

M A N A G E M E N T P A P E R

a healthy
outlook

local authority
overview and
scrutiny of health



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Preface

Local government is changing the way it carries out its business. New political structures formally distinguish between councillors' executive, or decision-making, role and their responsibility to monitor and scrutinise the impact of the council's activities. Authorities have also been given a new power to promote the social, economic and environmental well-being of their areas.

Simultaneously, the health service is undergoing massive upheaval. Over the coming months, the number of health authorities will reduce by two-thirds and primary care trusts will develop to the point where they manage 75 per cent of the NHS budget. At the same time, public expectations continue to rise and local NHS bodies face demanding new performance standards and targets.

The Government wants local authorities to become more effective channels for local views. Councils are already encouraged to look beyond their own service responsibilities to scrutinise issues of wider concern to local people. It is within this context that a specific new power has been introduced into legislation in England – to

scrutinise and report on matters relating to the local health service.

This paper has been written to help local authorities to develop and implement health scrutiny in their areas. It also aims to inform local NHS bodies about the new role, and to encourage them to become involved in how it works locally. Drawing on experiences of scrutiny to date, the paper highlights options and suggests good practice to ensure that scrutiny delivers meaningful improvements in local health. It also makes recommendations to the Department of Health concerning the content of regulations and guidance to be issued under the provisions of the Health and Social Care Act 2012.

The focus of this paper is England. The health scrutiny power is not being implemented in Wales (where community health councils are being retained and local authority members will have an executive role on local health groups). However, the paper will be of relevance to Welsh authorities in relation to scrutiny more generally and measures to promote community well-being. Similarly, it will be of interest to English district councils,

even though they do not have the statutory duty of health scrutiny.

This paper is based on visits to ten local authorities, in both one- and two-tier areas. Wherever possible, discussions with council officers and elected members were supplemented with interviews with CHC chief officers and senior NHS staff. In addition, the project team benefited from guidance offered by an Advisory Group, the membership of which is detailed in Appendix 1. All contributions are gratefully acknowledged, but, as always, the Commission takes full responsibility for the contents of this paper.

The Audit Commission looks forward to working with other stakeholders to publicise the messages within this paper, and to supporting local authorities and NHS bodies as they develop this challenging new role.

1. Introduction and background

1. Local authorities' role in relation to the health of their citizens has changed considerably over time. Recently, the emphasis has been on working in partnership with local health organisations to deliver seamless care. While this remains a key role, the Health and Social Care Act 2012 gives those English authorities with responsibility for social services^I a new power. Beginning in 2012/13, local authority overview and scrutiny committees (OSCs) will be able to make reports and recommendations on matters relating to the local health service, and to require local NHS representatives to attend meetings to answer questions. NHS bodies will have a duty to provide information to OSCs, and to consult them on proposals for major reconfigurations.

2. The challenge for local stakeholders – and the focus of this paper – is to ensure that the scrutiny role makes a positive contribution to the improvement of health and health services.^{II} An important first step is to understand the policy context for the new role – the respective modernisation programmes underway within local government and the NHS.

Scrutiny and local government modernisation

3. The 1998 DETR White Paper, *In Touch with the People*, set out a new vision for local government (Ref. 1). As a result, councils now have a duty to deliver continuous improvement in services through the best value regime; a new power to promote economic, social and environmental well-being; and are required to develop community strategies, ideally through Local Strategic Partnerships (LSPs).^{III} The impact of the modernisation agenda on local constitutional arrangements and its wide ranging implications for officers and councillors are addressed in a series of three Audit Commission discussion papers published in Autumn 2001 (Refs. 2, 3, 4).

4. The Local Government Act 2000 requires local authorities to adopt one of three new governance models during 2001/02. Under these models, councils must separate the executive function from an 'overview and scrutiny' function [EXHIBIT 1]. (District councils with a population of under 85,000 and those holding a referendum for an elected mayor have a fourth option: 'alternative arrangements', which

does not include an executive.) *All* authorities must set up at least one OSC, which cannot include any member of the authority's executive. Unlike the executive, OSCs must reflect the political balance of the council (unless the council unanimously determines otherwise) and must meet in public. By mid 2001, over three-quarters of local authorities were piloting new arrangements, the vast majority opting for the 'cabinet with leader' model.

^I London boroughs, county councils and unitary authorities.

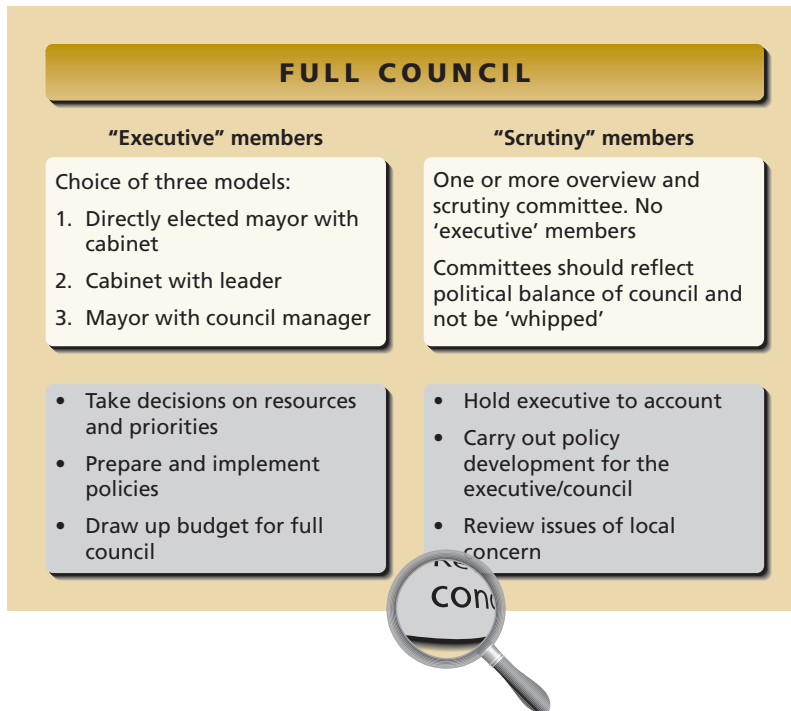
^{II} Throughout this paper, the term 'scrutiny' is used as shorthand for the overview and scrutiny function.

^{III} LSPs are non-statutory, non-executive organisations, bringing together public, private and voluntary sector bodies.

EXHIBIT 1

Executive structures in local government

Authorities must separate the 'executive' function from an 'overview and scrutiny' function.



Source: Adapted from Local Government Act 2000 and DTLR guidance (Ref. 5)

5. There are two main objectives of overview and scrutiny – to hold the executive accountable for the power it wields and to secure improvements in local practice. Although OSCs do not have

decision-making powers, they can make recommendations to the executive, the full council or to outside agencies. The responsibilities of the scrutiny function can be summarised as:

- holding the executive to account, by 'calling in' decisions and reviewing council policy, or the way in which decisions have been made;
- undertaking strategic policy development on behalf of the executive or council; and
- investigating issues of concern to local people, linked to the council's wider role of community leadership.

It is the last of these that provides the context for the new health scrutiny role.

6. Both the process and outcomes of scrutiny are intended to be outward-looking, strengthening and invigorating the representative role of councillors. The NHS Plan introduced the idea of local authority scrutiny of health by stating: "Local authorities are an important democratically elected tier of government. As they modernise, they will become more effective channels for the views of local people" (Ref. 6). Although many councils have already undertaken scrutiny reviews of external issues, they have had no power to require input from external organisations (although, in practice, most have been willing to co-operate). The

Health and Social Care Act 2001 grants local authority OSCs formal powers in relation to local NHS bodies [BOX A].

7. Government guidance allows considerable flexibility as to how scrutiny is operated. Councils are able to decide upon the number of

OSCs, their coverage, workload, and how many members should serve on each.^I There is, however, a growing body of advice to guide them (Refs. 7, 8, 9, 10). Most commentators agree that scrutiny requires members to develop a new, and very different, set of skills – becoming investigative, proactive

and achieving results through influence rather than direct control. It is pertinent to note that the ‘maturity’ of scrutiny arrangements – and hence the starting point for developing health scrutiny – varies substantially across local authorities.

Modernisation in the NHS

8. Scrutiny is just one of a raft of proposed changes in the NHS. The NHS Plan, published in July 2000, sets out an ambitious programme of reforms to NHS structure, processes and culture, aimed at driving performance improvement, strengthening accountability and making health services more patient centred [Ref. 6].^{II} The Government is expanding investment in the health service – particularly in staffing – but, in return, NHS bodies are expected to modernise their practices and deliver against national standards and targets [BOX B].

BOX A

The Health and Social Care Act 2001

The Health and Social Care Act 2001 gives OSCs in London boroughs, county and unitary authorities – ie, those with social service responsibilities – a statutory power to:

“...review and scrutinise, in accordance with regulations, matters relating to the health service in the authority’s area, and to make reports and recommendations on such matters in accordance with the regulations.”

Regulations to be issued under the Act are expected to make provisions such as:

- what matters may be scrutinised and reported upon;
- information which local NHS bodies must provide to the committee, and that which they should not disclose;
- which officers of local NHS bodies will be required to appear before the OSC;
- matters on which local NHS bodies must consult the OSC; and
- arrangements for joint scrutiny committees between local authorities (including, but not limited to, counties and districts in two-tier areas), for one authority’s OSC to operate on behalf of another authority, and for an OSC to co-opt members from other councils.

(In the Act, ‘the health service’ is defined to include health-related functions of local authorities, and ‘local NHS bodies’ means health authorities, primary care trusts (PCTs) and NHS trusts.)

Source: Health and Social Care Act 2001 (applies in England only)

^I Local authorities use differing terminology for OSCs, including ‘select’ or ‘scrutiny’, ‘committees’, ‘panels’ or ‘commissions’. This paper uses the term OSC to refer to all such non-executive arrangements.

^{II} The NHS Plan for Wales, published in January 2001, differs in several respects. In particular, there is no proposal to abolish CHCs or to give local authorities a statutory power to scrutinise health.

BOX B**Key aspects of the NHS modernisation agenda****Additional investment**

- the Government is increasing investment in staff and facilities
- the NHS Plan introduced the concept of 'earned autonomy', whereby trusts that perform well will have greater flexibility over how additional money is spent

More national standards and targets

- the NHS Plan sets a number of 'must do' targets – eg, cutting waiting times and reducing mortality rates for certain conditions
- the performance assessment framework for health authorities and trusts is being revised and expanded
- national service frameworks set out standards, targets and best practice for key conditions (eg, mental health, coronary heart disease)

Changes for NHS staff

- there will be new contracts for GPs based on meeting quality standards, rather than the quantity of services provided
- and new contracts for consultants to include job plans and performance review

Greater public and patient involvement

- the Government is proposing to replace community health councils with a range of new mechanisms to increase patient involvement in the NHS and to provide advocacy and advice services
- local authority OSCs will have the power to scrutinise local health issues on behalf of their electorate

Closer integration of health and social care

- local authorities and NHS bodies have the option of setting up Care Trusts, a new type of PCT that will provide both primary and social care services

9. When developing health scrutiny, therefore, councils will need to take account of other changes and pressures within the health and social care arena, in particular:

- **structural changes** – the existing 95 health authorities in England will merge to form about 30 new health authorities by April 2002, which will become 'strategic health authorities' following legislation later that year. Meanwhile, all primary care groups will become trusts, taking on devolved responsibilities from health authorities [See APPENDIX 2 for a glossary of health service terms]¹;
- **performance and regulatory pressures** – delivering the Government's NHS Plan is the overriding priority for local NHS bodies, backed up by new performance management demands and a strong inspection framework;

¹ In the longer term, these changes are likely to assist both scrutiny and joint working since many PCT boundaries will be coterminous with those of local authorities.

- **existing accountability mechanisms in the NHS** – in addition to their accountability to the Secretary of State, local NHS bodies are required to publish an annual report and accounts and hold an annual public meeting of their Board; and
- **expanded partnership working** – health and social care are increasingly interlinked, while local agencies are working together to address issues such as health inequalities. Local authorities will be able to delegate social services provision to new Care Trusts if they wish.

10. A key theme of the new NHS is ensuring that services better reflect the needs of local users and citizens. Local authority overview and scrutiny of health services is one element of wider proposals for patient and public involvement in healthcare. A recent Department of Health discussion paper sets out proposals to replace community health councils (CHCs) with statutory patients' forums in every trust, and statutory bodies called 'Voices' at health authority level (Ref. 11). As OSCs develop their role in health, they should draw on the

experience and expertise of CHCs (including those councillors who currently sit on CHCs, or have done so in the past). Looking to the future, OSCs will need to develop strong two-way links with the new patient involvement bodies.

