



*Overview and Scrutiny of
Health – Guidance*

July 2003

Overview and Scrutiny of Health – Guidance

This guidance is issued by the Secretary of State for Health. It:

Clarifies the primary and secondary legislation that provides local authority overview and scrutiny committees with the power to scrutinise health services;

Sets out the statutory guidance which is issued under section 38 of the Local Government Act 2000

Provides advice and recommendations on the undertaking of scrutiny of health services for both local authority overview and scrutiny committees and NHS organisations.

Whilst the guidance is primarily aimed at local authorities and NHS bodies, it will also be useful for patients' forums as well as other organisations representing the views and interests of patients and the public.

Context

The overview and scrutiny of health is an important part of the Government's commitment to place patients and the public at the centre of health services. It is a fundamental way by which democratically elected community leaders may voice the views of their constituents and require local NHS bodies to listen and respond. In this way, local authorities can assist to reduce health inequalities and promote and support health improvement.

Local authorities are already encouraged to look beyond their own service responsibilities by scrutinising issues of wider concern to local people. It is within this context that the new power of overview and scrutiny of the NHS has been introduced in England – aiming to secure health improvement for local communities. For the first time, democratically elected, community representatives have the right to scrutinise how local health services are provided and developed for their constituents. The powers enable overview and scrutiny committees to consider local services by inviting senior staff to provide information and explanations about how local needs are being addressed. This will enable open and transparent debate about health and health services to be developed locally.

This guidance is available on the Department of Health website www.doh.gov.uk/involvingpatients

Structure of this guidance

This guidance has been prepared to assist with the planning and development of effective overview and scrutiny of health and health services. Each of the following sections will refer to provisions within the relevant legislation where appropriate.

It is recommended that this guidance be read in conjunction with three key pieces of legislation:

Local Government Act 2000 –

<http://www.legislation.hms.gov.uk/acts/acts2000/20000022.htm>

Health and Social Care Act 2011, sections 7 – 10

<http://www.legislation.hms.gov.uk/acts/acts2011/20110015.htm>

Statutory Instrument 2012 No. 3048

The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2012 – www.legislation.hms.gov.uk/si/si2012/20123048.htm

1. Introduction

- *summary of the aims and objectives of overview and scrutiny of health*
- *reference to the need for overview and scrutiny committees to link to other key stakeholders, including the local authority's executive*
- *explanation of action required when dealing with potential conflicts of interest by committee members*

2. Impact on local authority constitutions – the requirement to have an overview and scrutiny committee to review health services

- *clarification of action required to enable overview and scrutiny committees to implement the power of scrutiny of local health services*

3. Definitions

- *explanation of the terms used in the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2012*

4. Planning overview and scrutiny of health

- *understanding the context of scrutiny in relation to performance management of the NHS and governance arrangements*
- *indication of the issues which might be scrutinised*
- *the relationship between health scrutiny and private or independent healthcare providers*
- *relationship between committees and patients' forums*
- *developing scrutiny plans*

5. Approaches to overview and scrutiny of health

- *methods of overview and scrutiny*
- *making reports and recommendations*

6. Co-options and methods of involving stakeholders

- *explanation of the power of co-option provided for county councils, and suggestions for other methods of involvement*

7. Delegated scrutiny

- *explanation of the power for local authorities to delegate health service scrutiny to another local authority, including for a county council to delegate to a district council*

8. Joint committees

- *explanation and guidance about the establishment of joint committees*
- *relationship between joint committees and political proportionality*
- *reports and recommendations made by joint committees*

9. Duties placed on NHS bodies

- *providing information to overview and scrutiny committees*
- *attendance to answer questions*
- *responding to reports and recommendations*

10. Duties placed upon NHS bodies – consultation

- *NHS consultations on issues of substantial variation or development to services, including guidance on identifying whether a proposed change to services is substantial*
- *referrals to the Secretary of State*
- *directing the establishment of joint committees*

11. Responding to consultations by NHS bodies

- *explanation of good practice in responding to consultations on substantial variation or development of services*

12. Joint committees and scrutiny of NHS bodies covering more than one local authority

13. Concluding the scrutiny process

Acknowledgements

References

Appendix A The new structures for patient and public involvement and the link with overview and scrutiny committees

Appendix B Documents that might influence priority setting for committees

a list of documents and reports that might help overview and scrutiny committees to identify priorities to be included in an annual scrutiny plan

Appendix C Exempt information

Appendix D Summary of the powers of overview and scrutiny committees and the duties of NHS bodies

Appendix E Summary of Cabinet Office guidance on consultation

Appendix F Glossary of useful terms and abbreviations

1. Introduction

- 1.1 Health scrutiny is both a challenge and an opportunity for local authorities and the NHS. Its primary aim is to act as a lever to improve the health of local people, ensuring that the needs of local people are considered as an integral part of the delivery and development of health services. The Government's intention is that the focus of health scrutiny is on health improvement, bringing together the responsibilities of local authorities to promote social, environmental and economic well-being and the power to scrutinise local services provided and commissioned by the NHS. This will be achieved by addressing issues of health inequalities between different groups, and working with NHS and other partners to develop a dialogue to achieve health improvement. Different models of scrutiny may be used, from reviewing statistics to major reviews of service provision.
- 1.2 If scrutiny is to have effective and positive impact, those involved need to focus on giving careful and early consideration to the objectives and context for scrutiny. Members of scrutiny committees need to take a constructive but challenging approach to the role, bringing together evidence and people's experience to identify priority issues and drive forward improvement. To achieve this, it is important for elected councillors who are involved in overview and scrutiny of health to gain an understanding of the NHS and the provision of health services, as well as to understand local needs.
- 1.3 It is important to be clear from the outset what health scrutiny is aiming to achieve. Committees might start by identifying 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 public health and the prevention of ill health.
- 1.4 The powers of overview and scrutiny of the NHS enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. It is recommended that best use of these powers will depend on committees scrutinising a health issue, system or economy, not just services provided, commissioned or managed by the NHS. Any scrutiny exercise is likely to include reviewing the local authority's contribution to the health of local people and the provision of health services, as well as other agencies involved in the health care of local people. The solutions to matters that are scrutinised, may therefore be the responsibility of a number of stakeholders. In this light the power to scrutinise health services should be seen and used in the wider context of the local authority role of community leadership and of other initiatives to promote and facilitate improvement. This includes local strategic partnerships and the development of compacts with the community and voluntary sectors. While the decision of what and how to scrutinise is one for local

authorities, NHS bodies and other local stakeholders need to be involved in discussions about the purpose and scope of each scrutiny in addition to finding solutions to problems and implementing recommendations.

- 1.5 The work of overview and scrutiny committees will focus on issues of local concern where objective review by elected lay representatives will help progress to be made. It is not the role of committees to performance manage the NHS. Other organisations exist to perform this role. Committees are best placed to concentrate on ensuring that health services address the needs of local communities and that local health and health-related issues are being tackled jointly across local agencies.
- 1.6 The overview and scrutiny of the NHS is one element of the Government's drive to strengthen patient and public involvement in the NHS (see Appendix B). Another element with a specific connection to effective health scrutiny is the establishment of patients' forums. Patients' forums will monitor trusts and PCTs at an operational level. To ensure an integrated approach locally, committees and patients' forums will need to set up clear lines of communication and information exchange.
- 1.7 A constructive approach based on mutual understanding between the committee, 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 an understanding between partners to ensure effective scrutiny. Scrutiny is challenging and will sometimes be uncomfortable for the organisation being scrutinised, but if the process is aggressive, or relies on opinion rather than evidence, it is unlikely to lead to positive or sustainable improvement. Likewise, health bodies will need to respond honestly to questioning and provide explanations if they are unable to implement overview and scrutiny committee recommendations.
- 1.8 More and more literature is becoming available to support health scrutiny. The Department is in the process of preparing further resources, which will be made available on www.doh.gov.uk/involvingpatients shortly.
- 1.9 Committees must take steps to avoid any conflict of interest arising from members' involvement in the bodies or decisions that they are scrutinising. Conflicts of interest may arise if scrutinising councillors are:
 - an employee of an NHS body, or
 - a non-executive director of an NHS body, or
 - an executive member of another local authority
 - an employee or board member of an organisation commissioned by an NHS body to provide goods or services.

These councillors are not excluded from membership of overview and scrutiny committees, but they must follow the local authority protocols regarding participation

where there is a risk of conflict of interest. Where such a risk is identified, they should consult their monitoring officer for advice on their involvement.

- 1.10 The power to scrutinise the NHS needs to be applied both robustly and responsibly. Scrutiny should be probing and incisive, focussing on its primary aim of improving services for members of local communities. Asking the ‘obvious question’ can be very revealing, but committees must also recognise that some of the problems facing the NHS have no simple or universally popular solution. Overview and scrutiny may help to find creative solutions to problems and ensure an open and transparent public dialogue.
- 1.11 Inevitably, committees 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. Moreover, individual councillors will wish to represent the views of their constituents on issues of local health concern. Although this is a matter for political parties to consider, it is the Government’s expectation that the scrutiny function should not be ‘whipped’ and should operate independently of the council’s executive. It is recommended that committees seek evidence and views from executive members where relevant, and keep abreast of the council’s wider aims and activities in relation to health. It should be remembered that executive members may not be members of an overview and scrutiny committee.

