   Department of Health
   Room 608 Richmond House
   79 Whitehall
   London SW1A 2NS

   or faxed to:
   **020 7210 4902.**

2. **Response by Carlisle City Council**
   1. A series of questions on which the Department of Health would particularly like to know the thoughts of consultees is listed in an annex to the consultation document. LGIU will be responding to the consultation, jointly with the Democratic Health Network, and have sought the views and comments of the City Council on the consultation.
   2. Among the points to be raised by these organisations are:

      - welcoming the broadening of the definition of health scrutiny to emphasise health improvement, as well as treatment, and measures that address health inequalities
      - the need for proper resources to support the health scrutiny function
      - the continued concern of district councils that they will be excluded from the health scrutiny role and a request that stronger guidance be issued to county councils in two-tier areas concerning the involvement of district councils
      - looking at some legal issues about co-option and membership of scrutiny

bodies, and the relation of health scrutiny bodies to the council and its executive

- continuing concern that the "Great Ormond Street" question has not been fully answered: that is, how will scrutiny of institutions that provide services across social services authorities' boundaries, regionally and nationally be addressed

- the need for further clarification and guidance on the role of local authority scrutiny committees in scrutinising health provision by the private sector and the need for clear guidance that legislation and regulations will apply to this sector

- concern that information essential to the proper scrutiny of proposed public private partnerships will not be forthcoming to local authority scrutiny committees on grounds of commercial sensitivity

- looking at how the new health scrutiny role can be developed in the context of community planning and Local Strategic Partnerships.

3. In addition to these general points made by the LGIU & DHN, other issues set out in the consultation document are considered important for the authority to comment upon. These are currently being compiled and will be circulated in advance of the meeting for Members consideration.

1. **Comments of City Solicitor & Secretary**

   The point should once again be emphasised in any response that, if establishing the Health Scrutiny Committee is to be a County function, then regulations should provide unequivocally and unambiguously that there will be a requirement for district council representation on that committee to ensure full democratic input.

2. **Comments of City Treasurer**

   There are no direct financial implications arising from the issues set out in this report.

3. **Access to Services Implications**

There are no direct implications to access to services within this report, however the furtherance of specific issues will have a direct impact and will need to be addressed when such services are pursued in detail.

**4. Environmental Implications**

Similar to the above, no direct impact is foreseen, however some positive influences are anticipated on the Councils LSP, LA21 and new powers for health and well-being.

**5. Consultative Arrangements**

The contents of the consultation document are being widely consulted upon nationally, with a copy of the document being available in the Members room for information.

**6. Recommendations**

1. The Overview & Scrutiny Committee are requested to endorse the views of the LGIU & Democratic Health Network as set out in 7.1 and the additional comments of the Council, in an addendum *(to be dispatched separately)* of this report
2. and recommend to the Executive Committee that a formal response is sent directly to the Department of Health by 16th April and incorporate our endorsement of views with partners in the Democratic Health Network by 1st April.

**T Bramley**

**Director of Housing**

# Addendum to Report H023/02

## Developing the Health Scrutiny Role

In addition to the general points made by the LGIU & DHN, other issues set out in the consultation document are considered important for the authority to comment upon. These are set out below, with a proposed response.

### Planning health overview and scrutiny

Early discussions of future scrutiny plans will, for example, identify that a review of the commissioning strategy of a particular PCT may be better delegated to the local District Council, while joint scrutiny will be appropriate when looking at specialist services like neonatal intensive care, or bone marrow transplants.

**Response:** In consideration of the close working relationships currently being developed with the 2 PCT's covering the Carlisle District and the importance of 'locality planning', this authority would favour the scrutiny role of PCT's being delegated to the District Council.

### Making use of local expertise and sources of information

Early discussions of local priorities for health scrutiny should be informed by available documentation. This could include:

- the local community strategy or plan
- outputs from the Local Modernisation Review
- the most recent report of the Director of Public Health
- any relevant inspection or audit reports
- completed best value reviews
- the intelligence generated through the Patients' Forums and the local network of the Commission for Patient and Public Involvement in Health (CPPIH)
- and, at least for the near future, reports and other information form CHCs.

**Response:** Endorse the approach that an integral part of the scrutiny process is that of informing the process utilising such documentation as the Local Community Strategy.

**Note: in compliance with section 100d of the Local Government (Access to Information) Act 1985 the report has been prepared in part from the following papers: None**

**Joint Overview and Scrutiny Committees**

There are four possible sets of joint working relationships. The first three are relationships where all the authorities involved have social services functions. They are:

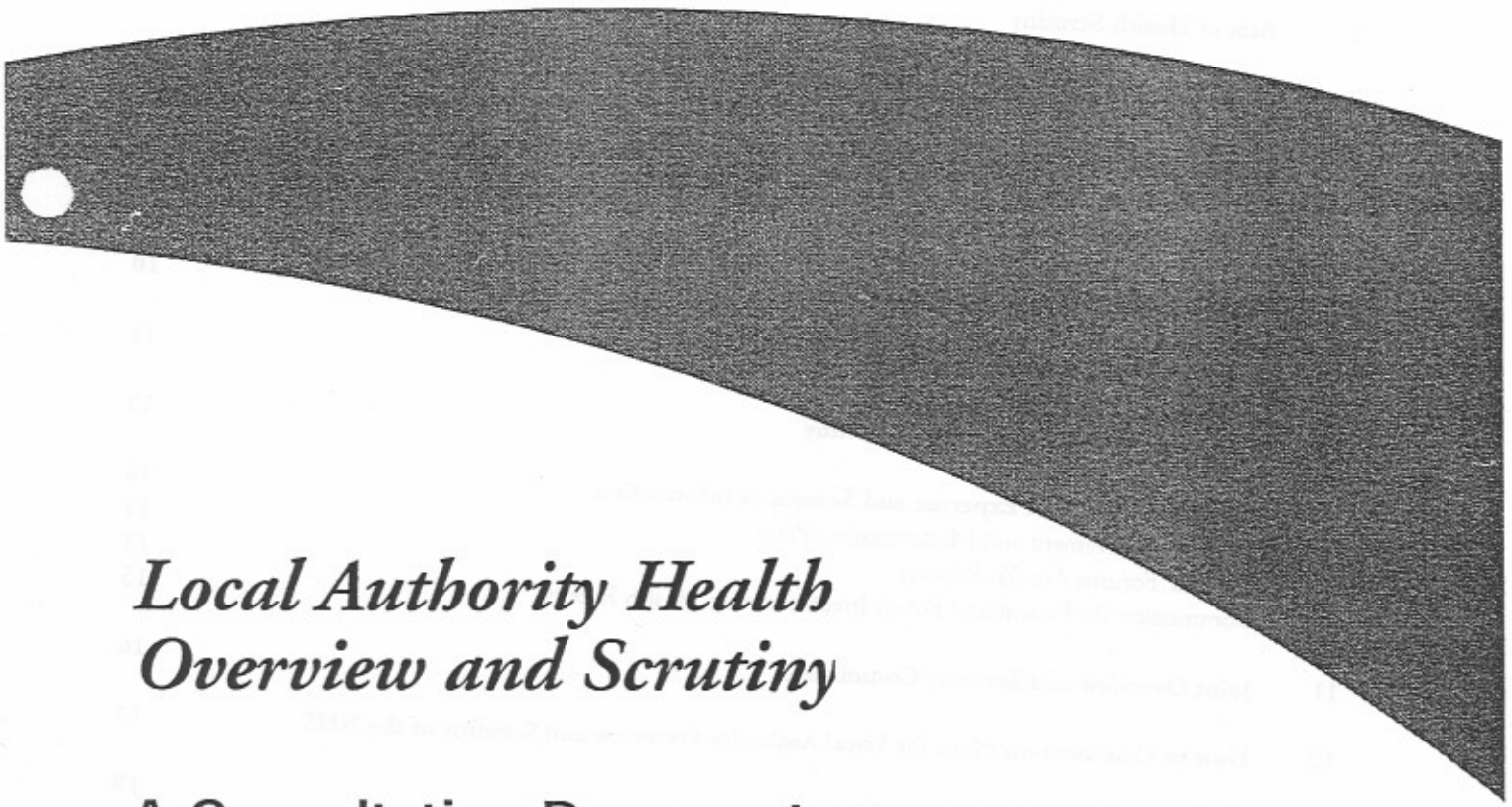
- Two or more authorities may work together
- One authority may delegate to another
- Authorities may co-opt members from other authorities to join their committee as a voting member.

