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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH AND ADULT SOCIAL CARE)

Meeting to be held in the Civic Hall, Leeds on
Monday, 2nd April, 2007 at 1.30 pm (pre meeting at 12.30 p.m.)

MEMBERSHIP

Councillors

S Bentley	-	Weetwood
D Coupar	-	Middleton Park
Mrs R Feldman	-	Alwoodley
S Hamilton	-	Chapel Allerton
R Harington	-	Gipton and Harehills
J Illingworth	-	Kirkstall
G Kirkland	-	Otley and Yeadon
B Lancaster (Chair)	-	Moortown
J Lewis	-	Kippax and Methley
L Russell	-	Farnley and Wortley
A Shelbrooke	-	Harewood

Co-opted Members

J Fisher	-	Service Users and Carers Alliance Group
A Giles	-	Leeds PPI Forums
E Mack	-	Leeds Voice Health Forum Co-ordinating Group
M Ndzinga	-	Leeds Voice Health Forum Co-ordinating Group

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25 of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded)	
2			**EXCLUSION OF THE PUBLIC** To identify items where resolutions may be moved to exclude the public	
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes)	
4			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81(3) of the Local Government Act 2000 and paragraphs 8 to 13 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE**	
6			**NHS ANNUAL HEALTH CHECK - DRAFT COMMENTS OF THE BOARD** To cinsider a report from the Head of Scrutiny and Member Development presenting draft comments of the Scrutiny Board in line with the NHS Annual Health Check process.	1 - 14

Item No	Ward/Equal Opportunities	Item Not Open		Page No
7			**FUTURE REDESIGN AND RE-COMMISSIONING OF LEEDS AND WEST YORKSHIRE URGENT CARE SERVICES** To consider proposals by the Leeds Primary Care Trust for the redesign and re-commissioning of Leeds and West Yorkshire Urgent Care Services.	15 - 22
8			**REVIEW OF THE PROTOCOL BETWEEN THE SCRUTINY BOARD AND NHS BODIES IN LEEDS** To review the exisiting protocol between the Scrutiny Board (Health and Adult Social Care) and NHS bodies in Leeds, with particular focus around consultation processes.	23 - 54
9			**DATE AND TIME OF NEXT MEETING** Monday, 23rd April 2007 at 10.00 a.m. in the Civic Hall, Leeds (pre-meeting at 09.30 a.m.)	

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Agenda Item 6

Originator:	A Brogden
Tel:	247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 2nd April 2007

Subject: NHS Annual Health Check – Draft Comments of the Board

Electoral Wards Affected:	**Specific Implications For:**	
	Equality and Diversity	☐
	Community Cohesion	☐
	Narrowing the Gap	☐

1.0 Introduction

1.1 In relation to the NHS Annual Health Check process, the Board considered reports from the 3 local NHS Trusts at its meeting on 19th March 2007. These reports detailed the progress made by the Trusts in complying with the core and developmental standards set by the Department of Health.

1.2 At this meeting, the Board also discussed areas relevant to the core and developmental standards that it would like to provide comments on based on the work of the Board over the last 12 months. Draft comments of the Board have now been produced based on an officer's interpretation of the Board's discussions. Members are therefore asked to endorse or make changes to the draft comments for inclusion into the Trust's final declarations as part of the Annual Health Check process.

2.0 Recommendation

2.1 The Board is asked to endorse or make changes to the attached draft comments for inclusion into the Trusts' final declarations as part of the Annual Health Check process.

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NHS Annual Health Check

Draft Comments of the Scrutiny Board (Health and Adult Social Care)

Leeds Teaching Hospitals NHS Trust

Core Standard 17
The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.

As a Scrutiny Board, we feel that compliance with this particular standard is most paramount if we are to move away from an NHS service that does things to and for its patients and create a more patient-led NHS which gives patients choice about how, when, and where they receive services.

We acknowledge that the NHS has been required to consult on changes to health services for many years. However, in relation to the current statutory duties around consultation, which are set out in sections 7 and 11 of the Health and Social Care Act 2001, we are disappointed as a Scrutiny Board to have needed to react to public concerns about a lack of consultation undertaken by the Trust on three separate occasions this year. These refer to decisions made by the Trust to reconfigure renal services in Leeds, to close an elderly ward at Wharfedale Hospital, and more recently, the decision to delay the application to fund a Children's and Maternity Hospital in line with the Making Leeds Better Programme.

We believe that any proposals for service change should be discussed at an early stage with key stakeholders, to identify whether the proposals are substantial, and to gain clarity and agreement on the purpose of consultation.

In future, we would welcome regular communication between local NHS bodies and the Scrutiny Board to help identify substantial proposals at an early stage so that scrutiny can be efficient and effective. We have agreed to revisit our local protocol with all NHS bodies to explore how we can work more effectively together to ensure that where the need for consultation is identified, such consultation is carried out effectively.

Core Standard 18
Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably. Access to services and treatment equitably.

The Government White Paper 'Our Health, Our Care, Our Say' states that service providers and commissioners must continuously find out what people

want from their services and emphasises the strengths of community-based health provision and the importance of giving people a choice in services.

As part of our work programme this year, we carried out an action learning project around Community Development in Health and Wellbeing. We explored the value of this approach in reducing health inequalities and promoting healthier lifestyles by empowering people to articulate their health needs and ways they might be met and then enabling action by local people. Whilst we are yet to publish a report setting out our final conclusions and recommendations, we would like to use this opportunity to emphasise the importance for all providers and commissioners of health and social care services to recognise the value of this approach in establishing the needs of the local population.

C6
Healthcare organisations cooperate with each other and social care to ensure that patients' individual needs are properly managed and met.

D5
Healthcare organisations work together and with social care to meet the changing health needs of their population by a) having an appropriately constituted workforce with appropriate skill mix across the community; and b) ensuring the continuous improvement of services through better ways of working.

In April 2006, the previous Scrutiny Board (Health and Wellbeing) concluded its Inquiry into Older People's Mental Health Services in Leeds. This Inquiry demonstrated the importance of healthcare organisations and social care cooperating with each other to meet the needs of a particular client group. Since April 2006, we have been monitoring the implementation of the recommendations arising from this inquiry.

It has been recognised, both nationally and locally, that older people with mental health problems have not benefited from some of the service developments seen in younger adult health services or for those older people without mental illness.

Whilst acknowledging that improvements had been made in recent years to services for older people with mental health problems in Leeds, there was a clear message from key partners during the Scrutiny Inquiry that resources remained tied up to a disproportionate degree in reactive, acute and institutionalised services and that not enough was being targeted at preventative measures. There was therefore a clear need for local partnerships across health, social care and the independent sector to work together and shift resources across the local economies to support and sustain such preventative services.

Fortunately the Department of Health's 'Partnerships for Older People Projects' (POPP), which was being led by its Older People and Disability Division, aimed

to test and evaluate, through the use of pilots, innovative approaches that would sustain prevention work in order to improve outcomes for older people. Leeds had been successful with its POPP bid application, which focused on the redesign and development of mental health services for older people, and consequently was awarded £4.1 million of pump-priming funding to progress with its redesign proposals.

We will continue to monitor progress in line with the inquiry recommendations and also with the delivery of the POPPs programme in Leeds. In particular, we will be monitoring the commitment from all partners to the whole system re-design of mental health services for older people in Leeds and towards the long term sustainability of the new services beyond the 2 years POPPs grant funding.

C13
Healthcare organisations have systems in place to ensure that a) staff treat patients, their relatives and carers with dignity and respect; b) appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information;
and c) staff treat patient information confidentially, except where authorised by legislation to the contrary.

As part of our work programme this year, we conducted an Inquiry into Dignity in Care for Older People. High quality health and social care should be delivered in a person-centred way that respects the dignity of the individual receiving them. However, it is recognised nationally that older people in particular are not always treated with the respect they deserve.

The timing of our Inquiry coincided with the official launch of the Dignity in Care Challenge by the Department of Health. During our Inquiry, we focused on issues such as personalising services, listening and supporting people in expressing their needs, tackling loneliness and isolation, addressing self esteem and confidence issues, and incorporating dignity in care within staff training programmes.

It is important to help create a zero tolerance of lack of dignity in the care of older people, in any care setting. There is a need to inspire and equip local people, be they service users, carers, relatives or care staff with the information, advice and support they need to take action to drive up standards of care with respect to dignity for the individual.

The findings and final recommendations of our Inquiry will be published end of April 2007 and will be shared with the Heathcare Commission in line with its current work around Dignity in Care.

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Healthcare organisations have systems in place to ensure that patients, their relatives and carers a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services; b) are not discriminated against when complaints are made; and c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

As part of our Inquiry into Dignity in Care for Older People, we explored the complaints procedures and whistle-blowing policies of local NHS Trusts. It is paramount that patients and their relatives and carers are able to voice any concerns regarding a service and that staff are also given opportunities to express concerns without the fear of retribution from an employer.