2. Impact of new powers on local authority constitutions

- 2.1 Section 7 of the Health and Social Care Act 2001 (the Act) amends section 21 of the Local Government Act 2000. The effect of the amendment is to require local authorities with social services responsibilities to ensure that their overview and scrutiny committee or committees have the power to scrutinise the planning, provision and operation of health services. It is, therefore, mandatory that such a local authority has in place arrangements to scrutinise health services.
- 2.2 The Local Government Act 2000 (Constitutions)(England) Direction 2000 states that scrutiny arrangements should be set out in local authority constitutions. Arrangements for the overview and scrutiny of health should be stated clearly in the local authority executive arrangements, which include overview and scrutiny arrangements as part of the constitution. Local authorities therefore need to make reference to which committee may principally carry out the power of scrutiny of local health services.
- 2.3 An explanation of how the overview and scrutiny of health will be implemented might include explaining the roles of any established joint arrangements with or delegated to other local authorities, with acknowledgement for ad hoc arrangements. This might include the terms of reference and functions of joint arrangements with or delegated to other local authorities, the membership of any joint committees or subcommittees, and rules governing proceedings of joint committees or sub committees.

3. Definitions

- 3.1 Section 7 of the Health and Social Care Act 2001 (“the Act”) inserts in section 21 of the Local Government Act 2000 the power for overview and scrutiny committees to scrutinise health services. The power applies to overview and scrutiny committees of a county council, the council of any district in an area for which there is no county council, London borough council, the Common Council of the City of London. Although district councils do not have the power under the Act, there are opportunities for them to become involved in joint committees, through co-option and to have the functions delegated to them as explained within this guidance.
- 3.2 The Act makes clear that the power is exercisable only by an overview and scrutiny committee of a local authority that has social services responsibilities, i.e. a county council, a council of a district where there is no county council (i.e. a metropolitan authority, or district council unitary authority), a London borough council and additionally, although it does not have social services responsibilities, the Common Council of the City of London. This excludes two tier district councils.
- 3.3 A **joint committee** is a committee that has been established by two or more local authorities. In this case “local authority” includes two tier district councils (see section 9 of this Guidance). Joint committees may be established for both a specific scrutiny review, and for ongoing scrutiny planning and review.
- 3.4 Overview and scrutiny committees are provided with the power to scrutinise health services provided or commissioned by local NHS bodies. The legal definition of health services is found within the National Health Service Act 1977 (as amended) which states that

‘it is the duty of the Secretary of State to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement—

- (a) in the physical and mental health of the people of those countries, and
- (b) in the prevention, diagnosis and treatment of illness,

and for that purpose to provide or secure the effective provision of services in accordance with this Act. The services provided shall be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment whenever passed.’

Health services therefore include services, which promote health or prevent ill health as well as those providing treatment for individual patients.

These include health services provided by an NHS body outside the area of the local authority to inhabitants within it.

- 3.5 The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (the “Regulations”) refer to **local NHS bodies**. This means a **strategic health authority, primary care trust, or NHS trust** which provides, or arranges or performance manages the provision of services to people living within the area of the overview and scrutiny committee’s local authority. Reference to primary care trusts and NHS trusts also applies to **care trusts**, which are PCTs or trusts that also provide social services commissioned through delegated authority from local authorities. Reference to PCTs also includes reference to **teaching PCTs** (tPCTs) which have recently been developed to implement training through primary care. NHS trusts is a term that covers ambulance trusts, mental health trusts, learning disability trusts, and partnership trusts. It is the Government’s intention that overview and scrutiny of health will apply to foundation trusts as above. Subject to legislation, NHS foundation trusts will be established from 1 April 2004. Detailed regulations and supporting guidance will be issued in due course.
- 3.6 Councils that do not have an elected mayor, cabinet or executive are described as operating under **alternative arrangements**. They are organised to have a streamlined committee system. Each will have at least one overview and scrutiny committee. These councils can be involved in health scrutiny through being on a joint committee or through delegation or co-option. Local authorities with social services responsibilities that operate alternative arrangements currently do not have the powers to undertake scrutiny of health services as conferred by section 7. This anomaly will be dealt with shortly by amending existing secondary legislation.
- 3.7 An **officer of an NHS body**, who is required to attend a committee by virtue of the powers of overview and scrutiny of health, means any officer of an NHS body. Some NHS bodies may designate a specific scrutiny link officer, or may consider that all invitations should be made to the chief executive to identify who is the most appropriate officer to attend.

A full glossary of useful terms and common language pertaining to scrutiny, and in particular health scrutiny, is provided at the end of this guidance.

4. Planning the overview and scrutiny of health

- 4.1 Clearly, the planning of the overview and scrutiny of health and health services should add value to existing processes. Committees will not manage the performance of the NHS, nor will they undertake inspection. However, they will monitor health services as they affect local people, making use of local intelligence. Performance data may therefore be used to inform scrutiny reviews. Committees should not seek to duplicate arrangements for support and advocacy on behalf of individual patients or service users. Anonymised collated data from Patient Advice and Liaison Services (PALS), Independent Complaints Advocacy Services (ICAS) and NHS complaints services will be a crucial input to the scrutiny process. Health scrutiny is a means of ensuring NHS bodies are held to account for their decisions on behalf of the people they serve. This is distinctive in being undertaken by lay, elected, local representatives and focused on meeting the needs and the well-being of the community at large.
- 4.2 Performance and planning in the NHS are also changing. The service and financial planning framework has been adapted to take on board local implementation of the NHS Plan. The Health Improvement and Modernisation Plan (HIMP) has had a key role in linking implementation of the NHS Plan to tackling health inequalities and the wider determinants of health at a local level. The new Local Delivery Plans (LDPs) will develop this further and provide supporting information that will be essential for understanding the planning, operation and development of local health services. For further information on LDPs and the new planning process see www.doh.gov.uk/ldp2003-2006 and www.doh.gov.uk/planning2003-2006 In addition, the national performance assessment framework (PAF) will include a larger number of indicators and more information available at trust level. For further information see www.doh.gov.uk/performance/2003/index.htm

4.3 Issues to be scrutinised

- 4.3.1 The new powers enable an overview and scrutiny committee to review any matter relating to the planning, provision and operation of health services within the area of its local authority. The Regulations do not specify specific issues to be considered, but they may include the following:
- a) arrangements made by local NHS bodies to secure hospital and community health services to the inhabitants of the authority's area and the services that are provided;
 - b) arrangements made by local NHS bodies for public health, health promotion and health improvement (including addressing health inequalities) in the authority's area;

- c) the planning of health services by local NHS bodies, including plans made in co-operation with local authorities setting out a strategy for improving both the health of the local population and the provision of health care to that population;
- d) the arrangements made by local NHS bodies for consulting and involving patients and the public under the duty placed on them by section 11 of the Act; and
- e) any matter referred to the committee by a patient's forum by virtue of powers under the NHS Reform and Health Care Professions Act 2002.

4.3.2 The role of committees is to take an overview of health services and planning within the locality, and then to scrutinise priority areas to identify whether they meet local needs effectively. Overview and scrutiny committees should take into account:

- the scope and focus of scrutiny – if it is to maximise its impact, it must look beyond health care services at the wider determinants of health, using the wider local authority powers to make recommendations to other local agencies as well as the NHS;
- appropriateness of scrutiny topics – review by the committee may 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; and
- the style of scrutiny – a positive and constructive process and therefore should focus on improvement.

4.3.3 When the scrutiny review has been completed, it is the responsibility of the overview and scrutiny committee itself to make its report to the NHS body or bodies concerned. The report is made on behalf of the committee, not the local authority, and therefore there is no requirement for the executive or full council to endorse the report. However, good practice would suggest that both should receive a copy of the report and a briefing identifying the main implications. (See also section 8 on *joint committees*)

4.4 The relationship between health scrutiny and private or independent healthcare providers

4.4.1 Although the duties relating to overview and scrutiny of the NHS apply to NHS bodies and not to private health care providers, there will be times when a scrutiny process needs to consider health care provided by the private and independent sectors on behalf of the NHS. In these circumstances, the committee will need to consider the issue through the commissioning body, which is likely to be the local or lead commissioning PCT for the service¹. The committee can require the chief executive or officers from the

¹ see *glossary* for definition of *commissioning*

local NHS body responsible for commissioning private or independently provided services to provide information to, or answer questions from, the committee (see section 9 *duties placed on NHS bodies*). It would be good practice for NHS bodies and local authorities to build clauses into their tendering documents and contracts with service providers requiring them, if requested, to provide information and to attend reviews at no cost to the committee.

- 4.4.2 Committees will also need to be aware that they do not have the power to require individual general practitioners (GPs), dentists, pharmacists or those providing ophthalmic services to attend a committee for the purpose of answering questions. It should be recognised that they are not officers of a PCT or NHS body. Of course, local independent practitioners such as GPs may be willing to participate at the request of the PCT. However, if a committee considers that a view from general practice would be helpful, an alternative source to request information from might be the local medical committee or appropriate professional organisation.