The fourth arrangement includes the involvement of district authorities in scrutiny. This could be achieved via:

- Two or more authorities working together, where one is a district council, to form a single overview and scrutiny committee. (The country will remain in the lead).
- A delegation of functions (but not responsibility) for overview and scrutiny by the country to the district.
- Counties could co-opt district non-executive members on to the country committee as voting members.

**Response:** Consideration of the differing options to aid flexibility towards efficient scrutiny as set out above, with Members views being sought on their preferred approach.

Department of Health



# *Local Authority Health Overview and Scrutiny*

## A Consultation Document

January 2002

# Contents

# 1. Introduction

1.1 This document sets out our intentions for local authority overview and scrutiny committees (OSCs) to represent democratically local views on the quality, performance and development of health services to local NHS bodies[1]. The introduction of overview and scrutiny of the NHS by local government will strengthen the way public and patients views and concerns are represented. It will complement the work being done within the NHS to ensure the service is responsive to people's needs, listens to their views, and acts on their concerns. The need for external scrutiny is part of the strategy to realise the Government's ambition to create a patient-centred NHS.

1.2 In this document we build on the proposals first set out in the NHS Plan. Our aim is to enable scrutiny of the NHS to be conducted, not in isolation, but as part of local government's wider responsibility to seek health improvements and reduce health inequalities for their area and its inhabitants.

1.3 The Government is clear that patients, carers and citizens must be properly involved so that they can influence their healthcare and health services in their community. This is to ensure the quality, performance and configuration of local health services meets the needs of the area and its inhabitants. We are committed to making the changes that are needed to achieve that aim. Your views on the new arrangements for the NHS to be scrutinised by local authority Overview and Scrutiny Committees are critical. They will help us to ensure that the new arrangements for health scrutiny by local government will be successfully introduced.

1.4 We would welcome your comments on the proposals for the new arrangements outlined in this document, your suggestions as to how to improve them together with any general points you may want to make. We have set out a list of the key questions on which we would particularly like your views. These questions tend to be around the issue of how the new arrangements should operate to best effect and are set out at Annex A.

1.5 We will consider all the feedback we receive in the context of the secondary legislation and guidance that will be produced later this year in relation to this topic. We also intend to undertake an additional listening exercise on the regulations and guidance that will follow.

1.6 Details of how you can get involved and have your say are on page 17.

1 In relation to an overview and scrutiny committee, this means a Health Authority, Primary Care Trust or NHS trust specified for those purposes by regulations in relation to the committee. This definition will also include StHAs following the introduction of the NHS Reform and Health Care Professions Bill.

# 2. Background

2.1 The modernisation agenda sets out the Government's commitment to meet people's expectations for high quality public services. This commitment is being met by redesigning the system round the user; be it the patient, the public, the passenger or the victim of crime.

2.2 Part 1 of the Local Government Act 2000 created a new discretionary power for councils to do anything they consider likely to *promote or improve the economic, social or environmental well-being* of the area. The modernisation of local governance through the 2000 Act creates a formal separation between executive and non-executive councillor's roles, with overview and scrutiny functions carried out by non-executive councillors. Overview and Scrutiny Committees (OSCs) hold the executive to account and assist in reviews of policy and strategy. They also scrutinise matters that extend beyond the council's statutory functions but nevertheless affect the economic, social or environmental well-being of the area. In those authorities operating alternative arrangements, scrutiny is carried out by councillors who are not members of policy committees.

2.3 The Health and Social Care Act 2001 provides for more explicit powers for OSCs to scrutinise health services within the authority's area as part of their wider role in health improvement and in reducing health inequalities for their area and its inhabitants. Importantly the 2001 Act details for the NHS what its duties are in the scrutiny process.

2.4 The ways in which health and social services may be delivered continue to develop and evolve. Traditional boundaries between health and social care are becoming more blurred. Councils may now be seen as assuring and promoting the well-being of their local population, not just in relation to provided or contracted services, but also in relation to any matters relevant to their well-being. OSC powers to scrutinise plans and look at outcomes are a significant step forward in making public services, including the NHS, more locally relevant and locally accountable.

2.5 We believe that the development of the arrangements to scrutinise the NHS set out here is a constructive and positive means by which we can foster relationships and provide the qualitative improvements in people's health and the health services that serve them that we are all looking to achieve.

# 3. Aim of health scrutiny

3.1 The aim of local health scrutiny on behalf of the local community is threefold.

- First, to ensure that people's needs and wishes for health and health related services that meet the needs of all the population (including minorities, socially excluded groups and other targeted equalities groups) have been identified towards achieving local health improvements.
- Second, to scrutinise whether services provided that impact on the health of local inhabitants are accessible to, and can be accessed by, all parts of the local community.
- And last, to scrutinise whether the outcomes of intervention (whether through services or other intervention designed to positively impact on the health of local inhabitants) are equally good for all groups and sections of the local population.

3.2 In summary, the aim of local overview and scrutiny of health including scrutiny of the NHS is to act as a lever to improve the health of local people. This will be achieved by addressing issues around health inequalities between different groups and working with NHS and other partners to secure the continuous improvement of health services and services that impact upon health.

# 4. Functions of health Overview and Scrutiny Committees

4.1 Local authority overview and scrutiny committees are part of the arrangements for local government under Part II of the Local Government Act 2000. Local authorities are given the power under the 2000 Act to review and scrutinise the totality of local services planned and provided as part of their wider responsibility to seek health improvements and reduce health inequalities for their area and its inhabitants.