Aims and structure of this paper

11. This paper is for local authorities *and* NHS bodies. It aims to provide a framework for local discussions about the health scrutiny role, highlighting key decision points and outlining possible approaches. On the basis of discussions with local stakeholders, the paper also suggests potential issues for inclusion in government regulations and guidance (expected during 2002). The chapters that follow discuss:

- **Critical questions for the health scrutiny role.** How does the new role fit into existing NHS accountability arrangements and partnerships between health and local government? Where and how will scrutiny add most value? What do local authorities and NHS bodies need to do to make the function credible and effective?

- **Developing the health scrutiny role locally.** A step-by-step guide to setting up and carrying out health scrutiny, illustrated with examples from practical experience.
- **Summary and recommendations.** The paper concludes with recommendations for local authorities, local NHS bodies and national government.

In addition, a series of key questions for local authorities and local NHS bodies is included as a pull-out in the centre of the report.

12. The legal provisions for health scrutiny will be clarified in regulations, to be issued by Government during 2002. The Health and Social Care Act 2001 lists a number of issues that regulations will address, including the role of district councils in two-tier areas and precisely who will be required to appear before OSCs [BOX A, page 8]. To avoid confusion, this paper does not make specific recommendations to local authorities or NHS bodies in these areas. Rather, it flags up issues that need to be addressed in formal regulations or guidance.

2. Critical questions for the health scrutiny role

13. If local authority scrutiny of health works well, it will provide a valuable forum for review and debate, engage local people, and generate realistic suggestions to improve services. Done badly, it could duplicate effort, damage partnerships and result in little more than political point scoring. At this early stage, opinion on the new role is divided between those who believe health scrutiny has the potential to be a 'triumph' and those who foresee 'disaster' [EXHIBIT 2].

14. Unsurprisingly, differing views relate partly to whether individuals' prior experience of scrutiny and working with other agencies is good or bad. But they also reflect uncertainty as to what health scrutiny is supposed to achieve and what will work best. Before implementing the role, then, some critical questions need to be addressed:

- How does health scrutiny fit with existing NHS accountability arrangements?
- How does it fit with other mechanisms for patient and public involvement in healthcare?

EXHIBIT 2

Health scrutiny – visions of triumph and disaster

Opinion on the potential of the new role is divided.



Source: Audit Commission fieldwork

- What does health scrutiny mean for relationships with the executive, and partnerships between health and local government?
- How can scrutiny by elected members have credibility with the NHS?
- Where and how will health scrutiny add most value?
- What can local NHS bodies contribute?
- What should central government do to help local agencies develop the process?

How does scrutiny fit with existing NHS accountability arrangements?

15. The NHS has complex regulatory arrangements. The boards of local NHS bodies (a mixture of executive and non-executive directors) are currently accountable to the Secretary of State for Health through regional offices of the Department of Health. From April 2002, PCTs and NHS trusts will have greater devolved powers and be accountable to the Secretary of State through new Strategic Health Authorities [EXHIBIT 3]. In addition, local NHS bodies are subject to

inspection by the Commission for Health Improvement (CHI), external audit through the Audit Commission, and guidance from bodies such as the National Institute for Clinical Excellence (NICE) [Glossary, APPENDIX 2]. And they must publish an annual report and accounts and hold an annual public meeting of the Board. The Royal Colleges also play a strong role, including regulating training and professional development.

16. Performance and planning mechanisms in the NHS are also changing. The existing service and financial planning framework is being adapted to take on board local implementation of the NHS Plan [‘Local Modernisation Reviews’, APPENDIX 2]. The Health Improvement and Modernisation Plan (HIMP, formerly known as the Health Improvement Programme) will have a key role in linking implementation of the NHS Plan to tackling health inequalities and the wider determinants of health. In addition, the national performance assessment framework (PAF) is likely to include a larger number of performance indicators and more information available at trust level. ‘Headline’ indicators, currently published annually, will soon be

accompanied by independent commentaries from the Audit Commission and CHI.

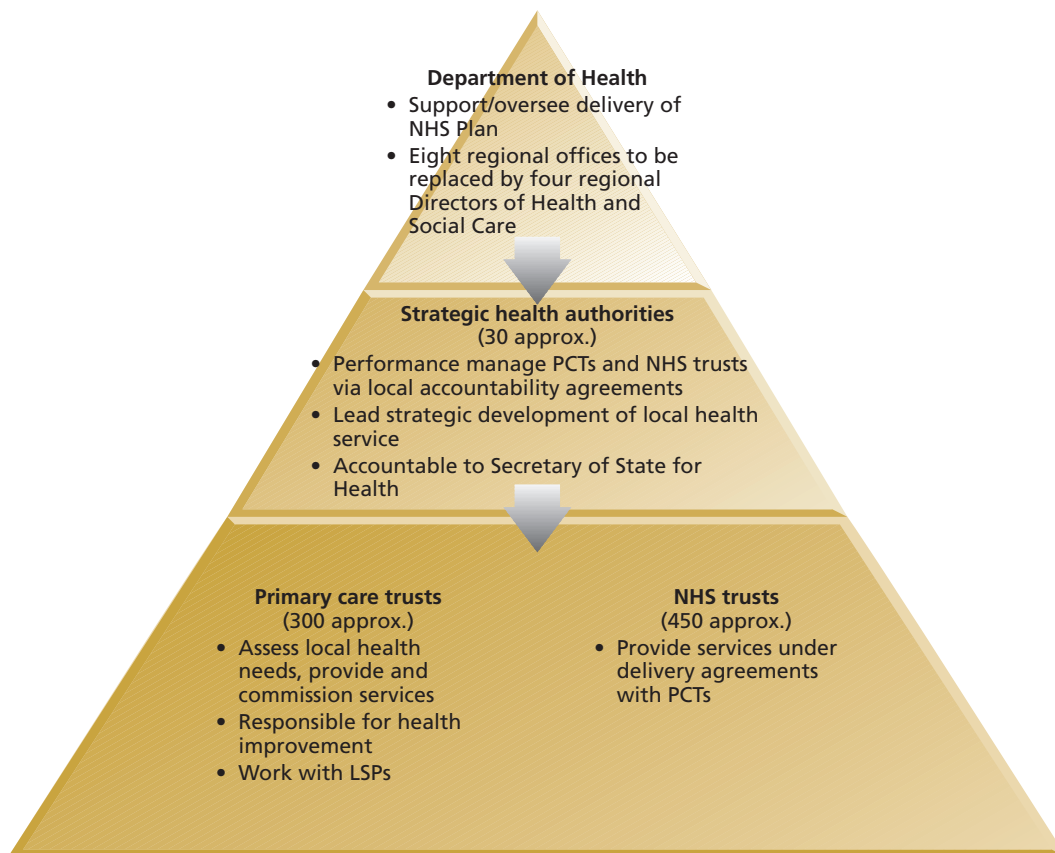
17. What does scrutiny add to these mechanisms? OSCs will not manage the performance of the NHS (although performance data should inform scrutiny reviews), nor are they another form of professional inspection. Similarly, OSCs should not seek to duplicate arrangements for advocacy on behalf of patients/service users (although collated data from these sources will be a crucial input to the scrutiny process – and vice versa). Health scrutiny is a new means of holding NHS bodies to account on behalf of the people they serve [EXHIBIT 4, overleaf]. It is distinctive in being undertaken by lay, elected local representatives and focused on improving well-being in the community at large.

The NHS has complex regulatory arrangements

EXHIBIT 3

Responsibilities and accountabilities within the NHS from April 2002

Trusts will be accountable to the Secretary of State through new Strategic Health Authorities.



Source: Department of Health, *Shifting the Balance of Power within the NHS* (Ref. 12)

EXHIBIT 4

How will local authority scrutiny fit into existing NHS accountability arrangements?

Scrutiny provides a mechanism to look at health issues across service providers and to hold agencies to account locally.



Source: Audit Commission

How does scrutiny fit with other mechanisms for patient and public involvement in healthcare?

18. The NHS Plan proposed the abolition of community health councils.¹ A recent discussion paper from the Department of Health announced the Government's intention to legislate to replace CHCs and their national association with a new system for public and patient involvement in healthcare, comprising:

- **patients' forums** in every trust, made up of patients and other members of the local community, with power to inspect all aspects of the work of trusts;
- teams of specialist workers, known as **Voices**, in every strategic health authority area, with a remit to support and build local capacity for public involvement; and

¹ CHCs are local statutory organisations, set up in 1974, to represent the interests of the public in their districts in the NHS.

- a **new national patients body**, called 'Voice: the Commission for Patient and Public Involvement in Health', to set standards and ensure consistency in the involvement system as a whole (Ref. 11).

These new bodies add to other arrangements to support patient advocacy – Patient Advocacy and Liaison Services (PALS) and independent complaints advocacy.

19. Local authority OSCs will take on some existing CHC functions, most notably the right to refer contested changes in local NHS services to the Secretary of State. They will also be able to make referrals if they have concerns about how a consultation process has been managed by the NHS locally. As patients' forums and Voices develop, it will be essential for OSCs to develop links to share information, avoid duplication and provide good local intelligence for scrutiny. In the meantime, councils should draw on the relevant experience and expertise of CHCs when deciding how and where to focus their health scrutiny activity.

What does health scrutiny mean for relationships with the council's executive, and partnerships between health and local government?

20. Of course, scrutiny will not be the only (or even the main) form of engagement between local authorities and local NHS bodies. Increasingly, health and local government provide and commission health and social care services in partnership. They also work together on the LSP and initiatives such as HIMPs and neighbourhood renewal. OSC members will need to understand and work within this context (including, in two-tier areas, taking account of the involvement of district councils in health issues). Councils' interest in health is reflected in their executive arrangements – a recent survey revealed that 85 per cent of local authorities have specified health within the portfolio of at least one cabinet member (Ref. 13).

21. Inevitably, then, OSCs looking at health issues will be scrutinising the actions and decisions of their own (or other local authorities') executive, as well as those of NHS bodies. For example, it is likely that the OSC would want to review a proposal to create a care trust, or assess how well the council is meeting its own objectives in relation to health. Moreover, individual councillors, including those on the executive, will wish to represent the views of their constituents on issues of local health concern. The scrutiny function – which, according to government guidance, should not be 'whipped' (Ref. 5) – must operate independently of the council's executive when exploring health issues. But OSCs should ensure that they seek evidence and views from executive members where relevant, and keep abreast of the council's wider aims and activities in relation to health.

Councils should draw on the relevant experience and expertise of CHCs

22. The role of OSCs is to provide independent (non-politically-partisan) monitoring of health service activities and plans. But, equally, they must recognise the reality and complexity of local agency relationships and responsibilities when deciding upon:

- the **scope and focus** of scrutiny – if health scrutiny is to maximise its impact, it must look beyond health care services at the wider determinants of health, and make recommendations to other local agencies as well as the NHS;
- scrutiny **topics** – review by the OSC will not always be the best way for local councillors to exert influence over an issue relating to health (an existing partnership or liaison board might be a more appropriate forum)^I; and
- the **style** of scrutiny – a process that seeks only to allocate blame, rather than focusing on opportunities for improvement, is likely to have a detrimental effect on day-to-day working relationships between the authority and its health partners.

How can scrutiny by elected members have credibility with the NHS ?

23. It is reasonable to argue that elected members need a broad understanding of how the NHS operates (for example, commissioner-provider relationships and the planning cycle) in order to view local performance in its proper context and to make realistic recommendations for improvement.^{II} They will need training and support – and this has resource implications. But, equally, it is important to understand that the scrutiny process is not intended to be ‘expert’, in the technical or professional sense of the word. Members’ credibility will come from their ability to ‘stand on the outside’ and to speak on behalf of local people who need and use health services.

I For example, Hertsmere Borough Council has run a Health Overview Group for eight years, including NHS chairs and chief executives alongside district and county councillors. The group develops partnership proposals as well as questioning local authority and NHS officers on new proposals.

II Parallels can be drawn with the development of non-executive directors of NHS Boards (Ref. 14).

24. OSCs do not make decisions – their role is to raise local concerns, to challenge the rationale for decisions and to propose alternative solutions. For scrutiny to achieve a positive impact, therefore, it needs to be persuasive. If members take an aggressive approach, or make assertions that are not supported by evidence, this will provoke a defensive reaction on the part of the NHS and make it difficult for scrutiny to add value. Similarly, councils must take steps to avoid any potential conflicts of interest arising from members’ involvement in the bodies or decisions they are scrutinising. For their part, representatives of NHS bodies will need to be open to challenge and willing to discuss issues in language accessible to the lay person.