4.5 Relationship between committees and patients' forums

- 4.5.1 Patients' forums will be established during 2003. They will comprise of lay members, including patients and representatives from community and voluntary organisations. There will be one forum for each PCT and trust, but they will be independent of them, being funded, staffed and managed separately.
- 4.5.2 The NHS Reform and Health Care Professions Act 2002 provides patients' forums with the power to refer issues to overview and scrutiny committees as appropriate. The regulations require overview and scrutiny committees to take account of relevant information provided to them by a patients' forum. If issues referred are not urgent, they may be considered by the committee when planning its future work programme and prioritised accordingly. As good practice, the committee should advise the patients' forum of the actions taken and the rationale behind those actions.
- 4.5.3 As patients' forums are established, overview and scrutiny committees will need to develop a close working relationship with the forums relating to the health services within their area. This might include discussing the outline and process of a scrutiny review with members of the forums prior to beginning the review, and also co-opting forum representatives onto the committee or inviting them to become expert witnesses or advisers. It will also be important for committees and forums to discuss appropriate responses to matters of concern to patient safety and welfare should such circumstances arise.

4.6 Developing scrutiny plans

- 4.6.1 It is recommended that committees produce an annual overview and scrutiny plan that is discussed and shared with local health bodies, including the patients' forums which relate to those bodies. The plan may identify priority issues for a given period (perhaps with more detail for the first year of the plan and identifying issues in outline for a further two years). It should also build in capacity for the committee to respond to

consultations on service reconfigurations or to issues raised by the local patients' forums. To ensure that scrutiny complements existing initiatives and makes effective use of resources, early discussions of local priorities should be informed by available documentation. A list providing examples of documentation which might be used to help identify priorities is attached as Appendix B.

4.6.2 Criteria for identifying priorities might 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.

It is recommended that health inequalities are given additional weight when identifying priorities.

5. Approaches to overview and scrutiny of health

- 5.1 Committees will need to consider the best approach to suit the issue or theme they are scrutinising. Scrutiny may be reactive, for example responding to referrals, decisions or consultations, or proactive where the committee determines its own subject matter and terms of reference based on community input or feedback.
- 5.2 There may be situations where a scrutiny review will be primarily ‘trust facing’, i.e. considering all or part of the work of one NHS trust or PCT. In other cases scrutiny may be thematic, considering issues that relate to more than one NHS body and which are likely to impact across more than just the provision of health and social care related services, including voluntary services. For example, consideration of the theme of winter pressures is likely to result in a scrutiny review of primary care, hospital care, social care, hospital and other transport services and voluntary and community support. Or, consideration of high levels of tooth decay within an area may consider dental health promotion, healthy eating, school meal provision and even fluoridation of water. A challenge for the committee will be to ensure that the priority issue is manageable and that it addresses issues that can be improved locally.
- 5.3 As the topics for scrutiny may involve a number of organisations, so the method of undertaking the scrutiny review may differ. Examples of different approaches to overview and scrutiny of health already exist from local authorities that have piloted the power.^{2,3} These range from a committee establishing small working groups that research an issue informally and then produce a composite report with recommendations, or; commissioning research from a local university into a specific issue; to formal ‘select committees’ calling for evidence from key stakeholders and NHS bodies when considering issues of consultation on substantial developments or variations in services. It is the responsibility of the overview and scrutiny committee to identify which approach is most suited to the issue under scrutiny.
- 5.4 The strength of scrutiny is its independence and ability to take on board differing perspectives. To be effective, committees must balance ‘expert’ opinion and public concerns where these conflict – for example in the case of service reconfigurations. To ensure credibility, committees should consider all views and evidence before finalising recommendations. Reports should incorporate the views and information received and, where possible, clear recommendations should be made. To achieve this effectively, committees will need adequate support and advice from the local authority’s officers.

² see IDeA *knowledge website* – www.idea.gov.uk/knowledge

³ *Local government scrutiny of health: Case studies in health improvement and tackling health inequalities*, Health Development Agency 2003

5.5 Making reports and recommendations

5.5.1 Overview and scrutiny committees have no power to make decisions or to require that others act upon their suggestions, although NHS bodies are required, on request, to respond in writing to recommendations made. A committee may make reports and recommendations to local NHS bodies on any matter reviewed or scrutinised under section 7 of the Act. The reports shall include the following:

- (a) an explanation of the issue addressed;
- (b) a summary of the evidence considered;
- (c) a list of the participants involved in the review or scrutiny; and
- (d) any recommendations on the matters considered.

5.5.2 Once the committee has completed its scrutiny and produced its draft report, it may send copies to those NHS bodies that have been the subject of the review to check for factual accuracy. At this stage it would be appropriate to inform the NHS body when the report will be published.

5.5.3 Where an overview and scrutiny committee request a response from the NHS body to which it has reported, the NHS body shall respond to the request within 28 days. Reports may also be made to the committee's local authority. Although there is no legal requirement for the report to be copied widely, it would be good practice to copy it to all key stakeholders.

5.5.4 It is recommended that the written response from NHS bodies sets out:

- a) the views of the body on the recommendations,
- b) proposed action in response to the recommendations,
- c) any reasons for inaction to the recommendations made.

If the NHS body is unable to provide a comprehensive response to the recommendations made within 28 days, it may want to negotiate with the overview and scrutiny committee to provide an interim response. It is recommended that this interim response include details of when the final report would be produced.

5.5.5 The overview and scrutiny committee report and the NHS response should be copied to key stakeholders which may include:

- the mayor (if any) or executive
- the full council of the committee's local authority
- Joint or partnership boards
- Local strategic partnerships
- Local MP(s)

- the strategic health authority
- relevant patient forum(s)
- local voluntary organisations with an interest
- other NHS trusts and PCTs
- other local authorities and overview and scrutiny committees, for example district councils or neighbouring authorities

It should also be made available within local libraries, community venues and on websites.

5.5.6 Scrutiny is not 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 development and implementation of local strategic partnerships (LSPs) and initiatives such as local community strategies and neighbourhood renewal. Involvement in LSPs is the role of executive councillors, whereas non-executive councillors participate in overview and scrutiny. The two roles complement each other, with the executive taking decisions on behalf of the local authority, and the non-executive holding them to account. Committee members will need to understand and develop approaches to overview and scrutiny of health within this context. It is likely to be important for the chair of the overview and scrutiny committee and the executive member leading on health partnerships to have regular contact to discuss priorities and approaches.

6. Co-option and methods of wider involvement

- 6.1 Co-opting people on to the overview and scrutiny committee is one method of ensuring involvement of key stakeholders with an interest in, or knowledge of, the issue being scrutinised. It is not; however, the only method of involvement, and it is intended that the new power should be implemented as creatively and effectively as possible. Local authorities already have powers to co-opt non-voting members onto overview and scrutiny committees by virtue of the Local Government Act 2000. The power of overview and scrutiny of health services provides county councils with additional powers of co-option.
- 6.2 The regulations state that county councils may appoint one or more of the members of an overview and scrutiny committee of district councils in its area as:
- a) a member of a committee of the county council or another local authority, for the purposes of relevant functions of the committee in relation to the county council; or
 - b) a member of a committee of the county council, for the purposes of relevant functions of the committee in relation to another local authority.

District councils are often closely associated and in many cases co-terminus with their local PCTs. County councils are encouraged to work closely with the district councils to make best use of resources and expertise.

- 6.3 A county council making an arrangement for an appointment may specify that the appointment is:
- i) for the life of the committee; or
 - ii) until such time as it decides to terminate the appointment; or
 - iii) for a particular review or scrutiny.

References to a committee of a county council include references to a joint committee.

- 6.4 This power enables county councils to co-opt members of overview and scrutiny committees from district councils to participate as full members of the county overview and scrutiny committee considering health services. Councillors who are members of a district council executive are, by definition, not scrutiny members and therefore cannot be co-opted onto the county council health overview and scrutiny committee, nor can district councillors who are not members of an overview and scrutiny committee. Councillors who fall into these categories and who may have a role to play in a scrutiny

process may participate in other ways, for example by providing information to the committee or attending as an expert witness.

- 6.5 Overview and scrutiny committees from unitary or metropolitan authorities may make use of their powers of co-option under the Local Government Act 2000 should they wish to co-opt members of other local authorities onto their committees. Or, they may need to consider establishing a joint committee with a committee from another local authority (see section 8, *joint committees*).
- 6.6 In some circumstances, it may be more appropriate for external stakeholders, including other councillors, to participate in sub-committees of the main overview and scrutiny committee, or to act as advisors to the committee rather than as co-opted members. For example, a support group for local people using or caring for people using a service might wish to provide evidence or information to the committee, in person or in writing, rather than be co-opted to participate in a scrutiny process. Or, the director of public health from a lead commissioning PCT might act as adviser to the committee for the duration of a scrutiny review. These approaches may be a more effective use of the participants' time and enable more diverse involvement in the scrutiny process.

7. Delegating overview and scrutiny

- 7.1 The Regulations enable a local authority to arrange for its overview and scrutiny functions to be undertaken by a committee from another local authority. This may happen, when the local authority, believes that the other would be better placed to consider a particular local priority and the latter agrees to exercise the function. For example, where a NHS body provides services across two local authority areas but the large majority of those using its services are in one of those authority areas
- 7.2 The regulations enable the delegation of scrutiny functions between local authorities including from county council to district council overview and scrutiny committees. This recognises that there may be some health priorities, which would be more effectively scrutinised at a district level. For example, scrutiny of community services provided by a PCT that is coterminous with a district council's boundaries
- 7.3 For delegation to be effective there must be clear terms of reference agreed between the local authorities and clarity about the scope and methods of scrutiny which might be used. The detail of the delegating arrangements should be shared with the relevant NHS body and with other bodies, which may be involved if the review goes wider than the NHS body concerned. To ensure the effective use of resources and to enable the report and recommendations to be agreed with the delegating and delegated authority, there will need to be regular communication between the two authorities.
- 7.4 When delegation takes place, the full powers of overview and scrutiny of health services are given to the delegated committee but only in relation to the specific delegated function. For example, where the function of reviewing accident and emergency services of a trust is delegated to the overview and scrutiny committee of another authority, the overview and scrutiny committee powers are delegated only for the purpose of that exercise. In the context of a proposal for a substantial development or variation to services where the review of any consultation has been delegated, the power of referral to the Secretary of State where such a proposal is contested is also delegated. The delegating committee therefore is no longer able to influence the content and outcomes of the review; other than through informal discussions as agreed when delegation takes place.