4.2 The Health and Social Care Act 2001 introduces new powers for some Overview and Scrutiny Committees in relation to the NHS and NHS bodies. Authorities that also hold responsibility for social services may review and scrutinise the operation of the health service in its area and make reports and recommendations to NHS bodies in respect of that review and scrutiny. In addition committee functions in relation to the NHS will include referring contested proposals for major service changes to the Secretary of State.

4.3 The committees of social services authorities will also have the power to scrutinise the social care services provided or commissioned by NHS bodies exercising local authority functions under section 31 of the Health Act 1999. This is in addition to their existing power to scrutinise local authority social services.

4.4 Social services authorities are:

- county councils
- unitary authorities and metropolitan borough councils
- and London borough councils.

The common council of the City of London may also establish a committee that mirrors the functions of an OSC in relation to scrutiny of the NHS.

# 5. Operation of Scrutiny of the NHS

5.1 OSCs may review or scrutinise health services commissioned or delivered in the authority's area within the framework set out below:

- arrangements made by local NHS bodies to secure hospital and community health services to the inhabitants of the authority's area;
- the provision of such services to those inhabitants;
- the provision of family health services (Primary Care Trusts), personal medical services, personal dental services, pharmacy and NHS ophthalmic services;
- the public health arrangements in the area; e.g. arrangements by NHS bodies for the surveillance of, and response to, outbreaks of communicable disease or the provision of specialist health promotion services;
- the planning of health services by NHS bodies, including plans made in co-operation with local authorities setting out a strategy for improving both the health of the local population and the provision of health care to that population;
- the arrangements made by NHS bodies for consulting and involving patients and the public under the duty placed on them by Section 11 of the Health and Social Care Act 2001.

5.2 Local authority overview and scrutiny committees must be open to the public except where certain confidential information may be disclosed, or when certain "exempt information" may be disclosed. The categories of "exempt information" (that is information that will only be disclosed in camera) where an Overview and Scrutiny Committee is dealing with NHS matters is set out in Part 1, Schedule 1 to the 2001 Act attached as Annex E to this discussion paper.

5.3 OSCs will make reports and recommendations to the Board of the NHS bodies scrutinised. We anticipate such reports will form the basis of constructive discussions between the committee and the scrutinised bodies. We also envisage that these reports will be copied to:

- the local Member/s of Parliament (MP/s)
- the Strategic Health Authority
- relevant Patients' Forum
- local office of the Commission for Patient and Public Involvement in Health
- local voluntary organisations with an interest
- other bodies or organisations with an interest in the issues dealt with in the report.

In addition we propose that a copy of the report should be placed in the local library, on local authority and Strategic Health Authority websites and made available to other local networks so as to be widely available to members of the public.

# 6. Duties and responsibilities of NHS bodies

6.1 Health bodies will have a statutory duty to provide to the committee any information about the planning and operation of health services in its area as the committee may reasonably require in order to discharge its functions. We would therefore expect health bodies to develop a co-operative working relationship with their local OSC in this respect.

6.2 Information that the committee may reasonably expect to receive to enable it to discharge its functions will not include:

- patient identifiable information; or
- information around personnel matters affecting any officer employed by the local NHS body where the interests of the individual may reasonably be expected to over-ride the public interest to the extent that the information could not be disclosed even in camera;
- information the disclosure of which is prohibited by law.

6.3 Guidance will set out that in the event of a local NHS body refusing to disclose information to the committee that is not prohibited by regulation, the committee may appeal to the Secretary of State for a decision as to whether the information is reasonably required in order for the committee to discharge its functions. The Secretary of States decision in response to such an appeal will be final.

6.4 Regulations will require the Chief Executives (CE) of local NHS bodies to come before the committee to answer questions if requested. The provision is aimed at allowing local citizens to have their concerns and questions raised with the local NHS. For this reason OSCs may also wish to invite chairs and non executive directors to give evidence and chairs and non-execs may on appropriate occasions wish to accompany officers giving evidence.

6.5 Regulations will also allow any officer of *any* NHS body to attend before the committee to answer questions where the information they are being asked to present is reasonably required in order for the committee to discharge its functions. The purpose of allowing other officers than just the CE to come before the committee is to ensure that where there is specific evidence/information requested or required the most appropriate officer is able to attend – e.g. director of finance. The functions of the OSC do not include issues of the individual performance of NHS employees and it will *not* be the purpose of regulations to require officers to attend OSC meetings to personally account for their actions.

6.6 Once the OSC has completed its scrutiny and sent its report to the NHS body the NHS body concerned will be required within 12 weeks to send its response to the committee. The reply should set out the views of the body on the recommendations, proposed action or reasons for inaction in response to the recommendations made. As with the OSC report, we envisage the NHS response will be copied to:

- Local MP(s)
- the Strategic Health Authority

- relevant Patients' Forum(s)
- local office of the Commission for Patient and Public Involvement in Health
- local voluntary organisations with an interest.

6.7 In addition to its duty to respond to requests *for* information and requirement to respond timeously to OSC reports, regulations under the 2001 Act will require local NHS bodies to actively consult the OSC at an early stage on its plans for:

- substantial developments of the health service in the council's area
- any proposals to make any substantial variation to the provision of such services.

6.8 Local NHS bodies will also be required to satisfy the committee in relation to the matters set out in 6.6 above that sufficient time has been allowed for consultation to take place in accordance with its duty to make arrangements to involve and consult under Section 11 of the Health and Social Care Act 2001. Where OSCs do not feel local people have had sufficient opportunity to have their say, or where the merit of the change is contested, they will be able to refer their concerns to the Secretary of State for Health who will be required to review matters for a final decision.

# 7. Right of Referral to Secretary of State

7.1 Under current arrangements there is a statutory duty for Community Health Councils (CHCs) to refer substantial variations in service to the Secretary of State on the basis of inadequate consultation. In addition Department of Health Guidance provides for CHCs to refer substantial variations to the Secretary of State where they have doubts about the merits of the proposal.

7.2 Where OSCs consider that the process of consultation has been inadequate, regulations will provide that they shall make a referral to the Secretary of State. In addition Department of Health guidance will provide for OSCs to make a referral if they have concerns about the merits of the proposals. In either case the Secretary of State will, if he wishes, be able to seek the advice of the Independent Reconfiguration Panel on contested decisions referred to him.

# 8. Independent Reconfiguration Panel

8.1 The Government believes that the current system, under which decisions are made on contested proposals, is insensitive, opaque and not sufficiently independent. Too little attention is paid to the impact on the total health care system, including the effect on social services.

8.2 The Independent Reconfiguration Panel (IRP) will provide government with a new source of independent advice on contested major service change in the NHS. It will assess whether the NHS has done all it can to take the views of local people into account in drawing up their plans for change. It will make recommendations to the Secretary of State, assessing proposed changes against clear criteria, taking account of both the local impact and national objectives. It will take explicit account of the rigour of the local consultation process. The panel will operate openly, publish its recommendations, the reasons for its conclusions and the evidence it considers.