Whilst procedures within different Trusts are there to meet the needs of patients and staff, we feel that there would be benefits in developing more consistent complaints procedures and developing common standards across the city to address concerns that have been raised, such as the length of time to resolve complaints and the lack of feedback following complaints.

Leeds Primary Care Trust

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C23
Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

In April 2006, the previous Scrutiny Board (Health and Wellbeing) concluded its Inquiry into Childhood Obesity Prevention and Management. In February 2007, we received a progress report on the implementation of the Board's recommendations and on the delivery of the new Leeds Childhood Obesity Strategy.

We learned that a full-time Childhood Obesity Coordinator to support the implementation of the Strategy is yet to be recruited and that the reconfiguration of Primary Care Trusts in Leeds had contributed to this delay in recruitment. We therefore urge that this is addressed as soon possible.

Leeds Mental Health Teaching NHS Trust

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Whilst procedures within different Trusts are there to meet the needs of patients and staff, we feel that there would be benefits in developing more consistent complaints procedures and developing common standards across the city to address concerns that have been raised, such as the length of time to resolve complaints and the lack of feedback following complaints.

C11
Healthcare organisations ensure that staff concerned with all aspects of the provision of health care a) are appropriately recruited, trained and qualified for the work they undertake; b) participate in mandatory training programmes; and c) participate in further professional and occupational development commensurate with their work throughout their working lives.

In October 2005, a scrutiny inquiry into the Fire Safety Standards of Leeds Mental Health Teaching NHS Trust's PFI Buildings was carried out. As it is mandatory for all staff to receive fire safety training and attend fire safety refresher courses on an annual basis, concerns were raised during the Inquiry about the lack of a consistent approach towards fire safety training for staff within the buildings.

It was recommended to the Trust that it carries out an audit of staff training immediately and reports the findings to its Health and Safety Committee for consideration and action. To help manage the monitoring of such training, it was recommended that this is carried out using a centralised mechanism rather than by individual ward areas.

We have continued to monitor the Trust's progress in implementing our recommendations this year and have welcomed the improvements made. However, it is vital that the Trust's own Health and Safety Committee now continues to monitor the training situation with staff.

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Leeds CITY COUNCIL

Originator: A Brogden

Tel: 247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 2nd April 2007

Subject: Future Redesign and Re-commissioning of Leeds and West Yorkshire Urgent Care Services

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
	Narrowing the Gap ☐

1.0 Introduction

1.1 In March 2008, Leeds Primary Care Trust's contract with Local Care Direct and North Yorkshire Primary Care Trust for the provision of GP Out of Hours services will expire.

1.2 In view of this, the Leeds Primary Care Trust is now consulting with stakeholders on proposals to redesign and re-commission urgent care services in Leeds and across West Yorkshire.

1.3 A copy of the briefing paper considered by the Leeds Primary Care Trust Board on 22nd March 2007 is attached for Members information. This briefing paper sets out the case for change, the proposed model of urgent care and outlines the timescales, structures and governance arrangements for delivery.

1.4 The Board is asked to consider the PCTs proposals prior to the formal consultation process, which is due to commence in May 2007.

1.5 Representatives from the Leeds Primary Care Trust will be attending today's meeting to present the proposals to the Board and to answer any questions from Members.

2.0 Recommendation

2.1 The Board is asked to consider and comment on the Leeds Primary Care Trust's proposals to redesign and re-commission urgent care services in Leeds and across West Yorkshire.

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Leeds PCT Board Briefing

Future Redesign and Re-commissioning of Leeds and West Yorkshire Urgent Care Services

1. Purpose of paper

The purpose of the paper is to:

- Brief the Board on the strategic development of Urgent Care services within Leeds and West Yorkshire.
- Confirm Board's support for the proposed process to redesign and re-commissioning future Urgent Care (UC) services in Leeds and West Yorkshire

2. The Case for Change

In March 2008 Leeds PCT's contract with Local Care Direct (LCD) and North Yorkshire PCT (NYPCT) for the provision of GP Out of Hours (OOHs) services will expire. This provides the PCT with a strong lever to enable the redesign and re-commissioning of UC services in response to local and national drivers including current performance issues. These can be summarised as follows:

- **Improved Patient Pathways and Benefits:** National and local feedback from patient and the public has emphasised the need to:
    - Improve integration between different UC services
    - Improve information sharing between different UC services to reduce repetition and duplication
    - Simplify and improve access to face to face UC treatment services

- **National Health Policy and Reform:** Joint planning and commissioning of UC services, integrated call handling and service provision, reduced service duplication and value for money, have been advocated through a raft of policies and reform over the last 5 years. These include the NAO report on provision of Out of Hours and the 2006 White Paper *The Direction of Travel for Urgent Care.*

- **Local Strategic Change:** Through the former 5 Leeds PCTs UC Board, significant work has been undertaken to develop a future model of UC services for Leeds. The model aspires to overcome the current duplication and fragmentation of Minor Injuries, Walk in Centre and Out of Hours care (Appendix 1) by delivering an integrated UC service for Leeds (Figure 1). The strategy, estates, finance and service requirements and implication of strategic planning and delivery are now being progressed as part of the wider MLB programme.

3. Proposed Model of Urgent Care

At a minimum, the PCT is required to tender the future provision of GP OOHs services for provision from April 08. The current provider of OOHs services for Leeds (LCD & NYPCT) is also commissioned to provide OOHs by Wakefield, Bradford, Calderdale and Kirklees PCT with all 5 contracts ending in March 08.

Significant work has been undertaken by UC Leads across the West Yorkshire PCTs to scope the future UC pathway following the contractual end of current OOHs providers. It is agreed across West Yorkshire UC Leads that there are significant advantages in the joint West Yorkshire commissioning of UC call handling and assessment. However, models for local face to face treatment of patients with UC needs should be specified and commissioned locally to meet local needs.

LCD & NYPCT currently provide both the call handling and assessment function for patients with UC needs. There is the requirement therefore to simultaneously but separately tender (for delivery from April 08) for :

- **Provision of a West Yorkshire UC call handling and assessment function :** To call handle and assess patients seeking Urgent Care In and Out of hours. Then advising, referring on and booking patients into Primary, Community, Intermediate, Emergency and Urgent Care. The 999 number will still exist however 999 calls assessed by YAS as not needing an emergency response (Cat C) could be routed to this function. NHS Direct would continue to exist (due to it being commissioned centrally) but with an improved interface with the call handling and assessment function.

- **Provision of Leeds Face to Face UC treatment services** for patients with an urgent care need. This would provide treatment currently provided within WiCs, MIUs and by the GP OOHs service and would be provided from centres (proposals and sites to be discussed both internally and through consultation process) across Leeds and on a domiciliary basis.

Figure 1 provides a high level overview of how these functions (elements 2 & 5) fit within the wider model of UC services for Leeds. Development of specifications for both service elements is required regionally and locally through local engagement and consultation with the public, patients, clinicians and current providers (see 6.2).

4. Strategic Context - West Yorkshire & MLB

The mandate to scope the potential redesign and re-commissioning of regional UC services was initially provided by the former 15 West Yorkshire PCT CEs in Spring 2006. In December 06 and January 07 the new West Yorkshire Chief Executives endorsed their support for the progression of the West Yorkshire Strategic Commissioning Programme (WYUSC). CEs supported a 6 month extension of the LCD contract to afford additional time for re-design, nominated of an executive sponsor Mike Potts (CE of Kirklees PCT) to oversee the co-ordination of the West Yorkshire elements of the programme and supported progression of a West Yorkshire collaboration in commissioning of call handling and assessment.

Within Leeds, the development of a wider future model of UC has been progressed over the last 2 years through the former Urgent Care Board. Within the new PCT, this critical area of re-design is a key element of the PCTs Strategic Development Programme, MLB. The strategy, estates, finance and service requirements and implication of strategic planning and delivery are now being progresses as part of the wider MLB programme and governance structure.

5. Benefits & Outcomes

The following benefits and outcomes should be achieved through delivery of the proposed redesign and re-commissioning:

- Improved patient experience – Responding to existing patient feedback both locally and nationally
- Improved performance in the areas of the A&E 4 hour standard, ambulance and OOHs
- Financial efficiency gains through the reduction of duplication within the system

6. Critical Timescales for delivery.

PCT re-organisations and the associated delay in affirming CE support for the programme has resulted in an extremely restrictive timetable for the consultation, specification and procurement of the future service. Pending Board approval of the work programme, the following milestones will apply:

Critical Milestone	Deadline
Adverts in HSJ & European Journal (West Yorkshire Call Handling and Assessment Specification & 5 Local Treatment Specifications)	May 07
Formal Consultation Period	May - July 07
Expressions of interest received	June 07
Return of Pre Qualification Questionnaires	June 07

Tender shortlist complete	July 07
Tenders Invited	August 07
Tenders Received	September 07
Tender clarification meetings	October 07
West Yorkshire contract awarded	October 07
Local Treatment contracts awarded	November 07
Transition period	November 07-March 08
Contract commences	April 08

6.1 Procurement and Tendering for both the West Yorkshire and Local specifications will be led and provided by the Yorkshire and Humber Procurement Collaborative on behalf of the 5 West Yorkshire PCTs.