8. Joint committees

- 8.1 Two or more local authorities, may appoint a committee (a “joint committee”) of those authorities and arrange for relevant functions in relation to any (or all) of those authorities to be exercisable by the joint committee. Membership of the joint overview and scrutiny committee, as with other committees, excludes councillors who are members of their authority’s executive. The appointing authorities can set terms and conditions for the joint committee. For example, where it appears to the appointing authorities that the joint committee has completed the scrutiny review for which it was appointed, or that it is not adequately performing those functions, they may provide that the appointment of the committee be terminated.
- 8.2 District councils wishing to participate in a joint committee must ensure that the councillors they wish to be involved are members of the council’s overview and scrutiny committee; and of course are not members of the executive.
- 8.3 A joint committee is only able to undertake the functions, which the appointing authorities allocate to it. It is, therefore, important that the local authorities participating in the committee are clear from the outset about its roles and responsibilities and terms of reference. Examples of when a joint committee might be appropriate include, where one NHS body provides services to patients living or working within a number of local authority areas, or where a health issue such as teenage pregnancy, cuts across geographical boundaries.
- 8.4 The Regulations ensure the maximum flexibility for local authorities to make the most of suitable arrangements to meet local circumstances whilst ensuring that NHS bodies are not burdened by multiple scrutiny exercises in one year. However, with flexibility comes responsibility. Whilst the legislation enables local authorities to identify the best approach to suit their area, they should give thought to the effectiveness of the process to be followed and work together across organisational boundaries.
- 8.5 Under the local Government Act 2000 provisions, overview and scrutiny committees must generally reflect the political make up of the full council. The Local Government and Housing Act 1989 enables local authorities to waive the political balance requirements if all elected councillors within that authority agree that it need not apply.
- 8.6 Where a joint committee is established, the political balance requirement applies for each participating local authority unless members of all authorities agree to waive that requirement.
- 8.7 Where a joint committee is established, good practice suggests that the local authorities participating should share the costs and resource implications of working together. Thus, joint committees will enable more effective use of local authority resources

as well as resources for the NHS. For example, where a joint committee is established by three local authorities, they may agree to each provide different types of support to the committee, including administration, research, and provision of meeting rooms within community venues.

- 8.8 When a joint committee has completed its scrutiny review, it should produce one report on behalf of the committee. The report should reflect the views of all local authority committees involved in the joint committee, but it should aim to be a consensual report. The NHS body or bodies receiving the report must respond in writing to any requests for responses to the report or recommendations, within 28 days of receipt of the request.

9. Duties placed upon NHS bodies – information, attendance and explanations

9.1 To help make scrutiny of the NHS effective the legislation places a number of duties upon local NHS bodies which apply to scrutiny by individual and joint overview and scrutiny committees.

9.2 Providing information

9.2.1 Local NHS bodies must provide an overview and scrutiny committee with such information about the planning, provision and operation of health services in the area of the committee's local authority as the committee may reasonably require to undertake effective overview and scrutiny. There are a number of exemptions to this requirement relating to confidentiality and information whose disclosure is prohibited by law.

9.2.2 Where a local NHS body relates to more than one overview and scrutiny committee and a joint committee has been established it will have fulfilled its duty in providing information to all those committees by providing it to the joint committee. It is therefore, important for joint committees to be clear about the information that they request and to make sure that they address issues relevant to all participating local authorities.

9.2.3 It is recommended that officers from local authorities and NHS organisations work closely together in planning the overview and scrutiny programme so that the NHS body is clear about the information that will be required and time-scales involved for the submission of that information.

9.2.4 Information that identifies a particular individual or individuals, for example a patient, carer, family member or NHS staff, may only be provided to the committee if the individual concerned agrees to its disclosure or in a way that ensures identification is no longer possible. The decision to give consent should be prompted by the individual or their advocate. Where this is not the case, the overview and scrutiny committee can require that the information be provided to the committee in an anonymised format.

9.2.5 If a request for information is made and an NHS body refuses to provide the information, the overview and scrutiny committee may refer the issue to the body responsible for performance managing the NHS organisation. The performance managing body should consider the request seriously and negotiate for a speedy resolution to the request.

9.3 Attendance at meetings and providing explanations

9.3.1 The Regulations enable overview and scrutiny committees to request the attendance of an officer from a local NHS body to answer questions. NHS bodies are under a duty to comply with these requests. Identification of the appropriate officer to attend may depend upon the type of scrutiny review being undertaken and its aims. The committee should make clear the nature of the information and how it is relevant to its review to allow the NHS body to identify the most appropriate officer.

For example, if the review is focussing on calling the NHS body to account for its actions, the officer that is accountable for that particular service may be the most appropriate. It is suggested that the officer of the NHS body receiving the request, often the chief executive, determine the most appropriate representative. In many cases, the chief executive himself may be required to attend and answer questions.

9.3.2 The committee must give sufficient notice of its request for an officer to attend, and should provide an indication of the issues being considered and where possible an outline of the potential lines of enquiry. The aim of attendance is to enable members of the committee to fulfil their functions – for example, to understand why action has taken place and the options that have been considered. Whilst the legislation does not require the chair or non-executive directors to attend before the committee, there may be times when they may wish to accept invitations to enable the committee to discuss issues of governance and policy relating to the NHS body.

10. Duties placed upon NHS bodies – consultation

10.1 Consultation of committees

10.1.1 Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities, or on any proposal to make any substantial variation in the provision of such service(s). This is additional to the discussions that NHS bodies will have with the local authority, as distinct from the overview and scrutiny committee, about service developments, especially where they link to services provided or commissioned by the local authority. The duty to consult the overview and scrutiny committee is also additional to the duty placed upon NHS bodies to consult and involve patients and the public as an ongoing process under section 11 of the Act.

10.1.2 The NHS body will need to discuss any proposals for service change with the overview and scrutiny committee at an early stage, in order to agree whether or not the proposal is considered substantial. At this point there should also be discussion about how consultation will be undertaken. This latter discussion should include agreement about the length of time the consultation will last and methods to be used taking into account local needs. It is good practice for consultation to follow Cabinet Office guidelines (see *Appendix E*).

10.1.3 Whilst there is a statutory duty for NHS bodies to consult the local overview and scrutiny committee on a substantial change, committees should also note the duty to 'consult and involve' patients and the public conferred on NHS organisations by section 11 of the Act. See 'Strengthening Accountability', policy and practice guidance at www.doh.gov.uk/involvingpatients. Section 11 makes it clear to NHS organisations that solely focusing consultation with the committee would not constitute good practice.

10.1.4 Guidance on service change has recently been issued to the NHS, and may provide a useful starting point for overview and scrutiny committees considering proposals for change. "Keeping the NHS local – a new direction of travel" sets out three core principles for the development of proposals for reconfiguration of services:

- Developing options for change with people, not for them, [starting from the patient experience and the commitment to improve choice, and working with staff to develop new ways of working];
- Focus on redesign of services rather than relocation;

- Taking a whole systems view, exploring the contribution of all health and social care providers, working together to build sustainable solutions for the whole community;

www.doh.gov.uk/configuringhospitals/framework.htm

10.1.5 Some exemptions exist in relation to the requirement for consultation. The requirement does not apply with respect to any proposal to establish or dissolve a NHS trust or primary care trust unless that establishment or dissolution represents a substantial variation or development. This will need to be determined through discussions between the NHS body and the overview and scrutiny committee prior to the consultation process. Likewise, the requirement for consultation will not apply to any proposals for pilot schemes within the meaning of section 4 of the National Health Service (Primary Care) Act 1997(1). The reason for these exclusions is that separate regulations specify who should be consulted on these issues. It is intended that the legislation will be amended during 2003 and overview and scrutiny committees may then be included in the list of statutory consultees under the relevant regulations:

- Legislation on PCT consultation is in the Primary Care Trust (Consultation on Establishment, Dissolution and Transfer of Staff) Regulations 1999 (SI 1999/2337). The amending SIs are 2001/3787 and 2002/2469.
- Legislation for changes to NHS trusts is in the National Health Service Trusts (Consultation on Establishment and Dissolution) Regulations 1996 (SI 1996/653). The amending SI is 2001/3786.
- For Care Trusts requirements are set out in Care Trusts (Applications and Consultation) Regulation 2001. The SI is 2001/3788.

Link <http://www.hmso.gov.uk>

10.1.6 Another exemption is that local NHS bodies do not have to consult the committee if they believe that a decision has to be taken on an issue immediately because of a risk to the safety or welfare of patients or staff. For example, if a ward within a hospital needs to be closed immediately due to a viral outbreak. This might be considered to be a substantial development but allowing time for consultation could place patients or staff at risk. These circumstances should be exceptional. In any such case, the local NHS body must notify the committee 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 the needs of patients and carers.