8.3 The Panel's assessments will be made on the basis of objective analysis of each case, weighing up professional opinions with those of the public affected by the change. The Panel is to be chaired by Dr Peter Barrett.

8.4 Panel members will be appointed on the basis of their skills and experience. In particular, they will need to demonstrate a good understanding of the difficult trade-offs involved in any complex organisational change. An independent assessor is overseeing the appointment process.

# 9. Planning health overview and scrutiny

9.1 The Health and Social Care Act requires local authorities to ensure that the relevant OSCs have the power to review and scrutinise matters relating to the health service in the authority's area and to make reports and recommendations on such matters. The main scrutiny panel will wish to hold early discussions on how the authority should approach the health scrutiny role and priorities for early scrutiny and how to build its relationship with local NHS and other partners. Local priorities for scrutiny will surface during discussions with other local authorities (including district councils), Patients' Forums, Commission for Patient and Public Involvement in Health, as well as other agencies and individuals and be informed by available documentation. (See also *Making use of local expertise and sources of information.*)

9.2 Early discussions of future scrutiny plans will, for example, identify that a review of the commissioning strategy of a particular PCT may be better delegated to the local District Council, while joint scrutiny will be appropriate when looking at specialist services like neonatal intensive care, or bone marrow transplants. (See also *Joint Overview and Scrutiny Committees.*)

9.3 The health of an area is affected by a wide range of factors that go beyond the impact of the NHS. Many important local government services also promote the health and well being of the community they are designed to serve. Not just social services, but housing, leisure, transport and other core local government functions. Therefore councils will wish to take full advantage of the powers of review under the Local Government Act 2000 to examine the full range of cross cutting issues that impact on peoples' health when planning health review and scrutiny.

9.4 Experience from authorities who have undertaken scrutiny of health issues is that a useful approach is to look thematically at the broader health needs of different groups within the wider population. For example how carers are supported by health and/or social services or patient/user experience of mental health services. Committee members have been equally interested to know how the NHS and local authority are working in partnership to meet the needs of local people as they have been in how they work separately. Where overview and scrutiny is experienced by the NHS as part of a range of arrangements for partnership the quality of OSC reports is perceived to be higher, recommendations on the way forward more likely to be welcomed and ultimately seen to be more useful.

9.5 It will be vital in planning a successful programme of scrutiny that the OSC representative and NHS Chief Executive discuss in advance the committee's probable programme of scrutiny for the year. This will allow the NHS body time to gather the appropriate information in preparation.

9.6 Having drawn up a forward programme of health scrutiny work in consultation with other local authorities (including district councils), NHS partners and other key stakeholders, OSCs need to consider the style and approach to be taken for each element. Scrutinising a proposal to close a local hospital will, necessarily, be a more formal and less collaborative process than a review aimed at joining up services across agencies. In each case consideration needs to be given to the make up of the committee.

9.7 In addition, in particular during the early years of scrutiny, OSC representatives will wish to ensure that the NHS Chief Executive and key staff understand the process of open scrutiny and the particular style or approach to be adopted on each occasion.

9.8 Councillors will always provide the core group of panel members with developing skill in health scrutiny. They will supply the democratic leadership for each scrutiny project, but not necessarily the totality of its membership. Health scrutiny panel members may consider:

- co-opting voting membership from District Councils or other social services authorities with residents that use the services to be scrutinised (or others with voting rights as per the 2000 Act)
- inviting representation from Patients' Forums
- inviting representation from a particular client group voluntary organisation
- inviting representation from CHCs while they continue to exist
- inviting the views of the local Commission for Patient and Public Involvement in Health – or commissioning this body to undertake targeted work across specific communities or patient groups.

These ad hoc arrangements for committee membership are flexible and ensure that for any given review or scrutiny the most appropriate style or approach is achievable while allowing the retention of a democratically determined balance of voting powers.

9.9 The core group of councillors who will plan and lead health scrutiny shall *never* include members of any authority's executive or councillors who are members of policy committees where alternative arrangements have been set up. However it may include members who are involved in the *executive* of a particular NHS body. To avoid any conflict of interest, such members must declare an interest and are barred from involvement in any scrutiny exercise that concerns the NHS body of which they are a member of the executive or are an employee. In addition scrutineers may not be involved in any scrutiny exercise that may advantage the NHS body where they have an interest. For example, an executive of a PCT may not be involved in scrutiny of an acute hospital from which the PCT purchases services.

9.10 Clearly there are issues that sometimes rise that need specific scrutiny attention and that are not part of a planned OSC programme. Overview and Scrutiny Committees will wish to scrutinise a specific service outside of their planned programme where they feel that it is in the interests of the local population to do so. OSCs are independent from both the executive of the local authority and the NHS and will scrutinise at short notice if they have concerns. With resources in mind this may impact on the agreed rolling programme, perhaps putting back some scrutiny plans until subsequent years.

9.11 In the spirit of creating a patient centred NHS, NHS Chief Executives will wish to co-operate if asked to attend at short notice on these sorts of occasion. Local authorities will wish to carefully manage such demands to ensure the maintenance of good working relationships with NHS bodies.

# 10. Making use of local expertise and sources of information

10.1 Early discussions of local priorities for health scrutiny should be informed by available documentation. This could include:

- the local community strategy or plan
- outputs from the Local Modernisation Review
- the most recent report of the Director of Public Health
- any relevant inspection or audit reports
- completed best value reviews
- the intelligence generated through the Patients' Forums and the local network of the Commission for Patient and Public Involvement in Health (CPPIH)
- and, at least for the near future, reports and other information from CHCs.

## Health Improvement and Modernisation Plans

10.2 Health Improvement and Modernisation Plans (HIMPs) are the key strategic document for local health communities to reflect local approaches to health improvement, health inequalities and the NHS modernisation agenda. HIMPs are developed in partnership between NHS bodies, local government and the community.

10.3 Primary Care Trusts (PCTs) will have lead responsibility for this process from April 2002. PCTs are being encouraged to work together in local groupings to take account of local boundary arrangements. It will be for the NHS to ensure that local plans stack up and are understandable to local partners. There is a role for the work of OSCs both to feed into the development of a HIMP and for an OSC to make use of a pre-existing HIMP in deciding on priorities for future local overview and scrutiny.

## Patients' Forum Annual Reports

10.4 The Government has introduced legislation to set up Patients' Forums in every NHS trust and Primary Care Trust (PCT) as independent statutory bodies. They will have the key role of monitoring and reviewing services and influencing and informing management decision-making in their Trust. One of the responsibilities of the Patients' Forum will be to produce an annual report of its work and make their findings available not only to trusts, but also to:

- Overview and Scrutiny Committees (OSCs)
- Local MPs

- Strategic Health Authorities
- The Commission for Health Improvement, and
- The National Patient Safety Agency, where adverse incidents are concerned.

These reports may be published as part of the trust's annual Patient Prospectus and will provide an important additional source of information to OSCs in the planning of a programme of scrutiny.