6.2 Consultations and Engagement with patients, public, professionals and current providers will inform the development of West Yorkshire and Leeds service specifications. A Communications and Consultation strategy for West Yorkshire and Leeds has been developed with a meeting scheduled with the OSC for early April (pending Board approval). The framework and approach to the MLB Consultation and Communications process will be used to implement the local Consultation and Communications including expertise, resource and structures from within the Corporate Development Directorate of Leeds PCT.

6.3 Programme Structure and Governance Arrangements have been developed, underpinned by PRINCE2 and MSP method. Distinct project areas have been identified, planned and are being led across West Yorkshire by an Urgent Care lead. Programme management funding and a programme office function are to be provided through YAHA (formerly WYPCO) with additional support being provided in like through the input and leading of work areas by PCT Urgent Care, Communications and PPI leads.

Accountability for programme delivery rests with each PCT with a West Yorkshire Urgent Care Board, chaired by SRO Mike Potts and consisting of an appropriate director for each PCT, overseeing overall programme delivery. Given the strategic context of the West Yorkshire and Leeds redesign and re-commissioning of UC within MLB, it is recommended that this is the Executive Director of Strategic Development.

7. Recommendations

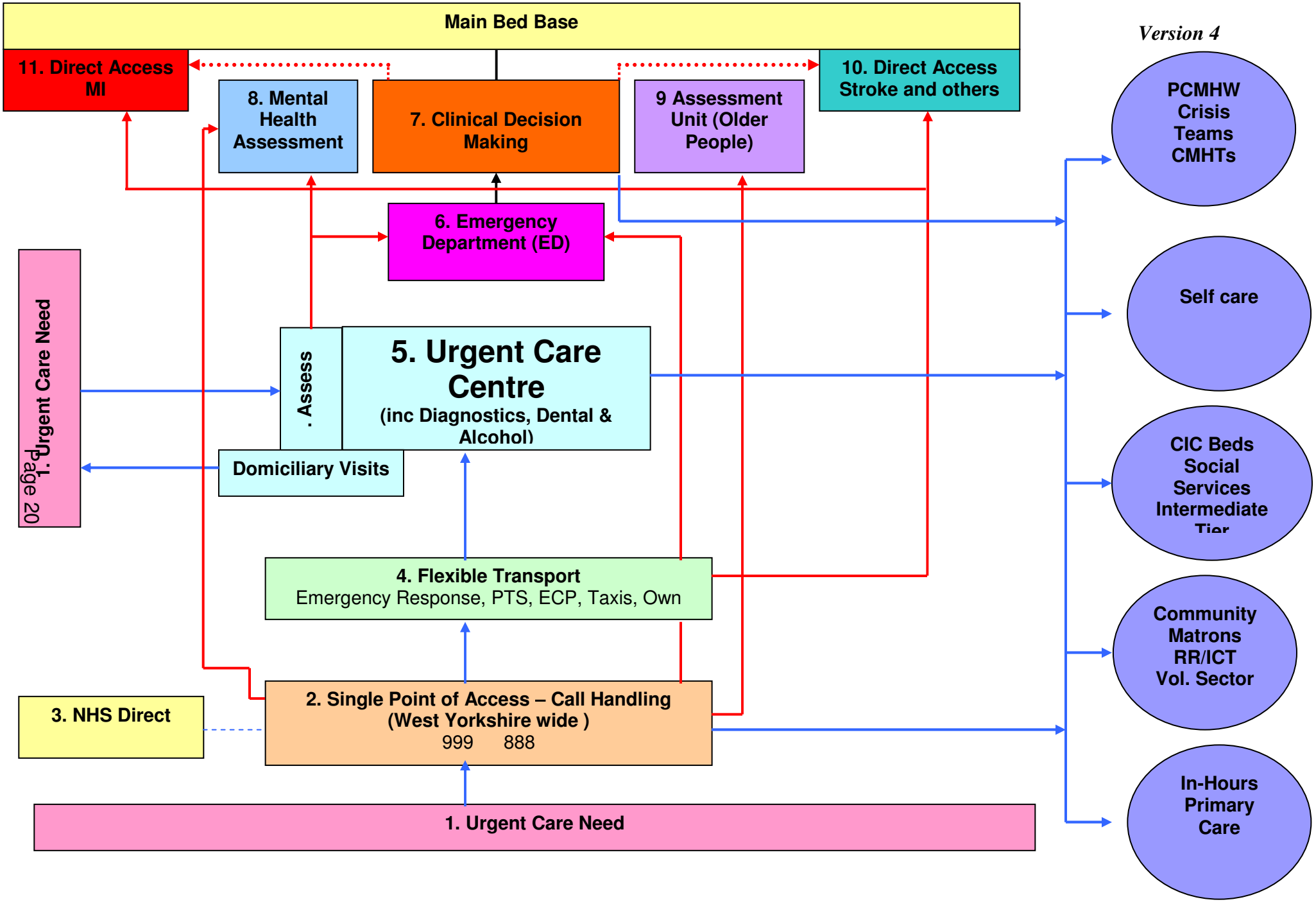
Board are asked to:

7.1 Note the content of this paper and support the continuation of the PCT's collaborative approach to the specification and commissioning of West Yorkshire UC services as well as the local specification.

7.2 Support and provide the mandate to place adverts in May 07, with options and costings on the Leeds UC treatment model and specification presented back to Board for sign-off prior to the formal tendering stage**.**

7.3 Support the representation of Leeds PCT on the West Yorkshire Urgent Care Programme Board by the Executive Director of Strategic Development.

Gina Long and Sue Hillyard
March 2007


Main Bed Base
Version 4
11. Direct Access MI
8. Mental Health Assessment
7. Clinical Decision Making
9 Assessment Unit (Older People)
10. Direct Access Stroke and others
PCMHW Crisis Teams CMHTs
6. Emergency Department (ED)
Self care
1. Urgent Care Need
. Assess
5. Urgent Care Centre
(inc Diagnostics, Dental & Alcohol)
Domiciliary Visits
CIC Beds Social Services Intermediate Tier
4. Flexible Transport
Emergency Response, PTS, ECP, Taxis, Own
Community Matrons RR/ICT Vol. Sector
3. NHS Direct
2. Single Point of Access – Call Handling
(West Yorkshire wide)
999 888
In-Hours Primary Care
1. Urgent Care Need

Appendix 1

Table 1 – Current Provision of Urgent Care services in Leeds

Service	Provider	Commissioner	Location
2 x Accident and Emergency Depts.	LTHT	Leeds PCT	LGI and St James
Two Walk In Centres	LTHT	Leeds PCT	St Georges, Middleton & Wharfdale General Hospital, Otley.
Jubilee Walk in Centre	LTHT	Leeds PCT	LGI (front-ends A&E)
Commuter Walk in Centre	Netcare UK	DoH	'The Light', Leeds City Centre
In-hours Primary Care	Various	Leeds PCT	Practices & Pharmacies throughout Leeds
GP Out of Hours Service	North Yorks PCT	Leeds PCT	Wharfdale General Hospital
NHS-Direct	NHS-Direct	DoH	National telephone number
GP Out of Hours Service	Local Care Direct	Leeds PCT*	Lexicon House, Sheepscar & St Georges
Emergency & Urgent Transport	YAS	Leeds PCT*	Throughout Yorkshire & Humber

** LCD and YAS are regional providers of urgent care and are individually commissioned by all 5 West Yorkshire PCTs (Leeds, Bradford, Kirklees, Calderdale and Wakefield)*

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Originator: A Brogden

Tel: 247 4553

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health and Adult Social Care)

Date: 2nd April 2007

Subject: Review of the Protocol between the Scrutiny Board and NHS bodies in Leeds.

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
	Narrowing the Gap ☐

1.0 Introduction

1.1 At the Board's February 2007 meeting, Members agreed to review the existing protocol between the Scrutiny Board and NHS bodies in Leeds, with particular focus around consultation processes.

1.2 A copy of the existing protocol is attached for Members' consideration.

1.3 The Centre for Public Scrutiny has also produced a guide to help clarify the roles of Overview and Scrutiny Committees (OSCs) considering health issues and how they relate to consultations on substantial variations and developments of health services. The guide also aims to encourage and enable OSCs and NHS bodies to reach agreement on what constitutes 'substantial' within their local context. Relevant extracts from this guide are attached for Members' information.