25. So the health scrutiny power needs to be applied both robustly and responsibly. Scrutiny should be probing and incisive, but always aimed at supporting improvement. Asking ‘the obvious question’ can be very revealing, but OSCs must also recognise that the most difficult problems facing the NHS have no simple, or universally popular, solution. Local NHS bodies have to make complex trade-offs between competing service

demands, and have only limited room for manoeuvre within a national framework of policies and standards. And there will sometimes be tensions between the wishes of local people and what is affordable and/or clinically effective.

Where and how will scrutiny add most value?

26. Those unfamiliar with local government modernisation ask, not unreasonably, ‘what is scrutiny for?’ And sceptics ask, ‘what has it actually achieved so far?’ Experience to date suggests a number of potential objectives for health scrutiny, including:

- reviewing proposed changes to local service provision and assessing the impact on the local community and service users;
- driving improvements in outcomes – in an area or for a particular client group;
- examining the effectiveness and efficiency of service processes or joint-working arrangements and suggesting how they could be improved;
- integrating local strategies in relation to health and measuring their impact; and

- raising the profile of an issue of local concern.

There are already some examples of the impact of scrutiny on local practice [BOX C, overleaf].

27. Although health scrutiny is potentially wide-ranging, it can never be fully comprehensive, in the sense of overseeing and scrutinising *everything* that local NHS bodies do. Resources are limited and scrutiny needs to complement other local arrangements, such as the proposed patients’ forums (which will inspect services in detail). It follows, therefore, that the health work of OSCs should focus on:

- things that scrutiny *must* do – such as reviewing local service reconfiguration proposals and referring contested proposals to the independent panel/ Secretary of State¹; and

- issues where the scrutiny approach, of open review by lay members representing the local community, could *make a distinctive impact*.

28. The NHS Plan introduced the scrutiny responsibility in the context of local authorities’ role in community leadership and promoting well-being. This implies that OSCs should be proactive as well as reactive in their work, seeing scrutiny as a tool for strengthening partnerships, not just calling to account. For example, it would be helpful for OSCs to be involved at an early stage in the development of service reconfiguration proposals. Crucially, they should look at whole health economies not just the NHS. If scrutiny becomes preoccupied with health services alone (or focuses too heavily on acute care, to the exclusion of primary and community services), an opportunity will be missed. Reducing health inequalities is a nationwide priority (Ref. 15) and it is well recognised that healthcare services have a relatively small impact on wider health and well-being. OSCs could provide a powerful mechanism to look across service boundaries from the perspective of users and to bring

¹ Currently, CHCs have the power to refer contested proposals directly to the Secretary of State for Health. The NHS Plan proposes that local authority OSCs be able to refer decisions to a new independent reconfiguration panel that will advise the Secretary of State.

BOX C

Examples of objectives and outcomes from local authority scrutiny of health issues

Kirklees MBC carried out a review of the local health authority's proposal to rationalise services for women and children across two hospital sites. The scrutiny process (and public response to this) led to a number of changes in the proposals – most notably the retention of a consultant-led obstetric service with paediatric cover at both sites and the setting up of a multi-agency group to consider transport issues within the reconfiguration. As a whole, the review helped local people to better understand this complex area of health planning. (Further details on the Kirklees scrutiny appear on the *IDeA Knowledge* website (Ref. 10).)

The London Borough of Lewisham reviewed the delivery of services for children under eight years old with special needs. This covered several local authority services as well as primary, community and acute health services. The objective of the review was to examine services from the user perspective and suggest ways to join up access.

Buckinghamshire County Council reviewed local arrangements for dealing with 'winter pressures' (the higher rate of admission of older people to hospital during periods of cold weather). The review brought together social services, NHS and private sector care providers to streamline processes and promote closer working between agencies. The Council's Cabinet accepted 10 of the 12 scrutiny recommendations and many have already been implemented, leading, for example, to fewer delays in assessing and placing patients.

The Greater London Authority (GLA) has a statutory duty to promote the health of Londoners and to take into account the effects of its policies on the health of Londoners. The London Assembly (the GLA's scrutiny body) receives reports from the London Health Commission – a multi-agency panel of experts – on the health impact of the Mayor's draft strategies. The Assembly itself is currently investigating smoking in public places and plans to look at access to primary care early in 2002.

Knowsley MBC explored concerns around the recruitment and retention of GPs. The review looked at ways to attract GPs into the borough, including the feasibility of using existing council premises with surplus capacity (such as schools) to address accommodation problems. The review also recommended that the Council work in partnership with other key agencies to attract more GPs into the area. As a result the health authority has embarked on a pilot scheme to recruit GPs from Spain.

together local stakeholders to address health inequalities

29. So what will successful health scrutiny look like? To be deemed successful, health scrutiny will need to make a *noticeable* impact. It will achieve this by addressing issues that are relevant to the public and to other local agencies, and doing so in a way that is open, thorough, persuasive and reflects user views [EXHIBIT 5]. It follows that the process and its outputs should be made as accessible as possible to local communities. Moreover, it must concentrate always on being a positive force for improvement; otherwise it will not engage the public or those expected to implement change. If this occurs, members are likely to lose interest and enthusiasm, and councils are unlikely to devote the necessary resources to the role.

30. During the research for this paper, the Commission invited the views of all English social services authorities on critical success factors for the health scrutiny role.

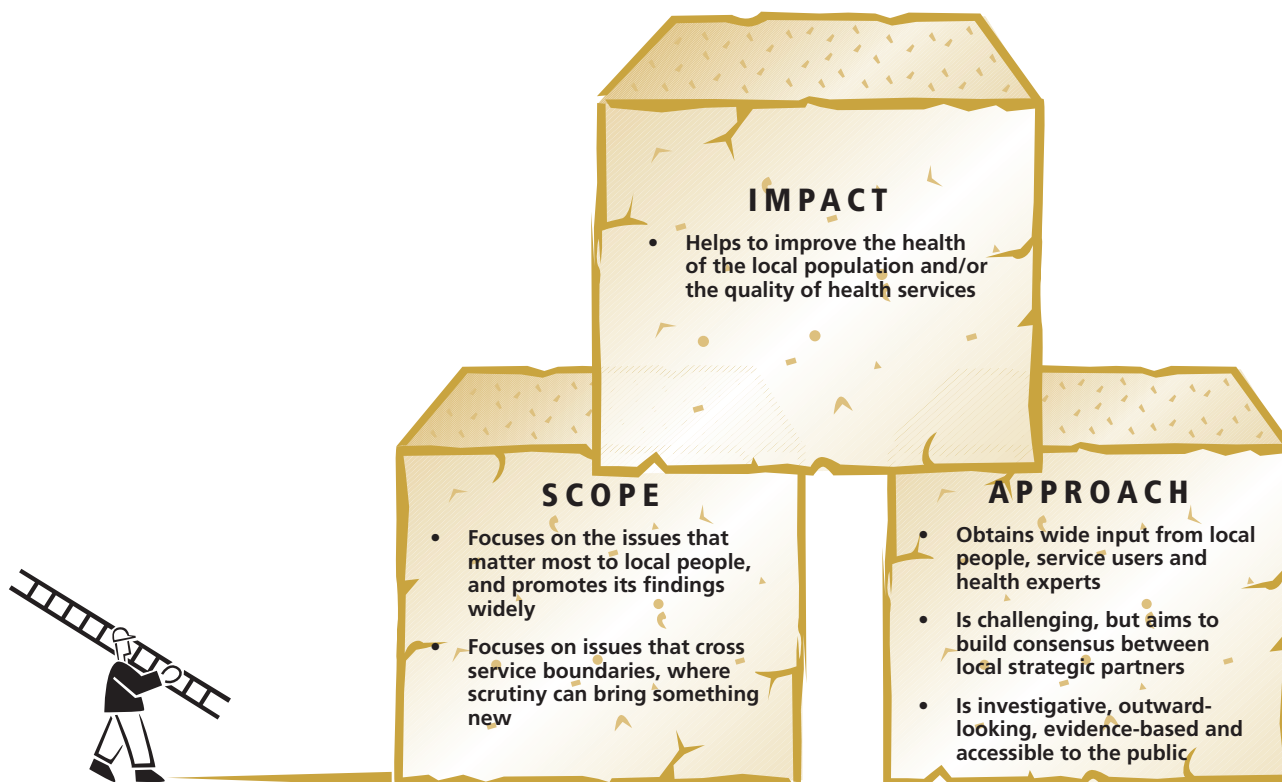
Authorities felt that the most *important* factors would be accessing the right information, building good relationships with local health bodies and developing

member knowledge. These were also expected to be the most *difficult* issues, although there was greater confidence about the ease of building relationships with

EXHIBIT 5

Building successful health scrutiny

Ultimately, success will be judged by impact.



Source: Audit Commission

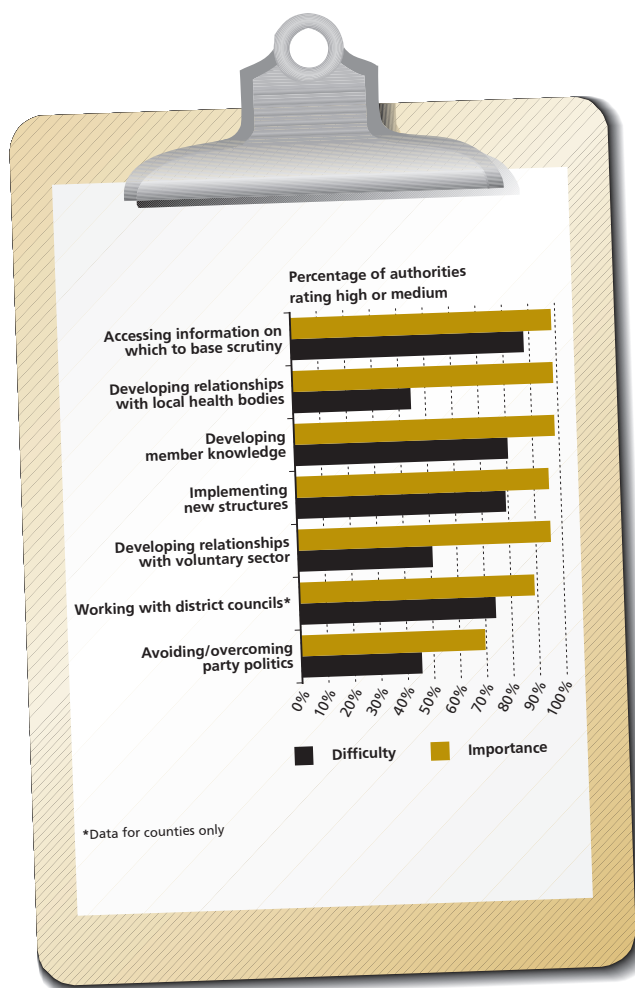
health. In two-tier areas, the challenge of organising scrutiny jointly with district councils was well recognised [EXHIBIT 6]. Clearly, resourcing is also a key issue; this is discussed in the next chapter.

31. More detailed discussions with local practitioners (including some from district councils) suggest that some authorities may be underestimating the difficulties involved. Councils start from very different positions. Developing the role will be more challenging for those authorities without much practical experience of scrutiny (or that are struggling with the role), and in those areas where relationships between health and local government have historically been poor. Councils would be well advised to develop experience of internal scrutiny and test ‘rules of engagement’ before taking on complex health topics. Health scrutiny will also be considerably more difficult in two-tier areas, where counties and districts must work together. But authorities at *all* levels will need to work with their neighbours to co-ordinate demands on local NHS bodies and address services/issues that cross local boundaries.

EXHIBIT 6

Local authority views on the importance and difficulty of various aspects of health scrutiny

The critical success factors are expected to be accessing information, building relationships and developing members’ knowledge of health issues.



Source: Audit Commission survey of social services authorities (70 responses received)

What can local NHS bodies contribute to the process?

32. Making a success of health scrutiny requires actions on the part of local authorities *and* NHS bodies [EXHIBIT 7]. Both parties have a stake in learning about each other’s roles, building effective working relationships and ensuring that the function retains a positive focus. While scrutiny itself will not always be a collaborative process, there is

considerable merit in local authorities and local health bodies working together to develop the framework for the new role. Local authorities need to develop their scrutiny experience and health knowledge, and work together to manage demands on the NHS. For their part, NHS bodies need to adopt a positive approach to scrutiny, recognising its legitimacy

and helping to identify areas where it could add value.