## Commission for Patient and Public Involvement in Health Reports

10.5 The Government is also establishing a national body, the Commission for Patient and Public Involvement in Health. The Commission will set standards and issue good practice guidance for the whole system of patient and public involvement. It will monitor the work of Patients' Forums and make reports to the Secretary of State and such other bodies as he may prescribe. Further, where it feels that a matter giving rise to concern about the safety or well-being of patients is not being dealt with satisfactorily, it must report to an appropriate body, for example the Commission for Health Improvement (CHI), the National Patient Safety Agency (NPSA) and/or the police.

10.6 The Commission will also operate at a local level. It will establish local networks that will work to promote the greater involvement of the public in decisions on matters that affect the health of the local population – not just NHS decisions. The local networks will, in particular, support Patients' Forums, commission independent complaints advocacy, and draw together the entirety of patient experience data. The Commission will make reports to key local decision makers, and will have a specific role in informing OSCs about the issues of concern for local people on health related matters.

10.7 The staff of the Commission will work alongside other community development agencies linking with Local Strategic Partnerships, and feeding into the range of area based initiatives that are already in place.

# 11. Joint Overview and Scrutiny Committees

11.1 In many places scrutiny committees from more than one authority will need to work together to ensure an efficient scrutiny process. The 2001 Act allows for a number of different options to aid flexibility towards efficient scrutiny. It may be appropriate for example, for London Boroughs to establish a pan London joint committee to look at London wide services and involve the Greater London Assembly. Similarly a group of OSCs might want to scrutinise a service that relate to more than one local authority – for example an ophthalmology managed clinical network, or an elective orthopaedic centre.

11.2 In England regulations will ensure the maximum flexibility for local authorities to make the most suitable arrangements to meet local circumstances whilst ensuring NHS bodies are not burdened by multiple scrutiny exercises in one year.

11.3 There are four possible sets of joint working relationships. The first three are relationships where all the authorities involved have social services functions. They are:

- Two or more authorities may work together
- One authority may delegate to another
- Authorities may co-opt members from other authorities to join their committee as a voting member.

11.4 The fourth arrangement includes the involvement of district authorities in scrutiny. This could be achieved via:

- Two or more authorities working together, where one is a district council, to form a single overview and scrutiny committee (The county council will remain in the lead)
- A delegation of functions (but not responsibility) for overview and scrutiny by the county to the district
- Counties could co-opt district non-executive members on to the county committee as voting members.

11.5 A County Council must retain responsibility for any delegated health scrutiny functions being undertaken in its area. Health bodies will have a statutory duty to provide to a district council with agreed delegated functions any information about the planning and operation of health services in its area as the committee may reasonably require in order to discharge its delegated functions.

11.6 The regulations that relate to normal arrangements for scrutiny and review of the NHS by OSCs will also apply to the scrutiny and review of the NHS where there is a joint or delegated scheme in operation.

# 12. How to comment on the plans for local authority overview and scrutiny of the NHS

12.1 This consultation will run for 12 weeks from Wednesday 23 January 2002. Throughout February and March 2002 there will be a series of road-shows, developed in collaboration with the Local Government Association, that provide the opportunity to learn more about and to discuss the proposals set out in this document. The road-shows will be one way for you to let us know your views, to ask further questions and to get answers to them.

12.2 Details of these events and who to contact will be placed on the consultation web site as they are arranged.

12.3 We would particularly welcome participation in these events from CHCs and patient/user/carer and voluntary sector groups, as well as representatives from the NHS and local government.

12.4 In addition you can feedback your views to our mailbox MBhealthscrutinyconsultation@doh.gsi.gov.uk If you want to write to us with your comments please send them to:

Health Scrutiny Consultation
Department of Health
Room 608 Richmond House
79 Whitehall
London SW1A 2NS

Or fax them to 020 7210 4902.

12.6 We are particularly interested in your thoughts on the questions we pose at Annex A. If you want to comment on a particular question please indicate which question you are commenting on. **We would be grateful if you could reply by Tuesday 16 April 2002.**

# 13. Patient and Public Involvement Timetable

13.1 The plans for implementation of the health scrutiny arrangements detailed here must synchronise with the Government's wider plans to strengthen patient and public involvement.

13.2 Section 12 of the Health and Social Care Act 2001 places a duty on the Secretary of State to make arrangements for the provisions of independent advocacy to assist people wishing to complain about the NHS

13.3 Patient Advice and Liaison Services (PALS) are being established in every trust and Primary Care Trust to provide on the spot assistance and advice to patients, their carers and families whilst they are using the NHS. PALS will be established throughout the country by April 2002.

13.4 Currently before Parliament is the NHS Reform and Health Care Professions Bill which provides for the establishment of Patients' Forums for every trust and Primary Care Trust, plus the establishment of the Commission for Patient and Public Involvement in Health.

13.5 It is intended that the Commission should be established by the end of 2002 since it will have the role of setting standards and issuing best practice guidance, for forums and for the provision of independent complaints advocacy. Additionally it will be the appointing body for Patients' Forum membership.

13.6 It is also intended that Forums will be established by April 2003. It is not intended that CHCs will be abolished until the new arrangements are in place.

13.7 This means that it is essential that OSCs are in a position to formally undertake their powers of NHS scrutiny some months before the abolition of CHCs. We think a period of time during which there is parallel operation of the scrutiny function is desirable to ensure that at no time is the NHS not being reviewed and held to account of local people. We currently believe that a three-month period of CHCs and OSCs working in tandem is right. See also **Annex C** ***Timetable for implementation of NHS scrutiny provisions.***

# 14. Conclusion

14.1 Giving local government a real role in the scrutiny of the NHS gives local people a genuine say in their local health service and makes the NHS answerable for its performance to locally elected councillors.

14.2 The Government believes that democratic scrutiny of local NHS services will work as part of a wider strategy to help us recast the relationship between the health service and the people it serves. The strength of the new approach comes from the new relationship between the OSC and the local authority executive functions and NHS bodies it scrutinises. At the heart of the Government's reforms is the recognition that local services are there to meet the needs of local people. Overview and scrutiny is a way of ensuring that needs have been properly identified and that services delivered by local partners do indeed promote the well-being of the community they are designed to serve.

**Department of Health**
**January 2002**

# ANNEX A

## Questions to help you make your comments

**We would welcome any general comments, both on the overall content of this document, and on the general functions and operation of the new arrangements we are proposing. In addition, there are some important areas where we are seeking your specific input. These are as follows:**

### Duty of NHS to consult

NHS bodies are to have a duty to consult their local OSC on:

- Substantial developments of the health service in the council's area
- Any proposals to make any substantial variations to the provision of such services.

1. Is there a need for criteria to be set out centrally defining the meaning of substantial development/substantial variation to developments and if so what would that criteria look like?

### Planning overview and scrutiny

Experience from authorities that have undertaken health scrutiny shows that a useful approach is to look thematically at the broader health needs of different groups within the wider population.

1. How can we ensure that the resources of local government and the NHS are best utilised to achieve improvements in the quality of services delivered locally via the scrutiny process? What is best practice?

