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Chief Executive

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Date 14 July 2014
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TO: All Members of Health Scrutiny Committee

Councillors : P Adams, P Bury (Chair), E FitzGerald, L Fitzwalter,
J Grimshaw, S Haroon, K Hussain, S Kerrison, J Mallon, T Pickstone,
S Smith and R Walker

Dear Member/Colleague

Health Scrutiny Committee

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Tuesday, 22 July 2014
Place:	Peel Room (Elizabethan Suite), Town Hall, Knowsley Street, Bury
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

The Agenda for the meeting is attached.

Reports are enclosed only for those attending the meeting and for those without access to the Council's Intranet or Website.



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The Agenda and Reports are available on the Council's Intranet for Councillors and Officers and also on the Council's Website at www.bury.gov.uk – click on **Agendas, Minutes and Forward Plan**.

Copies of printed reports can also be obtained on request by contacting the Democratic Services Officer named above.

Yours sincerely

A handwritten signature in black ink that reads "Mike Kelly". The signature is written in a cursive style with a horizontal line underneath the name.

Chief Executive

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of Health Scrutiny Committee are asked to consider whether they have an interest in any of the matters on the agenda and if so, to formally declare that interest.

3 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which this Committee is responsible.

4 MINUTES OF THE LAST MEETING (Pages 1 - 6)

The Minutes of the last meeting held on 18 June 2014 are attached

5 INFECTION CONTROL

A presentation will be given at the meeting.

6 RECENT REVIEWS AND REPORTS INTO CARE STANDARDS AND SAFEGUARDING - LOCAL IMPLICATIONS

A presentation/update will be given at the meeting.

7 ANNUAL COMPLAINTS REPORT - ADULT SOCIAL CARE SERVICES (Pages 7 - 22)

The Adult Social Care Services Annual Complaints Report is attached.

Appendices 1 – 3 are attached.

8 LOCAL AUTHORITY HEALTH SCRUTINY GUIDANCE (Pages 23 - 52)

The new Health Scrutiny Guidance published by the Department of Health – June 2014 is attached for information.

9 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Minutes of: HEALTH SCRUTINY COMMITTEE

Date of Meeting: 18 June 2014

Present: Councillor P Bury (in the Chair)
Councillors Adams, E Fitzgerald, J Grimshaw, S Haroon,
K Hussain, Kerrison, Mallon, T Pickstone, S Smith and
R Walker

Also in attendance:

Public Attendance: No members of the public were present at the meeting.

Apologies for Absence: Councillor L Fitzwalter

HSC.43 DECLARATIONS OF INTEREST

Councillor FitzGerald declared a personal interest in any item relating to the NHS as she was employed by an NHS joint venture.

Councillor Grimshaw declared a personal interest in any item relating to the NHS as she was a member of the Patients' Cabinet.

Councillor Mallon declared a personal interest as his relative was Head of Safeguarding for an NHS organisation.

Councillor Pickstone declared a personal interest as his partner was employed by the NHS locally.

HSC.44 PUBLIC QUESTION TIME

No questions were asked by the members of public present at the meeting.

HSC.45 MINUTES OF THE LAST MEETING

It was agreed:

That the Minutes of the last meeting held on 20 March 2014 be agreed subject to the following amendments:-

HSC.909 on page 626, that the word 'shred' be changed to 'shared'.

HSC.910 on page 629, that the following sixth transformational area be included:-

'a step-change in the productivity of elective care'.

HSC.46 MATTERS ARISING

- With reference to Minute HSC.909, GP Federation introduction. Members asked whether the Prime Ministers Challenge Fund bid that was referred to had been successful.

Stuart North reported that the bid had been successful and that the GP Federation had secured £2.8m to help roll out the Radcliffe Demonstrator Pilot across the borough.

- Councillor Bury referred to Minute HSC.909 and the question that had been asked in relation to patients moving from one GP practice to another. Councillor Bury asked whether patients could move to a practice in another geographical area from where they reside as he had been advised that this was not possible.

Stuart North stated that as far as he was aware it was possible to move to a surgery in another geographical area. GPs were nationally commissioned and it was common for people to be registered with a GP in another town.

- Councillor Mallon referred to Minute HSC.910 and asked when the Committee would be updated on the CCGs Strategic Plan.

It was explained that the CCG reported regularly to the Committee to keep them updated on CCG issues.

- Councillor Walker referred to Minute HSC.910 and the fact that Dr Schryer was lead for all mental health. Councillor Walker asked whether mental health should have a number of leads as it was such a large area. Councillor Walker referred to dementia as an example and the fact that this area would warrant a lead of its own.

Stuart North explained that Bury CCG was a lean organisation and wouldn't be able to have a large number of leads. Dr Schryer was an excellent lead for mental health. Stuart explained that Pat Jones Greenhalgh was national lead on dementia for adult care services.

HSC.47 HEALTHIER TOGETHER UPDATE

Stuart North, Chief Officer at NHS Bury Clinical Commissioning Group attended the meeting to report on the Healthier Together pre consultation business case that would soon be available on the Healthier Together website.

The Committees in Common had met earlier in the day with a view to agreeing to pre consultation business case and recommending that the consultation commence on 8 July for 90 days.

It was explained that the Committees in Common had received guidance from NHS England in respect of the consultation and that NHS England required the business case to meet 96 standards before consultation could begin.

Stuart explained the case for change and the need to change the way that services were provided;

- Variation in patient outcomes, quality and safety standards
- Rising demand on services
- Workforce availability

- Many patients using hospital rather than primary and community services
- More care needs to be provided within the community

The future model of care was set out;

- Deliver care locally for the majority of patients – Local Services
- Upgrade Local Services so all attain standards
- Create a smaller number of Specialist Services for the few patients with 'once in a lifetime' life threatening illness and injury delivered in line with GM standards
- Create Single Services – multi-disciplinary teams responsible for Specialist and Local Services for a population of GM
- Work with the Ambulance Service to direct patients to the right place at the right time
- Consultant led care delivered to best practice standards
- Effective clinical leadership and decision making

It was explained that local services would remain and provide care locally, specialist services would be provided at either 4 or 5 sites depending on the outcome of the consultation

Stuart explained that the consultation would be looking at where services should be provided. There were 8 options available with Manchester, Oldham and Salford already being identified as specialist sites and Bolton, Wigan, South Manchester and Stockport being considered as the possible other sites.

The key elements to appraise were explained:

- Capital Estate Capacity
All options reviewed to understand the capital estate requirement. Every option is possible, however the cost of the options varies dependent on existing estate capacity and quality
- Workforce Capacity
Analysis of the standards identifies a consultant requirement for 4 and 5 site options
This is then compared to the current number of consultants to determine a deficit
- Travel and Access Standards developed:
Standard 1: 20 minute emergency access to a hospital (general or specialist)
Standard 2: 45 minute emergency access to a specialist site
Standard 3: 75 minute public transport access to a specialist site
All options are compliant with Standards 1 and 2
There is a range between the options when meeting Standard 3 (Access by Public Transport)
The lowest compliance of any CCG area is 97%

4. Financial Revenue Implications

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Health Scrutiny Committee, 18 June 2014

Plus, understanding different ways Single Service could be developed.

Stuart explained that all existing sites are included within these options and there is no preferred option.

Options were proposed as a way forward to achieve Quality & Safety Standards, however consultation response may provide alternative suggestions.

The next steps were explained:-

- NHS England will review PCBC documentation and submitted evidence against their 96 Assurance Criteria
- Greater Manchester Joint Overview & Scrutiny Panel will review the consultation material
- No change is not an option and the challenge is immediate
- Significant improvements in Community and Primary Care before Hospital changes
- No District General Hospital will close
- No A&Es will close
- All existing sites included within options; no preferred option

- Launch of the consultation to gain people's input and opinions of these proposals.

Members were given the opportunity to ask questions and make comments and the following points were raised:-

Councillor Bury explained that he was a member of the Joint Overview and Scrutiny Panel that had been tasked with reviewing the consultation material. Councillor Bury stated that he was impressed with the document that had been produced as he felt that it was set out well and easy to understand.

Councillor Bury referred to specialist services and the fact that Stroke Services were already situated at Fairfield Hospital in Bury. Councillor Bury asked whether this would continue to be the case.

Stuart North explained that not all specialist services were being considered within the consultation and as far as Bury CCG were concerned there were no plans to move the stroke services from Fairfield Hospital.

Councillor Walker referred to Pennine Acute NHS Hospital Trusts indication that A & E at Fairfield Hospital would remain open. Councillor Walker stated that he always felt uncomfortable when such statements were made and asked that confirmation be given that Fairfield A & E was safe.

Stuart explained that the consultation document stated that the plan was to retain all 10 sites but to use them differently than currently. All options to be considered included 10 hospital sites.

Councillor Smith referred to the specialist hospitals working jointly and asked whether this would have implications in relation to the different trusts across Greater Manchester. Councillor Smith asked whether the trusts would need to reorganise to accommodate the changes in service provision?

Stuart explained that the provider reference group would be reviewing this issue.

Councillor Smith referred to Wythenshawe Hospital as being included as a possible option for a specialist site and the fact that the Metrolink network was planned to be extended. Councillor Smith asked whether any decisions on specialists services would impact on this.

Councillor FitzGerald referred to transport issues and asked that all transport issues be reviewed to ensure that patients' and visitors' access to hospitals was straightforward.

Councillor Pickstone asked the committee to recognise that North Manchester General Hospital was the 'local' hospital for residents in the south of the borough and as such should be considered by the Committee when looking at the possible options.

Councillor Mallon referred to the 20, 45 and 75 minute access requirements and asked when the timing started, would it be when the patient called or when the ambulance left?

Stuart explained that he would seek clarification on this.

It was agreed:

1. That Stuart be thanked for his attendance at the meeting.
2. That Members would receive regular updates on the consultation process.

HSC.48 DEVELOPMENT OF A WORK PROGRAMME

Members of the Committee were asked to discuss items to be included on the work programme for the 2014/2015 municipal year.

The Committee were also asked to discuss topics that could be considered for task and finish/sub group work.

The Committee discussed the following agenda reports:-

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Health Scrutiny Committee, 18 June 2014

- Drug and Alcohol Team – introduction from new service provider
- Patient appointment
- Public Health – the work of and future work programme
- Care Quality Commission
- Legal highs
- Update from the Integrated Community Diabetes Service
- Complaints report
- Adults and Children’s Safeguarding update
- Update on the Radcliffe Demonstrator

Sub Groups would be established to look at the following areas:-

- Dentistry provision across the borough to include the number of children and adults without access to an NHS dentist.
- Transport issues relating to Healthier Together.
- Supporting Carers or Dementia

It was also discussed that Members needed to receive information in relation to the recent reviews that had been undertaken – Francis, Winterbourne, Keogh etc and the implications from these.

COUNCILLOR P BURY
Chair

(Note: The meeting started at 7 pm and ended at 9.10 pm)

REPORT TO HEALTH SCRUTINY COMMITTEE

Title:	ANNUAL COMPLAINTS REPORT – ADULT SOCIAL CARE SERVICES – FOR INFORMATION ONLY
Date of Meeting:	Strategic Management Team 9 June 2014 Health Scrutiny 22 July 2014
Report from :	Pat Jones-Greenhalgh, Executive Director of Communities and Wellbeing
Contact Officer :	Sharon Wells, Customer Services Manager (Complaints)

1.0 PURPOSE/SUMMARY

There is a statutory requirement to produce an Annual Complaints Report relating to Adult Social Care Complaints. This report is to update Members and provide current information in respect of complaints related to Adult Social Care Services. The report looks at the period 1 April 2013 to 31 March 2014 and the purpose in presenting the report is for Members to oversee the extent and complexity of Adult Care Services' span of activity and to receive information relating to the quality of services delivered.

Members are asked to note the content of the report.

2.0 INTRODUCTION

2.1 In line with guidance from the Department of Health, Local Authorities are required to publish an Annual Complaints Report covering the council year.