10.1.7 The local NHS body must make clear when the consultation period will end. Government guidance on consultations states that full consultation should last for a minimum of twelve weeks, and that consultations should ensure that groups the

4 <http://www.cabinet-office.gov.uk/servicefirst/2000/consult/code/ConsultationCode.htm>

NHS has traditionally found hard to reach and the wider community should be consulted.⁴ It is also considered good practice for staff from the NHS body or bodies carrying out consultation, to work closely with the local overview and scrutiny committee during this period. This should help all parties to reach agreement about how the proposed substantial development or variation might be progressed.

10.2 Roles and responsibilities

10.2.1 It is important for there to be clarity about the roles and responsibilities of different NHS bodies for consultation with overview and scrutiny committees. The obligation applies to the body which has a proposal “under consideration”. Which body that is will depend on the facts of each case.

10.3 Primary care trusts (PCTs)

10.3.1 PCTs have the responsibility for planning and commissioning services for the local population. The PCT leading the commissioning process will usually be responsible for undertaking consultation on any variation or development to local health services that it commissions.

10.3.2 In circumstances where a proposed service change spans more than one PCT, they 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. See regulation 10 of S.I.2002/2375 for relevant PCT provisions.

10.3.3 Where a proposed substantial variation to the provision of services has an impact across the strategic health authority or several strategic health authorities, the relevant PCTs may wish to invite the strategic health authorities to co-ordinate the consultation process. The decision for doing this will rest with the PCT(s) leading the commissioning process. It is important that the strategic health authorities 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 a strategic health authority.

10.4 NHS trusts

10.4.1 Where a **NHS trust** plans to vary or develop services locally, it will need to discuss the proposal with the overview and scrutiny committee to determine whether the proposal is substantial. If the outcome of those discussions is that it is a substantial development or variation, the trust must consult the overview and scrutiny committee.

10.5 Strategic health authorities

10.5.1 The role of **Strategic health authorities** is to improve performance and create a coherent strategic framework for the development of services across the full range of

local NHS organisations. They perform the critical roles of ensuring that PCTs and trusts develop proposals for service change in line with current guidance, and carry out consultations appropriately. Where an issue spans more than one PCT or trust, a strategic health authority will want to be satisfied that the consultation is undertaken in a way that ensures the full and relevant involvement of all stakeholders. Where a proposed substantial variation to the provision of services has an impact across the strategic health authority or several strategic health authorities, consultation may be more effectively undertaken if co-ordinated by the strategic health authority/ies. See regulation 9 of S.I.2002/2375.

10.6 Understanding 'substantial variation and substantial development'

10.6.1 The Regulations for overview and scrutiny do not define 'substantial'. Local NHS bodies should aim to reach a local understanding or definition with their overview and scrutiny committee(s). This should be informed by discussions with other key stakeholders including patients' forums.

10.6.2 In considering whether the proposal is substantial, NHS bodies, committees and stakeholders should consider generally the impact of the change upon patients, carers and the public who use or have the potential to use a service.

10.6.3 More specifically they should take into account:

- a) **changes in accessibility of services**, for example both reductions and increases on a particular site or changes in opening times for a particular clinic. Communities attach considerable importance to the local provision of services, and local accessibility can be a key factor in improving population health, especially for disadvantaged and minority groups. At the same time, development in medical practice and in the effective organisation of health care services may call for reorganisation including relocation of services. Thus there should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location;
- b) **impact of proposal on the wider community** and other services, including economic impact, transport, regeneration;
- c) **patients affected**, changes may affect the whole population (such as changes to accident and emergency), or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example, renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial;
- d) **methods of service delivery**, altering the way a service is delivered may be a substantial change – for example moving a particular service into community settings rather than being entirely hospital-based. The views of patients and patients' forums will be essential in such cases.

10.6.4 However, where the committee is not satisfied:

- a) with the content of the consultation or that sufficient time has been allowed; or
- b) that the reasons given for not carrying out consultation are inadequate;

it may report the issue to the Secretary of State in writing. Any such referral should make clear the grounds on which it has reached its conclusion. It should be noted, that the referral power for overview and scrutiny committees in the context of inadequate consultation, only relates to the consultation with committees by the NHS and not consultation with other stakeholders. Section 11 of the Act requires more wide ranging involvement and consultation (see 10.3) but no referral power relates to that wider duty.

10.6.5 The Secretary of State may require the local NHS body concerned to carry out such consultation or further consultation with the committee as he considers appropriate. Where any such consultation has been required by the Secretary of State, the local NHS body shall, having regard to the outcome of such further consultation, reconsider any decision it has taken in relation to the proposal in question.

10.6.6 Likewise, where the committee considers that the proposal is not in the interests of the health service in its area, it may refer the issue to the Secretary of State in writing who may make a final decision on the proposal. In such cases Secretary of State can require the NHS body to take such action or desist from taking such action as he may direct.

10.6.7 Referral on the basis of a proposal not being in the interests of the health service should also set out the grounds on which the committee has come to that conclusion. The power of referral to the Secretary of State should not be used lightly. Where possible, local resolution of issues is always preferable. In considering whether a proposal is in the interests of the health service a committee should consider the extent to which patients, the public and stakeholders more widely have been involved in the planning and development of the proposal. Only by full involvement activity will NHS bodies be able to take a considered view as to whether its plans are in the interests of the health service for which it is responsible. Again, section 11 of the Act is relevant here.

10.6.8 Where a referral has been made, the Secretary of State may ask the Independent Reconfiguration Panel (IRP) to advise him on the matter. The IRP will wish to be satisfied that all options for local resolution have been fully explored. Only those contested proposals where it is clear that all other options have been exhausted are likely to be considered in detail by the panel. In these cases, the IRP may visit the local NHS body and will also consider the report and recommendations from the overview and scrutiny committee as part of its work.

10.6.9 The IRP is an advisory non-departmental public body. It has a chair and members drawn equally from health service professionals, health service managers and patients and citizens. The panel provides advice to ministers on proposals for NHS change in England that have been contested locally and referred to the Secretary of State. More information on the IRP can be obtained from www.doh.gov.uk/configuringhospitals/framework.htm

10.6.10 NHS Foundation Trusts will also be under the duty to consult relevant overview and scrutiny committees, as set out above, on any substantial variation in the provision of protected NHS services. However, where committees contest a proposal they should refer their concerns to the independent regulator for NHS foundation trusts, not to the Secretary of State.

10.7 Directing the establishment of a joint committee

- 10.7.1 Regulation 10 enables the Secretary of State to make directions to authorities requiring the establishment of joint committees. Directions will be made requiring the establishment of a joint committee to respond to consultation on any proposal to substantially develop or vary services where those services are provided to areas that span more than one overview and scrutiny committee.
- 10.7.2 All the local authorities whose residents receive services provided or commissioned by the NHS body proposing the change may participate in the joint committee. When a joint committee is established as a result of Directions, the provisions on co-option apply as with other joint committees.
- 10.7.3 Where there are proposals for substantial variation or developments to services covering more than one overview and scrutiny committee area, the consulting NHS body must consult all overview and scrutiny committees in each of those areas. The Directions, issued 17 July 2003, require the local authorities of those areas to establish a joint committee for the purpose of responding to the consultation, using the method most appropriate to the areas and the issues being considered. Only the joint committee (not each overview and scrutiny committee in the various areas) may then comment back to the NHS body.
- 10.7.4 In such circumstances the duties of the consulting NHS body to provide information to the relevant committees and to attend before the committees to answer questions will be fulfilled through the provision of information to or attendance at the joint committee and only the joint committee may require such information or attendance.
- 10.7.5 In undertaking its function to consider a proposal for substantial variations or developments in services the joint committee should aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal.
- 10.7.6 The joint committee may, on receipt of the NHS body's response to its comments, report to the Secretary of State on the grounds described in 10.6.4.
- 10.7.7 The power to report to the Secretary of State should only be exercised once the NHS body proposing the change has responded to the joint committee's comments. However, it may be exercised by any of the overview and scrutiny committees originally consulted.

11. Responding to consultations by NHS bodies

- 11.1 An NHS body undertaking a consultation should be prepared to attend the overview and scrutiny committee, if so requested, to explain the rationale behind the proposals and the options for change being considered.
- 11.2 When the committee has considered the proposals and local evidence, it should prepare its comments (if any) to the local NHS body undertaking the consultation. It must respond within the time-scale (if any) specified by that local NHS body. If the committee does not support the proposals (i.e. regulation 4(7)), it should provide reasons and evidence for this. In circumstances where the committee is concerned about the adequacy of the consultation (i.e. regulation 4(5)) it should make the reason why clear in its comments. The committee should not consider any referral to the Secretary of State until the relevant NHS body has had an opportunity to respond to the committee's comments, if it so wishes, and an effort at local resolution has been made.