2. Do you have experience of piloting NHS scrutiny in your area that you would like to share with us? We would like to include examples of good practice in the policy and practice guidance that will be published to coincide with the enactment of these provisions of the Health and Social Care Act.

3. What kind of support has successfully been provided to the OSC, eg expert advisers, secondments from health bodies, help from patient bodies or pooling resources with neighbouring councils?

4. How should plans for local scrutiny be made accessible to the public?

5. The make up of the scrutiny panel should be dictated by the style and approach appropriate for that element of the health scrutiny programme. Is there a need for some minimum guidance on how the committee should be constituted?

## Joint Scrutiny

Where a NHS body covers two or more Social Services Authorities (SSAs) the body could be scrutinised by the OSCs of all these authorities.

1. How can we ensure that NHS bodies are not burdened by multiple scrutiny exercises in one year while ensuring that important issues of concern to local people are properly scrutinised by community representatives?

2. Is there an argument for setting out criteria that in some circumstances joint scrutiny or delegation of the scrutiny role to one of the authorities with scrutiny powers is the only option available to local councils? If so in what circumstances should such criteria be laid down?

## Overview and Scrutiny Member Training

We envisage establishing the Commission for Patient and Public Involvement in Health, its local networks, and Patients' Forums at the beginning of 2003 and the CHCs and ACHCEW ceasing to operate in April 2003. For OSCs we also see their new powers being introduced at the beginning of 2003 so they can work alongside CHCs in the transition period.

The Department of Health is setting up an external reference group to ensure arrangements are in place for the smooth transition from current to the new arrangements for patient and public involvement in the NHS. We will be asking this Transition Advisory Board to consider OSC member training. It would be helpful for the Board to have the view of the field of the sort of training needs health scrutiny members are likely to have and how they may best be met.

1 What training and development will be required for members?

# Annex B

## Final package of measures for Involving Patients and the Public in Healthcare

Following the listening exercise based on the document *Involving Patients and the Public in Healthcare* we announced our response. [2]

First and foremost, we want to set out the principles that underpin all our proposals. The system we introduce must fulfil six criteria for successful patient and public involvement. It must be:

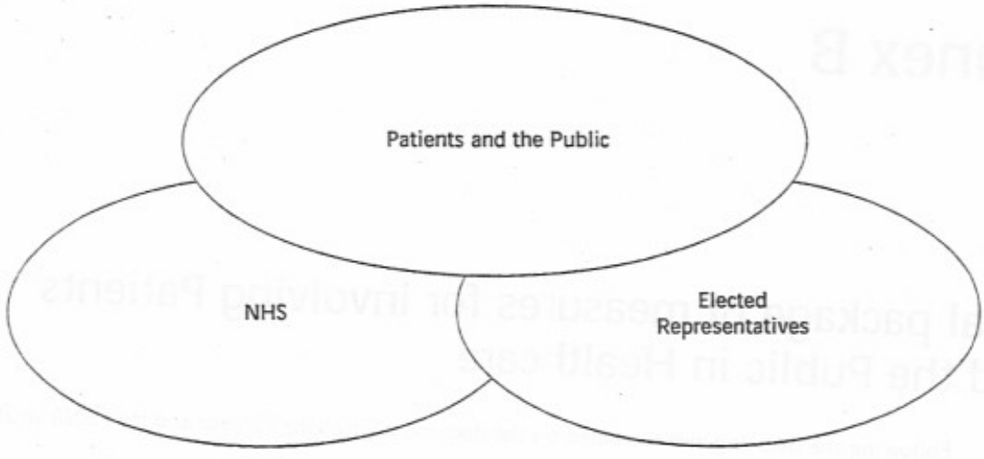
- **Effective**, in representing and strengthening the voice of patients and communities;
- **Accessible** at a local level to people using health services;
- **Accountable** in a clear and transparent way;
- **Integrated** to match the structures of the NHS;
- **Independent** to be able to scrutinise Health Services;
- **Adaptable, building on the best of existing local practice and ensuring high quality.**

Our final package, as set out below, fulfils these criteria. It will be backed up by legislation. It will be *accessible* both through every part of the NHS, and within communities, and will be *accountable* at all levels to and influenced by lay people.

To achieve an *integrated* system, we have embedded systems of involvement and representation at every level within the Health Service. But we need to make sure that *effective*, external scrutiny and representation is not lost, so that we have also made sure that other bodies, *independent* of the NHS, exist and are able to fulfil this function.

We believe that this system can be described very simply, as a partnership between three key groups – patients and the public; their elected representatives; and the NHS itself.

2 Published on 16 November at:www.doh.gov.uk/involvingpatients



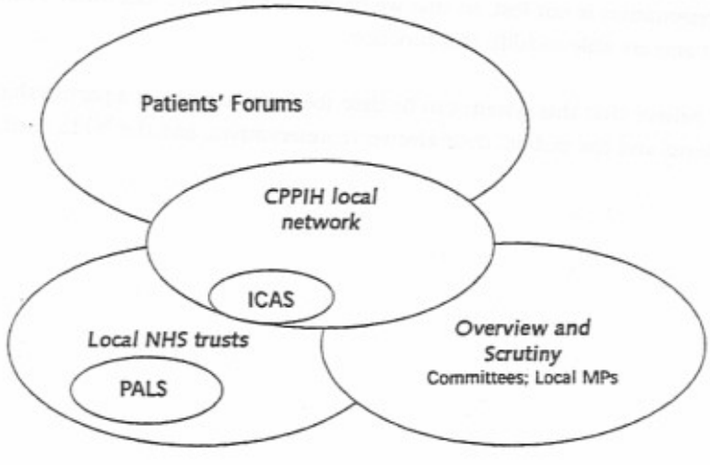

This partnership exists at every level of the NHS – local, strategic and national. The arrangements for each of these levels are set out below.

## Arrangements for Patient and Public Involvement Locally

At a local level, we see the partnership described above incorporating the four main components from the new system. These are as follows:

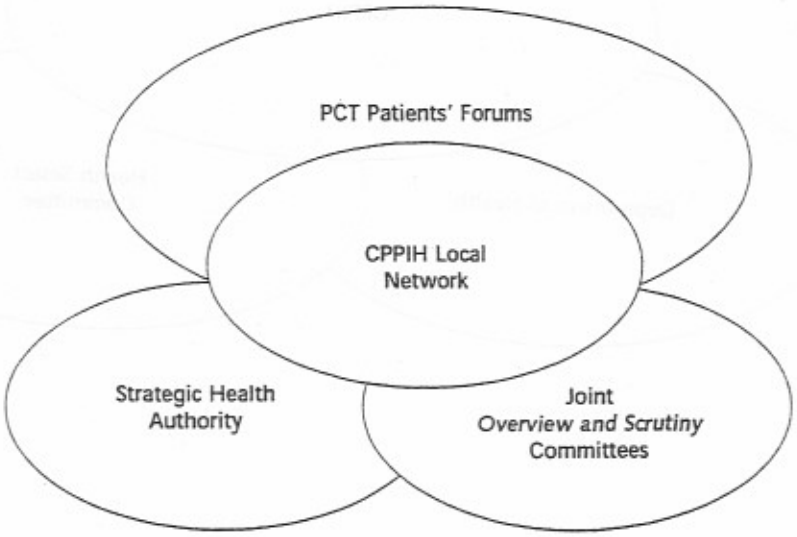
- Local NHS organisations, incorporating Patient Advice and Liaison Services (PALS);
- Patients' Forums,
- The Commission for Patient and Public Involvement in Health, which will have local networks and community outreach workers responsible for commissioning the Independent Complaints Advocacy Service (ICAS);
- Overview and Scrutiny Committees (OSCs).