2.2 This report is to update Members and provide information in respect of complaints related to Adult Social Care Services during 2013/14. More frequent monitoring is undertaken by the Adult Care Services Strategic Management Team to review performance and agree, as appropriate, any remedial action in response to concerns.

2.3 Members' comments regarding the report are invited.

3.0 BACKGROUND

3.1 A complaint is generally defined as 'an expression of dissatisfaction or disquiet about the actions, decisions or apparent failings of a local authority's adult social services provision which requires a response.'

- 3.2 Complaints principally concern service issues, including the perceived standard of services and their delivery by service providers. Recorded figures however only represent a percentage of instances where people are dissatisfied as many complaints/concerns are managed and resolved at the time, avoiding the need for people to resort to the more formal statutory complaints process.
- 3.3 Within the regulations which govern the process, the Council adopts a flexible approach which prioritises local resolution of complaints although people still have the option to take their case to the Local Government Ombudsman should they remain dissatisfied.
- 3.4 It is not easy for some customers to make a complaint. The process is therefore designed to ensure that all complaints are treated seriously, in confidence, investigated and given due attention. Integral to this is the role of the Customer Services Manager (Complaints) who provides a degree of independence and support to the complainant whilst ensuring the complaint follows the statutory procedure. Customers may also make complaints through advocates (including Councillors and MPs) – providing any necessary and appropriate consent has been received which enables personal information to be shared.
- 3.5 The Complaints Procedure is not designed to deal with allegations of serious misconduct by staff. These situations are covered under separate disciplinary procedures of the Council.
- 3.6 In order to ensure any safeguarding issues which are contained within social care complaints are captured and processed through the Safeguarding Procedures, the Customer Services Manager (Complaints) and the Safeguarding Co-ordinator have an agreed protocol regarding joint working which is accessible on the Council's website.

4.0 ANALYSIS OF COMPLAINTS

- 4.1 The attached appendix 1 provides statistical data in graph format for the period 1 April 2013 to 31 March 2014 and includes:-
 - A comparative study of the number of complaints received for the period 2011/12, 2012/13 and 2013/14 (Fig. 1)
 - A comparative study of the nature of complaints received for the period 2012/13 and 2013/14 (Fig. 2)
 - A comparative study of the number of complaints received by Teams for the period 2012/13 and 2013/14 (Fig. 3)
 - A comparative study of the time taken to resolve complaints for the period 2012/13 and 2013/14 (Fig. 4)
 - A comparative study of the number of concerns raised by Local Councillors, Members of Parliament and the Local Government Ombudsman for the period 2012/13 and 2013/14 (Fig. 5)
 - The number of compliments received and the service area they relate to 2013/14 (Fig. 6)
 - The attached appendix 2 shows the number of complaints received relating to categories of Equality and Diversity

- The attached appendix 3 shows Evidence of Learning and improvements made to services as a result of complaints

4.2 The headline statistic is that the total number of complaints received during 2013/2014 (74) has reduced from the previous year (84). Although this may be considered a small reduction in terms of numbers, it is significant given the changes to services which have taken place within the Department over the last year together with decreased budgets and resources.

Together with the fact that this is the third successive year the number of complaints has shown a reduction is evidence the Department manages change better and that staff are effective in handling concerns raised at the first point of contact, to prevent escalation to a formal complaint.

4.3 In relation to the volume of complaints, the Assessment and Reintegration Team received the highest number 33% (25). This is followed by 20% (15) complaints relating to the Vulnerable Adults Team. The numbers of complaints against other teams are relatively small when considered over a twelve month period i.e. 7 or lower.

4.4 With respect to timescales, over 36% of complaints were responded to within 30 working days of the complaint being received.

4.5 The number of concerns raised by Members of Parliament and local Councillors has decreased by 29%, from 14 in 2012/13 to 10 last year.

4.6 The number of Local Government Ombudsman (LGO) enquiries the Department received and dealt with during 2013/14 was 3 – a decrease of 7 or 30% on the previous year. Following information provided by the Department to the LGO, the outcomes to these three cases were:

1. The LGO decided not to investigate further because the Council had not caused the customer an injustice and closed the case
2. The LGO decided that although the Council did not apply the *Halfway Home* criteria properly, they were satisfied with the actions taken by the Council and closed the case
3. The Parliamentary Health Service Ombudsman (PHSO) and the LGO jointly considered the complaint and came to a decision that the Council and Pennine Care NHS Foundation Trust were both at fault. The Trust should have communicated a decision to the Council so that a decision could be made on whether any follow up action was necessary. The PHSO and the LGO were both satisfied with the agreed action taken by both organisations to suitably remedy the complaint and closed the matter.

4.7 To put the total number of complaints in context, the Department provides services to approximately 5,069 individuals. 74 complaints therefore equates to 1.4% of customers.

- 4.8 The Department received 424 compliments about the work carried out by individuals/teams. These are also recorded and celebrated in recognition of the good work that is taking place.
- 4.9 Complaints (and compliments) can give valuable feedback and alert managers to issues with regard to service quality or delivery. The Department seeks to learn from such occurrences and recommendations made as a result of complaints made during 20013/14 have resulted in improvements or changes to services. These are listed in Appendix 3.

5.0 CONCLUSIONS

- 5.1 The number of complaints has reduced despite some major changes to services.
- 5.2 The process has been designed to reduce barriers for complainants.
- 5.3 The Department monitors feedback and uses these experiences to learn and improve operations. This approach will continue and steps will be taken to minimise dissatisfaction although this will be a challenge in an environment of rising demand and diminishing resources.

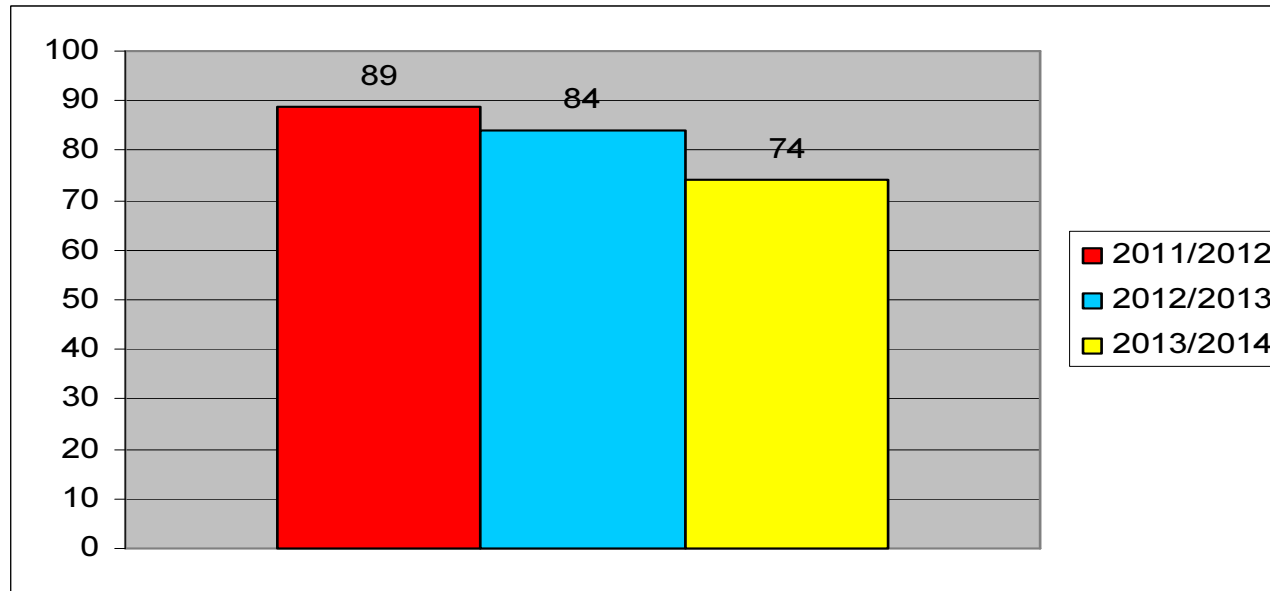
Appendices 1, 2 and 3 attached

Appendix 1

Adult Care Services Annual Complaint Report
1st April 2013 – 31st March 2014

Figure 1

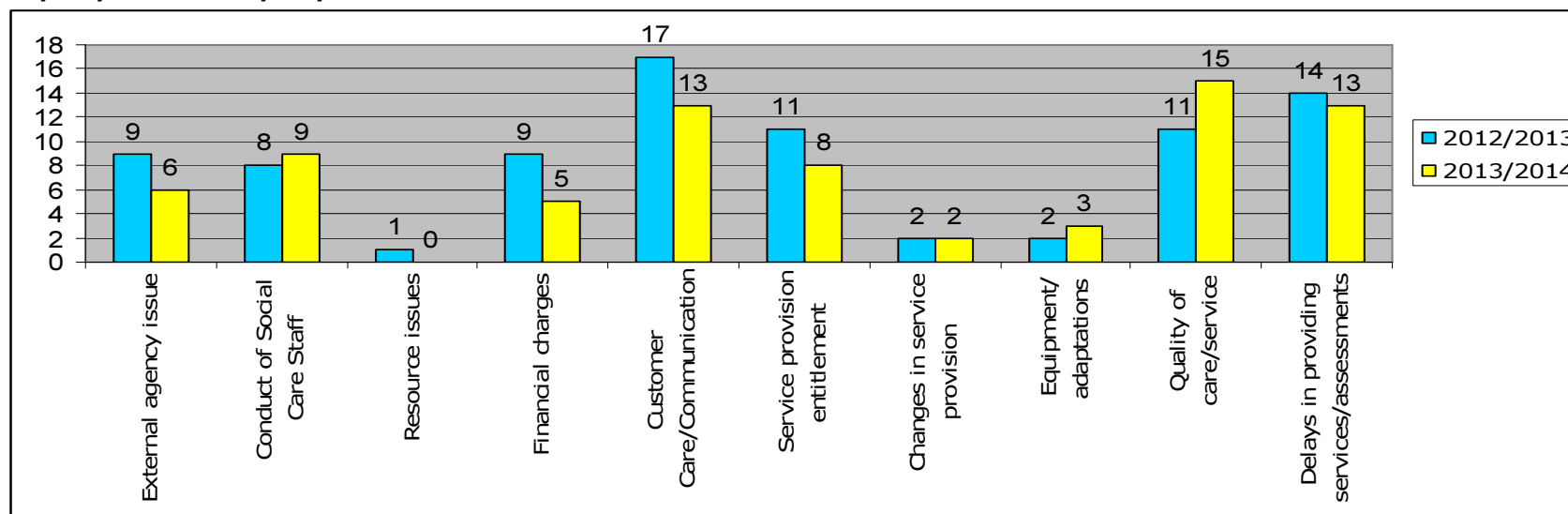
A comparative study of the number of complaints received for the period 01/04/2011 – 31/03/2012, 01/04/2012 - 31/03/2013 and 01/04/2013 - 31/03/2014.



- The total number of complaints in 2013/2014 has decreased by 12% when compared to the previous year and by 17% when compared to 2011/2012.
- The number of customers the Department provided a service to in 2013/14 was 5,069 and 74 complaints equates to 1.4%

Figure 2

A comparative study of the nature of complaints received for the period 01/04/2012 - 31/03/2013 and 01/04/2013 - 31/03/2014.