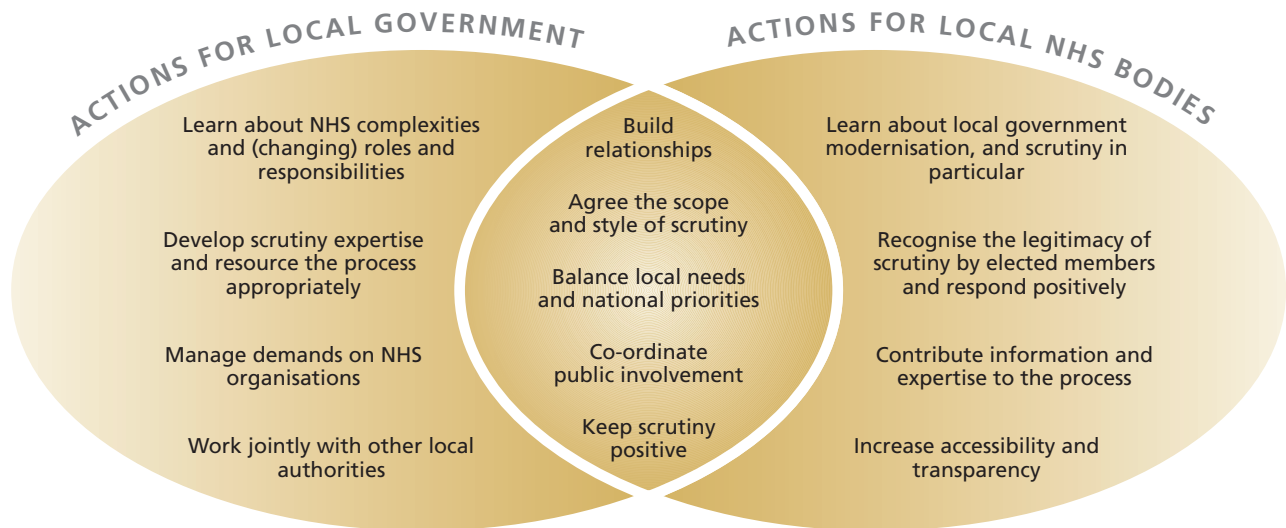
33. In practical terms, local NHS bodies should consider how they can contribute to the success of the process locally, for example by:

- putting together basic information about their services, priorities and performance, and sharing this with local councillors, perhaps in a briefing session;

EXHIBIT 7

Critical success factors for effective local authority scrutiny of health

Both local government and the NHS need to contribute if scrutiny is to achieve its objectives.



Source: Audit Commission

- identifying issues where independent local scrutiny could add value – for example, jointly provided services or issues requiring a higher public or national profile; or
- contributing resources in kind to the scrutiny process, for example through the public health function of health authorities and PCTs.

What should central government do to help local agencies develop health scrutiny?

34. The Government’s expectations for health scrutiny remain somewhat unclear. The NHS Plan and the Health and Social Care Act

state *what* local authority OSCs will be able to do, but say little about *why* or *to what end*. When drafting guidance on health scrutiny, it would be helpful if the Department of Health could also clarify its expectations (but avoid prescription if possible) in terms of:

- the coverage of scrutiny – for example, will OSCs be expected to maintain an overview of all local NHS bodies (if so, how should cross-boundary and specialist services be addressed and what are the funding implications?) or would the duty be fulfilled by a series of issue-focused reviews?;
- the role of district councils in health scrutiny in two-tier areas;

- how scrutiny by local authorities fits within existing accountability and performance management arrangements in the NHS;
- the impact and measures of success for the role (for example, are OSCs expected to have an impact on local health policy?);
- the expected response of local NHS bodies to OSC recommendations; and
- the resource implications for local authorities and NHS bodies, and whether there will be any government support or advice for implementation.



3. Developing health scrutiny locally

35. Although the scrutiny function is still fairly new to most local authorities, useful lessons are already emerging. This chapter draws on the experience of individuals who have carried out, been subject to, or begun to set up scrutiny, to provide advice on the new health scrutiny role under six headings:

- Identifying initial priorities for health scrutiny
- Deciding how to organise and resource scrutiny
- Developing local rules of engagement
- Drawing up a work programme and selecting appropriate scrutiny approaches
- Carrying out scrutiny reviews
- Launch and follow-up [EXHIBIT 8, overleaf].

Most of these activities require input from local NHS bodies as well as local authorities.

Step 1 – Identifying initial priorities for health scrutiny

36. Members and officers who will be involved in health scrutiny need to take time to familiarise themselves with the territory.

Authorities have found the following activities to be useful at an early stage:

- holding a discussion forum with representatives from the main NHS organisations that provide services to residents of the authority (ideally including practitioners as well as managers). This could discuss expectations and ideas for scrutiny, as well as giving OSC members some background on local health priorities [CASE STUDY 1, overleaf];
- establishing close links with the local community health council and voluntary organisations, likely to be very useful sources of local intelligence;
- holding preliminary discussions with district and/or neighbouring councils; and
- identifying the health issues that have been raised recently in local authority area committees/forums or

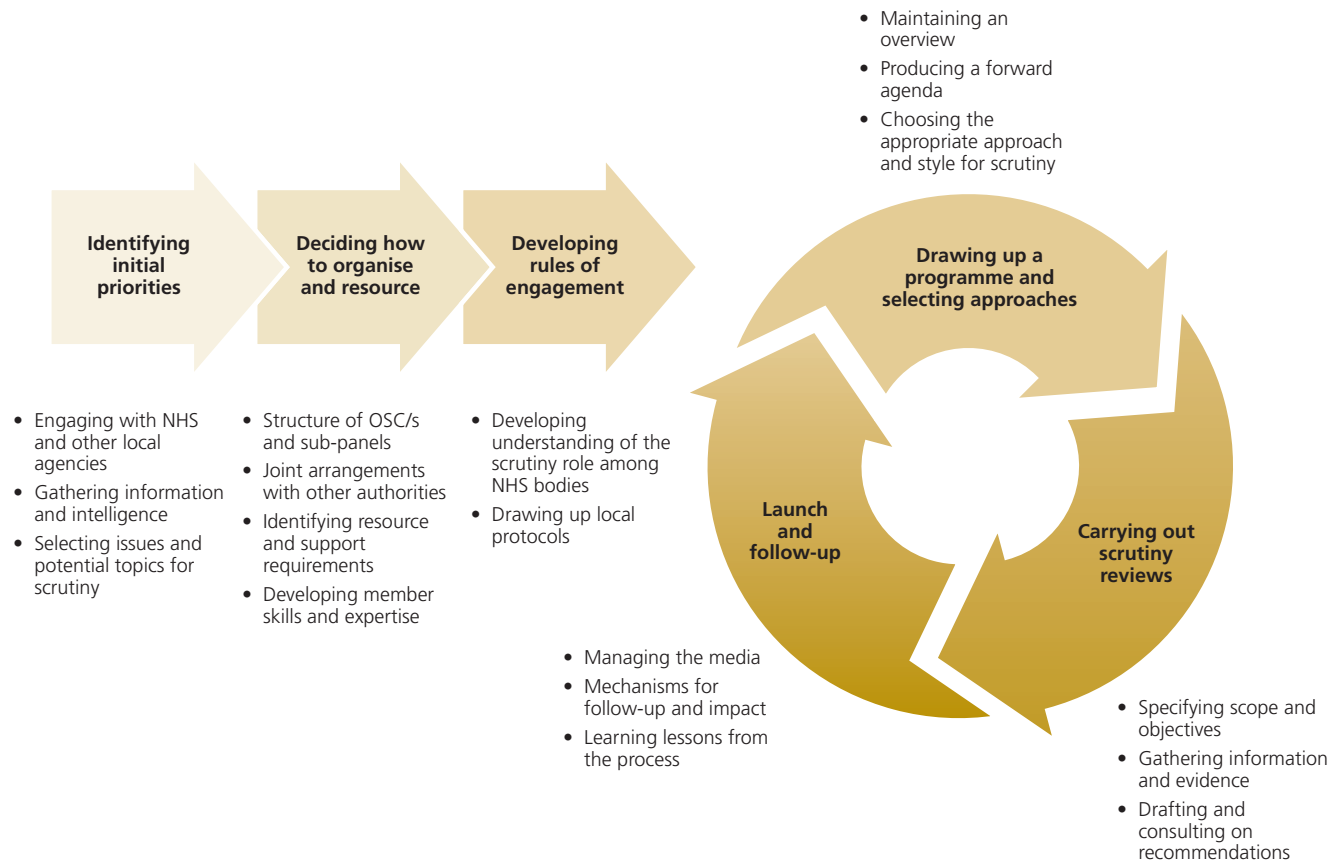
councillors' surgeries. (Elected members are encouraged to seek local views as part of their scrutiny work, but the OSC is not the appropriate vehicle for addressing individual problems or complaints.)

37. Early discussions of local priorities should also be informed by available documentation. This could include the local community strategy or plan, the HIMP, outputs from the LMR, the most recent report of the Director of Public Health and recommendations from inspection or audit reports (the latter being in the public domain following a public meeting of the trust board). Completed best value reviews and issues arising from modernisation boards within local NHS bodies may also provide some suggestions. It is possible for councils to directly access some information on the comparative performance of their local NHS bodies [APPENDIX 3]. However, local NHS bodies could assist by collating key documents and information about their services.

EXHIBIT 8

Summary of key stages in developing and carrying out health scrutiny

There are six stages to the health scrutiny role.



Source: Audit Commission

CASE STUDY 1

Identifying local priorities for health scrutiny

The main scrutiny panel of the London Borough of Hammersmith and Fulham held an initial discussion on how to approach the health scrutiny role. Officers had prepared an introductory paper outlining options, and the Chief Executive of the health authority attended the meeting to provide advice and information. Members decided that the objective of health scrutiny should be to improve healthcare and health outcomes, but they would need to 'start small'. A select committee approach of in-depth reviews was the preferred approach, leveraging in expertise and working with local health bodies to devise a scrutiny programme. Members felt that the scrutiny role would add most value if it focused on services that overlap the health/social services boundary, particularly in relation to the public health agenda and health inequalities.

Early discussions at officer level within Surrey County Council have identified a number of possible approaches to health scrutiny:

- scrutiny of issues as and when identified by an OSC;
- systematic reviews of all local NHS bodies (numbering over 15), area by area;
- systematic reviews of health and social care services – eg, on a client basis; and
- using the scrutiny power only for major NHS reorganisations.

Members will be asked to consider the implications of each option for structures and resources. Informal meetings have been arranged with CHCs and local NHS bodies to inform decisions about the new role.

38. At an early stage, OSCs (drawing on advice from other agencies and individuals) need to consider which local issues would be most suited to scrutiny and how potential topics will be selected.

Criteria could include:

- the ability to make a distinct and positive impact through the scrutiny function;
- topics that are timely and relevant, but not already under review elsewhere; and
- maintaining a balance between health improvement and health services (and between acute services and primary and community care).

Although it is not feasible to draw up a work programme at this stage, it will be useful to generate ideas for possible topics [EXHIBIT 9, overleaf]. OSCs would be well advised to avoid complex topics in the early stages, thereby allowing members to build up expertise gradually; or to focus on partnership issues, thus demonstrating that local authorities are willing to scrutinise themselves as well as other agencies.

EXHIBIT 9

Topic areas and possible topics for health scrutiny

Scrutiny has the potential to add value across a range of local health issues.



Source: Audit Commission fieldwork

Step 2 – Deciding how to organise and resource scrutiny

39. The Health and Social Care Act requires councils to give their OSC/s the power to examine local health issues. A number of structures are possible, including:

- setting up a dedicated health OSC;
- adding health to the remit of the existing social care/social services OSC; or
- giving all existing OSCs the power to consider health issues when appropriate (for example, as part of a review of economic development or environmental issues).

The decision will vary, depending upon the authority's existing scrutiny framework. However, if more than one committee is involved, care will be needed to co-ordinate demands for information and attendance from local NHS bodies. It will also be possible for two or more authorities to appoint a joint OSC to carry out health scrutiny.

40. In two-tier authorities, the situation is more complex. Under the Local Government Act 2000, district councils are encouraged to undertake external scrutiny, which could include examining health issues. However, they do not have the power to require attendance from NHS bodies, which the Health and Social Care Act gives to county councils in two-tier areas. Common sense dictates that counties and districts should work together in relation to local health issues – for example, consulting each other on scrutiny programmes in advance. Similar considerations apply to neighbouring authorities in unitary areas, particularly where the catchment areas of NHS services cross local authority boundaries; London boroughs being an obvious example.