These components fit together as follows:



## Strategic Level Arrangements

At a Strategic Health Authority (StHA) level, we envisage 3 key players in the partnership; OSCs working jointly, the StHA, and PCT Patients' Forum representatives – all of these being informed by the activities of the Commission's local networks. The picture therefore looks like this:

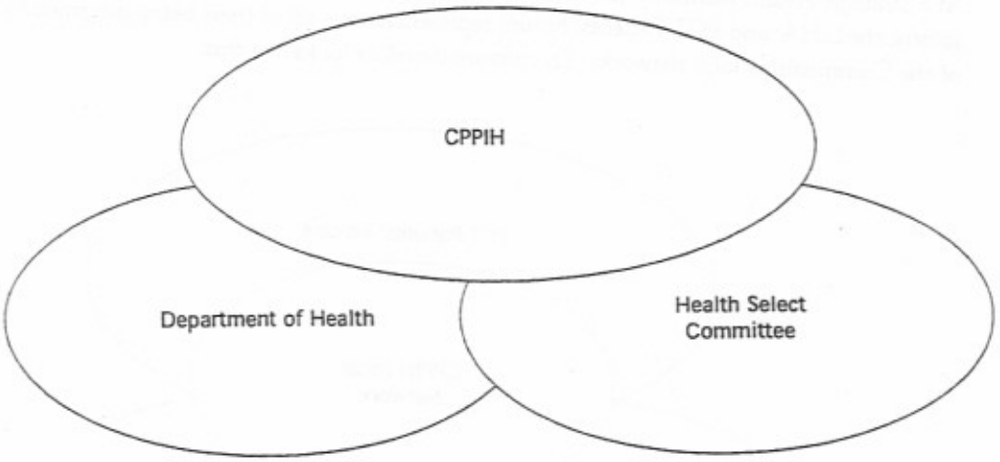



## National Level Arrangements

Until now, the role of national co-ordinator of patient and public involvement interests has fallen to the Association of CHCs for England and Wales (ACHCEW). However, its remit has been formally limited in statute to supporting CHCs. In addition, whilst ACHCEW has been able to develop some excellent training and support for CHC members, there has been no means of instituting minimum standards of performance and service nationally.

It was with this in mind that "Voice: The Commission for Patient and Public Involvement in Health" was proposed. We have now shortened this title to call it the *Commission for Patient and Public Involvement in Health (CPPIH).*

This completes the three-way partnership at the national level, with the Department of Health, and elected scrutiny through the Health Select Committee and Parliament:



# Annex C

## Timetable for implementation of health scrutiny provisions

| Date | Action |
|---|---|
| 23 January 2002 | Hazel Blears MP, Parliamentary under Secretary of State, Department of Health to launch 12 week period of consultation on OSC policy at LGA/Audit Commission one-day conference on Scrutiny in London. |
| | A series of Regional Road Shows will be developed and held in collaboration with the Local Government Association during the 12 week consultation period. |
| 16 April 2002 | Last day of consultation period. |
| Summer 2002 | Consultation on draft Regulations and Guidance. |
| Winter 2002 | Final draft guidance available on web to allow planning for introduction of 2001 Act scrutiny provisions. |
| January 2003 | Intended coming into force of regulations.<br>Introduction 2001 Act health scrutiny powers. |

# Annex D

## Health and Social Care Act 2001

## SCHEDULE 1

### Exempt Information Relating to Health Services

#### PART 1

DESCRIPTION OF EXEMPT INFORMATION

1. Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, a relevant body.

2. Information relating to any particular occupier or former occupier of, or applicant for, accommodation provided by or at the expense of a relevant body.

3. Information relating to any particular applicant for, or recipient or former recipient of, any service provided by a relevant body.

4. Information relating to any particular applicant for, or recipient or former recipient of, any financial assistance provision by a relevant body.

5. The amount of any expenditure proposed to be incurred by a relevant body under any particular contract for the acquisition of property or the supply of goods and services.

6. Any terms proposed or to be proposed by or to a relevant body in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

7. The identity of a relevant body (as well as off any other person, by virtue of paragraph 6 above) as the person offering any particular tender for a contract for the supply of goods or services.

8. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between a relevant body or a Minister of the Crown and employees of, or office-holders under, a relevant body.

9. Any instructions to counsel and any opinion of counsel (whether or not in connection with any proceedings) and any advice received, information obtained or action to be taken in connection with:

   (a) any legal proceedings by or against a relevant body, or

   (b) the determination of any matter affecting a relevant body, (whether, in either case, proceedings have been commenced or are in contemplation).

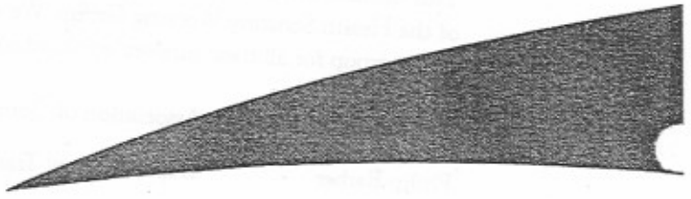
# Annex E

## External Membership of Department of Health

### Health Scrutiny Working Group

This document has been produced by officials at the Department of Health with the close involvement of the Health Scrutiny Working Group. We wish to give our thanks to the following external members of the group for all their support and hard work:

| | |
|---|---|
| Ray Appleby | Association of Community Health Councils for England & Wales |
| Philip Barber | Department of Transport and Local Government and the Regions |
| Jeni Bremner | Local Government Association |
| Dr Fiona Campbell | Democratic Health Network |
| Brenda Cook | NHS Eastern Regional Office |
| Hazel Day | NHS Confederation |
| Michael Downing | Association of Community Health Councils for England & Wales |
| Barbara Edmonds | NHS South East Regional Office |
| Gary Fereday | NHS Confederation |
| Jackie Glatter | Consumer Association |
| Shaun Gordon | Bedfordshire County Council |
| Bill Hamilton | Bedfordshire County Council |
| Alastair Henderson | NHS Confederation |
| Clara MacKay | The Patients' Forum |
| Helen Oxtoby | Audit Commission |
| Mick Rolfe | NHS South East Regional Office |
| Mark Stevenson | Local Government Association |
| Paul Thorpe | Barnsley Council |
| Cllr David Whiting | Lewisham Council |



DH Department of Health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This document is available from our website on:
http://www.doh.gov.uk/healthscrutinyconsultation