Key Findings

- 20% (15) of complaints received related to Quality of Care/Service
- 17% (13) of complaints received related to Delays in providing services/assessments
- 17% (13) of complaints received related to Customer Care/Communication

Increased Number of Complaints

- 27% (4) increase in complaints relating to Quality of Service

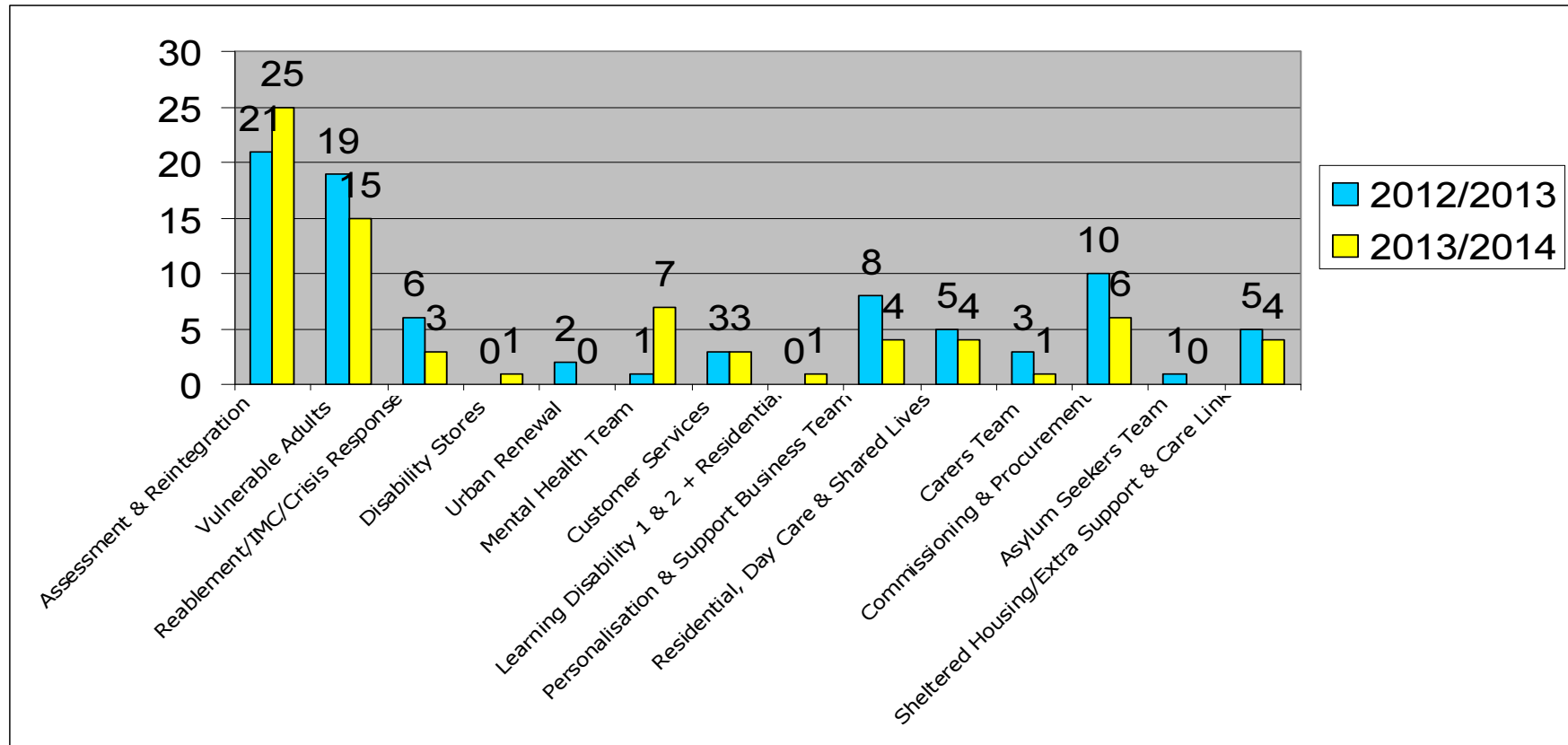
Decreased Number of Complaints

- 33% (3) decrease in complaints received relating to External agency Issues
- 45% (4) decrease in complaints received relating to Financial Charges
- 24% (4) decrease in complaints received relating to Customer Care/Communication
- 27% (3) decrease in complaints received relating to Service Provision Entitlement

- The number of complaints remained static for Changes in Service Provision (2)

Figure 3

Complaints received in respect of Adult Care Services by teams for the period 01/04/2012 – 31/03/2013 and 01/04/2013 – 31/03/2014.

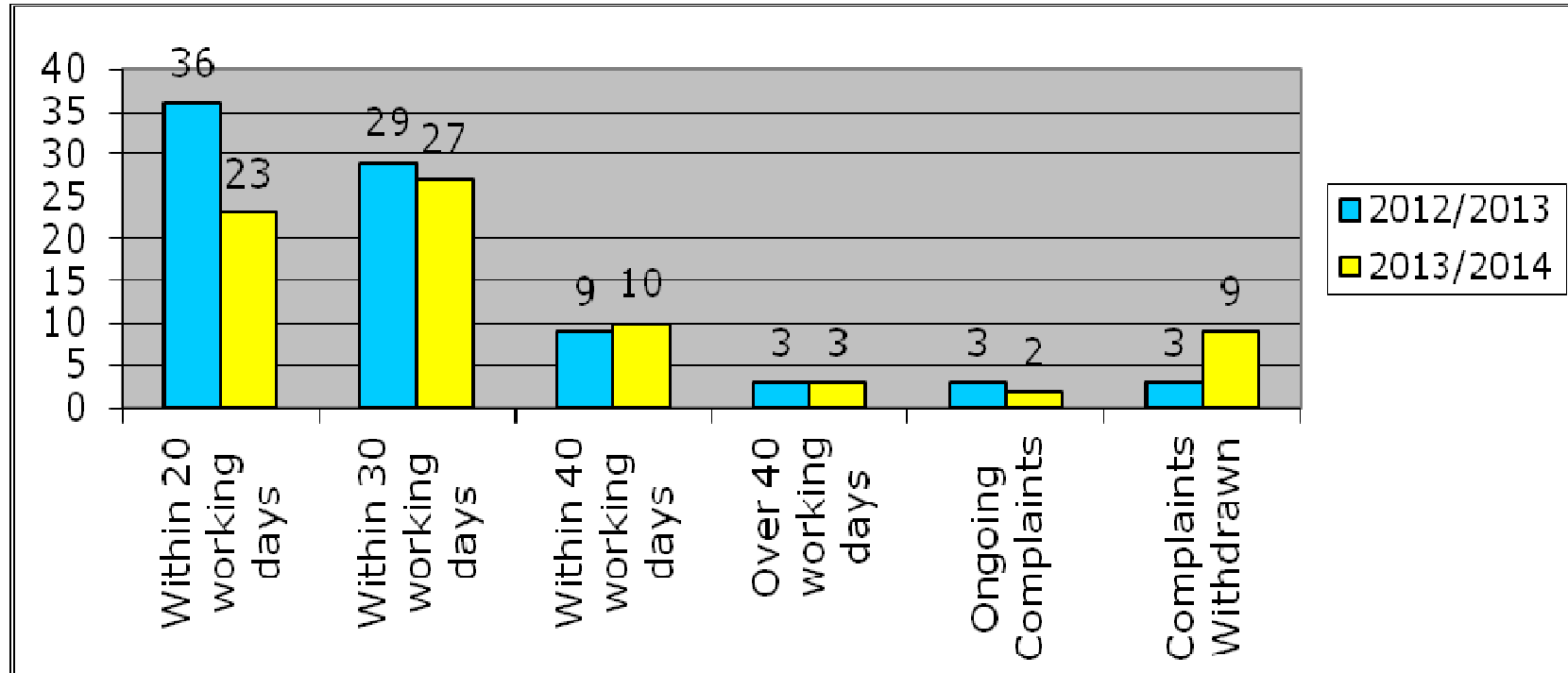


Key Findings

- 33% of complaints (25) related to the Assessment and Reintegration Team
- 20% of complaints (15) related to the Vulnerable Adults Team

Figure 4

Timescales for complaints for the period 01/04/2012 – 31/03/2013 and 01/04/2013 – 31/03/2014.

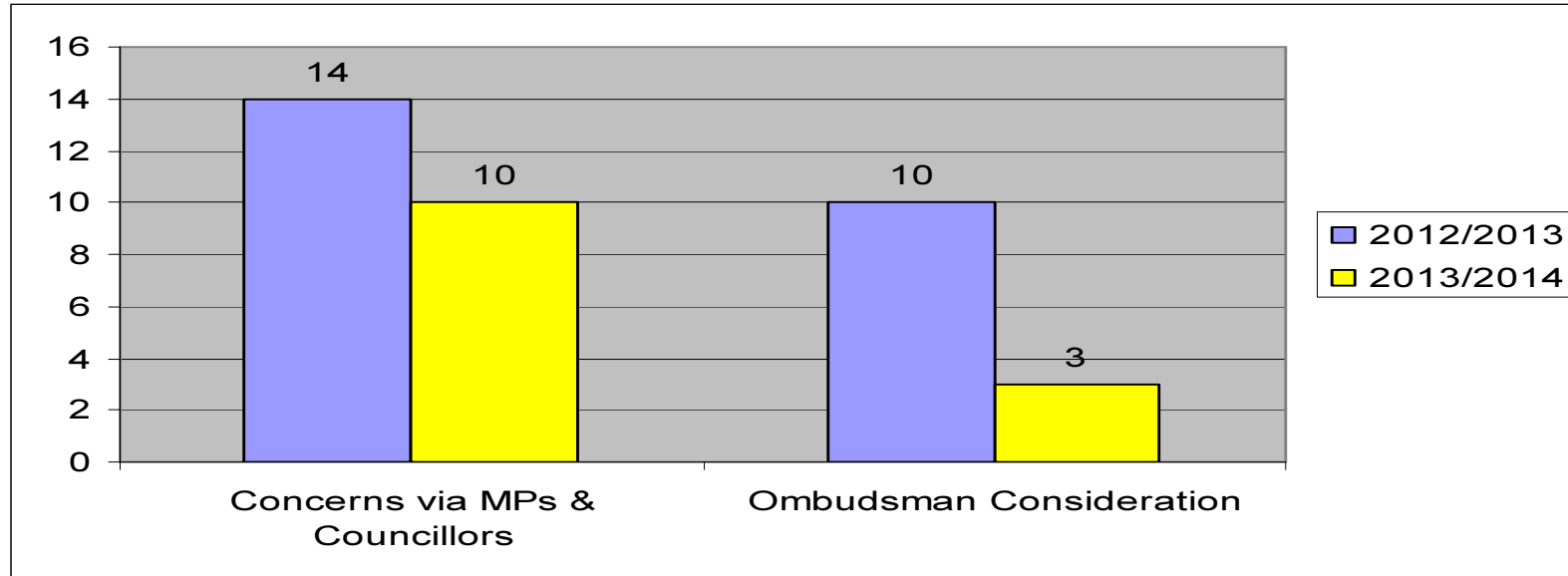


Key Findings

- Total number of complaints dealt with within 20 working days has decreased by 36% (13)
- Total number of complaints dealt with within 30 working days has decreased by 7% (2)
- Total number of complaints dealt with within 40 working days increased by 10% (1)
- Total number of complaints dealt with over 40 working days remained static at 3
- Total number of ongoing complaints has decreased by 33% (1)
- Total number of complaints withdrawn has increased by 66% (6)

Figure 5

Number of MP and Councillors concerns and Ombudsman considerations/enquiries for the period 01/04/2012 – 31/03/2013 and 01/04/2013 – 31/03/2014.