41. Regulations to be issued under the Health and Social Care Act 2001 are expected to outline several possible arrangements, whereby:

- member/s of each district council are co-opted on to the county's standing OSC;
- district members are co-opted only when the county OSC is considering an issue that affects their specific area, for example,

something relating to a local PCT; or

- the health scrutiny power, or specific reviews, are delegated to a district OSC.

Clearly, it makes sense for county councils to play the lead or co-ordinating role. But attention needs to be given – both locally and in government guidance – to how issues of concern to district councillors (which may not be a priority for the county council) can also be scrutinised, without overburdening local NHS bodies.

42. Structural arrangements should also reflect the relative emphasis to be placed on oversight and in-depth reviews. A number of councils have created ad hoc scrutiny panels (sub-units of the main OSC) to carry out detailed reviews. The membership of such panels can usefully (but selectively) be extended to include outside experts and/or service users. The benefit of separating in-depth work from the 'regular' business of the OSC is that it reduces disruption to the main agenda. It may also be simpler to co-opt outside experts on to an ad hoc panel than the formal OSC [CASE STUDY 2, overleaf].

CASE STUDY 2

Committee structures for health scrutiny

Different approaches in two-tier areas

Bedfordshire and Luton are constructing a joint NHS scrutiny committee, including one representative from each of Bedfordshire's three district councils, plus a CHC observer. This will act as the co-ordinating committee for seven trust-focused NHS scrutiny panels – one for each local NHS trust and the health authority – each with membership from the relevant local councils. There will be a joint secretariat with an administrative, analytical and research capacity. The structure is testimony to good joint working in the area, although it remains to be seen how manageable it will be in practice.

Buckinghamshire County Council plans to set up a single health scrutiny committee, with co-opted members from each of the district councils. Contrasting with Bedfordshire's trust-based model, members favour an approach centred on strategic issues. The authority will consider additional co-options – for example from patient representative or advocacy bodies – for relevant reviews.

An issue-based approach in a unitary area

Kirklees Council has successfully run scrutiny commissions – ad hoc member panels looking at issues of local concern – since the early 1990s. In future, the Council's existing Social Affairs and Health Scrutiny Panel will maintain an overview of health issues and manage a programme of detailed scrutiny reviews. In-depth work will be undertaken by select commissions, put together to look at the particular issues. Consideration is being given to including non-executive members of the health authority on scrutiny commissions, together with user representatives.

43. Authorities have found that scrutiny is a resource-intensive activity, for both members and officers. For example, a scrutiny of the patient/user experience of mental health services would require an OSC to map services, explore linkages, survey users,

analyse resource allocation and investigate the practicalities of recommendations for change. In relation to the health role, then, councils need to give serious thought to:

- the available time and commitment of elected members, and the nature of development that is required; and
- the quantity and quality of officer support for scrutiny.

There may also be costs associated with research and information gathering, for example, travel, witness expenses or commissioning expert advice.

44. Elected members will face a steep learning curve in relation to the NHS. However, half of all local authorities already involve members in joint planning or partnership boards with health, and almost two-thirds have experience of member involvement in the HIMP process.¹ While it is helpful for members to have some prior knowledge of the key issues affecting the service being scrutinised, they should not be experts; experience of carrying out scrutiny and an interest in the area under review have been found to be as important. Rather, OSCs

¹ Audit Commission survey of English social services authorities, June 2001.

should draw on external advice and expertise in the course of their reviews. In addition to sources within the NHS, local universities and voluntary/patient groups could provide affordable input.

45. Elected members interviewed for this research readily acknowledged that scrutiny took a lot of getting used to: 'It was a whole new culture; we had to become much more involved and do a lot more work outside of meetings.' This suggests that member development in relation to health scrutiny should focus on two aspects:

- developing greater experience of scrutiny in general and identifying what works best in terms of impact. For example, what are the most effective ways of framing questions, briefing witnesses and presenting recommendations? How do we get greater input from service users?; and
- building understanding of the high-level issues affecting local health bodies. One way of achieving this would be to organise a training day and seek contributions from local NHS bodies, voluntary and user groups and the CHC [CASE STUDY 3].

CASE STUDY 3

Development for scrutiny members

Before starting the health scrutiny process, Kingston Upon Hull Council ran three training days, each with a different approach and objectives.

Day 1 provided all interested members and relevant senior officers with:

- information about local health services and partnerships, using speakers from social services, the NHS regional office, and local 'Sure Start' and drugs diversion projects;
- an opportunity to hear from a local authority with experience of health scrutiny; and
- time to discuss the immediate implications for Hull – for example, how would members work with other, very different, local authorities? How could they use their constituents' experiences without getting into too much individual detail? How could they ensure that their recommendations had an impact?

Day 2, four months later involved more detailed discussion of lessons from other authorities, the health issues facing the local area, and the skills and experience that members could bring to the process.

Day 3, another four months later, will bring in representatives from local health organisations to talk with scrutiny board members. This meeting will consider the way in which they will work together and select the first issue to be looked at.

46. Although scrutiny is a member-led activity, members are likely to require support for:

- administration – such as arranging meetings, calling witnesses and clerking meetings;
- developing networks – making local contacts and gathering intelligence;
- research and analysis – for example, background research, informal interviews and visits, framing questions, running focus groups and data analysis/interpretation; and
- drafting reports – for example, framing recommendations in the most effective way.

Local authorities need to be realistic about what they can afford, but it is already clear that many have not resourced the scrutiny function beyond administrative support. In response to an Audit Commission survey in June 2001, only 20 per cent of authorities said they would recruit additional staff to support the health scrutiny role; 30 per cent expect to second staff from other organisations, while 10 per cent would consider using external consultancy.

47. The extent to which councils have the capacity, or the inclination, to adequately resource the health scrutiny function will be a critical issue for its success. Experience suggests that successful scrutiny must draw on a range of support skills and resources; this will be particularly true of complex health issues [CASE STUDY 4]. Local NHS bodies are multi-million pound operations. If OSCs are to deliver what the Government expects in terms of independent monitoring, they will need dedicated research and analytical support. It is recommended that Department of Health guidance should include a clear statement of the resource implications of the role, and what level of additional government support is envisaged.

CASE STUDY 4

Resourcing in-depth scrutiny reviews

Kirklees' review of a local service reconfiguration lasted eight months, including nine formal meetings and many more informal visits and focus groups. The authority does not have a dedicated scrutiny support function – a senior administrator, the Council's health policy co-ordinator, and two other officers supported this review. Members commented on the value of good advance briefing and highly developed clerking skills.

Barnsley MBC employ a dedicated adviser for each of their six scrutiny commissions. The role of the adviser includes putting forward topic options; preliminary research to identify lines of enquiry and suitable witnesses; organising meetings and briefing members; keeping the investigation on track; drafting a first report for members; and briefing the press. The initial advisers were subject specialists, seconded to support a particular scrutiny commission. However, over time, it has become apparent that skills – in particular the ability to assimilate large amounts of information and make the best use of members' time – are at least as important as any specialist knowledge.

Until recently, Derbyshire County Council employed one dedicated officer for its scrutiny function. This officer provided advice and support to a single Improvement and Scrutiny Committee. Following an increase in the number of committees from one to four, support was increased to two officers and remains under review in the longer term. In addition, the County Council, in partnership with Sheffield University, is using a PhD student to carry out some of the scrutiny research work and also has a small budget to engage consultants.



Step 3 – Developing local rules of engagement

48. Most local authorities have, or are developing, some form of protocol for internal scrutiny. This will need to be updated to include the health duty [CASE STUDY 5]. A written document is a useful reference point, but there is, perhaps, greater value in the *process* of drawing it up – it is always wise to experiment before finalising such a document. Local authorities have discovered that it takes time for elected members to learn what the scrutiny function is about. It follows, therefore, that significant time and energy will need to be devoted to helping local NHS bodies to understand the scrutiny process and be able to contribute positively to it.

49. The formal powers of scrutiny will be prescribed in government regulations and guidance – for example, in relation to disclosure of information. Beyond this, however, there should be as much local discretion as possible. While the content will vary, the coverage of local protocols should be fairly standard, incorporating:

- general principles for scrutiny, including reference to style and standards of conduct;
 - role and membership of OSCs, including safeguards to avoid conflicts of interest;
 - how evidence will be gathered, such as the range of methods to be used, who can be called and what is expected of witnesses; and
 - protocol for consultation, reporting and managing the media [EXHIBIT 10, overleaf].
50. Of course, protocols can only set out the theory. In practice, managing conflict between different political and managerial cultures is no small task. For example, many within the NHS fear that scrutiny will politicise complex decisions or prioritise public opinion over clinical evidence. Being challenged by local authority

CASE STUDY 5

Developing local rules of engagement for scrutiny

Sheffield City Council has developed a number of principles, as follows:

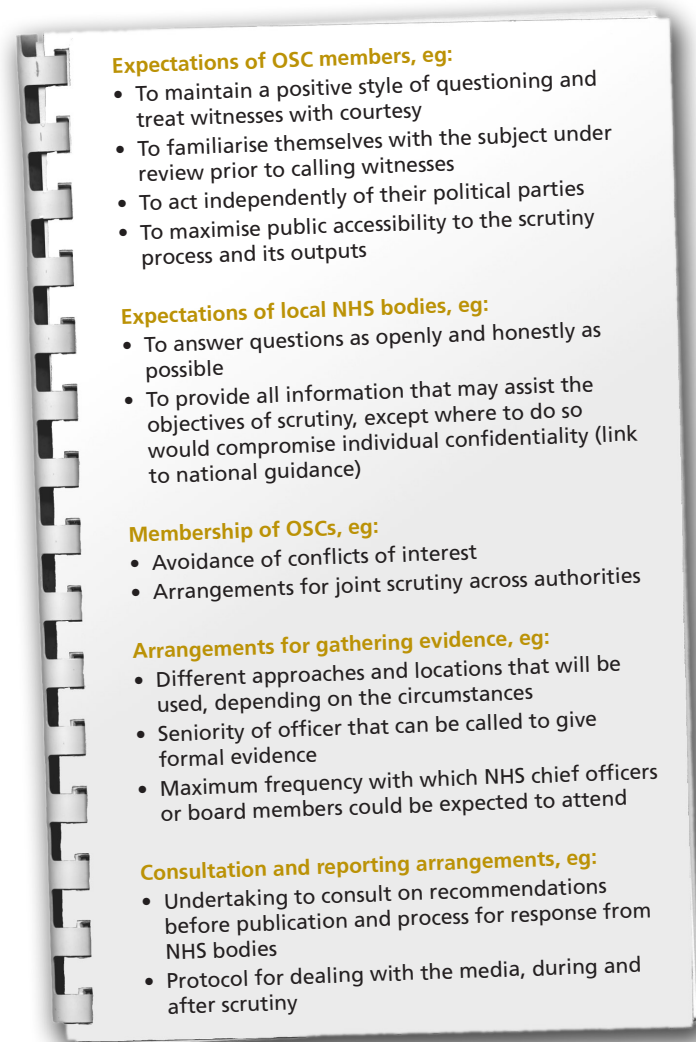
- scrutiny should help to develop a positive relationship between the Council and the health community;
- the Scrutiny Board should ensure that the community's aspirations with regard to improvement in health are pursued;
- relationships must be constructive and deal with disagreements in the same way;
- the scrutiny process will be inclusive and will relate to other processes of patient and public involvement; and
- all meetings will be held in public and will be based upon a forward plan.

The Council had extended the definition of a 'key decision' (ie, one that can be 'called in' by an OSC) in its existing protocol to apply to NHS decisions. The protocol reads: 'a key decision is one which sets or shapes a major strategy, or which falls outside of existing strategies, and which affects services to the value of or above the level set by the Council for this purpose, and/or which is considered to be a matter of major concern.'

EXHIBIT 10

Suggested contents of local rules of engagement for health scrutiny

While the content of local protocols will vary, the coverage should be fairly standard.



members will be a different experience for NHS chief executives to questioning by their own boards. For OSCs, maintaining a non-party-political approach (in line with government guidance) will be more crucial than ever when dealing with external services and agencies. Without this, scrutiny will have no credibility with those it seeks to influence.

51. It will be through actions – for example, treating witnesses with courtesy, taking an investigative and evidence-based approach, and using the media responsibly – not words, that OSCs will win the confidence and respect of NHS staff and board members [CASE STUDY 6]. In addition, OSC members should familiarise themselves with the different roles and cultures within the health service and its professions. The key to winning the confidence of the public and service users will be ensuring that the scrutiny process is as open and accessible as possible, and that its recommendations have real impact.