1.4 Representatives from local NHS Trusts have been invited to today's meeting to contribute to the Board's review of the existing protocol.

2.0 Recommendation

2.1 The Board is asked to review the existing Protocol between the Scrutiny Board and NHS bodies in Leeds and to identify any necessary changes.

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LEEDS
CITY COUNCIL

Scrutiny Board (Health)

Protocol between the Scrutiny Board (Health) and NHS Bodies in Leeds

Agreed by the Board: 7th April 2003

Introduction

The Health and Social Care Act 2001 provides explicit powers for local authorities to scrutinise health services within their areas as part of their wider role in reducing health inequalities. The Act also identifies duties for the NHS within the Scrutiny process to ensure effective implementation. In Leeds the Health Scrutiny responsibilities will be undertaken by the Scrutiny Board (Health).

The purpose of this protocol is to provide guidance and a common understanding for how Health Scrutiny will operate in Leeds and provide a framework for the scope and style of Scrutiny in the City. In so doing the aim is for all parties to help ensure that Scrutiny remains a positive and challenging process.

Coverage

Health Scrutiny in Leeds covers all aspects of health and health related services provided to the population of Leeds; this includes the planning, provision and operation of Health services commissioned and provided by NHS bodies and the local authority in Leeds.

The Scrutiny Board will not manage the performance of NHS Trusts in the City (although performance data will inform Scrutiny inquiries), or provide another form of inspection. The Strategic Health Authority, the National Institute for Clinical Excellence and the Commission for Health Improvement will perform these activities.

In addition the Board will not duplicate advocacy arrangements on behalf of patients/service users[1] (although collated data will be important).

Scrutiny will be distinctive in being undertaken by lay, elected representatives and focussed on improving health and well being across Leeds.

Scrutiny Board Composition

The Scrutiny Board (Health) will be composed of Elected Members selected to represent the political balance of the local authority. These Members will be the only members of the Board with voting rights and will be selected to serve for a period of 12 months. The membership of the Board will seek to avoid conflicts of interest and where potential for this exists interests of those Members will be declared and subject to the Council's procedures on these matters[2].

In addition the Board may seek nominations from other representative groups to be members of the Board. These nominations may be for a year or on an inquiry by inquiry basis.

[1] A separate protocol will be published on the relationship between the Scrutiny Board and the developing Patient and Public Involvement bodies once they become formally established.
[2] Leeds City Council Constitution - Scrutiny Board Procedure Rules Section 2

Responsibilities

Board Members

Scrutiny Boards do not have decision-making powers. The role of Board Members is to hold the Council's Executive and local NHS organisations to account and secure improvements in local practice for local people.

A separate Member/Officer protocol [3] has been agreed by the City Council. This will be used as the basis for the conduct of Scrutiny Board Members in their dealings with officers from NHS bodies.

NHS Officers

NHS officers are responsible to a range of bodies. These include NHS Trust Boards, the Strategic Health Authority, the Department of Health and emerging patient and public involvement bodies.

NHS bodies welcome the role of the Local Authority Scrutiny as an integral and essential method for publicly holding them to account.

In order to facilitate this representatives of NHS bodies will answer questions openly and honestly and provide all information that will assist the Scrutiny Members in their consideration of Scrutiny Inquiries.

The Role of Directors of Public Health

To assist the Scrutiny Board (Health) the Directors of Public Health (from Primary Care Trusts) may be requested to assist the Scrutiny Board (Health) in matters under investigation. In most cases this input will be outlined in Terms of Reference for an Inquiry and notification given to the relevant Director well in advance.

Scrutiny Support Unit

In summary, the work of the Scrutiny Support Unit entails:

- Providing a research and intelligence function to Scrutiny Boards (each of which has been allocated a different area of specialism)

- Managing programmes of Inquiries for each of the Scrutiny Boards

- Managing the presentation of witnesses, research and reports to Scrutiny Boards and/or carrying out research and reports "in house" as appropriate

- Assisting Scrutiny Boards to prepare reports of their Inquiries and steering recommendations through the Council's decision making arrangements

- Leading the continuing development of the Overview and Scrutiny function

[3] Leeds City Council Constitution - Section 5

Information to be supplied to the Board

The work of the Scrutiny Board (Health) will involve a combination of maintaining an overview of local health issues, including developing awareness of what health bodies are doing, and undertaking in-depth Scrutiny Inquiries.

To support and enable this work Board Members will require information from NHS bodies. Some of this may, by necessity, include information currently stipulated in the freedom of information Act 2000. As a general rule the information expected by the Scrutiny Board (Health) will include:

- minutes from meetings of the Board open to the Public (it is anticipated that these will be circulated to Members in separately to the normal Agenda Papers for Scrutiny Board (Health) meetings).
- advance notification of proposals for substantial development or reconfiguration[4] of local services
- notification of monitoring and review activity taking place or pending in trusts in the City.
- information of sufficient detail to enable the Board to discharge their Scrutiny duties

Where confidential information has been requested by the Scrutiny Board (Health) in connection with their Inquiries it is incumbent upon NHS bodies to take all reasonable steps to anonymise this information. Where this is not possible the public must be excluded from the meeting whilst the Scrutiny Board (Health) considers the confidential information provided.

Notice

Although some matters may arise at short notice the Scrutiny Board (Health) will publish a forward work programme. This will be revised and widely circulate on a monthly basis.

Where information or attendance before the Scrutiny Board is being requested by the Scrutiny Board (Health) a reasonable notice period will be provided for NHS bodies to respond. This period will be at least 15 working days notice of the meeting at which attendance is being requested.

Where attendance will require the production of a report then sufficient notice will be given for the preparation of that documentation.

Where the Scrutiny Board (Health) requests a response from a local NHS body to whom it has made a report or recommendation, that body will respond to the Board in writing within 28 days of the request.

[4] Further guidance on the definition of Substantial is provided within this protocol

Attending Scrutiny Board Meetings

Meetings are usually held monthly in a committee room in the Civic Hall although from time to time meetings will be arranged at different venues - often dictated by the nature of the inquiries taking place.

The Scrutiny Support Unit will endeavour to give approximate times for when items are likely to be discussed. However, as items may over run, there may be a short waiting time.

Prior to a Scrutiny Board (Health) meeting the Chair receives a briefing on items to appear on the forthcoming agenda from Officers in the Scrutiny Support Unit. On occasion NHS officers may be requested to attend this or a separate session to enable the Chair of the Scrutiny Board to be briefed ahead of the Scrutiny meeting.

Conduct of Scrutiny Board Inquiries

The role of Terms of Reference

The majority of Scrutiny Inquiries have agreed terms of reference. These identify the subject areas Members of the Board wish to pursue and are used to inform departments of the Council and NHS bodies of the emphasis of a particular inquiry.

Officers in Scrutiny Support will liaise with NHS bodies during the preparation of Terms of Reference to ensure that the focus of the inquiry is relevant and the timing of it appropriate.

Usually a written report is required by the Board. This will provide a basis for discussion between officers and Members of the Board. The Scrutiny Support Unit will advise on the particular information required.

Gathering Evidence

The evidence to be gathered will be detailed in the Inquiry's Terms of Reference. This material may considered at a Scrutiny meeting which is open to the public or by a small working group of Board Members deputed to undertake a specific evidence gathering task. In the latter case Board Members will report back to a full meeting of the Scrutiny Board (Health) on their findings.

The Scrutiny Support Unit will endeavour to give guidance on what will be asked and sometimes possible question areas will be passed on to allow some time for preparation before the meeting. However, Members may follow a related line of discussion and ask other questions on the day.

Preparation of Reports

At the conclusion of an Inquiry the Board will, where it considers appropriate, produce a preliminary report. This will be drafted by the Scrutiny Support Unit in conjunction with the Scrutiny Board Chair and agreed by the Board. This report will provide a summary of the evidence submitted and the Board's conclusions and

recommendations. Where the Scrutiny Board (Health) is considering making recommendations to an NHS body it will invite advice from the relevant Chief Executive prior to finalising its recommendations.

Publication of Report Findings

The Scrutiny Board (Health), once it has completed its inquiry, may make reports and recommendations to the Board of the NHS bodies scrutinised.
The report will also be copied to:

- The local MPs and MEPs
- West Yorkshire Health Authority
- Leeds Voice
- Local voluntary organisations that have expressed an interest in an inquiry
- Other bodies or organisations that have expressed an interest in the issues dealt with in the report.
- A copy of the report should also be placed in local libraries, on local authority and Strategic Health Authority websites and made available to other local networks so as to be widely available to members of the public.