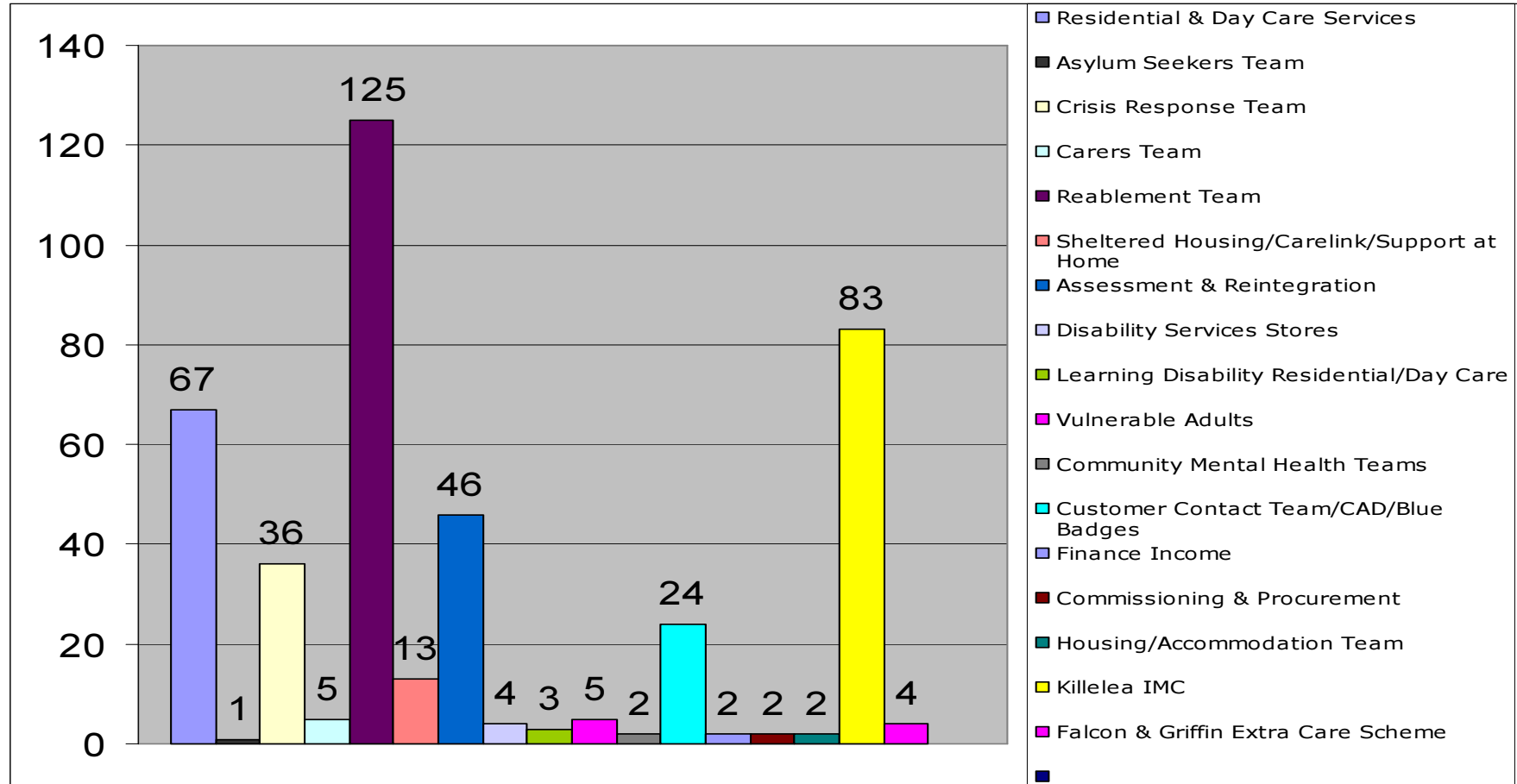


Key Findings

- Total number of concerns via MP's & Councillors has decreased by 29% (4)
- Total number of Ombudsman Consideration/Enquiries has decreased by 30% (7)

Figure 6

424 no. of compliments received and the service area they relate to for the period 01/04/2013 – 31/03/2014.



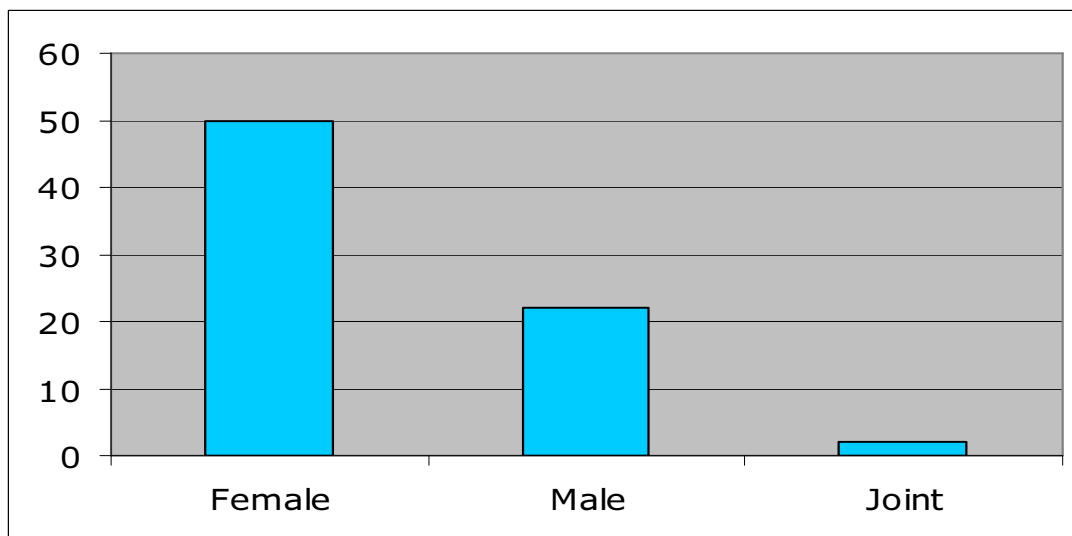
Key Findings

- 30% (125) of compliments received were in respect of the Reablement Team
- 350 more compliments than complaints were received over the year

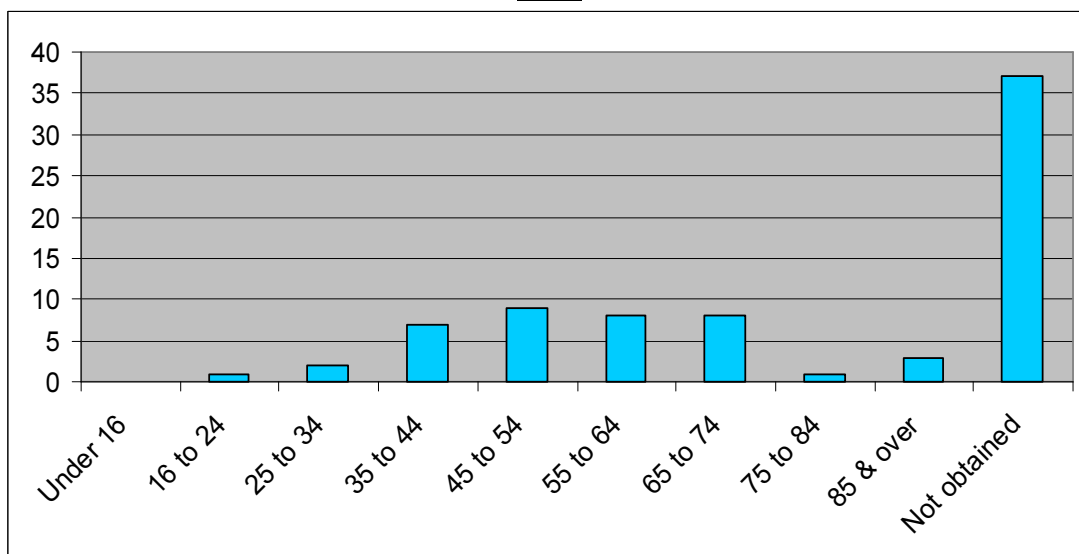
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E & D COMPLAINTS MONITORING
1st April 2013 – 31st March 2014

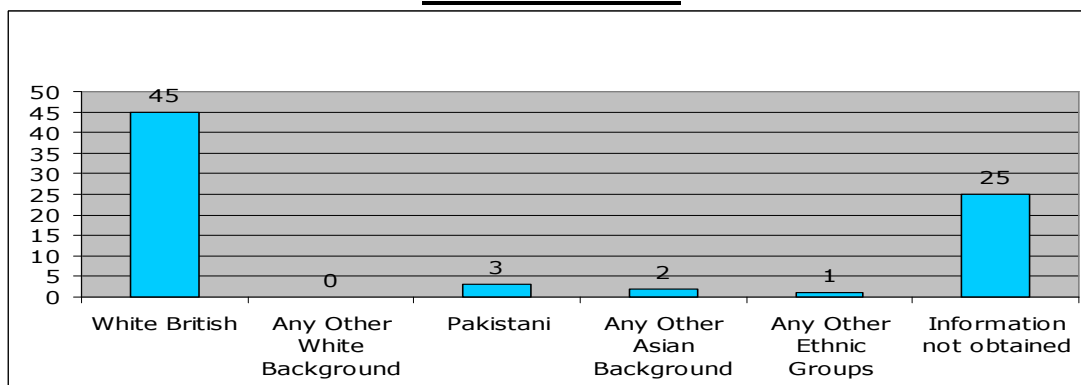
GENDER



AGE



ETHNIC ORIGIN



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Appendix 3

Evidence of Learning from Complaints 1 April 2013 to 31 March 2014

1. Additional audit checks of food and fluid charts have been introduced at Elmhurst Elderly Persons Home to ensure these charts are fully completed for customers whose fluid and food intake needs to be monitored. This is to prevent the risk of dehydration
2. To prevent undue delay in ordering and supply of hoist slings, the approved supplier has agreed to email quotations to the appropriate social care staff in future
3. Spot checks to be made by staff when returning customer's personal belonging upon discharge from Spurr House. This is to ensure that soiled underwear is packed separately and all personal belongings are packed
4. A number of Continuing Health Care (CHC) training sessions to both Health and Social Care staff in Bury are scheduled in order to increase knowledge and understanding of the CHC framework since it was revised in November 2012
5. Commissioning section to ensure that Creative Support provide customers with clear documentation on the duration of support offered and how the hours of support are determined according to level of assessed need. This is to ensure that customers are clear on how and when the support is planned to be withdrawn
6. Improvement to admission process including timeframe for admissions to be made more flexible where necessary
7. Additional training for Carelink staff has taken place to reinforce procedures for responding to calls
8. Introduction of Personal Hygiene Charts for daily completion at Killelea House

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Department
of Health

Local Authority Health Scrutiny

Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

Title: Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny
Author: SCLGCP/PCLG/18280
Document Purpose: Guidance
Publication date: June 2014 To be reviewed in June 2015
Target audience: <ul style="list-style-type: none">• Local Authorities• Local Government Association• Health and Wellbeing Boards• Clinical Commissioning Groups• NHS trusts (acute, community, mental health)• NHS England• Healthwatch
Contact details: Local Government Team Department of Health Room 330, Richmond House 79 Whitehall London SW1A 2NS

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Local Authority Health Scrutiny

Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

Prepared by the People, Communities and Local Government Division of the Department of Health.

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Key messages

- 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.
- 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.
- 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”¹) and in testing this information by drawing on different sources of intelligence.
- 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.
- 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.
- 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.
- 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.