Source: Audit Commission fieldwork

CASE STUDY 6

Managing tensions and conflicts

Lewisham Council made the deliberate decision to use its most experienced scrutiny members to carry out its pilot health scrutiny review. Their experience enabled them to:

- question witnesses insistently but without being aggressive;
- be able to hear criticism of the authority without becoming defensive (recognising that they are not part of the executive); and
- give credibility to the views of individual service users, but place them in the context of other experiences and factors.

In Barnsley, some senior officers had difficulty adapting to being scrutinised. They felt that scrutiny was a drain on their time and were not used to detailed questioning. Scrutiny support officers have the following advice for witnesses:

- *don't be defensive* – be prepared to use the opportunity of scrutiny to help improve the way in which you and your staff work;
- *develop a thick skin* – cherished policies and practices will be challenged and sometimes criticised; and
- *don't pander to scrutiny* – the members want to have an intelligent discussion with you; if you think they are wrong, tell them why. The worst thing you can do is just nod vigorously and then not take any notice of what was said when you get out.

Step 4 – Drawing up a work programme and selecting scrutiny approaches

52. Once health scrutiny is 'up and running', the work of OSCs is likely to involve a combination of:

- maintaining an overview of local health issues, including

developing awareness of what other agencies are doing; and

- in-depth scrutiny reviews.

To support the former, OSCs need to decide what information they wish to receive on a regular basis – for example, monthly minutes from local NHS board meetings. They should identify what information is particularly relevant to the scrutiny

role. For example, it would be wise for OSCs to receive advance notification of major reconfiguration proposals or other issues likely to arouse public concern, but they should not seek involvement in issues that have no impact on the local community.

53. Although some matters will necessarily arise at short notice, OSCs should try to develop a forward programme for both in-depth scrutiny reviews and shorter items. There is a danger of over-ambition; OSCs are unlikely to be able to carry out more than two or three major reviews each year. And it is better to do one or two good ones, than a larger number of superficial inquiries. To avoid duplication, it is imperative that OSCs regularly check what other monitoring/review activity is taking place or pending in their area – including work within trusts or the health authority, by CHI, external auditors, patient representative bodies or other local authority OSCs. Draft scrutiny programmes should be shared widely with partners and neighbouring authorities (including between counties and districts) before being finalised.

54. Having drawn up a forward programme of health scrutiny work, OSCs need to consider the style and approach to be taken to each element. There are two broad approaches to scrutiny – retrospective and prospective – although these are not mutually exclusive. Both are valid, but the style and methods of each are quite different. Scrutinising a proposal to close a local hospital ward will necessarily be a more formal and less collaborative process than a review aimed at joining up services across agencies. OSCs will need to adapt their methods depending on the circumstances [BOX D].

Step 5 – Carrying out scrutiny reviews

55. Once an issue has been selected for scrutiny, the work of an OSC should have three distinct phases:

- **scoping** – resulting in a brief specification of what the scrutiny is seeking to achieve, its methods, timescale and resource requirements;
- **gathering information and evidence** – using a variety of methods and sources; and
- **drafting and consulting on recommendations** – ensuring

they are realistic and will have a positive impact.

Scoping reviews

56. A common learning point from early scrutiny (and best value review) experiences is: ‘We didn’t realise what we wanted to achieve until quite far into the process.’

Although one can never fully anticipate what will emerge during research, good preparation will reduce wasted effort. Before embarking on the main evidence-gathering phase, OSCs need to establish:

- the objectives of the scrutiny review, ensuring that these are manageable;
- the evidence required and how this will be obtained;
- the timescale for the review and the resources/support required.

57. Scoping should involve some preliminary research and analysis to ‘map’ the issue and the key players [CASE STUDY 7, overleaf]. For example, in Lewisham’s scrutiny of services for children with special needs, it was soon discovered that different agencies had different definitions of what constituted ‘special needs’ and that a wide range of

organisations needed to give evidence to reflect these differing perspectives. The appropriate timescale and number of meetings will vary, but it is desirable to aim for – and stick to – a fairly short review period, in order to maintain momentum and keep the issues fresh in members’ minds. The outcome of scoping should be a short document that will serve as a point of reference throughout the activities and meetings that follow.

Gathering information and evidence

58. For scrutiny to have credibility, it must be evidence-based. Local NHS bodies are unlikely to act on recommendations that are based only on assertion or opinion. Effective scrutiny will apply a number of different techniques, including:

- questioning witnesses and holding them to account in formal OSC meetings;
- gathering other evidence – in particular, the views and experience of members of the public and service users – in less formal settings;

BOX D

Choosing the right approach to health scrutiny

	APPROACH 'A' 'Retrospective'	APPROACH 'B' 'Prospective'
What is scrutiny trying to achieve?	<ul style="list-style-type: none"> • learning lessons from poor performance • reviewing/referring contested service reconfigurations 	<ul style="list-style-type: none"> • improving public health and well-being • improving/integrating services, identifying gaps and increasing accessibility
Sample topics	<ul style="list-style-type: none"> • following up a critical inspection report • assessing a service closure or development proposal (eg, new hospital, PCT merger) 	<ul style="list-style-type: none"> • improving the health of ethnic minorities • recruitment and retention of local health professionals • joining up services for people with mental health problems
Style of scrutiny	<ul style="list-style-type: none"> • formal, objective • asking difficult questions 	<ul style="list-style-type: none"> • informal but still challenging • collaborative
Likely methods of scrutiny	<ul style="list-style-type: none"> • public 'hearings', taking evidence from local service providers and users, plus expert witnesses • data analysis • members go out to 'reality check' evidence 	<ul style="list-style-type: none"> • extended research projects • work carried out by a sub-group of members, possibly some commissioned externally, who report back to the main OSC • external experts co-opted on to the OSC or sub-group
Prerequisites	<ul style="list-style-type: none"> • clear terms of reference and rules of engagement • reliable data and analysis • good preparation before conducting questioning • questioning skills 	<ul style="list-style-type: none"> • clear objectives • good inter-agency relationships and participation • spirit of partnership and openness • research skills
Sources of information	<ul style="list-style-type: none"> • views of individuals and users • national/professional guidance • inspection or audit reports • comparative practice and outcomes in other areas 	<ul style="list-style-type: none"> • views of individuals and users • local area statistics • existing reports/documents – eg, HIMP, best value reviews • good practice/innovation from other areas

Source: Audit Commission

CASE STUDY 7

Scoping scrutiny reviews

Before announcing an inquiry, Parliamentary Select Committees will typically:

- consult with the government department under scrutiny to check whether a review is (or is not) timely – eg, if there are consultation exercises or new legislation pending;
- contact specialists in the field (eg, academics) to identify key issues and identify potential witnesses – these conversations can be quite detailed, since they are aimed at establishing specific questions and objectives for the inquiry; and
- draw up draft terms of reference for the inquiry, setting out the precise range of questions that the inquiry will seek to answer.

In Kirklees, for each topic that is recommended for scrutiny, a pro forma must be completed, detailing:

- which scrutiny panel will undertake the investigation;
- how the issue will be scrutinised (eg, formal panel investigation or quick action by one or two named members) and what officer support is required;
- objectives of the scrutiny review;
- what scrutiny methods will be used;
- which council services, members and external agencies will be involved;
- how the public, and other stakeholders, will be involved in the review; and
- estimated date of start, key stages and final report.

- reality-checking – for example, testing transport routes or service accessibility; and
- desk research – for example, analysing comparative data or commissioning research from external groups (for example, universities or patients' forums).

59. The formal public hearing is the traditional form of scrutiny. It is probably most suited to 'reactive' scrutiny, where the objective is to test the rationale of policy decisions that have already been taken or are proposed. OSC members need to prepare carefully, to get the most

from such sessions. They must decide on the initial questions they wish to ask and what to probe with secondary questioning. One elected member reflects: 'It was difficult to remain within our agreed scope once we began talking to people.' Councils have found that hearings are more productive where witnesses have been briefed on what to expect from the committee – 'ambushing' witnesses is unlikely to be an effective method of scrutiny. Some ask witnesses to submit a brief paper in advance, or to make a short presentation, setting out their position [CASE STUDY 8]. If a witness is unable to answer a question on the day, it is reasonable for the OSC to request that a note of detail or clarification be supplied after the session.

60. The civic centre is not always the best location for scrutiny, particularly since the process should strive to reflect the perspectives of 'ordinary people'. Representatives of patients or users may be happy to give formal evidence, but the committee room environment is unlikely to put most individuals at their ease. Elected members will need to go out and meet service users in places that are convenient and comfortable for them. (A key

role of the new 'Voices' will be to advise and support this type of input.) Another way for elected members to get to grips with the issues at stake is for them to 'test' services through personal experience [CASE STUDY 9, overleaf]. It should be recognised, however, that these processes can be very time and resource intensive.

61. A wide range of players should contribute evidence, depending on the topic. For example, a scrutiny of why local people are experiencing long delays in obtaining an appointment with their GP would call in the chief executive of the relevant PCT for formal questioning. But OSC members might also wish to talk to, and learn from,

neighbouring PCTs where problems are less severe. If major changes were proposed to the services provided by the local hospital, OSCs would need to seek input from local public and patients, and call in representatives from:

- the NHS trust, whose chief executive is accountable for the services provided;
- local PCT(s), which negotiate delivery agreements on behalf of their patients; and
- the strategic health authority, which sets the overall framework within which trusts operate and controls their capital allocations.

62. Scrutiny may also draw on published information – for example, comparative data on NHS performance, or analysis of health needs from the public health department. Health is an area rich in data, but great care is needed in interpretation.¹ OSCs need to

CASE STUDY 8

Preparing for formal scrutiny questioning

Surrey County Council has a set procedure for briefing external scrutiny witnesses. An initial letter inviting the person to attend is followed up with a phone call from one of the scrutiny support officers. This enables the 'witness' to have an informal chat about the background to the scrutiny review, the issues that members wish to explore and the practicalities of the process (including any particular interests of individual members).

In Buckinghamshire, once the OSC has decided whom it wants to call in, a brief is prepared and sent to witnesses. Each witness is asked to submit a paper in advance. Support officers then work with members to identify what they are looking for from each interviewee, possible points of tension and how to handle these. They reflect: 'Even where there is an agreed outcome for the review, our experience has shown that there is also merit in having a clear outcome for each meeting, otherwise things can easily drift.'

Lewisham used an external facilitator for its pilot health scrutiny. The facilitator ensured that everyone who came before the committee had a clear idea of what local authority scrutiny was, as well as of the aims of this particular review. Simply sending out a letter was found to be inadequate: people needed to talk to someone – preferably face-to-face – who could 'demystify' the process and reassure them about its objectives. Witnesses were encouraged to attend an earlier meeting if possible, to get a feel for proceedings.

¹ From 2002, the Audit Commission and CHI will produce independent commentaries on local NHS performance, known as 'report cards'. These will be a useful source of information for scrutiny.

CASE STUDY 9

Gathering scrutiny evidence

North Tyneside's Health Select Committee investigated the effectiveness of community mental health services. Their information gathering fell into four distinct phases:

1. a series of meetings with local user groups to obtain their views and experiences;
2. presentations from professional experts, to inform members about relevant national guidance/policy and outline local problems and possible solutions;
3. informal meetings with two local GPs (nominated by their PCTs as having an interest in mental health issues) to obtain their perspective on what needed to be done;
4. raising issues identified from phases 1 to 3 with senior officers from the local authority, NHS Trust and an independent provider of mental health services (the first two appeared before the Committee; the last provided written representations).

Kirklees Council's review of health authority proposals to reconfigure services for women and children took evidence from 18 witnesses in 9 formal sessions. Following questioning by members, officers or members of the public were also invited to ask questions. In between the formal meetings, small groups of members went out to discuss the proposals on an informal basis. This included visiting the hospitals to talk to patients and staff, and going out to meet with groups of users, particularly hard-to-reach groups, such as women whose first language is not English. Members also tested public transport services between the two hospital sites.

Salford CHC takes a proactive approach to identifying the concerns of local people, at the same time as enthusing and informing its members: 'We go out and talk to people in bus queues, post offices, at bingo and tea dances – people tell you what is really bothering them.' The CHC's experience of obtaining user views is that different methods are needed, depending on the issue – contrast services with a clear, stable and well-informed client group (eg, renal or diabetes services) with services such as orthopaedics or accident and emergency, which individuals use only periodically or at times of crisis.