Response to Reports

Where the Scrutiny Board (Health) has sent a report to an NHS body the NHS body concerned will be required within 28 days to send its response to the Board. The reply should set out the views of the NHS body on the recommendations, proposed action or reasons for inaction in response to the recommendations made. The NHS response should also be copied to:

- The local MPs and MEPs
- West Yorkshire Health Authority
- Leeds Voice
- Local voluntary organisations that have expressed an interest in an inquiry
- Other bodies or organisations that have expressed an interest in the issues dealt with in the report.
- A copy of the report should also be placed in local libraries, on local authority and Strategic Health Authority websites and made available to other local networks so as to be widely available to members of the public.

Consultation with the Scrutiny Board (Health) by NHS Bodies in Leeds

The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 provide for local NHS bodies to consult the Scrutiny Board (Health) where the NHS Body has under consideration any proposal for a substantial development of the health service or for a substantial variation in the provision of such a service in the local authorities area.

Section 11 of the Health and Social Care Act 2001 reinforces this by placing a duty on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in planning service provision, in the development of proposals for changes, and in decisions about changes to the operation of services.

Within this context the period and nature of any necessary consultation should be discussed with the Scrutiny Board (Health) prior to a consultation process commencing. In seeking to determine whether a development or variation is substantial the NHS body concerned and the Scrutiny Board (Health) will have regard to issues such as (but not limited to) the number of people to be affected, whether changes in the accessibility of services will result and whether changes in the deployment of the workforce will be necessary.

*****

Fuller guidance on this issue has been produced by the Department of Health and has been adopted as local practice. *Please note that this is due to be published by 1st week in April.*

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substantial variations **and developments** of health services

a guide

cfps the centre for public scrutiny
better scrutiny for better government

Acknowledgements

This guide was written on behalf of the Centre for Public Scrutiny by Brenda Cook, a freelance consultant and facilitator.

CfPS is grateful to representatives of the Department of Health, Local Government Association, NHS Confederation, NHS Alliance, Monitor, Independent Healthcare Forum, Democratic Health Network and the Independent Reconfiguration Panel who acted as a reference group for the guide. The health scrutiny support programme Practitioners Forum was also involved in the development of the guide.

CfPS is grateful to Capsticks Solicitors who provided information and advice about case law around substantial variations and developments.

The Centre for Public Scrutiny

The Centre for Public Scrutiny promotes the value of scrutiny in modern and effective government, not only to hold executives to account but also to create a constructive dialogue between the public and its elected representatives to improve the quality of public services. The Centre has received funding from the Department of Health to run a three-year support programme for health overview and scrutiny committees of social services authorities as they develop their power to promote the well-being of local communities through effective scrutiny of healthcare planning and delivery and wider public health issues.

Published by The Centre for Public Scrutiny
December 2005

introduction

This guide is for local authority overview and scrutiny committees (OSCs), NHS bodies and other organisations with an interest in developments to health services within England. The guide is about working together, within the legal framework, to improve the experience of patients. Whilst concentrating on substantial variations or developments of health services, a recurrent theme is the need for the NHS and OSCs to remain focussed on the needs of patients and opportunities to improve their care.

The guide aims to:

- clarify the roles of OSCs considering health issues and how they relate to consultations on substantial variations and developments of health services;
- encourage and enable OSCs and NHS bodies to reach agreement on what constitutes 'substantial' within their local context;
- help OSCs and NHS bodies to develop their understanding of their respective and distinct roles and to suggest ways of joint working to improve their contribution to public accountability of health services.

The guide is not about establishing 'rules' on how to consider substantial issues, but suggests criteria and protocols based on legislation and the experience of OSCs and NHS bodies from across the country.

The successful modernisation of health services to meet the needs of local people and improve patient experiences relies on developing good relationships between organisations and individuals. Much can be achieved by co-operation, clarification of issues, and understanding each other's priorities and constraints at an early stage.

requirement for the NHS to consult patients and the public

The NHS has been required to consult on changes to health services for many years. However, the establishment of the current structure for involving patients and the public developed the requirements for consultation, and identified new statutory consultees. NHS bodies have specific duties in relation to consultation that are set out in sections 7 and 11 of the Health and Social Care Act 2001.

ongoing involvement and consultation – section 11

Section 11 places a duty on strategic health authorities, PCTs and NHS trusts to make arrangements to involve and consult patients and the public in:

a) planning services;

b) developing and considering proposals for changes in the way services are provided; and

c) decisions to be made that affect how those services operate.

Guidance on the duty to involve and consult recommends:

a) discussing with patients and the public how services could be improved and resources used more effectively, to produce plans for change – *this constitutes involvement in planning;*

b) discussing ideas, experiences, and the reasons why the NHS body has identified the need for change with patients and the public, and with key partner organisations – *this constitutes involvement in the development of health services;*

c) consultation on proposals for change, using evidence from the involvement activities as well as clinical evidence for improvement of treatment and care – *this constitutes consultation*.[8]

The duty to involve and consult must be implemented in the planning and development of services and in relation to decisions that might affect services.

It is important that involvement and consultation is meaningful. Plans should take into account time allowed, content, and detail appropriate to the scale of the issue being considered. For example, part of the involvement process might be to find out from stakeholders the best way to involve them.

PPIFs have a role in monitoring how effectively NHS bodies involve and consult patients and the public, and to advise them on how this might be improved. The performance management of NHS trusts and PCTs in implementing the duty to involve and consult is undertaken by Strategic Health Authorities and through the Healthcare Commission's annual healthcheck. More information about NHS bodies and the section 11 duty is available at www.dh.gov.uk

consultations on substantial variations or developments of services – section 7

Regulations under section 7 require NHS bodies to consult relevant overview and scrutiny committees on any proposals for substantial variations or developments of health services. This duty is additional to the duty of involvement or consultation under section 11 i.e. other stakeholders should be consulted and involved in addition to OSCs.

It is important that NHS bodies recognise the difference between the Executive members and the OSC members within a local authority. If a proposal for change impacts upon the provision of social care or other local authority services, it is likely that early discussions will have included staff and councillors with an interest in these services. It should not be assumed that this involvement would have included OSCs. Often the officers involved may be service managers who have little contact with overview and scrutiny, and the councillors involved may be Executive members with delegated powers to make decisions relating to the services that they lead. OSCs are separate from the Executive, to enable them to scrutinise Council services and Executive decision-making. A proposal, which might be substantial, may impact on local authority services as well as NHS services, for example where health and social services are developed in partnership. It is therefore important for NHS bodies to make direct contact with OSCs and to treat this as unconnected from other local authority input into proposals that might have already taken place.

Proposals for service change should be discussed at an early stage, to identify whether the proposals are substantial, and to gain clarity and agreement on the purpose of consultation.

Initial discussions should also aim to reach agreement on conduct of the consultation taking into account local circumstances and other constraints, e.g. timescales for external funding bids. Cabinet Office guidelines recommend that full consultations should last a minimum of twelve weeks and that consultations should ensure that groups that are traditionally hard to engage are involved, in addition to the wider community and OSCs. The guidelines set out the basic minimum principles for conducting effective consultation and aim to set a benchmark for best practice. The guidance is available at www.cabinet-office.gov.uk

It may be possible for OSCs and NHS bodies to reach agreement about a different timescale for consultation. What is important is the quality of consultation.

what is a ‘substantial variation or development’?

models and protocols

A ‘substantial variation or development’ of health services is not defined in Regulations. Proposals may range from changes that effect a small group of people within a small geographical area such as changes in the timing of podiatry services within a health centre, to major reconfigurations of specialist services involving large numbers of patients across a wide area. The key feature is that there is a major change to services experienced by patients and future patients.

OSCs and NHS bodies are encouraged to develop local agreements or sets of criteria about what might be regarded as ‘substantial’ in the local context. This should be informed by discussions with other key stakeholders, including PPIFs and service user groups. It also requires OSCs to have a clear picture of local health needs and the provision of health services. This information may be collated from a number of sources, including:

- Director of Public Health annual reports;
- data collated by regional Public Health Observatories;
- PCT local delivery plans and NHS trust business plans;
- reports from strategic health authorities;
- Healthcare Commission inspection and improvement reports;
- support from the Centre for Public Scrutiny advisory team under the health scrutiny support programme.

Although a number of OSCs and NHS bodies have attempted to define what is ‘substantial’, definitions either tend to be very broad, covering all changes or so targeted that some significant changes may be missed. It is difficult to have a standard, rigid definition of what is ‘substantial’ but some NHS bodies and OSCs have agreed protocols or procedures to help identify whether proposed variations or developments in services are ‘substantial’. These have proved very useful in distinguishing proposals that require formal consultation with OSCs from proposals which do not. Research undertaken by Manchester University on behalf of the Centre for Public Scrutiny[9] has identified that whilst around 3/4s of NHS bodies responding to the research had consulted OSCs about substantial variations, only around 1/3 had agreed criteria with OSCs for identifying whether an issue was in fact ‘substantial’. This finding from the research indicates that a lack of agreement about what might be considered ‘substantial’ in the local context might lead to uncoordinated and ineffective scrutiny that potentially might overburden OSCs and the NHS. This guide encourages OSCs and NHS bodies to agree a method of evaluating the need for formal consultation.

Example: In Bath and North East Somerset, Bristol, North Somerset, Gloucestershire, South Gloucestershire, Swindon and Wiltshire, OSCs and NHS bodies have an agreed process that officers and managers should follow when considering whether an issue is substantial, and how to address such issues. Partner organisations meet regularly to identify potential issues. The agreement also identifies basic information that OSCs need to consider. A key part of this process is asking some patient groups for their opinion about whether issues are substantial.

Example: In Lewisham, NHS trusts are developing an impact assessment tool intended to clarify whether a proposed change is substantial or not and whether it requires full consultation. The tool is used at an early stage in the development of proposals or discussions about service change, and then submitted by the lead NHS trust to the OSC. It addresses specific issues such as changes in accessibility; effect on the wider community; the patient population affected; and, methods of service delivery. The impact assessment requires the local NHS trusts to score the potential consequences of the proposals. It also requires a score from representatives of people affected by the proposals, i.e. patients, service users or carers.

Example: In Norfolk, Suffolk and Cambridgeshire the OSCs, NHS trusts, PCTs and SHA have produced a framework and signposting document for health overview and scrutiny. The document states that the NHS has accepted that OSCs may decide whether a proposal requires formal consultation and that the NHS bodies will accept this decision.

However useful a protocol or tool can be, it is important that agreement is reached. Department of Health guidance, and good practice, indicate that in deciding whether a proposal is substantial, the following issues should be considered:

a) changes in accessibility of services;

b) impact of the service on the wider community and other services, including economic impact, transport and regeneration;

c) number of patients affected, changes may affect the whole population of a geographical area or a small group. If a change affects a small group of patients it may still be 'substantial', especially if patients need to continue to access that service for many years;

d) methods of service delivery, e.g. moving a particular service into a community setting from an acute hospital setting.

The evidence used to identify these should include feedback from patients and the public.

Example: Oxfordshire County Council's OSC has developed a table to help it identify whether a service development or variation is likely to be substantial. The table considers issues that include:

Characteristics likely to lead to a view that formal consultation is *not* required	**Characteristics likely to lead to a view that formal consultation *is* required**
Nature of impact upon patients and the public	
For example: Legal obligations set out under Section 11 (Health and Social Care Act) to 'involve and consult' have been fully complied with. (Details of the methods of public involvement used must be provided)	**For example:** Legal obligations under Section 11 have not been implemented, either partially or fully.
Rationale/policy behind proposed service change or development	
For example: The proposed service change or development is primarily driven by clinical factors but also has financial and/or staffing and/or other managerial benefits.	**For example:** The proposed service change or development is primarily driven by financial, staffing or other managerial factors but also has clinical merit.
Clinical Factors	
For example: The proposed service change improves clinical governance and reduces risk, and is based upon agreed best practice e.g. N.S.F. standards, N.I.C.E. Guidance.	**For example:** The proposed service change plays no part in improving clinical governance or reducing risk, and does not support or enable the implementation of e.g. N.S.F. standards, N.I.C.E. Guidance
Other	
For example: The commissioning body/ies is/are aware of and has/have been involved in the drafting of the proposal/s.	**For example:** The commissioning body/ies is/are not fully aware of and supportive of the proposal/s.

Example: In Hampshire, Isle of Wight, Portsmouth, and Southampton the OSCs have produced a framework for assessing substantial change in NHS provision. The framework was developed with input from the IRP and was subject to full consultation with local NHS bodies, district councils and other partners. It has been particularly helpful as a starting point for dialogue about whether a proposal is substantial or not, and has served as a guide to NHS managers who are dealing with OSCs for the first time. The OSCs have identified that publication of the framework has resulted in a better understanding in the NHS between section 11 and section 7 requirements, and has increased engagement with key stakeholders regardless of whether section 7 applies.

Another approach is for OSCs to identify standard questions to ask NHS bodies. For example, Warwickshire County Council has developed four standard questions that are used when the OSC has been notified for the first time about a proposal to vary or develop services.

a) How the views of the public were obtained in the earlier stages of the change programme, including consultation procedures used, numbers involved, timescales for consultation and the questions asked.

b) What views were expressed by the public, to establish how well informed, clear and representative these views are, and how they influence the options available.

c) How these views were interpreted by NHS bodies and factored into the development of the proposals, whether for or against.

d) What the public response is now to any proposals that differ from those submitted to the public in the initial round of consultation.

The answers to the questions are used to identify whether witnesses would be required to attend a future meeting and give oral evidence.

case law

Previously, health authorities (and subsequently strategic health authorities) were required to consult Community Health Councils on proposals for any substantial variations or developments.[10] As there was no definition of 'substantial', it led to the establishment of case law, which may be used today to help define whether a proposal is substantial. There has been no case law since the implementation of the responsibility to consult OSCs on 'substantial' issues, but following case law from the previous framework may be helpful in reaching agreement about what is substantial.

R-V-West Sussex Health Authority ex parte Littlehampton Town Council

Decision to close temporarily 12 beds at cottage hospital and withdraw minor casualty service from 8.00pm to 9.30am. There was another hospital 2 miles away and extra beds would be opened there. The Health Authority (HA) undertook to carry out a strategic review of services in the locality and to consult on any proposals for permanent changes. The Court held that bearing in mind the temporary nature of the proposals and the undertaking to keep the effect under review, the HA was entitled to conclude that the proposals did not involve a substantial variation.

R-V-Hampstead Health Authority ex parte LB Camden

In order to keep within its financial allocation the HA decided to move 100+ geriatric patients from New End Hospital to the Royal Free Hospital. It subsequently planned to close and sell the New End Hospital, but the relocation of patients was seen as an immediate, and temporary, cost-saving measure. The Court held that this was a substantial variation.

R-V-Tunbridge Wells Health Authority ex parte Goodridge

HA decision temporarily to close Tunbridge Cottage Hospital. Formal consultation took place over the use to which the hospital should be put in future, with a proposal that it should be a mental health rehabilitation unit. Court held that proposal was a substantial variation since (a) it would result in hospital never reopening as a cottage hospital; and (b) in any event, proposal for a "temporary" closure of one year or more would be a substantial variation.

R-V-West Thames Regional Health Authority ex parte Daniels

Decision to close Westminster Children's Hospital (WCH) and transfer services to the Chelsea and Westminster Hospital (C&W). Initially, it was proposed that the bone marrow transplant unit at WCH would close and be replaced at C&W. However, capital funding was not available for the bone marrow unit and it was therefore allowed to run down and close without replacement. The Court held that this was a substantial variation requiring consultation.

(Summary of case law provided by Capsticks Solicitors)

The application of case law and the development of local protocols demonstrate that where NHS bodies can provide evidence that they have fulfilled their duties under section 11, it is less likely that OSCs will wish to be formally consulted.

Whilst it is desirable for OSCs and NHS bodies to agree whether issues are substantial in order to help health scrutiny to be co-ordinated and effective, it is not a requirement. Alternatively in the absence of a local agreement, where OSCs believe that there is a substantial variation and there has been no formal consultation with the OSC on the proposal, the OSC is able to refer the proposal to the Secretary of State on the grounds of inadequate consultation.

exemptions to the requirement to consult on a substantial variation or development

A number of circumstances are exempt from the requirement for NHS bodies to consult OSCs.

Exemptions identified in the OSC regulations

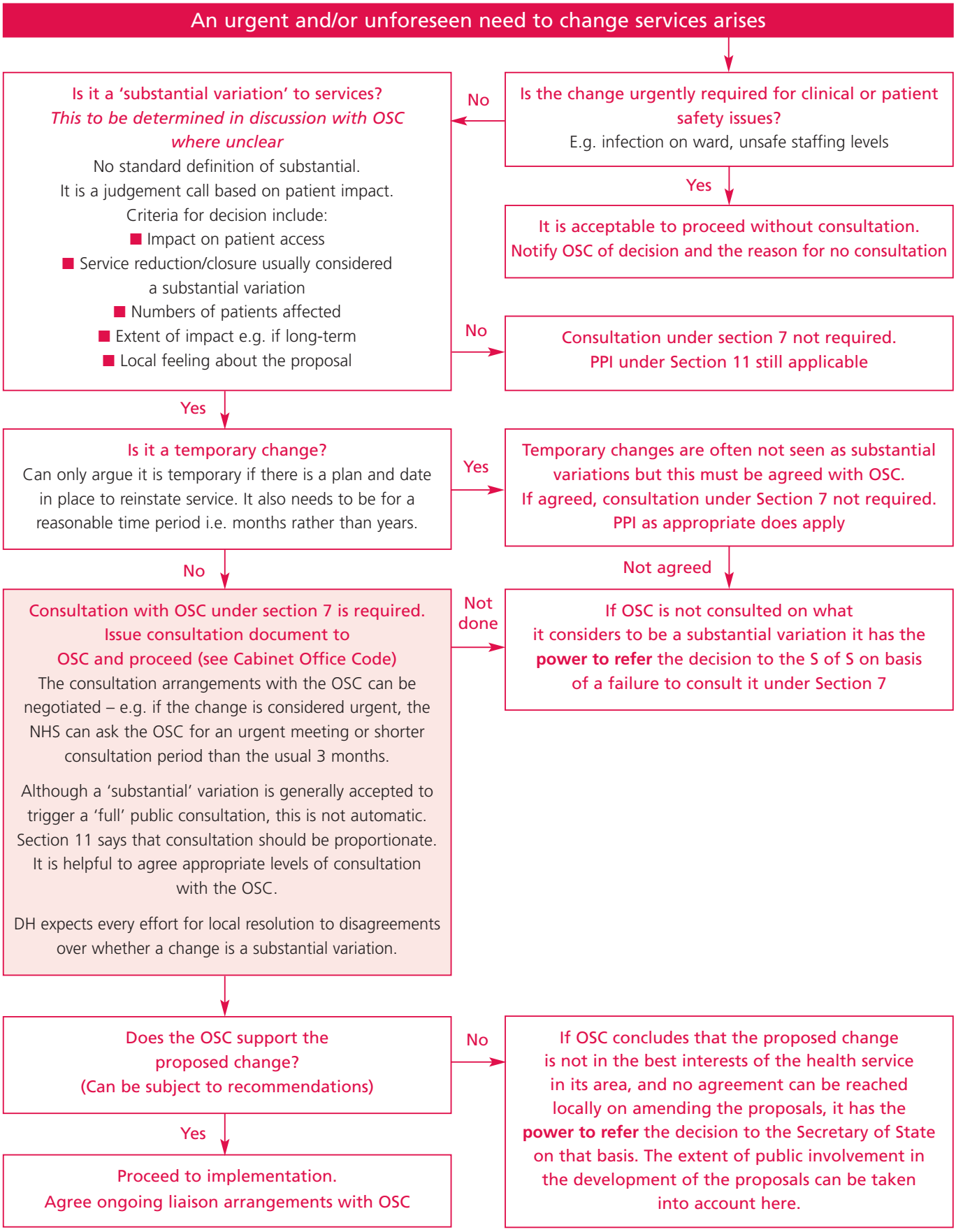
a) any proposal to establish or dissolve an NHS trust or PCT unless dissolution represents a substantial variation or development to the services that will be delivered in the future;

b) pilot schemes within the meaning of Section 4 of the National Health Service (Primary Care) Act 1997 (1);

c) when an NHS body believes that a decision has to be taken on an issue immediately because of a risk to the safety or welfare of patients or staff, e.g. if a hospital ward needs to be closed immediately due to a viral outbreak. This might be considered a substantial variation but allowing time for consultation could place patients or staff at risk. In such cases, the NHS body must notify OSCs immediately of the decision taken and the reason why no consultation has taken place. As good practice, the NHS body should also provide information about how patients and carers have been informed about the change to the service and what alternative arrangements have been put in place to meet their needs. It should also provide information about the recovery plan for restoring the original service.

Where OSCs are not satisfied about the reasons given for not carrying out consultation, they may refer the issue to the Secretary of State.

Example: Surrey and Sussex Strategic Health Authority has developed the following chart, or 'decision tree', which may be used to help determine whether consultation is required under section 7 HSC Act in the event of unforeseen or urgent need to vary services.


An urgent and/or unforeseen need to change services arises
Is the change urgently required for clinical or patient safety issues?
E.g. infection on ward, unsafe staffing levels
No
Yes
It is acceptable to proceed without consultation.
Notify OSC of decision and the reason for no consultation
Is it a 'substantial variation' to services?
This to be determined in discussion with OSC where unclear
No standard definition of substantial.
It is a judgement call based on patient impact.
Criteria for decision include:
■ Impact on patient access
■ Service reduction/closure usually considered a substantial variation
■ Numbers of patients affected
■ Extent of impact e.g. if long-term
■ Local feeling about the proposal
No
Consultation under section 7 not required.
PPI under Section 11 still applicable
Yes
Is it a temporary change?
Can only argue it is temporary if there is a plan and date in place to reinstate service. It also needs to be for a reasonable time period i.e. months rather than years.
Yes
Temporary changes are often not seen as substantial variations but this must be agreed with OSC.
If agreed, consultation under Section 7 not required.
PPI as appropriate does apply
Not agreed
No
Consultation with OSC under section 7 is required.
Issue consultation document to OSC and proceed (see Cabinet Office Code)
The consultation arrangements with the OSC can be negotiated – e.g. if the change is considered urgent, the NHS can ask the OSC for an urgent meeting or shorter consultation period than the usual 3 months.
Although a 'substantial' variation is generally accepted to trigger a 'full' public consultation, this is not automatic. Section 11 says that consultation should be proportionate. It is helpful to agree appropriate levels of consultation with the OSC.
DH expects every effort for local resolution to disagreements over whether a change is a substantial variation.
Not done
If OSC is not consulted on what it considers to be a substantial variation it has the **power to refer** the decision to the S of S on basis of a failure to consult it under Section 7
Does the OSC support the proposed change?
(Can be subject to recommendations)
No
If OSC concludes that the proposed change is not in the best interests of the health service in its area, and no agreement can be reached locally on amending the proposals, it has the **power to refer** the decision to the Secretary of State on that basis. The extent of public involvement in the development of the proposals can be taken into account here.
Yes
Proceed to implementation.
Agree ongoing liaison arrangements with OSC

For planned changes to services, the process is the same, but discussion with the OSC about whether the change constitutes a substantial variation should take place at a very early stage.

changes that result from national policies for service modernisation

The pace of change within the NHS and delivery of health services has increased rapidly since the publication of the NHS Plan in 2000. Currently a number of changes are being made to the way in which the NHS is organised, e.g. as part of *Commissioning a Patient-led NHS*.[11] In these circumstances, although significant changes may be proposed about how NHS organisations are structured, they do not automatically constitute substantial variations or developments. Changes that either alter the delivery of management or administrative functions of NHS bodies, or the number of NHS bodies, are not substantial variations or developments as outlined in the exemptions within Regulations. The NHS bodies concerned are required to consult key stakeholders on proposals and OSCs should be included in the list of consultees. However, as the consultation is not about a substantial issue, OSCs would be consulted in the same way as the other consultees and the power of referral to the Secretary of State would not be available.

Proposals may become substantial at the point at which specific changes to service delivery, which impact upon patients, carers and the public, can be identified. At this point, the process of agreeing whether the issue is substantial, and addressing it as such, may begin.

Likewise, the establishment and development of an Independent Treatment Centre (ITC) is not initially a substantial variation or development, as it is the establishment of a new service provider. When an ITC is proposed, the commissioning PCT should consult all key stakeholders about the proposal. OSCs should be included in the list of primary consultees, but at this stage they would not be able to use their powers of referral to the Secretary of State. If OSCs are concerned about issues of reliability of the ITC, they may wish to ask the commissioning PCT for details of its risk management strategy to ensure continuity of services for patients and the public. If, as a result of the establishment of an ITC, the commissioning PCT proposes changes to services received by patients, it should discuss the proposals with the local OSC(s) to agree whether or not these proposals are substantial.

A number of policies that impact upon the health and well-being of local people, but are not 'health services', are not bound by the regulations for health scrutiny and as such would not constitute substantial variations or developments. For example, proposals to implement fluoridation of the water supply is subject to a separate consultation framework (The Water Fluoridation (Consultation) Regulations 2005)

handling disagreements about what is 'substantial'

Where agreement is not initially reached on whether an issue is 'substantial', it is recommended that NHS bodies and OSCs discuss the reasons for their decisions with each other. OSCs should take into account all available information, including the reasons why NHS bodies consider that the issue is not substantial, and may wish to seek views from other NHS bodies. OSCs or NHS bodies can also ask the Independent Reconfiguration Panel for informal advice on whether the issue is substantial.

If agreement still cannot be reached and OSCs maintain the belief that the issue is substantial, it may refer the issue to the Secretary of State on the basis of inadequate consultation. At this point it will be for the Secretary of State, and then potentially the Courts, to determine whether it is substantial.

Example: The following flow chart has been developed by NHS bodies and OSCs within Norfolk, Suffolk and Cambridgeshire SHA area to help stakeholders understand the different roles and responsibilities in relation to sections 7 and 11 Health and Social Care Act 2001.