¹ In this guidance, “health service commissioners and providers” is a reference to:

a) certain NHS bodies, (i.e. NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) and

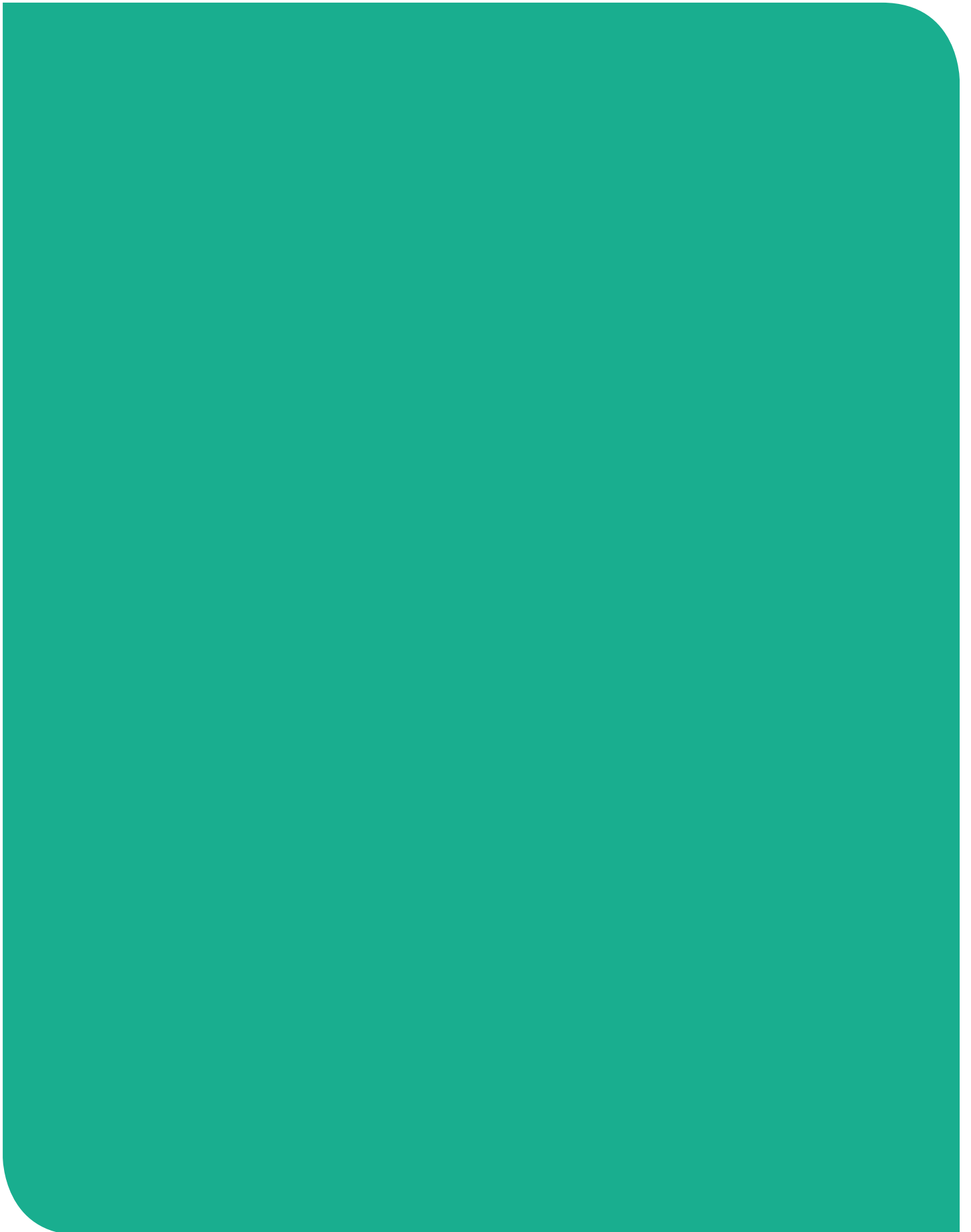
b) providers of NHS and public health services commissioned by NHS England, clinical commissioning groups and local authorities.

Each of these is “a responsible person”, as defined in the Regulations, on whom the Regulations impose certain duties for the purposes of supporting local authorities to discharge their health scrutiny functions.

- 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.
- 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)² and/or the Centre for Public Scrutiny³. 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.
- 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.
- 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.

² Independent Reconfiguration Panel website: www.irpanel.org.uk/view.asp?id=0

³ Centre for Public Scrutiny website: www.cfps.org.uk



1. Introduction

This guidance is intended to support local authorities, relevant NHS bodies and relevant health service providers in discharging their responsibilities under the relevant regulations; and thereby supporting effective scrutiny. The guidance needs to be conscientiously taken into account. However, the guidance is not intended to be a substitute for the legislation or to provide a definitive interpretation of the legislation. Only the courts can provide a definitive interpretation of legislation. Anyone in doubt should seek legal advice.

1.1 Background

1.1.1 The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services. For some time, local authority overview and scrutiny⁴ of health has been an important part of the Government's commitment to place patients at the centre of health services. It is even more important in the new system.

1.1.2 Health scrutiny is a fundamental way by which democratically elected local councillors are able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account. To this end, it is essential that health scrutiny functions are also carried out in a transparent manner, so that local people have the opportunity to see and hear proceedings, in line with the new transparency measure in the Local Audit and Accountability Act 2014. Local government itself is making an even greater contribution to health since taking on public health functions in April 2013 (and will itself be within the scope of health scrutiny). Social care and health services are becoming ever more closely integrated and impact on each other, with the result that scrutiny of one may entail, to a certain extent, scrutiny of the other. In many cases, health scrutiny reviews will be of services which are jointly commissioned by the NHS and local government.

1.1.3 Within the NHS, there has been increasing emphasis on the need to understand and respond to the views of patients and the public about health and health services: the NHS Constitution, the Government's Mandate to NHS England and the NHS Operating Framework together provide a strong set of principles underpinning the NHS's accountability to the people it serves. Responding positively to health scrutiny is one way for the NHS to be accountable to local communities.

1.1.4 This is an important and challenging time for local authority scrutiny of the health service in England. The wider context includes huge financial pressures on the public services and the challenges of an ageing society in which more people are living for longer with illness and long-term medical conditions and disability. The NHS and local government are operating in a completely new health landscape underpinned by new legislation; with care commissioned and, in many cases, potentially delivered, by more and varied organisations. New health scrutiny legislation permits greater flexibility in the way that local authorities discharge their health scrutiny functions. Local government is working ever more closely with the NHS through health and wellbeing boards, taking a holistic view of the health, public health and social care system.

⁴ Referred to as 'review and scrutiny' in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

- 1.1.5 At the same time, the whole health and care system and the public accountability mechanisms that surround it are grappling with the implications of the Francis inquiry into the shocking failure of care at Mid-Staffordshire NHS Trust. Among many other recommendations, the Francis report says that:
- The Care Quality Commission should expand its work with overview and scrutiny committees.
 - Overview and scrutiny committees and local Healthwatch should have access to complaints information.
 - The “quality accounts” submitted by providers of NHS services should contain observations of commissioners, overview and scrutiny committees and local Healthwatch.
- 1.1.6 Following the Francis report and recommendations, the role and importance of effective health scrutiny will become more prominent. The Francis inquiry increased expectations for local accountability of health services. It is expected that health scrutiny will develop working relationships and good communication with Care Quality Commission local representatives, NHS England’s local and regional Quality Surveillance Groups as well as with local Healthwatch. While there is no legislative stipulation as to the extent of support that should be made available for the health scrutiny function, the health and social care system as a whole will need to think about how the function is supported nationally, regionally and locally to enable the powers and duties associated with the function to be exercised appropriately.

1.2 Purpose of guidance

- 1.2.1 It is against this background that this guidance has been prepared. It is intended to provide an up-to-date explanation and guide to implementation of the regulations under the National Health Service Act 2006 governing the local authority health scrutiny function. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (“the Regulations”), which came into force on 1st April 2013⁵. They supersede the 2002 Regulations under the Health and Social care Act 2001⁶. The Regulations have implications for relevant NHS bodies and relevant health service providers, including local authorities carrying out the local authority health scrutiny function⁷, health and wellbeing boards and those involved in patient and public engagement activities. The duties in the Regulations are aimed at supporting local authorities to discharge their scrutiny functions effectively. Failure to comply with those duties would place the relevant NHS body or relevant health service provider in breach of its statutory duty and render it at risk of a legal challenge.
- 1.2.2 This guidance is, therefore, of relevance to:
- Local authorities (both those which have the health scrutiny functions and district councils).
 - Clinical commissioning groups (CCGs).
 - NHS England.

⁵ References to numbered Regulations throughout this guide are to the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013.

⁶ These had effect as if made under the National Health Service Act 2006.

⁷ The health scrutiny function is conferred on the 152 councils with social services responsibilities.

- Providers of health services including those from the public, private and voluntary sectors.
- Those involved in delivering the work of local Healthwatch.

The guidance should be read alongside other guidance issued by the Department of Health and NHS England, such as the guidance on the NHS duty to involve⁸, and guidance for NHS commissioners on the good practice principles and process for planning of major service change.

1.3 Scope of the Regulations

- 1.3.1 The Regulations explained in this guidance relate to matters relating to the health service, i.e. including 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 (this is discussed in more detail in section 3).
- 1.3.2 The NHS Constitution, the Mandate to NHS England, and the NHS Outcomes Framework provide a set of guiding principles and values for the NHS which indicate that the NHS is not just a sickness service, but is there to improve health, wellbeing and to address health inequalities: “to pay particular attention to groups or sections of society where improvement in health and life expectancy are not keeping pace with the rest of the population⁹”. The Mandate makes clear that one of NHS England’s priorities should be a focus on “preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health¹⁰”. Since the creation of the health scrutiny functions under the Health and Social Care Act 2001, local authority scrutiny committees have prioritised issues of health improvement, prevention and tackling health inequalities as areas where they can add value through their work. In their reviews, local authorities have looked at the wider social determinants of health and health inequalities, not least because of local government’s own contribution through the whole range of its services.
- 1.3.3 NHS services can themselves impact on health inequalities and general wellbeing of communities, for example, by improving access to services for the most deprived and least healthy communities. Moreover the Department of Health has always advised and local authorities have recognised that the best use of their health scrutiny powers will depend on scrutiny extending to health issues, the health system and health economy rather than being limited to services commissioned or managed by the NHS or local authorities.
- 1.3.4 The duties of health service commissioners and providers under the Regulations apply to NHS commissioners and to providers of health services as part of the health service, including NHS bodies and local authorities, as discussed below. However, local authority health scrutiny committees have often drawn on their wider powers to promote

⁸ <http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

⁹ NHS Constitution, *The NHS belongs to us all*, March 2013:

<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf>

¹⁰ The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015, p8: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf

community wellbeing to carry out overview and scrutiny of a range of health issues which go beyond NHS services. In the new health landscape, public health is a responsibility of local government and health and wellbeing boards provide strategic leadership of the health system through partnership, with a specific duty to encourage integrated working across health and social care. We can expect an increasing number of services to be jointly commissioned between local authorities and the NHS. Any health scrutiny exercise may therefore include reviewing the local authority's own contribution to the health of local people and the provision of health services, as well as the role of the health and wellbeing board, and of other agencies involved in the health care of local people.

- 1.3.5 Responses to matters that are scrutinised may therefore be the responsibility of a number of stakeholders. In this light, the power to scrutinise the health service should be seen and used in the wider context of the local authority role of community leadership and of other initiatives to promote and facilitate improvement and reduce inequalities. In the context of the NHS reforms, this includes:
- A greater emphasis on involving patients and the public from an early stage in proposals to improve services.
 - The work of health and wellbeing boards as strategic bodies bringing together representatives of the whole local health and care system.
 - The work of other relevant local partnerships, such as community safety partnerships and partnerships with the community and voluntary sectors.
- 1.3.6 The new legislation in the 2012 Act lays increased emphasis on the role of patients and the public in shaping services. This is recognised in the introduction of local Healthwatch organisations and their membership of health and wellbeing boards. The Regulations make provision about the referral of matters by local Healthwatch to local authority health scrutiny. This is discussed in section 3 below.
- 1.3.7 Section 2 below outlines those aspects of the health scrutiny system that remain the same for each of the key players: local authorities, the NHS and the patient and public involvement system. Section 3 discusses in detail what has changed following the new legislation for each of these key players and how the changes should be implemented. Section 4 discusses the important issue of consultation on substantial reconfiguration proposals (i.e. proposals for a substantial development of the health service or for a substantial variation in the provision of such service). Section 5 provides references and links to relevant additional documents.

2. What remains the same following the new legislation?

2.1 For local authorities

2.1.1 Under the Regulations, local authorities in England (i.e. “upper tier” and unitary authorities¹¹, the Common Council of the City of London and the Council of the Isles of Scilly) have the power to:

- 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.
- 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.
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:
 - The consultation has been inadequate in relation to the content or the amount of time allowed.
 - 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.
 - A proposal would not be in the interests of the health service in its area.

(In the case of referral, the Regulations lay down additional conditions and requirements as to the information that must be provided to the Secretary of State – these are listed in section 4.7 below.)