West Essex CHC carried out a survey of patients waiting for angiograms, as a result of concerns over unnecessary delays in diagnosis and treatment. Initial contact was followed up by short interviews on a monthly basis for the next three months. The review focused on the quality of information (written and verbal) provided to patients, as well as the time they had been waiting. Improvements in trust practice were noted as a result.

avoid being 'snowed under' by quantitative information or drawing conclusions without probing further into causal factors. In the words of one chief executive: 'Our members are not statisticians or auditors; they want to know where we are doing well, where not, and why not.' APPENDIX 3 suggests some potential sources of information to support the scoping and evidence-gathering stages of scrutiny. Audit and inspection reports will provide evidence for scrutiny (for example, members could challenge local NHS bodies on whether they have implemented recommendations) and, in exceptional circumstances, it might be appropriate for an OSC to call in the authors for questioning.

Drafting and consulting on recommendations

63. Since OSCs have no power to make decisions or to require that others act on their suggestions, recommendations need to be persuasive. This means they must be based on careful analysis of evidence *and* framed in an appropriate way. OSCs should ensure that their recommendations are realistic, reflecting the capacity of organisations to implement (and fund) them. Local NHS bodies are

already subject to requirements and recommendations from many other sources. Reflecting its status, scrutiny recommendations are best phrased as proposals for consideration, rather than imperatives, but they should be specific as to who is asked to act and when. One head of scrutiny advises: ‘We try to focus on the “what”, not the “how”.’

64. A strength of scrutiny is its independence and ability to take on board differing perspectives. Perhaps the most difficult challenge facing OSCs will be to balance ‘expert’ opinion and public concerns where these conflict – for example, in the case of service reconfigurations. To ensure credibility, OSCs should consult widely before finalising recommendations. While OSCs are not obliged to take on board consultation comments, it will be in their interest to do so if the points made are well founded. It is also good practice, and demonstrates transparency, for reports to acknowledge points that have been made, even if the OSC has decided not to incorporate them.

65. Similarly, pressure on local NHS and other agencies to act on recommendations will be greater

where these are well evidenced and have been agreed as realistic. Even if local NHS bodies do not agree with OSC recommendations it will be valuable for them to trace the underlying argument and understand the authority’s views. Scrutiny reports should emphasise positive, as well as critical, messages, recognising the impact of recommendations on those who will be expected to deliver them.

Step 6 – Launch and follow-up

66. OSCs will want to secure good coverage for their reports, both to disseminate messages and to encourage participation in later reviews. Councils should strive to develop constructive relationships with local media that will ensure responsible reporting of sensitive issues such as changes to local health services (but avoid seeking coverage just for the sake of it). They also need to be proactive towards the press – for example, releasing good news stories and progress reports on major changes – not waiting for the media to pick up a story and run with it without the facts. In this respect, they have much to learn from the experience of CHCs [CASE STUDY 10, overleaf].

Councillors should actively publicise the results of scrutiny reviews – and, crucially, what has happened as a result – in their area.

67. Scrutiny should not stop at the point that recommendations are delivered. OSCs must follow up their recommendations and look for evidence of impact – for example, a change in practice or resource allocation, strengthened clinical governance systems, reduced delays or higher patient satisfaction. Councils need to design a (flexible) process for follow-up, which could be included in their scrutiny protocol/rules of engagement. For example, OSCs may wish to request a written or oral update from relevant NHS bodies (or a member of the council’s executive) at regular intervals. This could include a general update on strategic issues in the organisation, as well as reference to the action that has been taken in response to a scrutiny review.

Scrutiny should not stop at the point that recommendations are delivered

CASE STUDY 10

Maximising the impact of scrutiny and managing the media

Barnsley MBC has discovered that scrutiny reviews can have a high public profile *if* you get out and sell it to the press – ‘press coverage is the key to public engagement’. Tips from the Council’s experience include:

- make sure that reports are written in a media-friendly style;
- talk to the press early and often, giving them as much background as possible;
- produce press releases during the review process, as well as at the end;
- use the releases to explain which witnesses are attending and what questions will be asked of them; and
- follow up press releases with telephone calls to increase media interest and clear up any potential misunderstandings.

Local authorities might wish to follow the lead of CHCs that have agreed media protocols with their local trusts. These provide, for example, for CHCs to be consulted on draft press releases, or, at the very least, to receive them early. In contrast, one CHC reports that its local acute trust repeatedly failed to share press releases or reports in advance, even on major public interest issues or ‘scandals’. This created even worse publicity for the trust when the press contacted the CHC for comment and it became clear that they had not been informed of the problem.

OSCs also have responsibilities towards the bodies they scrutinise. The national association of CHCs (ACHCEW) carries out an annual survey of waiting times in A&E. Before releasing the figures to the press, ACHCEW contacts the trusts with the longest waits. This enables trusts to double-check the figures and prepare a response as to why they were performing poorly on that particular day and what action is being taken.

that action will occur as a result of scrutiny: ‘In our experience, few executive members want to come back and admit that they have not implemented a County Council decision of some six months standing.’ A similar culture is required in relation to local NHS bodies.

69. Reports and recommendations for local NHS (and other) bodies will not be the only outcomes of scrutiny. Each completed review adds to the expertise of those involved and provides learning points for future work. Experience has highlighted the importance of good communication between scrutineers and scrutinised, before, during and after the scrutiny itself. While scrutiny is not intended to be an entirely comfortable experience, the process will be stronger if it learns lessons from the experiences of all involved.

68. There needs to be an expectation that local NHS bodies will implement OSC recommendations, or offer an explanation as to why they have not done so. For example,

Bedfordshire’s select committees ask for an update from the relevant executive member six months after each report has been published and debated by the Council. This has created a culture of expectation

4. Summary and recommendations

70. Health scrutiny is both a challenge and an opportunity, for local authorities and the NHS. If scrutiny is to have meaningful and positive impact, those involved need to focus on two key success factors:

- giving careful, early consideration to the objectives and context for scrutiny; and
- taking a constructive but challenging approach to the role, aimed at bringing together evidence and experience to address problems and drive improvement.

What is health scrutiny for?

71. It is crucial to be clear from the outset what health scrutiny is aiming to achieve. If scrutiny concentrates on developing solutions to issues and problems that really matter to local people, it will also capture members' interest and engage local NHS bodies. If not, the process risks becoming a costly and time-consuming chore. Authorities could start by identifying some positive outcomes for scrutiny – for example, breaking logjams that prevent vulnerable people from accessing the services they need, co-ordinating public consultation on health issues across

agencies, or attracting greater resources for health promotion.

72. Councils will be scrutinising a health system or economy, not just individual NHS bodies. Therefore, local authorities' power to scrutinise health should be seen in the context of their role in community leadership and local strategic partnerships. Acting in isolation, OSCs cannot deliver improvements in the health of the local population or the quality of services they receive. Neither will they achieve progress by taking 'cheap shots' at other local agencies. While the decision on what and how to scrutinise is one for local authorities, NHS bodies and other local stakeholders should be involved in discussions about the purpose and scope of the new role.

73. The field of NHS regulation is a crowded one. The purpose of the local authority scrutiny role should be to fill a gap in existing arrangements, not to duplicate them. In particular, the work of OSCs should focus on issues of local concern, where objective review by elected lay representatives will help progress to be made. Scrutiny is one part of wider developments in public and patient involvement in the NHS. To ensure an integrated

approach locally, OSCs, strategic health authorities and patient advocacy bodies need to set up clear lines of communication and information exchange.

Making it work

74. A constructive approach – based on mutual understanding between the OSC, the local authority executive function and local NHS bodies – will be a prerequisite for success. Where inter-agency relationships are currently poor, steps should be taken to build understanding before embarking on scrutiny. Scrutiny should always be challenging and will sometimes be uncomfortable for those on the receiving end. But if the process is confrontational, or relies on opinion rather than evidence, it is unlikely to lead to positive improvement. OSCs should aim to be a 'critical friend', while health bodies need to respond honestly to questioning and provide convincing explanations for why they do not take up scrutiny recommendations.

75. Getting scrutiny right is difficult. And health is a complex area for scrutiny. Those authorities that are new to scrutiny are strongly advised to develop their expertise internally first, identifying

what techniques work best, setting up support arrangements and developing member skills. They should also seek to incorporate learning from other authorities and draw on expertise within the health service, in particular the public health function. Successful health scrutiny will require investment of time and resources on the part of both local authorities and NHS bodies. OSCs should plan ahead and be realistic about what can be achieved in the early days of the new role. They must also manage demands on external agencies, working jointly with neighbouring authorities where necessary.

76. OSC members need to develop a basic understanding of how the NHS works and of the key issues within the local health economy. However, their role is not to become experts, but to ask challenging questions as elected lay representatives of their communities. The approach to individual health scrutiny reviews should depend upon the topic being addressed and the desired outcome. There is a good case for early reviews to focus on topics that are not technically complex and suit a developmental approach, helping

to build knowledge and develop trust between agencies.

77. The local authority scrutiny role in health will be as successful as local stakeholders want it to be. This paper has argued that the function can play a key role in improving local health, provided that local agencies approach it in a systematic way and a culture of openness. However, success will not be easy or automatic. Actions are required on the part of local authorities, local NHS bodies and central government [BOX E].

Successful health scrutiny will require investment of time and resources on the part of both local authorities and NHS bodies



BOX E**Recommendations****Local authorities should:**

1. Agree the purpose and scope of overview and scrutiny of health before undertaking any detailed work. Involve other local stakeholders in these discussions and create links to other citizen and patient organisations.
2. Develop and apply members' scrutiny skills internally before addressing health issues. Avoid highly complex issues in early reviews if possible.
3. Arrange for OSC members to receive a basic grounding in how the NHS works and learn about the key issues and pressures affecting the local health economy.
4. Devote an appropriate level of officer support to the scrutiny function, recognising the need for policy, research and facilitation skills, as well as administrative support.
5. Work with other local authorities and agencies to avoid duplication and manage the demands of scrutiny on local NHS organisations.
6. Draw up local rules of engagement for health scrutiny, in consultation with NHS bodies.
7. Consider co-opting external stakeholders on to scrutiny panels to strengthen expertise and credibility.
8. Ensure scrutiny is based on evidence, balancing expert opinion and user experiences.
9. Consult formally with affected bodies before finalising reports and recommendations. Ensure recommendations are practical and realistic.

Local NHS bodies should:

1. Seek early discussions with local authorities to learn about, and contribute to the development of, the overview and scrutiny process.
2. Suggest ideas for where scrutiny could add most value locally.
3. Consider what information about their services, priorities and performance it would be helpful to make available to OSCs at an early stage.
4. Adopt a positive approach to scrutiny, recognising the legitimate right of local elected representatives to ask questions about local health services and to receive answers.
5. Approach local authority scrutiny in the context of the wider modernisation of the NHS, aimed at delivering services that are patient focused and of a high standard.
6. Identify issues that need to be covered by local protocols to ensure that the scrutiny process works effectively.
7. Ensure that scrutiny recommendations are given serious consideration and clear explanations provided if any will not be adopted.

Continued overleaf...

BOX E**Recommendations (continued)****Central government should:**

1. Develop regulations and guidance that clearly establish the principles and legal powers of scrutiny, but allow local stakeholders freedom to decide how best to achieve objectives.
2. Provide guidance to local authorities and NHS bodies on:
 - the objectives of local authority scrutiny as distinct from other players in the complex NHS accountability and patient/public involvement frameworks;
 - the broad content and coverage of local rules of engagement (or ‘protocols’);
 - public access to the scrutiny process, with an emphasis on maximising openness;
 - the role of district councils in health scrutiny;
 - the circumstances in which joint scrutiny between local authorities or at regional/sub-regional level is expected, and suggestions of ways to approach this; and
 - expectations of local NHS bodies in relation to recommendations made by OSCs.
3. Clarify the expected resource implications of the new role – for local authorities and local NHS bodies – and whether there will be any government support for implementation.

Appendix 1

Members of the Project Advisory Group

Paul Corrigan	Policy Advisor to Secretary of State for Health, formerly Executive Director, Public Management Foundation
Donna Covey	Director, Association of Community Health Councils in England and Wales (ACHCEW)
Dr Jennifer Dixon	Director, Health Care Policy Programme, The Kings Fund
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Mike Reardon	Modernisation Team, Department for Transport, Local Government and the Regions
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Meredith Vivian	Head of Public Involvement Team, Department of Health

Audit Commission project team

Irene Payne	Associate Director, Public Services Research
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Appendix 2

Health service glossary

NHS trust	A hospital or group of hospitals that provides a wide range of health services. Trusts are self-governing public bodies accountable to health authorities and PCG/Ts.
Care trusts	A new type of primary care trust that will provide both primary healthcare and social care, delegated to them by local authorities. Creation of care trusts is optional, under the Health and Social Care Act 2001.
Clinical governance	Clinical governance is a statutory duty, falling on trust chief executives on behalf of their boards, to ensure that patients receive high quality healthcare. The local development of clinical governance is being overseen by the Commission for Health Improvement.
Commission for Health Improvement (CHI)	CHI is a statutory body, set up to provide advice and guidance on clinical governance issues and to oversee local arrangements. It carries out a rolling four-year programme of clinical governance reviews in trusts and health authorities.
Earned autonomy	A new incentive system, linked to the NHS Performance Fund, under which NHS organisations will be given a rating on the basis of their performance against the PAF. High-performing organisations will be rewarded with greater financial autonomy and less frequent monitoring.
Health Improvement and Modernisation Plan (HIMP)	The Health Act 1999 placed a duty on health authorities to work in partnership with local authorities to produce a health improvement programme (HIMP). These have been renamed Health Improvement and Modernisation Programmes (HIMPs). HIMPs will provide a framework for the delivery of NHS Plan objectives, as well as addressing health inequalities and the wider determinants of health.
Local Modernisation Reviews	Reviews in each local health community during 2001 to identify how to deliver the commitments in the NHS Plan. Reviews will consider the 'gap' between current performance and long-term targets and identify required investment (in staff, equipment etc) and organisational development. Outline plans will be converted into three-year delivery plans for each health authority area.
National Institute for Clinical Excellence (NICE)	NICE was established in April 1999 to assess clinical treatments and technologies and to produce national guidance that will reduce inconsistency in standards across the country. It intends to assess 30 to 50 drugs each year.

National Service Frameworks (NSFs)	Designed to reduce inequalities and drive up standards for certain medical conditions, NSFs set national standards and performance targets, and identify best practice models. NSFs will be developed on a rolling basis; three had been published by summer 2001 – coronary heart disease, mental health and older people – with a fourth, diabetes, expected soon. The implementation of NSFs will be monitored by CHI.
NHS Performance Fund	A new fund, building up to £500m a year by 2003/04, to support locally developed schemes to implement the NHS Plan. The Fund is intended to incentivise staff. The degree of freedom that local organisations have over how money is spent will depend on their performance rating.
NHS Performance Assessment Framework (PAF)	The conceptual framework within which NHS performance is assessed. The framework covers six areas – health improvement, fair access, effective delivery, efficiency, patient/carer experience and health outcomes – and is supported by a set of high-level indicators (see Appendix 3).
Patient Advocacy and Liaison Services (PALS)	Expected to be in place in every NHS trust and PCT by April 2002, PALS will provide information to patients and carers to help resolve problems and concerns quickly. They will also put people in touch with specialist or independent advocacy services should they wish to make a complaint.
Patients' forums	Proposed new statutory bodies in every NHS trust and PCT, made up of patients and other local people, with wide-ranging powers to inspect services from the user perspective.
Primary care groups and trusts (PCGs and PCTs)	<p>Formed on 1 April 1999, PCGs brought together all local general practices and community nurses. PCGs were tasked with:</p> <ul style="list-style-type: none"> • commissioning hospital and community-based health services; • promoting the health of the local population; and • developing primary healthcare. <p>Each PCG is managed by a board, with a guaranteed majority of GPs. The board also includes one or two community or practice nurses, a representative from the local authority social services department, a lay member, a health authority non-executive director and a chief executive who is appointed by the health authority.</p> <p>Since their creation, many PCGs have merged and/or achieved primary care trust (PCT) status. All PCGs will become PCTs by April 2002. PCTs will be freestanding statutory bodies (as opposed to sub-committees of the health authority, like PCGs) that will both provide and commission care, taking on responsibilities and budgets from health authorities.</p>

**Strategic health
authorities (StHAs)**

New larger health authorities will be formed in April 2002, which, subject to Parliamentary approval, will become strategic health authorities later in 2002. Strategic health authorities will performance manage NHS trusts and PCTs. They will be accountable to the Secretary of State for ensuring delivery of local health services in line with the NHS Plan.

Voices

Proposed groups of specialist workers, one for each strategic health authority area, to develop the capacity of patients' forums and draw together patients' experiences across the area. Voices are expected to be based in a host local authority. There will also be a national Voice to oversee the whole patient and public involvement system.

Appendix 3

Potential information sources for health scrutiny

National comparative data

The Department of Health's high-level indicators provide a good overview of local health issues and service performance. Last published in July 2000, new data is likely to be available in late 2001, possibly including greater detail at NHS trust level. From 2002, the indicators for each trust will be accompanied by a commentary by the Audit Commission and CHI. An indication of relative levels of deprivation – a proxy for health need – is available from the DTLR's deprivation index. Comparative information on individual hospitals, aimed directly at patients, is available at www.drfooster.co.uk

As with any comparative data sources, these indicators provide a starting point for further exploration and questioning. Care is needed in interpreting data and verifying its accuracy before arriving at judgements.

Topic/source	Information available
<p>NHS comparative performance</p> <p>DoH www.doh.gov.uk/nhsperformanceindicators</p> <p>Published annually in July (2001 indicators not yet available)</p>	<p>A set of 49 high-level indicators at health authority level, plus 7 at NHS trust level, arranged in 6 categories:</p> <ol style="list-style-type: none"> 1. Health improvement, eg: <ul style="list-style-type: none"> • deaths between ages of 15–64 • deaths from cancer 2. Fair access, eg: <ul style="list-style-type: none"> • inpatient waiting list • number of GPs 3. Effective delivery of appropriate healthcare, eg: <ul style="list-style-type: none"> • childhood immunisations • inappropriately used surgery 4. Efficiency, eg: <ul style="list-style-type: none"> • length of stay • maternity unit costs 5. Patient/carer experience, eg: <ul style="list-style-type: none"> • cancelled operations • outpatients seen within 13 weeks of referral 6. Health outcomes of NHS care, eg: <ul style="list-style-type: none"> • cancer survival rates • conceptions below age 18
<p>Social services comparative performance</p> <p>DoH www.doh.gov.uk/paf</p> <p>Published annually in October</p>	<p>50 performance indicators, arranged under 5 headings:</p> <ol style="list-style-type: none"> 1. National priorities and strategic objectives, eg: <ul style="list-style-type: none"> • stability of placements of children looked after • emergency psychiatric re-admissions 2. Cost and efficiency, eg: <ul style="list-style-type: none"> • unit costs of different types of care 3. Effectiveness of delivery and outcomes, eg: <ul style="list-style-type: none"> • older people helped to live at home • adoptions of children looked after 4. Quality of services for users and carers, eg: <ul style="list-style-type: none"> • waiting time for care packages • carer assessments 5. Fair access, eg: <ul style="list-style-type: none"> • ethnicity of children in need • assessments of older people per head population
<p>Comparative data on health needs</p> <p>DTLR www.regeneration.dtlr.gov.uk/research/id2000</p>	<p>Deprivation index, most recently calculated in 2000. Ward-level index based on 33 indicators across 6 domains:</p> <ul style="list-style-type: none"> • income; • employment; • education, skills and training; • housing; • geographical access to services; and • health deprivation and disability.

Commission for Health Improvement

Reports of all CHI investigations and local clinical governance reviews are available on the Commission's website, www.chi.nhs.uk. The site also includes action plans resulting from inspections.

Public Health Observatories

Following the 1998 White Paper, *Saving Lives: Our Healthier Nation*, the Government set up eight regional public health observatories (PHOs). The role of the PHOs is to monitor health and its determinants; to highlight future health problems; to assess the health impact of existing and potential policies; and to work in partnership with regional and local practitioners and policymakers.

The PHOs, with support from the Department of Health, have recently carried out a review of available health data sources. As part of this work, they have created a database of public health national data sources, which can be accessed at www.pho.org.uk. It is possible to search the database for particular areas of interest (eg, cancer or ethnicity). Authorities will also find a link to their local PHO from this website and can register to receive regular updates on data issues.

Sources of local information and intelligence

In addition to published comparative data, local authorities may wish to draw upon:

- reports from the health authority public health department;
- the local health improvement programme;
- publications by the local community health council;
- trust and health authority annual reports; and
- CHI inspection reports.

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T O P T E N Q U E S T I O N S

a healthy
outlook

local authority
overview and
scrutiny of health



For local authorities:

- 1** What do we want our scrutiny of health to achieve? Where can we add most value? What are sensible limits for the scope of the role?
- 2** What are the key issues affecting our local health economy? What are the public's main concerns?
- 3** Which other organisations are looking at these issues (eg, CHCs, local voluntary organisations, auditors and inspectors, local NHS bodies) and how can we make links with these?
- 4** What have we learnt from our scrutiny experience so far that will help us when looking at health issues?
- 5** What should be the criteria for selecting a health issue for scrutiny (as opposed to raising the council's concerns through the executive, the local strategic partnership or other forum)?
- 6** When and how will we need to co-ordinate, or work jointly with, neighbouring local authorities or district councils?
- 7** How should we incorporate the health scrutiny responsibility into our new political structures?
- 8** Realistically, what workload can the scrutiny function support in relation to health?
- 9** What skills, techniques and support do members need to develop in order to perform the role effectively? How can this be resourced and achieved?
- 10** How can we best involve local people in the scrutiny process?

For health authorities, NHS trusts and PCTs:

- 1 Where do we think scrutiny by elected members could add most value? What are the positive outcomes we would like to achieve?
- 2 How can we help local authorities to understand our priorities and the policy context in which we work?
- 3 Do we know how scrutiny is currently operated by the local council(s) – what methods and style have they used, how does it feel to be on the 'receiving end' and what tangible benefits have resulted?
- 4 What expertise can we contribute to local discussions about the role, and to the process itself, once it is up and running?
- 5 What information could we supply to the local authority on a regular basis to help them maintain an overview of local health issues?
- 6 What experience can we pass on from our relationship with CHCs?
- 7 What issues do we want to see addressed in formal 'ground rules' for the new process?
- 8 What seniority of officer would we be willing to have appear before the overview and scrutiny committee?
- 9 How should we involve non-executive board members in the scrutiny process?
- 10 How should we respond to recommendations made by overview and scrutiny committees?

The Audit Commission has produced a number of studies covering related issues. The following may be of interest to readers of this paper:

Change Here!

Managing Change to Improve Local Services

Managing change is one of the greatest challenges facing public services. Public service leaders have no option but to improve users' experiences of services if public and political expectations are to be met. The Audit Commission has drawn on its considerable accumulated experience of how local bodies can manage change successfully to improving services in *Change Here!*, a guide for top managers in local government and the NHS responsible for delivering services to their communities. *Change Here!* is intended as a light and interesting read for chief executives and their teams as they steer their own local organisations through change. It will also be of great interest to all those in specialist and corporate roles who are concerned with organisational change.

An interactive web-based tool is also available at www.audit-commission.gov.uk/changehere. This provides a quick and engaging route into the guide's key ideas, and helps users to find and explore topics and case studies of particular interest.

Management paper, 2001, ISBN 1862402752, £25, stock code GMP1804

Changing Gear

Best Value Annual Statement 2001

Changing Gear: Best value annual statement 2001 reviews the evidence of the first 18 months of the best value programme. It draws on a wide range of best value evidence to get below the headlines and see what is happening on the ground. *Changing Gear* considers how well councils are performing in response to the new framework. It examines the factors behind improved performance, what councils have learned and where improvement is needed. Common problems and difficulties are explored, and actions needed to deliver best value in the future explained. Crucially, it also looks at the role of best value audit and inspection, outlining the key criticisms of the national regime and the steps that need to be taken to address them.

This report contains important lessons that need to be learnt by best value authorities, auditors and the inspection service alike, if best value is to be made to work better. It will be a highly useful document for senior management, board members and service managers in all areas of local government.

National Report, 2001, ISBN 1862403074, £10, stock code LNR1849

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Health scrutiny is a key aspect of the modernisation agendas in both local government and the NHS. It develops local authorities' community leadership role and is one of a series of measures intended to strengthen public and patient involvement in the NHS. However, making a success of health scrutiny – so that it promotes real improvements in local health and healthcare – will be a significant challenge.

This paper explores the main questions facing local government and health bodies as they develop the new role. For example:

- Where and how will health scrutiny add most value?
- How does the role fit within existing NHS accountability arrangements?
- How can councils ensure that scrutiny has credibility with the public and those it seeks to influence?
- What are the practical implications for local authorities, in terms of skills, resources, structures and external relationships?
- What should local NHS bodies do to ensure that scrutiny works well?

Drawing on councils' experiences of scrutiny to date, *A Healthy Outlook* highlights ideas and good practice for the new role in health, and contains a range of practical checklists and case study examples.

The paper will be essential reading for local authority members and officers involved in scrutiny. It also aims to provide members of NHS boards with an introduction to the scrutiny role and help them to become involved in making it work locally.

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