Building and sustaining successful relationships with Overview and Scrutiny Committees and understanding how Section 11 & 7 fit together – Norfolk, Suffolk and Cambridgeshire SHA and OSCs

Section 11 Strengthening Accountability
This area is NHS driven

Keeping the OSC informed
■ Briefing OSC Officers ■ Horizon scanning
■ Agenda sharing ■ Advance notice to OSC Officers

Involvement in the process
■ Service reviews ■ Financial reviews
■ Acute service reviews ■ Cancer services
■ Etc (Mainly applies to OSC Officers, who will ensure the committee is informed)

Consultation with patients and the public and consultation with the OSC
■ Through involvement the OSC will decide if it requires a formal consultation (if this is required the code of practice on public consultation should be adhered to).
■ Substantial variation is defined through discussion with each OSC ■ OSC input required for successful capital investment schemes to the SHA

Scrutiny
May be fed by:
■ PPI forums ■ Evidence of public opinion
■ LSP activity ■ Interests of individual members
■ Media interest ■ Suggestions from NHS bodies
■ General intelligence gained by OSC and Officers
■ Decision to scrutinise substantial variation

Section 7 Overview and Scrutiny Powers
This area is Overview and Scrutiny driven

These processes are not mutually exclusive but are rather parts of the same continuum.
Key to their successful implementation is ■ Shared understanding ■ Partnership culture

identifying who is the consulting body

When changes are planned within a health economy, all NHS bodies need to be clear about who is responsible for consulting OSCs about issues of substantial change.

PCTs are responsible for consulting on the planning and commissioning of services for the local population. Where a number of PCTs commission services from an acute or other type of NHS Trust (e.g. a mental health trust or ambulance trust) it is common for one PCT to take a lead role, commissioning on behalf of the other PCTs within the health economy. The lead commissioning PCT will usually be responsible for consulting on any substantial variation or development to local health services that it commissions. If there is no lead commissioning PCT, or if the proposal relates to services across more than one PCT, the relevant PCTs will need to agree a process of joint consultation. The board of each PCT will need to formally delegate the responsibility to a joint PCT committee, which should act as a single entity. Following the consultation, the joint PCT committee will be responsible for making the final decision on behalf of the PCTs for which it is acting.

Where a proposed substantial variation to the provision of services has an impact across a strategic health authority (SHA) or several SHAs, the relevant PCTs may wish to invite them to co-ordinate the consultation process. This approach is optional. The decision for doing this rests with the PCT(s) leading the commissioning process. It is important that the SHAs are fully informed of, involved in and agreeable to taking on this role. Following the consultation, the responsibility for taking the final decision on any revision of service rests with the PCT(s), even where that consultation has been co-ordinated by an SHA.

Where an **NHS trust** plans to vary or develop services locally, it should discuss the proposal with OSCs to determine whether the proposal is substantial. If the outcome of the discussion is that it is a substantial development or variation, the trust must consult the OSC.

Where a **NHS Foundation Trust** intends to vary its authorisation, it must consult OSCs. If OSCs consider that it should refer the issue, the referral should be made to Monitor and not to the Secretary of State.

Where an issue of proposed change spans more than one PCT or NHS trust, an SHA will want to be satisfied that the consultation is undertaken in a way that ensures the full and relevant involvement of all stakeholders.

There may be times when a proposal for substantial change impacts on services across all NHS bodies within a health economy. In such cases it may be more difficult to establish how consultation might be carried out. The NHS (Functions of Strategic Health Authorities and Primary Care Trusts) Regulations may be of help. The Regulations regulate the exercise of functions, and the division of functions between SHAs and PCTs. They identify that:

- the duty to promote a comprehensive health service is a function exercisable by SHAs;
- the provision of services considered appropriate for discharging duties imposed on the Secretary of State, and doing other things to facilitate the discharge of such duties, is to be exercised by both SHAs and PCTs, and
- that the provision of hospital and other accommodation and medical, dental, nursing and ambulance services is a function exercisable by PCTs (and by SHAs for the purposes of performance management only).

In view of these Regulations, a provisional legal view is that the primary decision making responsibility in respect of the future provision of healthcare services will lie with PCTs. This will continue with the implementation of practice-based commissioning, as PCTs will remain responsible for the services received by local people although they will be commissioned at a more local level.

However, for this decision-making to be exercised in a manner which is consistent with the duty to promote a comprehensive health service, and in order to enable the SHA to performance manage the PCTs in its area, the SHA is also a relevant decision-maker. Both SHAs and PCTs may arrange for their functions to be exercised jointly with other SHAs and/or PCTs. The Regulations also provide that any functions that are exercisable by a PCT jointly with an SHA may be exercised by a Joint Committee or Sub-Committee of those bodies.

The provisions referred to do not apply to NHS Trusts. Thus, Trusts are unable to participate in joint committees with PCTs and SHAs. To the extent that they are required to make decisions following consultation exercises, they must do so separately.

Within some health economies, protocols have been produced to help NHS bodies identify which organisation should take the lead role in consulting OSCs and what action the lead organisation should take.

Example: South West Peninsula and Essex Strategic Health Authorities have written guides, which include information about general principles for patient and public involvement as well as good practice in consultation.

gathering information about potential proposals for 'substantial' change

Most OSCs produce annual plans identifying a programme of scrutiny over a 12 month period. Plans should include some capacity for the committee to respond to issues that arise during the year, but it is important for OSCs to be aware about potential proposals for change when producing their plans.

Example: In Norfolk the OSC periodically contacts its local NHS bodies to ask for their top priorities for the coming six or twelve months. This information is compiled into a long list of potential issues, which might be monitored.

Opportunities for identifying information about NHS changes include:

- sharing annual reports and forward plans;
- regular meetings between OSC support staff and NHS staff;
- discussions between OSC members and NHS staff during the drafting of the local delivery plan;
- the involvement of local authority staff in regular or ongoing work with NHS bodies, e.g. in partnership boards or in the governance of PCTs, may enable them to identify potential changes and alert OSC support staff;

It is important for NHS bodies to be aware that most OSC support staff within regions or SHA areas meet on a regular basis. If a proposal is being developed which may impact across a wide catchment area there is the potential to raise this with all OSCs at one meeting and at an early stage.

checklist for dealing with ‘substantial variations and developments’

The following ‘checklist’ has been drawn from good practice across the country to help OSCs and NHS bodies plan their work regarding issues of substantial variation or development of health services:

1. NHS bodies should recognise the difference between local authority Executives and Overview and Scrutiny Committees.
2. Regular communication between NHS bodies and OSCs can help to identify substantial proposals at an early stage so that scrutiny can be efficient and effective.
3. OSCs should be clear about the information they need from NHS bodies to identify whether an issue is likely to be substantial.
4. It is acceptable for OSCs and NHS bodies that keep in close contact to agree that an issue is not substantial.
5. The quality of consultation is more important than rigidly sticking to a 12-week timescale.
6. By developing partnerships with district councils and other social services authorities, the power of delegation may help OSCs to use their powers more effectively.
7. In responding to a consultation, OSCs should consider the range of information they need to judge the proposals and the witnesses that may be able to help them form a view. This may include establishing whether similar changes have been made elsewhere, and if so what was the experience of the OSC, NHS body(ies) and patient and service user groups.
8. An OSC can choose not to be consulted on an issue that has been defined locally as being substantial, if it does not believe that it would add additional value to involvement and consultation already undertaken.
9. OSCs should be able to identify how they have added value to the consultation process relating to substantial variations or developments after their involvement.
10. Consultation on substantial change is only one part of health overview and scrutiny. It may not always have as large an impact on improving the health of the local population as scrutinising other issues, such as public health issues.

The following flow chart has been developed to help OSCs to undertake their roles more effectively.

Flow Chart Illustrating the Stages of Consultation

developed by Essex County Council and partner NHS bodies

Examples of issues and potential proposals	Informal involvement → Informal consultation → Formal consultation			
Major service reconfiguration e.g. proposals involving re-provision/closure or development of new services				**Category 4** Formal consultation process required
Change in demand for specific services e.g. proposal to relocate GP surgery or cessation of some surgery sessions			**Category 3** Formal mechanisms established to ensure that patients/service users/carers and the public are engaged in planning and decision-making (ref: Section 11 Health & Social Care Act)	
Need for modernisation of hospital based service e.g. proposal to relocate and modernise day surgery unit on a particular hospital site		**Category 2** More formalised structures in place to ensure that patients/service users/carers and patient groups views on the issue and potential solutions are sought		
Changes in demand for specific services (e.g. Baby clinics) e.g. proposal to extend or reduce opening hours of Health Visitor Clinics	**Category 1** Informal discussions with individual patients/service users/carers and patient groups on potential need for changes to services and solutions			

OSC normally involved

OSC may be involved

NB The examples listed on this continuum are not definitive and there may be some local variation in the way they are dealt with
**It is envisaged that health bodies will submit brief details of these proposals to O&S committees to indicate which category they fall into and why.

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