2.1.2 As previously, executive members may not be members of local authority overview and scrutiny committees, their sub-committees, joint health overview and scrutiny committees and sub-committees. Overview and scrutiny committees may include co-opted members i.e. those who are not members of the relevant local authority (for example, co-opted members of overview and scrutiny committees of district councils or representatives of voluntary sector organisations). Co-opted members may not be given voting rights except where permitted by the relevant local authority in accordance with a scheme made by the local authority¹².

¹¹ i.e. county councils, district councils other than lower-tier district councils and London Borough councils. However, in general, health scrutiny functions may be delegated to lower-tier district councils (except for referrals – see regulations 28 and 29) or their overview and scrutiny committees, or carried out by a joint committee of those councils and another local authority.

¹² Section 9FA of and Schedule A1 to the Local Government Act 2000, Regulations 5 and 11 of the Local Authorities (committee system) (England) Regulations 2012 and Regulation 30 of the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013.

2.1.3 The position of councils which have returned to a committee system of governance is discussed in section 3 below.

2.1.4 The position in relation to these matters remains following the new legislation, but the legislation is extended to cover additional and new organisations and diverse local authority arrangements, as described in section 3 below.

2.2 For the NHS

2.2.1 Regulations under the Health and Social Care Act 2001 created duties on the NHS which mirror the powers conferred on local authorities. These duties are carried forward into the new legislation, and require the NHS to:

- Provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny (section 3 lists all those now covered by this requirement).
- Attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny.
- Consult on any proposed substantial developments or variations in the provision of the health service¹³.
- Respond to health scrutiny reports and recommendations: NHS service commissioners and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request. This applies to requests from individual health scrutiny committees or sub-committees, from local authorities and from joint health scrutiny committees or sub-committees.

2.2.2 These duties remain in place, and (following the abolition of PCTs and Strategic Health Authorities) now apply to CCGs; NHS England; local authorities as providers of NHS or public health services; and providers of NHS and public health services commissioned by CCGs, NHS England and local authorities. Additional responsibilities are described in section 3 below.

2.3 For patient and public involvement

2.3.1 Legislation has created a number of far-reaching requirements on the NHS to consult service users and prospective users in planning services, in the development and consideration of proposals for changes in the way services are provided and in decisions affecting the operation of those services.

2.3.2 For NHS trusts, the duty as to involvement and consultation is set out in section 242 of the 2006 Act (as amended by the Health and Social Care Act 2012). The public involvement duties of NHS England and of CCGs are set out in sections 13Q and 14Z2 respectively of the 2006 Act. These are separate duties from those set out in the Regulations discussed here. Together they add up to a web of local accountability for health services.

2.1.1 The Health and Social Care Act 2012 introduced local Healthwatch to represent the voice of patients, service users and the public; and health and wellbeing boards to promote partnerships across the health and social care sector. The Regulations set up formal relationships between local Healthwatch and local authority health scrutiny, to ensure

¹³ Subject to exceptions as set out in the 2013 Regulations.

that the new system reflects the outcomes of involvement and engagement with patients and the public, as described in section 3 below.

3. Changes arising from the new legislation

3.1 Powers and duties – changes for local authorities

Councils as commissioners and providers of health services

- 3.1.1 As commissioners or providers of public health services and as providers of health services to the NHS, services commissioned or provided by local authorities are themselves within the scope of the health scrutiny legislation.
- 3.1.2 To that end local authorities may be bodies which are scrutinised, as well as bodies which carry out health scrutiny.
- 3.1.3 The duties which apply to scrutinised bodies such as the duty to provide information, to attend before health scrutiny and to consult on substantial reconfiguration proposals will apply to local authorities insofar as they may be “relevant health service providers”¹⁴.
- 3.1.4 Being both scrutineer and scrutinee is not a new situation for councils. It will still be important, particularly in making arrangements for scrutiny of the council’s own health role, to bear in mind possible conflicts of interest and to take steps to deal with them.

Councils as scrutineers of health services

- 3.1.5 The Local Government Act 2000 (as amended by the Localism Act 2011) makes provision for authorities:
- To retain executive governance arrangements (i.e. comprising a Leader and cabinet or a Mayor and cabinet).
 - To adopt a committee system of governance.
 - To adopt any other form of governance prescribed by the Secretary of State.
- 3.1.6 Health scrutiny arrangements will differ in some respects depending on the system that the council chooses to operate. Most importantly:
- Councils operating executive governance arrangements are required to have at least one overview and scrutiny committee. In this case, the scrutiny is independent of the executive.
 - If a council adopts a committee system, they can operate overview and scrutiny committees if they choose, but are not required to do so.
- 3.1.7 At present, most local authorities are retaining executive governance arrangements. For those councils moving to a committee system, a further discussion of the differences and implications for health scrutiny is included on page 16 below.
- 3.1.8 Generally health scrutiny functions are in the form of powers. However, there are certain requirements under the Regulations as follows. Local authorities on whom health scrutiny functions have been conferred should:
- Have a mechanism in place to deal with referrals made by Local Healthwatch organisations or contractors¹⁵.

¹⁴ See section 244 of the NHS Act and Regulation 20 of the 2013 Regulations for the meaning of “relevant health service provider”.

¹⁵ See Regulation 21 of the 2013 Regulations.

- Have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals. Such responses could be made through the full council, an overview and scrutiny committee with delegated powers from the full council, a joint overview and scrutiny committee or a committee appointed under s101 of the Local Government Act.
- Councils also need to consider in advance how the members of a joint health scrutiny committee would be appointed from their council where the council was required to participate in a joint health scrutiny committee with other councils to respond to substantial reconfiguration proposals covering more than one council area.

Conferral of health scrutiny function on full council

3.1.9 The National Health Service Act 2006, as amended by the Health and Social Care Act 2012, confers health scrutiny functions on the local authority, as distinct from any overview and scrutiny committee or panel within the local authority section 244 (2ZD). This new provision is designed to give local authorities greater flexibility and freedom over the way they discharge health scrutiny functions. The full council of each local authority will determine which arrangement is adopted. For example:

- It may choose to continue to operate its existing health overview and scrutiny committee, delegating its health scrutiny functions to the committee.
- It may choose other arrangements such as appointing a committee involving members of the public and delegating its health scrutiny functions (except the function of making referrals) to that committee.
- It may operate its health scrutiny functions through a joint scrutiny committee with one or more other councils.

3.1.10 As indicated above local authorities may delegate their health scrutiny functions under section 101 of the Local Government Act 1972 but are not permitted to delegate the functions to an officer (Regulation 29).

3.1.11 Executive members of councils operating executive governance arrangements (that is a Leader and cabinet or a Mayor and cabinet) may not be members of local authority overview and scrutiny committees or of their sub-committees or of joint health overview and scrutiny committees and sub-committees.

3.1.12 Overview and scrutiny committees are a proven model offering a number of benefits that other structures may not, including having a clear identity within the local authority, political balance and, in many cases, an established reputation within the local community for independence and accessibility.

Delegation of health scrutiny function by full council

3.1.13 The legislation enables health scrutiny functions to be delegated to:

- An overview and scrutiny committee of a local authority or of another local authority (Regulation 28).
- A sub-committee of an overview or scrutiny committee (Local Government Act 2000).
- A joint overview and scrutiny committee (JOSC) appointed by two or more local authorities or a sub-committee of such a joint committee.
- A committee or sub-committee of the authority appointed under section 102 of the Local Government Act 1972 (section 101 of the Local Government Act 1972) (except for referrals).
- Another local authority (section 101 of Local Government Act 1972) (except for referrals).

3.1.14 Local authorities may not delegate the health scrutiny functions to an officer – this option under the Local Government Act 1972 is disapplied (disallowed) by Regulation 29.

3.1.15 If a council decides to delegate to a health scrutiny committee, it need not delegate *all* of its health scrutiny functions to that committee (i.e. it could retain some functions itself). For example, it might choose to retain the power to refer issues to the Secretary of State for Health as discussed below. Equally, it might choose to delegate that power to the scrutiny committee.

Joint health scrutiny arrangements

3.1.16 As before, local authorities may appoint a discretionary joint health scrutiny committee (Regulation 30) to carry out all or specified health scrutiny functions, for example health scrutiny in relation to health issues that cross local authority boundaries. Establishing a joint committee of this kind does not prevent the appointing local authorities from separately scrutinising health issues. However, there are likely to be occasions on which a discretionary joint committee is the best way of considering how the needs of a local population, which happens to cross council boundaries, are being met.

3.1.17 Regulation 30 also requires local authorities to appoint joint committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals (referred to below as a mandatory joint health scrutiny committee). In such circumstances, Regulation 30 sets out the following requirements (see section 4 on consultation below for more detail).

- Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation.

3.1.18 These restrictions do not apply to referrals to the Secretary of State. Local authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so. If a local authority had already appointed a discretionary committee, they could even delegate the power to that committee if they choose to.

3.1.19 If the local authority has delegated this power, then they may not subsequently exercise the power of referral. If they do not delegate the power, they may make such referrals.

3.1.20 A situation might arise where one of the participating local authorities had delegated their power of referral to the joint committee but not the other(s). In such a case a referral could be made by: the JOSC or any of the authorities which had not delegated their power of referral to the JOSC, but not the authorities which had delegated their power of referral to the JOSC.

Reporting and making recommendations

3.1.21 Regulation 22 enables local authorities and committees (including joint committees, sub-committees and other local authorities to which health scrutiny functions have been delegated) to make reports and recommendations to relevant NHS bodies and health

service providers. The following information must be included in a report or recommendation:

- An explanation of the matter reviewed or scrutinised.
- A summary of the evidence considered.
- A list of the participants involved in the review or scrutiny.
- An explanation of any recommendations on the matter reviewed or scrutinised.

3.1.22 A council can choose to delegate to an overview and scrutiny committee (including joint committee, sub-committee or another local authority) the function of making scrutiny reports and recommendations to relevant NHS bodies and health service commissioners. Alternatively, a council can choose to delegate only the function of *preparing* such reports and recommendations, and retain for itself the function of actually *making* that report or recommendation. The latter approach would give the full council the opportunity to endorse the report or recommendation before it was sent to the NHS.

3.1.23 Where a local authority requests a response from the relevant NHS body or health service provider to which it has made a report or recommendation, there is a statutory requirement (Regulation 22) for the body or provider to provide a response in writing within 28 days of the request.

Conflicts of interest

3.1.24 Councils should take steps to avoid any conflict of interest arising from councillors' involvement in the bodies or decisions that they are scrutinising. A conflict might arise where, for example, a councillor who was a full voting member of a health and wellbeing board was also a member of the same council's health scrutiny committee or of a joint health scrutiny committee that might be scrutinising matters pertaining to the work of the health and wellbeing board.

3.1.25 Conflicts of interest may also arise if councillors carrying out health scrutiny are, for example:

- An employee of an NHS body.
- A member or non-executive director of an NHS body.
- An executive member of another local authority.
- An employee or board member of an organisation commissioned by an NHS body or local authority to provide services.

3.1.26 These councillors are not excluded from membership of overview and scrutiny committees, and, clearly, where the full council has retained the health scrutiny function, they will be involved in health scrutiny. However they will need to follow the rules and requirements governing the existence of interests in matters considered at meetings. Where such a risk is identified, they should consult their monitoring officer for advice on their involvement.

Councils operating a committee system

3.1.27 Councils which have returned to a committee system under the Local Government Act 2000 may or may not have retained a council-wide overview and scrutiny function. If they have retained such function, they will be able to delegate their health scrutiny functions to overview and scrutiny committees in the same way as those councils operating executive arrangements that have executive and scrutiny functions.