LGiU

22 Upper Woburn Place, London WC1H 0TB

# AFFILIATE POLICY BRIEFING

## Developing the health scrutiny role: consultation

**Date** 7 February 2002 **Circular No** 021/02 **Contact** Jo Dungey

**Summary**

**This briefing summarises the proposals for local authority scrutiny of health, outlined in the consultation document, *Local Authority Health Overview and Scrutiny*, published recently by the Department of Health. The deadline is 16 April 2002. This is applicable to England only.**

### Introduction

The new consultation document *Local Authority Health Overview and Scrutiny* outlines the government's proposals for local government scrutiny of health which was first proposed in the NHS Plan – the stated intention of which is to make the NHS a "patient-centred organisation". The consultation document summarises the provisions of two major pieces of legislation, which give councils the power of health scrutiny. They are:

**The Local Government Act 2000:** This requires all councils to establish overview and scrutiny committees, which in addition to holding the executive to account, can also scrutinise and report on 'matters which affect the authority's area or the inhabitants of that area'. This could include health issues. The Act also gives a general power to the council to do anything to promote or improve the economic, social or environmental well being of the area. Each council must develop (with consultation) a community strategy, which sets out how the economic, social and environmental well being of the area will be promoted. The quality of health services and the capacity for health improvement are clearly issues that affect the economic, social or environmental well being of local areas.

**Tel: 020 7554 2800** **Fax: 020 7554 2801** info@lgiu.org.uk www.lgiu.gov.uk

**The Health and Social Care Act 2001:** This introduces a more general power for scrutiny committees of social services authorities to scrutinise health services. The Act includes powers for the Secretary of State for Health to issue regulations on how this should be done. The new consultation document will contribute to the development of these regulations.

### Aim of health scrutiny

The consultation document defines the aim of health scrutiny, including scrutiny of the NHS, as: "To act as a lever to improve the health of local people. This will be achieved by addressing issues around health inequalities between different groups and working with NHS and other partners to secure the continuous improvement of health services and services that impact upon health."

### Content of the consultation document

The document discusses issues under the following headings:

- **Function of health scrutiny committees:** includes a definition of councils that will have the health scrutiny power, which includes county, metropolitan, unitary and London boroughs, but not district councils.

- **Operation of scrutiny of the NHS:** lists the framework of health services to be scrutinised, indicates that health scrutiny committees must meet in public except in certain cases, lists bodies to receive health scrutiny committee reports.

- **Duties and responsibilities of NHS bodies:** indicates that NHS bodies will be required to supply certain information to health scrutiny committees; lists NHS officers and board members who will be required and who will be likely to attend scrutiny committees; outlines circumstances in which NHS bodies will be required to consult health scrutiny committees; and sets out a timetable for NHS responses to health scrutiny reports.

- **Right of Referral to Secretary of State:** indicates that regulations will give scrutiny committees the power to make referrals to the Secretary of State for Health on grounds of merit or inadequate consultation, for example on NHS proposals to make major changes such as hospital closures.

- **Independent Reconfiguration Panel:** notifies the government's intention to set up a panel to advise on contested major service change in the NHS.

- **Planning health overview and scrutiny:** discusses the type of health-related issue that scrutiny committees might choose as the subject of a scrutiny exercise; how they might plan a forward programme of scrutiny; possible co-opted membership of health scrutiny committees; and councillors' eligibility for taking part in health scrutiny committees (where they are NHS employees, for example).

- **Making use of local expertise and sources of information:** discusses existing resources and new patient structures that might provide information and support to health scrutiny committees.

- **Joint Overview and Scrutiny Committees:** outlines the different possible permutations for setting up joint scrutiny committees and options for involving district councils in the health scrutiny function.

The report also explains how to take part in the consultation, and sets out a timetable for implementation of scrutiny arrangements and other plans for patient representation. The timetable is for consultation until 16 April, consultation on draft Regulations and Guidance in summer 2002, final draft Guidance in winter 2002, and scrutiny power to come into force in January 2003.

**Timetable and mechanisms for consultation**

The Department of Health is seeking responses to the consultation paper **by Tuesday 16 April 2002.** There will be a series of "road-shows" to discuss the proposals throughout February and March. Details of these will be given on the Department's consultation website, www.doh.gov.uk/healthscrutinyconsultation as they are arranged. Copies of the consultation document may also be downloaded from this website.

Councils are encouraged to take part in this consultation. Comments on the document may be sent to the Department's email address:

Mbhealthscrutinyconsultation@doh.gsi.gov.uk or sent by post to:

Health Scrutiny Consultation
Department of Health
Room 608 Richmond House
79 Whitehall
London SW1A 2NS

or faxed to:
**020 7210 4902.**

A series of questions on which the Department of Health would particularly like to know the thoughts of consultees is listed in an annex to the consultation document. LGIU will be responding to the consultation, jointly with the Democratic Health Network. It would be very helpful to know your views and comments, and to have copies of any responses to the consultation. Among the points we will be raising are:

- welcoming the broadening of the definition of health scrutiny to emphasise health improvement, as well as treatment, and measures that address health inequalities

- the need for proper resources to support the health scrutiny function

- the continued concern of district councils that they will be excluded from the health scrutiny role and a request that stronger guidance be issued to county councils in two-tier areas concerning the involvement of district councils

- looking at some legal issues about co-option and membership of scrutiny bodies, and the relation of health scrutiny bodies to the council and its executive

- continuing concern that the "Great Ormond Street" question has not been fully answered: that is, how will scrutiny of institutions that provide services across social services authorities' boundaries, regionally and nationally be addressed

- the need for further clarification and guidance on the role of local authority scrutiny committees in scrutinising health provision by the private sector and the need for clear guidance that legislation and regulations will apply to this sector

- concern that information essential to the proper scrutiny of proposed public private partnerships will not be forthcoming to local authority scrutiny committees on grounds of commercial sensitivity

- looking at how the new health scrutiny role can be developed in the context of community planning and Local Strategic Partnerships.

**About the Democratic Health Network**

The scrutiny of health, including NHS services, is a major new role for local government. Working with NHS services is also central to the development and implementation of community strategies and NHS bodies are important partners in Local Strategic Partnerships. The Democratic Health Network was set up as part of LGIU to provide policy advice, information, and a forum for good practice on the growing partnership between local government and health. Its co-ordinator, Dr. Fiona Campbell, is a member of the Health

Scrutiny Working Group advising the Department of Health. Members of the DHN receive more detailed and regular policy briefings on these important issues and, given their growing importance, LGIU affiliates who are not already members of DHN (which has a separate subscription base) may wish to continue joining. The DHN is introducing free trail membership which we urge LGIU affiliates to take up so they can see the value of DHN membership. An information pack is available: fiona.campbell@dhn.org.uk

JO DUNGEY
Policy Officer

This briefing has been circulated to Management Committee Representatives, Leaders and Chief Executives and Directors of Social Services

Email distribution category: Corporate, Social Care

It can also be found on the Web in the following three categories: Health, Local Government Act 2000, New political structures