12. Joint committees and scrutiny of NHS bodies covering more than one local authority

- 12.1 The legislation for overview and scrutiny of health refers to the health services in the area of an overview and scrutiny committee's local authority. In many cases one NHS body will provide and or commission both local services and services across a number of committee boundaries. It is not uncommon for services to be provided and commissioned regionally and sometimes nationally. It is important for patients and the public that these services are subject to the same levels of overview and scrutiny, whilst also ensuring that the process is effective and does not duplicate effort across the wider area. It is therefore recommended that scrutiny of services provided, commissioned or planned by a single NHS body covering more than one local authority area, is undertaken by a joint committee as outlined in section 8 of this guidance
- 12.2 The make up of a joint committee should be determined by a number of factors, including the nature of the issue under review, the best use of resources, the interests and expertise of other stakeholders who may also be involved through co-option or as 'experts'. All authorities concerned with the issue under review should be involved in decisions about the establishment of a joint committee. Whatever the nature of the joint committee, it must be able to:
- represent the interests of the population that receives services provided by or commissioned by the NHS body;
 - operate in a way that will lead to a rigorous and objective scrutiny of the issues under review.
- 12.3 Where a joint committee has not been set up and committees plan to review an NHS body which spans more than one authority area it is recommended that committees share information about their work with other committees. In this way unnecessary requests for information and NHS officer time will be avoided and committees may learn from the scrutiny activity of others.

12.4 Scrutiny in London

- 12.4.1 In the case of the London Ambulance Service and other pan-London services, it is recommended that authorities seek to work with the London Assembly and the Association of London Government to ensure the best use of resources and to avoid the development of duplicating scrutiny regimes. It must be remembered, however, that it is the London borough councils and the Common Council for the City of London that have the legal powers and must remain in the lead role.

12.5 Maintaining local priorities

12.5.1 The recommendation to establish a joint committee to scrutinise NHS bodies which provide or commission services across more than one authority area does not prevent an overview and scrutiny committee within one local authority from scrutinising such a body individually. The requirement to establish a joint committee will only apply for statutory consultation.

13. Conclusion of the scrutiny process

- 13.1 The effective implementation of the new power for local authority overview and scrutiny of health services will develop over time. As local authorities and local NHS bodies develop their working arrangements and share good practice and learning, the needs of patients and the public will become more influential in the planning, management and delivery of health services. This will enable more effective NHS services, and more sustainable health improvement.
- 13.2 Following the publication of a scrutiny report and recommendations, the executives of all key stakeholder organisations are encouraged to implement recommendations or provide reasons why no action is taken. Subsequently, the overview and scrutiny committee may wish to review progress after a reasonable time has passed, enabling the committee to have time to scrutinise other priorities.
- 13.3 Good practice suggests that overview and scrutiny committees and NHS bodies may also identify ways in which they can evaluate the impact of scrutiny reviews in improving the health of the local population and reducing health inequalities. This may be informed by intelligence collected by patients' forums and key stakeholders working with local communities.

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Membership of the Overview and Scrutiny of Health Reference Group comprised representatives from:

Association of Community Health Councils for England and Wales

Barnsley Council

Bedfordshire County Council

Democratic Health Network

Health Development Agency

Improvement and Development Agency (IDeA)

Local Government Association

London Borough of Lewisham

NHS Confederation

Office of the Deputy Prime Minister

Peterborough City Council

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Appendix A

How overview and scrutiny of health relates to the wider patient and public involvement structure

The *NHS Plan* set out the Governments intentions to establish a new system of patient and public involvement for England to replace Community Health Councils (CHCs) in England as part of the modernisation programme. The new structure is also designed to respond to the Bristol Royal Infirmary Inquiry report, which recommended representation of patient interests “on the inside” of the NHS and at every level.

In summary:

In each trust and PCT there will be a Patient Advice and Liaison Service (PALS) providing on the spot help and information about health services. PALS is an NHS managed service designed to deal with queries and concerns quickly and to enable change within organisations that is based on the needs and experiences of patients, carers and the public.

Independent Complaints Advocacy Services (ICAS) is independent support for patients and carers wishing to make a complaint against the NHS. A range of agencies will provide ICAS, with PCT patients’ forums taking the lead once they are established.

Patients’ forums will be set up for every NHS trust and PCT. Forums will be independent of the bodies to which they relate. They will comprise patients, carers and members of voluntary organisations that represent the interests of patients or carers. They will monitor and review services, including carrying out inspections. They will make reports to the board of the NHS organisations and the intention is to have one of their number on the board as a non-executive director. They will be funded, supported and performance managed by the Commission for Patient and Public Involvement in Health. The Commission will also facilitate the co-ordination of patients’ forums’ activities.

In each community, PCT patients’ forums will be a key resource for local citizens, helping and supporting community groups and promoting better public involvement. They will also help to integrate the work of patients’ forums and PALS strategically by bringing together data from their activities regularly to share lessons and identify trends. Patients’ forums will work in partnership across wider health economy areas, to guide local work programmes. An important function for the patients’ forums will be the reporting of trends and conclusions drawn from the entirety of patient experience data and reporting this to local decision-makers. In particular this will be to overview and scrutiny committees undertaking the role of health scrutiny.

At the centre the Commission will oversee the new system. It will fund and performance manage patient's forums and oversee the delivery of ICAS. It will be a powerful means of aggregating and promoting information picked up from the work of patients' forums and from the delivery of ICAS. It will report to the Secretary of State and other relevant bodies its evaluation of the system of patient and public involvement, and importantly it will also have the function of reporting any issue of concern on patient safety and welfare that it becomes aware of in the course of exercising any of its functions. In such circumstances it will report to bodies such as the Commission for Health Improvement, the National Patients Safety Agency, and perhaps the police if that is appropriate. The commission may also report or make recommendations to the Secretary of State or such persons or bodies as it thinks fit on issues brought to its attention through reviewing the reports of patients' forums.

Appendix B

Documents which might inform the identifications of local priorities to be scrutinised

- Work of the local strategic partnership (LSP)
- The local community strategy or plan
- Delivery plans
- Reports of the local director of public health
- Health equity audits
- Recommendations from inspection or audit reports (in the public domain following a public meeting of the trust board)
- Completed Commission for Health Improvement reports
- Patients survey and prospectus
- Reports from local Patient Advice and Liaison Service (PALS)
- Reports from Independent Complaints Advocacy Service (ICAS)
- Information from patients' forums within the local authority area
- Reports by local voluntary and community organisations which focus on health issues
- Local transport plans
- Crime and disorder reduction strategies
- Housing needs surveys
- Local neighbourhood renewal plans
- Completed best value reviews by local authorities
- Completed health or environmental impact assessments
- Issues arising from modernisation and partnership boards within or in partnership with local NHS bodies

This list is not exhaustive and it is likely that elected councillors and officers will be able to identify other local intelligence which might be useful in influencing the health scrutiny planning process.

Appendix C

Exempt Information

Health and Social Care Act 2001, Schedule 1

Exempt Information Relating to Health Services

Part 1

Description of Exempt Information

1. Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, a relevant body.
2. Information relating to any particular occupier or former occupier of, or applicant for, accommodation provided by or at the expense of a relevant body.
3. Information relating to any particular applicant for, or recipient or former recipient of, any service provision by a relevant body.
4. Information relating to any particular applicant for, or recipient or former recipient of, any financial assistance provision by a relevant body.
5. The amount of any expenditure proposed to be incurred by a relevant body under any particular contract for the acquisition or disposal of property or the supply of goods or services.
6. Any terms proposed or to be proposed by or to a relevant body in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.
7. The identity of a relevant body (as well as off any other person, by virtue of paragraph 6 above) as the person offering any particular tender for a contract for the supply of goods or services.
8. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matters arising between a relevant body or a Minister of the Crown and employees of, or office-holders under, a relevant body.
9. Any instructions to counsel and any opinion of counsel (whether or not in connection with any proceedings) any advice received, information obtained or action to be taken in connection with:

- a) any legal proceedings by or against a relevant body; or
 - b) the determination of any matter affecting a relevant body, (whether, in either case, proceedings have been commenced or are in contemplation).
10. Information relating to a particular person who is or was formerly in, or is an applicant for inclusion in, a list of persons undertaking to provide services under Part 2 of the 1977 Act prepared by a health authority.
 11. Information relating to a particular person who is or was formerly included in, or is an applicant for inclusion in, a list of persons undertaking to provide services under Part 2 of the 1977 Act prepared by a health authority.
 12. Information relating to a particular person who is or was formerly performing personal medical services or personal dental services in accordance with arrangements under section 28C of the 1977 Act.
 13. Information relating to any particular employee, former employee, or applicant to become an employee, of a person referred to in paragraph 10, 11 or 12.
 14. Information relating to the physical or mental health of a particular individual.

Appendix D

Summary of responsibilities for local authorities and NHS bodies

Overview and scrutiny of health is an important part of the Government's commitment to place patients and the public at the centre of health services. It is also an opportunity for democratically elected community leaders to voice the views of their constituents and require local NHS bodies to listen and respond. In this way, local authorities can assist to address health inequalities and support health improvement. The power of overview and scrutiny of health services is given to the overview and scrutiny committee of the following local authorities: county councils, councils of districts where there is no county council (i.e. district council unitary authorities and metropolitan councils), London borough councils and the Common Council of the City of London. A full explanation of the powers and duties placed upon local authorities and local NHS bodies, including definitions of terms and phrases, may be found in the Department of Health Guidance of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

Powers of local authority overview and scrutiny committees

Overview and scrutiny committees may:

1. review and scrutinise any matter relating to the planning, provision and operation of health services in the area of the committee's local authority;
2. make reports and recommendations to local NHS bodies and to its local authority on any matter reviewed or scrutinised using the overview and scrutiny of health power;
3. require the attendance of an officer of a local NHS body to answer questions and provide explanations about the planning, provision and operation of health services in the area of the committee's local authority;
4. require a local NHS body to provide information about the planning, provision and operation of health services in the area of the committee's local authority, subject to exemptions outlined in the Health and Social Care Act 2001;
5. establish joint committees with other local authorities to undertake overview and scrutiny of health services;
6. delegate functions of overview and scrutiny of health to another local authority committee;
7. co-opt members of the overview and scrutiny committees of district councils onto the committee as full members (County Council committees only);
8. be able to report to the Secretary of State for Health:

- a) where the committee is concerned that consultation on substantial variation or development of services has been inadequate;
- b) where the committee considers that the proposal is not in the interests of the health service.

Duties of local NHS bodies

NHS bodies must:

1. provide information requested by the overview and scrutiny committee, subject to exemptions;
2. attend before committees to answer questions, subject to exemptions;
3. on request, respond to reports and recommendations within 28 days of the request of the committee;
4. consult the local overview and scrutiny committee (including joint committees) on matters of substantial development or variation to services, (in addition to the duty under section 11 of the Health and Social Care Act 2001 to involve and consult patients and the public).

Appendix E

Framework for Consultation

(Adapted from the Cabinet Office Code of Practice on written consultation)

1 – Timing

- Time must be set aside so that a written consultation document can be properly designed and disseminated where appropriate.
- Early involvement is often the key to the success of a consultation, and to securing co-operation in it: omitting it may cause delay and expense later.
- Let interested parties know about the timing of the events that will form part of the consultation.
- Set aside sufficient resources for the consultation. Effective consultation may involve significant expenditure of time and money.
- Allow a reasonable time for receiving the responses and for analysing them.

2 – Clarity

You should:

- explain which people and groups the consultation is particularly aimed at
- identify who has been involved in developing the issues that are being consulted on
- includes an assessment of the impact of the issues on groups likely to be particularly affected and particular impact by gender, age, ethnicity or disability
- be clear about any aspects of an issue on which decisions have been taken, or are inevitable
- indicate where the PCT/trust provisionally favours a particular course of action. NB the agenda should not be so rigidly defined as to deter respondents on related questions of interest to them
- set out the deadline for responses and the timetable envisaged
- make it clear that representative groups must provide a summary of the people and organisations they represent when they respond
- specify that responses may be made public unless confidentiality is requested.

3 – The documents

Any document should:

- be simple and concise
- have numbered paragraphs
- include a two-page summary
- include the membership of the steering group so that people can see that patients and the public have been involved in the drafting
- be drafted in plain language and not too glossy or elaborate
- set out the main information and competing arguments relevant to a decision
- include a set of key questions
- give email as well as postal address for responses
- provide contact details of someone who will respond to questions and someone independent to the consultation process, who will pursue complaints or comments about the consultation process
- be available in paper format, free of charge and on a website from the start of the consultation.

4 – Communication

- Make every effort to communicate effectively with all those who are, or potentially are, interested. This may involve contact with representatives of voluntary or other interest groups as well as narrowly defined groups. Patients, the public and front-line staff should be included.
- Make any document widely available both in paper form and electronically. Send it to all interested parties and make it available, free of charge, to the general public and front line staff.
- Consider how to effectively reach socially excluded groups and people the NHS has traditionally found hard to reach:
 - does the issue impact on other linguistic groups, or particular minority ethnic groups?
 - does any document need to be reproduced in different languages or formats? E.g. be made available in a format for people with a visual impairment (Braille, large print, tape)
- Prepare a press release or make a similar announcement about the consultation.

- Use different methods of publicity e.g. flyers, advertisements, word of mouth, letters, email and websites and in an accessible form for people with learning disabilities.
- Make face-to-face visits, do presentations and discuss the issues with interested organisations, stakeholder groups, user groups etc.
- Make sure feedback that is given orally is properly recorded.
- Consider funding independent facilitators to undertake outreach work with socially excluded groups and groups the NHS has traditionally found hard to reach that may have little central organisation.

5 – The consultation and considering the responses

- Ensure you allow adequate time for obtaining the responses – avoid consultation periods being limited in order to meet deadlines. The consultation period should never be shortened for reasons of **convenience**.
- Twelve weeks should be the standard minimum period for a consultation, any variation to this must be agreed at the planning stage with main stakeholders.

Policy – when to consult

- Where consultation takes place on the basis of amendments made in the light of earlier consultation, a shorter period may be acceptable but would need to be agreed.
- The set up of organisations should always be taken into account when agreeing the consultation period. The issues may be complex and organisations that may not have many staff members, or that need to consult members through a structure of committees to draft responses, may require longer.
- Consider when the consultation period falls – it may be less effective if it falls within a substantial holiday period.
- In order to ensure consistency between respondents, a provisional view should be taken at the planning stage about how to deal with requests for deadlines to be extended.

6 – Analysing the responses

- Responses should be carefully and open-mindedly analysed, and the results made widely available. An account of the views expressed and the rationale for the decisions finally taken should be given.
- Responses to consultations should be acknowledged.
- Responses should be carefully analysed for:

- Possible new approaches to the issue consulted on
- Further evidence of the impact of the proposals
- Levels of support among particular groups.
- Look out for single-issue groups monopolising the debate, pay particular attention to the views of representative bodies, voluntary organisations user groups and other organisations representing groups that are especially affected by the issues.
- Keep as full an account as possible of both formal and informal responses. Ensure that everyone's view is considered fairly.
- Decisions should be made public promptly with a summary of the views expressed and clear reasons for rejecting options that were not adopted. This information should be made available to everyone who responded and made available on the website.
- Respondents who ask why individual issues have been rejected should receive an explanation. Individual responses should be made available to anyone else who asks for them.
- It may be necessary to keep confidential responses that may affect third parties' interests or privacy.
- If new and significant options emerge from the consultation, it may be right to consult on them again (though a shorter consultation period may be justified).

7 – Monitoring and evaluating consultations

A consultation lead/co-ordinate should be designated to ensure:

- Consultations are, where possible, co-ordinated across the organisation/s;
- the progress of the consultation is monitored;
- dissemination of the lessons learnt.

When completed the consultation should be evaluated with independent involvement to find out:

- which techniques were particularly effective in securing a range of useful responses, and which were not;
- which represented value for money (taking into account staff time, as well as direct expenditure);
- how far service provision changed as a result of the consultation. If it did not, the reasons should be explored;

- respondents' feedback. This may emerge from response rates, an analysis of the comments or by surveying users after major consultations.

There is no one recipe for successful consultation. It is inevitable that local circumstances will influence how a consultation is carried out. Factors such as the quality of ongoing relationships with partners, the local political context, the urgency of the service change being consulted upon, the relationship with the local media and the skills and interests of the NHS staff involved, will impact upon the consultation. Nevertheless if any of the elements of good practice outlined here are not practised, the consulting body should be ready to respond to the question “why not?” with robust and plausible reasons.

Link <http://www.cabinet-office.gov.uk/servicefirst/2000/consult/code/ConsultationCode.htm>

Glossary and useful terms or jargon buster

A&E	Accident and Emergency
ACPC	Area Child Protection Committee
Acute services	Medical and surgical treatment and care provided typically in hospitals
Advocacy (in the context of ICAS)	Where a person supports someone making a complaint against the NHS
ALG	Association of London Government
Ambulatory Care Centre	See walk-in centre
APH	Association for Public Health
ASH	Action on Smoking and Health
BBV	Blood borne virus
BDA	British Dental Association or British Dietetic Association
Bed blocking (also known as delayed discharge)	Where patients that are fit for discharge remain in acute hospital beds when other more suitable forms of care are not being provided
Best Value	System of quality improvement in local government which sets a duty to deliver services of a clear standard, covering cost and quality by the most effective, economic and efficient means available. It is not currently applied to NHS services
BMA	British Medical Association – professional association of doctors, acting as a trade union, scientific and educational body and publishing house
BMJ	British Medical Journal
Booked admissions scheme	An airline-style booking system which makes arranging NHS appointments easier and more convenient for patients. Piloted in 24 areas
BPAS	British Pregnancy Advisory Service
BTS	Blood Transfusion Service
Caldicott guardian	All NHS organisations are required to appoint a Caldicott guardian – a person who has responsibility for policies that safeguard the confidentiality of patient information
CAMHS	Child and Adolescent Mental Health Services

Care trust	PCT or NHS trust which includes social services commissioning on delegated authority from local government
CDS	Community dental service
Centre for Public Scrutiny	New organisation established to share good practice and innovation in all forms of public scrutiny
CHC	Community Health Council
CHD	Coronary heart disease
CHI	Commission for Health Improvement. A national body to support and oversee the quality of clinical governance and clinical services
Clinical governance	A framework through which NHS organisations and individual health professionals are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish
Clinical negligence	A breach of duty by healthcare practitioners in the performance of their duties
Clinical network	A network of health professionals from different NHS organisations working together across institutional and local boundaries, to provide optimum care for a particular disease or patient group
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
Cochrane collaboration	An international network of nine centres whose role is to build, maintain and disseminate up-to-date information from systematic reviews of healthcare trials
Collaborative	Established regional partnership to develop and provide services to address a specific medical condition, e.g. cancer collaboratives check/verify
Commissioning	The process of deciding what local people need from the NHS and buying those services with public money from the most appropriate providers. This can range from large contracts commissioning acute care from hospitals to smaller contracts with voluntary sector providers for a range of services to provide care and improve health. PCTs are responsible for commissioning the majority of health services

Community care	Services provided by a county council or unitary authority social services department, the NHS and volunteers, designed to keep people independent, and to support elderly people, or people with mental health problems or learning difficulties who might previously have been in a long stay hospital
Community Health Services	NHS services provided outside a hospital. This includes district nurses, health visitors, community midwives, district dieticians, chiropodists, and community psychiatric nurses. Many community health staff are attached to GP practices and health centres
Contract (NHS)	Agreement between two health service bodies for provision of goods or services eg a PCT and a provider (such as a hospital trust), by which health care, or in some places, social services care is bought for local people
County Council	Upper tier authority in shire areas responsible for strategic services including education, social services, highways, trading standards. Counties provide around 80% of services (by value) in the two-tier areas
CPPIH	Commission for Patient and Public Involvement in Health. Commission established to set national standards for patient and public involvement, and to support patient forums at a local level
CSR	Comprehensive spending review
Councillors	Democratically elected community representatives. Elected by local people for a term of four years
CVD	Cardiovascular disease
DAT	Drug Action Team
DEFRA	Department for Environment, Food and Rural Affairs
DfES	Department for Education and Skills
DGH	District General Hospital
DH	Department of Health
District Council	Lower tier authority in two-tier shire areas responsible for local service provision including housing, environmental health and development planning
DPH	Director of public health
DTI	Department of Trade and Industry
DfT	Department for Transport
DWP	Department for Work and Pensions

EAZ	Education Action Zone: national government initiative aimed at building on the roles of schools by using partnerships and raising levels of educational attainment
EHR	Electronic Health Record
ENB	English National Board of Nursing, Midwifery and Health Visiting
ENT	Ear, nose and throat
EPR	Electronic Patient Record
Equality	The degree to which a resource is equally distributed
Equity	Concerned with how fairly resources are distributed throughout a group of people according to population, not individual need. Initiatives to address health equity tries to distribute resources, opportunities, access, etc, fairly (according to need) not equally
ESF	European Social Fund
Feasibility Study	A project to identify whether a certain action should be carried out
Foundation Trust	NHS Foundation Trusts will be established as new public interest organisations accountable to local people and free from Whitehall control. Drawing on models from co-operative societies, mutual organisations and charities in Britain and abroad, NHS Foundation Trusts will work for NHS patients and the wider public benefit. Each NHS FT will have a Board of Governors, including governors elected by members from the local community and NHS staff, to provide accountability to local stakeholders
FPA	Family Planning Association
FPC	Family Planning Committee
GDC	General Dental Committee
GDP	General Dental Practitioner
GMC	General Medical Council
General Medical Services	Services provided by local doctors
GLA	Greater London Assembly
GOC	General Optical Council
GP	General Practitioner. A doctor who works from a local surgery or health centre providing medical advice and treatment to patients who have registered on his/her list. A GP is usually an independent contractor providing services to patients through a contract with the local PCT. Practice nurses based at the surgery usually support the doctor

GUM	Genito urinary medicine
HAZ	Health Action Zone. An initiative to bring together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people
HCHS	Hospital and Community Health Services. These are all the services provided from hospitals and PCTs (such as operations, out-patient services, community and district nursing)
HDA	Health Development Agency
Health inequality	Generally refers to variations in health that relate to variations in socio-economic status
HES	Hospital Episode Statistics
HFEA	Human Fertilisation and Embryology Authority
HI	Health improvement
HIMP	Health Improvement Modernisation Programme
HMR	Hospital Medical Record
HLC	Healthy Living Centre
HP	Health promotion
HSG	Health Service Guidelines
HV	Health visitor
HWI	Healthy workplace initiative
ICAS	Independent Complaints Advocacy Service
ICU	Intensive care unit
IDeA	Improvement and Development Agency. Provides information, training and support to local authority councillors
IMT	Information management and technology
Independent Reconfiguration Panel (IRP)	Independent panel established to provide the Secretary of State with advice when issues of substantial variation or development have been referred to him for a decision. Issues are referred to the IRP only by the Secretary of State and the panel has no direct role with either NHS bodies or overview and scrutiny committees
IV	Intravenous
JCVI	Joint Committee on Vaccination and Immunisation
LA	Local authority
LAC	Local Authority Circular
LGA	Local Government Association

LDP	Local delivery plan: Under the new three year planning framework for health and social care (see PPF), LDPs will show how the NHS, working with social services and other partners, will make visible improvements in health, including a reduction of health inequalities, and expand and reform services over the next three years. LDPs will be produced by strategic health authorities and informed by PCT led local plans
London Borough Council	A single, all purpose authority in the Greater London area which became the unitary tier of local government when the Greater London Council was abolished in 1986 and the Inner London Education Authority in 1990
LSP	Local strategic partnership
Metropolitan District Council	A single, all purpose authority in the areas of the former metropolitan county councils which became the unitary tier of local government when the MCCs were abolished in 1986
M(H)	Minister of Health
MH	Mental health
MDO	Mentally disordered offender
MHAC	Mental Health Act Commission
MMR	Measles, mumps and rubella
Morbidity	A diseased condition or state; the incidence of a disease or all of a disease in a population
Mortality	The number of deaths in a population, including overall deaths and comparisons of several types of deaths
MRC	Medical Research Council
NAO	National Audit Office
NDC	New Deal for Communities
NGO	Non-Government Organisation
NHS	National Health Service
NHS trusts	Provide most NHS services, through contracts with primary care trusts (PCTs). A board of a lay chair, non-executive directors and executive directors (the senior staff of the trust) manages them. An NHS Trust may run one or several hospitals. Ambulance trusts run the emergency and routine ambulance transport services under contracts with purchasers. Acute trusts run the district and specialist hospital services

NICE	National Institute for Clinical Excellence. A national body created to ensure every NHS patient gets fair access to quality treatment. It sets clear national standards of what patients can expect to receive from the NHS. It promotes clinical and cost effectiveness through guidance and audit to support front-line staff
NPSA	National Patient Safety Agency. Established to run a mandatory reporting system for logging errors across the NHS, so as to improve safety by reducing the risk of harm. The aim is to create a more blame-free NHS where lessons are shared and learnt
NSF	National Service Framework. National plan, including national targets, to address service improvements to address specific issues, e.g. coronary heart disease, or services for older people
OATs	Out of area treatments. Agreements for patient treatments that are outside the standard contracts negotiated with local hospitals and other providers and need special approval from the appropriate PCT (i.e., the one covering the area in which the patient lives)
ODPM	Office of the Deputy Prime Minister – responsible for policy relating to local authorities
OHN	Our Healthier Nation – national strategy for health improvement
OSCs	Overview and scrutiny committees established by local authorities
PALS	Patient Advice and Liaison Services. Provided within NHS trusts and PCTs to provide on the spot help and advice to patients and carers
Pathfinder	The first of a programme that acts as a pilot and uses new approaches
PCT	Primary Care Trusts. Organisations on which health and social care professionals and lay members are represented and which commission and, in some cases, provide, health services for their area, including acute and specialised services and family health services (e.g. GPs, dentists) PCTs typically cover about 100,000 patients. They are responsible for the local health planning, public health at a local level, and have a budget reflecting their population's share of the available resources for almost all local health care needs. They assess the needs of the local population and determine local targets and standards to improve quality and efficiency.
PDS	Personal Dental Services
PFI	Private Finance Initiative. A government led programme to enable the private sector to become involved in the provision of public sector facilities

PHel	Public health electronic library
PPF	The Priorities and Planning Framework guidance 2003-06 sets out the national priorities and targets for health and social care that will need to be built into local planning over a three year planning cycle
PPI	Patient and Public Involvement
Public Health Observatory	There are 9 regional Public Health Observatories across the country. They aim to improve access to, and analysis of, routine population-based health data. All are linked via a national association in order to share knowledge, develop external collaborations, support national agencies and avoid duplication of work
Procurement	The securing of funding or resources
Quantitative	Information about the numbers of something, used for statistics
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
Red Book	The conditions under which GPs are paid
Regeneration	Upgrading an area through social, physical and economic improvements
RTA	Road traffic accidents
Secondary care	Care provided by hospitals
Section 31 Arrangements	Section 31 of the Health Act 99 enables local authorities and NHS bodies to delegate commissioning of particular health-related functions to a lead partner, to integrate the provision of services, and to pool budgets in order to improve the coordination and delivery of services that increasingly cross the traditional boundaries of 'health' and 'social care'
SHA	Strategic Health Authority. Renamed former Health Authorities with the role of performance managing NHS trusts and PCTs
SLA	Service level agreement
SMR	Standardised mortality ratio
Social exclusion	Excluded or alienated from society
SoS	Secretary of State
Stakeholder	A group or individual with an interest in an initiative, project or activity and its outcomes
Statutory	Having its basis in statute i.e. an Act of Parliament

Telemedicine	The use of communications systems to provide remote diagnosis, advice, treatment and monitoring.
Terms of service (GPS)	Terms and conditions to which GPs work (National Contract)
Tertiary care	Care provided by specialist hospitals or departments (e.g. cancer centres) for patients referred from district hospitals
Unitary authority	A single, all purpose local authority created by local government reorganisation after 1992
Walk-in Centres	Centres which deliver accessible services on a drop-in basis. Offer free consultations and provide treatment for minor injuries and illnesses, general health information, self-treatment advice, information about out of hours GP and dental services and local pharmacy services. They are nurse-led, though a number of other health professionals and social care staff may be involved
Working time directive	The European working time directive regulations came into force in 1998, and apply to all directly employed NHS workers except junior doctors. They set a working time limit of an average of 48 hours per week