- 3.1.28 Councils with a committee system that have not retained a council-wide scrutiny function will need to decide what to do about their health scrutiny functions. The health scrutiny function is conferred on the full council but delegation to a committee, joint committee, sub-committee or another local authority is permitted (except in the case of referrals in relation to which delegation under section 101 of the Local Government Act 1972 is not permitted). Therefore such a council might retain health scrutiny functions or delegate these to a committee, joint committee or sub-committee (or indeed to another council or its overview and scrutiny committee).
- 3.1.29 In deciding how to operate a health scrutiny function, councils operating a committee system will need to consider issues of potential conflicts of interest. Like upper tier and unitary councils, they will need to have a health and wellbeing board whose work will be within the scope of health scrutiny insofar as it relates to the planning, provision and operation of the health service. They may also have a health and social care committee or a stand-alone health committee which makes decisions about the commissioning of public health services. A conflict might arise where, for example, under a committee system, the members of any committee of the council which is taking commissioning decisions on public health services, are also members of its health scrutiny committee or where a health and social care committee of a council operating a committee system is also acting as a health overview and scrutiny committee. The solution might be to have a separate health overview and scrutiny committee, with different members.
- 3.1.30 Regardless of the governance arrangements being operated by a council, the health scrutiny function may not be delegated to an officer (Regulation 29).

The role of district councils

- 3.1.31 As previously, under the new Regulations (Regulation 31), district councillors in two tier areas, who are members of district overview and scrutiny committees, may be co-opted by the upper tier county council onto health overview and scrutiny committees of those councils or other local authorities. Such co-option may be on a long term (i.e. for the life of the overview and scrutiny committee or until the county council decides) or ad hoc basis (i.e. for review and scrutiny of a particular matter) (Regulation 31).
- 3.1.32 District councillors in two tier areas may also (Regulation 30 read with the Local Government Act 2000) be co-opted onto joint health scrutiny committees between the upper tier county councils and other local authorities.
- 3.1.33 District councillors in two tier areas may also be on joint health scrutiny committees of the relevant district council and the upper tier county council (Regulation 30).
- 3.1.34 Many county councils have taken the opportunity to co-opt district councillors onto their scrutiny committees, as district councillors bring very local knowledge of their communities' needs and may also provide a useful link to enhance the health impact of district council services. Health and wellbeing strategies in two-tier areas are likely to include reference to the role of district councils in improving health and reducing inequalities, for example through their housing and leisure functions. As health and wellbeing boards' functions including their strategies (insofar as related to the planning, provision and operation of the health service) will be within the scope of health scrutiny, this provides an additional reason for considering the co-option of district councillors.

3.2 Powers and duties – changes for the NHS

Extension of scope of health scrutiny

3.2.1 A significant change for the NHS in the new health landscape is the extension of certain duties in the Regulations to cover providers of health services (commissioned by NHS England, CCGs or local authorities) who are not themselves NHS bodies. Together with relevant NHS bodies these are known as ‘responsible persons’ in the legislation and these include:

- CCGs
- NHS England
- Local authorities (insofar as they may be providing health services to CCGs, NHS England or other local authorities).
- NHS trusts and NHS foundation trusts.
- GP practices and other providers of primary care services (previously not subject to specific duties under health scrutiny regulations as independent contractors, they are now subject to duties under the new Regulations as they are providers of NHS services).
- Other providers of primary care services to the NHS, such as pharmacists, opticians and dentists.
- Private and voluntary sector bodies commissioned to provide NHS or public health services by NHS England, CCGs or local authorities.

3.2.2 Under the Regulations, ‘responsible persons’ are required to comply with a number of duties to assist the health scrutiny function. These duties are underpinned by the duty of co-operation which applies between the NHS and local authorities under section 82 of the NHS Act 2006 which requires them, in exercising their respective functions, to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

Required provision of information to health scrutiny

3.2.3 Regulation 26 imposes duties on ‘responsible persons’ to provide a local authority with such information about the planning, provision and operation of health services in the area of the authority as it may reasonably require to discharge its health scrutiny functions. All relevant NHS bodies and health service providers (including GP practices and other primary care providers and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority) have a duty to provide such information.

3.2.4 In addition, the duty of candour under the NHS Standard Contract is also relevant in relation to the provision of information to patients generally.

3.2.5 The type of information requested and provided will depend on the subject under scrutiny. It may include:

- Financial information about the operation of a trust or CCG, for example budget allocations for the care of certain groups of patients or certain conditions, or capital allocations for infrastructure projects, such as community facilities.
- Management information such as commissioning plans for a particular type of service.
- Operational information such as information about performance against targets or quality standards, waiting times.

- Patient information such as patient flows, patient satisfaction surveys, numbers and types of complaints and action taken to address them.
 - Any other information relating to the topic of a health scrutiny review which can reasonably be requested.
- 3.2.6 Confidential information that relates to or identifies a particular living individual or individuals cannot be provided unless the individual or individuals concerned agree to its disclosure. However, the information can be disclosed in a form from which identification is not possible. In such a situation, health scrutiny bodies (i.e. councils or council health overview and scrutiny committees or sub-committees carrying out delegated health scrutiny functions) can require that the information be put in a form from which the individual cannot be identified in order that it may be disclosed.
- 3.2.7 In some cases, information, such as financial information, may be commercially sensitive. In such cases, it may be possible for health scrutiny to receive this information in confidence to inform, but not be directly referred to in, its reports and recommendations.

Required attendance before health scrutiny

- 3.2.8 Members and employees of a relevant NHS body or relevant health service provider have a duty to attend before a local authority when required by it (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions. This duty now applies to all those listed at the beginning of this section. So, for example, if a local authority were to require the attendance of a member of a CCG, or of a private company commissioned to provide particular NHS services, it could do so under the Regulations. Bodies, the employees or members of which are required to attend by local authority health scrutiny, are expected to take the appropriate steps to ensure the relevant member or employee complies with this requirement¹⁶.
- 3.2.9 As regards the attendance of particular individuals, identification of the appropriate member or employee to attend will depend on the type of scrutiny review being undertaken and its aims. By way of example, where the local authority has required attendance of a particular individual, say the accountable officer of a clinical commissioning group, and it is not practicable for that individual to attend or if that individual is not the most suitable person to attend, the CCG would be expected to suggest another, relevant individual. Thus, in such situations, both the local authority and the commissioner or provider (as the case may be) would be expected to co-operate with each other to agree on a suitable person for attendance and, in doing so, to act reasonably at all times.

Responding to scrutiny reports and recommendations

- 3.2.10 Depending on the topic being reviewed, reports and recommendations by local authority health scrutiny bodies may be made to any of the relevant NHS bodies or health service providers covered by the legislation (and, in the case of health scrutiny by a body to which the function has been delegated, to the delegating authority e.g. the relevant local authority or in the case of a sub-committee appointed by a committee, that committee or its local authority).

¹⁶ The meaning of 'member' is given in section 244 of the NHS Act 2006 and includes people who are members of committees or sub-committees of CCGs who are not members of the CCG, directors of NHS trusts and directors and governors of NHS foundation trusts. They also include directors of bodies which provide health services commissioned by NHS England, CCGs and local authorities.

- 3.2.11 Relevant NHS bodies and health service providers to which a health scrutiny report or and recommendation has been made must by law, if a response is requested, respond within 28 days of the request. Reports and recommendations are expected to be based on evidence. Respondents should take the evidence presented seriously, giving a considered and meaningful response about how they intend to take forward reports or recommendations. Meaningful engagement is likely to lead to improvements in quality and access to services.
- 3.2.12 Many local authorities, as part of their work plan, return to completed scrutiny reviews after a certain period – usually 6 months or a year – to find out whether and how their recommendations have been implemented and how they have influenced improvements. Relevant NHS bodies and health service providers to whom scrutiny reports have been presented should be prepared for this kind of follow-up and be able to report on progress and improvements resulting from scrutiny reviews.

3.3 Powers and duties – referral by local Healthwatch

- 3.3.1 Local Healthwatch organisations and contractors have specific roles which complement those of health scrutiny bodies. For example, they can “enter and view” certain premises at which health and social care services are provided. This can enable local Healthwatch to act as the “eyes and ears” of patients and the public; to be a means for health scrutiny to supplement and triangulate information provided by service providers; and to gain an additional impression of quality of services, safety and issues of concern around specific services and provider institutions. Health scrutiny bodies and local Healthwatch are likely each to benefit from regular contact and exchange of information about their work programmes. It may also be helpful in planning work programmes, to try to ensure that certain aspects are aligned. For example, if a health scrutiny body is planning a review of a certain service, it might be useful if local Healthwatch plans to visit the service in a timely way to inform the review.
- 3.3.2 Local Healthwatch organisations and their contractors carry out certain statutory activities including that of making reports and recommendations concerning service improvements to scrutiny bodies. This would cover the provision of information and the referral of matters relating to the planning, provision and operation of health services in their area (which could potentially include concerns about local health services or commissioners and providers) to local authority health scrutiny bodies.
- 3.3.3 Regulation 21 sets out duties that apply where a matter is referred to a local authority by a local Healthwatch organisations or contractors. The local authority must:
- Acknowledge receipt of referrals within 20 working days.
 - Keep local Healthwatch organisations (or contractors as the case may be) informed of any action it takes in relation to the matter referred.

4. Consultation

4.1 The context of consultation

- 4.1.1 The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public. Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS's public involvement and consultation duties as these are separate. The NHS should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed.
- 4.1.2 The backdrop to consultation on substantial reconfiguration proposals is itself changing. The ideal situation is that proposals for change emerge from involving service users and the wider public in dialogue about needs and priorities and how services can be improved. Much of this dialogue may take place through representation of service users and the public on health and wellbeing boards and through the boards' own public engagement strategies. With increasing integration of health and care services, many proposals for change may be joint NHS-local authority proposals which may have been discussed at an early stage through the health and wellbeing board. Health scrutiny bodies should be party to such discussions – local circumstances will determine the best way for this to happen. If informally involved and consulted at an early enough stage, health scrutiny bodies in collaboration with local Healthwatch, may be able to advise on how patients and the public can be effectively engaged and listened to. If this has happened, health scrutiny bodies are less likely to raise objections when consulted.
- 4.1.3 NHS England has published good practice guidance for NHS commissioners on the planning and development of proposals for major service changes and reconfigurations. The guidance is designed to support commissioners, working with local authorities and providers, to carry out effective service reconfiguration in a way that puts quality of care first, is clinically evidence-based and which involves patients and the public throughout. It is intended to be used as a reference guide to help develop and implement plans in a clear and consistent way. The guidance is available at:
<http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf>

4.2 When to consult

- 4.2.1 Regulation 23 requires relevant NHS bodies and health service providers to consult a local authority about any proposal which they have “under consideration” for a substantial development of or variation in the provision of health services in the local authority's area. The term “under consideration” is not defined and will depend on the facts, but a development or variation is unlikely to be held to be “under consideration” until a proposal has been developed. The consultation duty applies to any “responsible person” under the legislation, i.e. relevant NHS bodies and health service commissioners which now come under the scope of health scrutiny as described above.
- 4.2.2 As previously, “substantial development” and “substantial variation” are not defined in the legislation. Many local authority scrutiny bodies and their NHS counterparts have developed joint protocols or memoranda of understanding about how the parties will

reach a view as to whether or not a proposal constitutes a “substantial development” or “substantial variation”. Although there is no requirement to develop such protocols it may be helpful for both parties to do so. The local authority may find a systematic checklist, of the kind often contained in such protocols, useful in reaching a view about whether a proposed development or variation is substantial and, for example, NHS commissioners may find it helpful in explaining to providers what is likely to be regarded as substantial.

4.3 Who consults

4.3.1 In the case of substantial developments or variation to services which are the commissioning responsibility of CCGs or NHS England, consultation is to be done by NHS commissioners rather than providers i.e. by the relevant CCG(s) or NHS England. When these providers have a development or variation “under consideration” they will need to inform commissioners at a very early stage so that commissioners can comply with the requirement to consult as soon as proposals are under consideration.

4.4 Timescales for consultation

4.4.1 The Regulations now require timescales to be provided to health scrutiny bodies and to be published by the proposer of substantial developments or variations, (Regulation 23). When consulting health scrutiny bodies on substantial developments or variations, a relevant NHS body or health service provider is required by the Regulations to notify the health scrutiny body of the date by which it requires the health scrutiny body to provide comments in response to the consultation and the date by which it intends to make a decision as to whether to proceed with the proposal¹⁷. These dates must also be published. This is so that local patients and communities are aware of the timescales that are being followed. Any changes to these dates must be notified to the relevant health scrutiny body and published. Constructive dialogue between relevant NHS bodies and health service providers on the one hand, and health scrutiny bodies on the other, when communicating on timescales for comments or decisions in relation to substantial developments or variations should help ensure that timescales are realistic and achievable.

4.4.2 It is sensible for health scrutiny to be able to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion.

4.5 When consultation is not required

4.5.1 The Regulations set out certain proposals on which consultation with health scrutiny is *not* required. These are:

- Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might for example cover the situation where a ward needs to close immediately because of a viral outbreak) – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this.

¹⁷ Government guidance on consultation principles was published in July 2012 (see references).

- Where there is a proposal to establish or dissolve or vary the constitution of a CCG or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.
- Where proposals are part of a trusts special administrator's report or draft report (i.e. when a trust has financial difficulties and is being run by an administration put in place by the Secretary of State) – these are required to be the subject of a separate 30-day community-wide consultation.

4.6 Responses to consultation

- 4.6.1 Where a health scrutiny body has been consulted by a relevant NHS body or health service provider on substantial developments or variations, the health scrutiny body has the power to make comments on the proposals by the date (or changed date) notified by the body or provider undertaking the consultation. Having considered the proposals and local evidence, health scrutiny bodies should normally respond in writing to the body undertaking the consultation and when commenting would need to keep within the timescale specified by them.
- 4.6.2 Where a health scrutiny's body's comments include a recommendation and the consulting organisation disagrees with that recommendation, that organisation must notify the health scrutiny body of the disagreement. Both the consulting organisation and the health scrutiny body must take such steps as are reasonably practicable to try to reach agreement. Where NHS England or a clinical commissioning group is acting on behalf of a provider, in accordance with the Regulations, as mentioned above, the health scrutiny body and NHS England or the CCG (as the case may be) must involve the provider in the steps they are taking to try to reach agreement.
- 4.6.3 Where a health scrutiny body has not commented on the proposal or has commented but without making a recommendation, it must notify the consulting organisation as to its decision as to whether to refer the matter to the Secretary of State and if so, the date by which it proposes to make the referral or the date by which it will make a decision on whether to refer the matter to the Secretary of State.

4.7 Referrals to the Secretary of State

- 4.7.1 Local authorities may refer proposals for substantial developments or variations to the Secretary of State in certain circumstances outlined below. The circumstances remain largely the same as in previous legislation.
- 4.7.2 The new Regulations set out certain information and evidence that are to be provided to the Secretary of State and the steps that must be taken before a referral can be made. On receiving a referral from a local authority, overview and scrutiny committee, joint committee or sub-committee, the Secretary of State may ask for advice from the Independent Reconfiguration Panel (IRP), an advisory non-departmental public body. The new Regulations do not affect the position of the IRP. The IRP will undertake an initial assessment of any referral to the Secretary of State for Health where its advice is requested. It may then be asked to carry out a full review. Not all referrals to the Secretary of State for Health will automatically be reviewed in full by the IRP – this is at the Secretary of State's discretion. The IRP has published a summary of its views on what can be learned from the referrals it has received and the reviews it has undertaken from the perspective both of the NHS and of health scrutiny. The IRP also offers pre-

consultation advice and support to NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change - including advice and support on methods for public engagement and formal public consultation.

Relevant NHS bodies, health service providers and local authority scrutiny may also find it helpful to read its report on the *Safe and Sustainable* review of children's heart surgery, the first national reconfiguration proposal referred to the IRP, whose recommendations were accepted by the Secretary of State (see references).

4.7.3 The powers under the previous Regulations to refer matters relating to NHS foundation trusts to Monitor have been removed, as this was not considered appropriate to the role of Monitor and the new licensing regime.

Circumstances for referral

4.7.4 The circumstances for referral of a proposed substantial development or variation remain the same as in previous legislation. That is, where a health scrutiny body has been consulted by a relevant NHS body or health service provider on a proposed substantial development or variation, it may report to the Secretary of State in writing if:

- It is not satisfied with the adequacy of content of the consultation.
- It is not satisfied that sufficient time has been allowed for consultation.¹⁸
- It considers that the proposal would not be in the interests of the health service in its area.
- It has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

4.7.5 However, there are certain limits on the circumstances in which a health scrutiny bodies may refer a proposal to the Secretary of State.

In particular, where a health scrutiny body has made a recommendation and the relevant NHS body or health service provider has disagreed with the recommendation, the health scrutiny body may not refer a proposal unless:

- it is satisfied that reasonably practicable steps have been taken to try to reach agreement (with steps taken to involve the provider where NHS England or a CCG is acting on the provider's behalf) but agreement has not been reached within a reasonable time; or
- it is satisfied that the relevant NHS body or health service provider has failed to take reasonably practicable steps to try to reach agreement within a reasonable period.

In a case where a health scrutiny body has not commented on the proposal or has commented without making a recommendation, the health scrutiny body may not refer a proposal unless:

- It has informed the relevant NHS body or health service provider of-
 - its decision as to whether to exercise its power of referral and, if applicable, the date by which it proposed to exercise that power, or
 - the date by which it proposes to make a decision as to whether to exercise its power of referral.
- In a situation where it informed the relevant NHS body or health service provider of the date by which it proposed to decide whether to exercise the power of referral, it has made that decision by that date and informed the body or provider of the decision.

¹⁸ The referral power in the context of inadequate consultation only relates to the consultation with the local authority, and not consultation with other stakeholders.

Who makes the referral?

- 4.7.6 Where a local authority has a health overview and scrutiny committee (e.g. under section 9F of the Local Government Act 2000, as amended by the Localism Act 2011) as the means of discharging its health scrutiny functions, the health overview and scrutiny committee may exercise the power of referral on behalf of the local authority where this has been delegated to it. The power of referral may also be delegated to an overview and scrutiny committee of another local authority in certain circumstances (Regulation 28). Where a local authority has retained the health scrutiny function for the full council to exercise, or where it has delegated some health scrutiny functions, but not the power of referral to a committee, the full council would make the referral.
- 4.7.7 Where a local authority has established an alternative mechanism to discharge its health scrutiny functions, such as delegation to a committee, sub-committee or another local authority under section 101 of the Local Government Act 1972, the referral power cannot be delegated to that committee, sub-committee or other local authority but must instead be exercised by the local authority as a function of the full council (or delegated to an overview and scrutiny as above, although local authorities would need to consider the appropriateness of separate delegation to an overview and scrutiny committee in such circumstances)¹⁹.
- 4.7.8 Where a local authority is participating in a joint overview and scrutiny committee (JOSC) (see pages 14-15), who makes the referral will depend on whether the power to refer has been delegated to the joint committee or retained by the local authority.
- 4.7.9 The following applies to both discretionary joint committees (i.e. where councils have chosen to appoint the joint committee to carry out specified functions) and mandatory joint committees (i.e. where councils have been required under Regulation 30 to appoint a joint committee because a local NHS body or health service provider is consulting more than one local authority's health scrutiny function about substantial reconfiguration proposals):
- Where the power to refer has been delegated to the joint committee, only the joint committee may make a referral.
 - Where the power to refer has not been delegated to the joint committee, the individual authorities that have appointed the joint committee (or health overview and scrutiny committees or sub-committees to whom the power has been delegated) may make a referral.
- 4.7.10 In the case of either mandatory or discretionary JOSCs, where individual authorities have retained the power to refer, they should ensure that they are in a position to satisfy the relevant requirements under Regulation 23 to include certain explanations and evidence with the referral. They should also ensure that they can demonstrate compliance with the conditions set out in Regulation 23(10), bearing in mind that in the case of a mandatory JOSC, only that JOSC may make comments to the consulting body and that, where the JOSC makes a recommendation which is disagreed with by the consulting body, certain requirements have to be satisfied before a referral can be made.

Information and evidence to be sent to Secretary of State

¹⁹ See Regulation 29.

4.7.11 When making a referral to the Secretary of State, certain information and evidence must be included. Health scrutiny will be expected to provide very clear evidence-based reasons for any referral to the Secretary of State. These requirements are new since the previous Regulations, so they are given here in full. Referrals must now include:

- An explanation of the proposal to which the report relates.
- An explanation of the reasons for making the referral.
- Evidence in support of these reasons.
- Where the proposal is referred because of inadequate consultation, the reasons why the health scrutiny body is not satisfied of its adequacy.
- Where the proposal is referred because there was no consultation for reasons relating to safety or welfare of patients or staff, reasons why the health scrutiny body is not satisfied that the reasons given for lack of consultation are adequate.
- Where the health scrutiny body believes that proposals are not in the interests of the health service in its area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area.
- An explanation of any steps that the health scrutiny body has taken to try to reach agreement with the relevant NHS body or health service provider.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has been made.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has not been made, or where no comments have been provided on the proposal.

4.7.12 The terms of reference of the IRP, in assessing proposals and providing advice to the Secretary of State, are to consider whether the proposals will provide safe, sustainable and accessible services for the local population. Referrals to the Secretary of State and information provided by consulting bodies when consulting health scrutiny will, therefore be most helpful if they directly address each of these issues.

5. References and useful links

5.1 Relevant legislation and policy

- Department of Health (2013), *The NHS Constitution: the NHS belong to us all*:
<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf>
- Department of Health (2012), *The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf
- Government guidance on consultation principles (2012):
<https://www.gov.uk/government/publications/consultation-principles-guidance>
- Health and Social Care Act 2001, sections 7 – 10:
<http://www.legislation.gov.uk/ukpga/2001/15/contents>
- Health and Social Care Act 2012, sections 190 – 192:
<http://www.legislation.gov.uk/ukpga/2012/7/contents>
- Local Government Act 2000:
<http://www.legislation.gov.uk/ukpga/2000/22/contents>
- The Localism Act 2011:
<http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted>
- National Health Service Act 2006, sections 244 – 245:
<http://www.legislation.gov.uk/ukpga/2006/41/contents>
- Statutory Instrument No. 2013/218 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013:
<http://www.legislation.gov.uk/uksi/2013/218/contents/made>

5.2 Useful reading

- Centre for Public Scrutiny (2013): *Spanning the system: broader horizons for council scrutiny* (based on health scrutiny work on the health reforms in 14 local authority areas):
http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L13_19_CfPSspanning_the_system_web.pdf
- Centre for Public Scrutiny (2012): *Local Healthwatch, health and wellbeing boards and health scrutiny: roles, relationships and adding value*:
http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_693_CFPS_Healthwatch_and_Scrutiny_final_for_web.pdf

- Centre for Public Scrutiny (2011), *Peeling the Onion*, learning, tips and tools from the DH-funded Health Inequalities Scrutiny Programme:
http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf
- Centre for Public Scrutiny (2007): *Ten questions to ask if you're assessing evidence*:
<http://www.cfps.org.uk/publications?item=209&offset=150>
- Independent Reconfiguration Panel (2010): *Learning from Reviews*:
<http://www.irpanel.org.uk/lib/doc/learning%20from%20reviews3%20pdf.pdf>
- Independent Reconfiguration Panel (2013): *Advice on Safe and Sustainable proposals for children's heart services*:
<http://www.irpanel.org.uk/lib/doc/000%20s&s%20report%2030.04.13.pdf>
- Institute of Health Equity (2008), *Fair Society, Healthy Lives* (the Marmot report):
<http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>
- LGA and ADSO (2012), *Health and wellbeing boards: a practical guide to governance and constitutional issues*:
http://www.local.gov.uk/c/document_library/get_file?uuid=ca8437aa-742c-4209-827c-996afa9583ca&groupId=10171
- NHS England's guidance on the duty to involve (2013): *Transforming Participation in Health and Care* - <http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>
- NHS England (2013): *Planning and Delivering Service Change for Patients* - <http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf>