APPENDIX

Nottinghamshire County Council Local Authority Health Scrutiny Consultation Response 7th September 2012

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons.

A. Such regulations would be unhelpful and limit the ability of local councillors to represent the views of local people. There should not be a single window for referral.

While Health Scrutiny Committees (or the body carrying out this scrutiny function on behalf of the Council) will, in the main, be able to give a view on whether or not they are content with a variation or development after they have received results of the consultation this will not always be the case. If major concerns are brought to the committee's attention some time after this point, the committee should be free to make a referral.

Q2. **Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?**

A. No. See answer to Q1.

Q3. **Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your views?**

A. No**.** Financial considerations may well form part of referrals but it is too prescriptive to encumber committees with the duty to develop alternative proposals and engage with the public and stakeholders. This seems highly onerous and does not take account of the limited support available for committees to call on. The proper purpose of Health Scrutiny is to highlight concerns, not to fully realise alternative proposals – such an activity would seem to go well beyond what is commonly understood to be scrutiny.

Q4. **Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board.**

A. Firstly, it is important to realise that a Health Scrutiny Committee's intention to make a referral is not necessarily indicative of a dispute (as at paragraphs 63 and 66) and this is an unhelpful perspective to have on the exercise of this power (for example the referral may be pointing out a failure of total lack of consultation). If this intermediate referral stage assists CCGs in engaging with Health Scrutiny Committees and resolving issues then it is to be welcomed. However it appears to duplicate the initial assessment process carried out by the Independent Reconfiguration Panel (IRP). The independence of the IRP

is fundamental to ensuring confidence in the whole referral process and it is unclear whether an intermediate referral to another NHS body would have the same credibility. Any intermediate referral should not delay access to the Independent Review processes carried out by the IRP.

There would seem to be no need for a lesser interim referral to be ratified by full council, it would seem to be quite sufficient for interim referrals to be made following the vote of a Health Scrutiny Committee.

Q5. **Would there be any additional benefits or drawbacks of establishing this intermediate referral?**

A. The interim referral is likely to increase levels of engagement but quite possibly at the cost of slowing the overall process down in the event of a second referral. There is the possibility that the total number of referrals will increase since making a referral will no longer be seen as a 'final option.' Any intermediate referral should not delay access to the Independent Review processes carried out by the IRP.

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasize the local resolution of disputes?

A. Again, the issues that arise in relation to substantial developments and variations should not necessarily be regarded as a dispute in need of arbitration. It might be helpful if referral letters contained a statement from the local authority confirming either a) all local avenues of resolution have been exhausted or b) all faith has been lost in those proposing the changes. Following a referral, representatives of the Independent Reconfiguration Panel should engage directly with referring local authorities and speak to the Chairman of the referring Health Scrutiny Committee to get clarification when necessary. Where a referral is not upheld by the Panel, representative(s) of the Independent Reconfiguration Panel should attend a meeting of the Health Scrutiny Committee <u>in person</u> in order to explain the reasons and answer questions.

To ensure that the referral process reflects the new commissioning system the role and procedures employed by MONITOR should be evaluated. Local authorities increasingly engage with NHS foundation trusts and when considering substantial variations/developments the referrals route for these Trusts is to MONITOR. MONITOR has confirmed that it has no formal procedures in place for managing referrals. This should be urgently addressed.

Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

A. Referral from full council may be seen as an attractive measure in that it signifies major concerns from the Authority as a whole rather than a single

committee; this may, in fact, be a practical way forward. However, this change is associated with a number of disadvantages: a) it is likely to slow down local decision making and the process of referral as full council meetings are held less frequently than committees; b) the full council will not have the advantage of having heard all of the evidence first-hand nor will the Members have had the opportunity to ask questions of or hear counter-arguments from the representatives of NHS bodies, patients and the public who have attended Health Scrutiny Committee meetings; c) Health Scrutiny is a specialist activity in which Members build expertise, and so such a change would put the final decision on referral out of the hands of Members with the most experience and into the hands of a larger group of Members with less experience, d) the different standing orders for full Council and committees create different forums for debate with scrutiny of NHS proposals more suited to committee and e) joint committees including councillors from a number of local authorities and are bodies owned by each participating local authority, in this instance each of those authorities would need to ratify a referral at a full council meetings. Such meetings are not aligned and no detail is provided as to whether one or all would need to agree the motion in such circumstances.

Paragraph 73 indicates that scrutiny functions need to assemble a full suite of evidence in relation to a referral. It would perhaps be useful for guidance to provide links to the sort of suites that the Independent Reconfiguration Panel might find useful. There is, of course, more than one type of evidence, and where – for instance – all levels of local political leadership have stated that they have serious concerns about a substantial variation and that they have lost faith in the local NHS then that sort of statement speaks for itself. It is indicative of a failure of consultation and engagement and there is little point seeking to produce reams of material to demonstrate what is self-evident.

Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?

The formation of joint committees should be left to local determination rather than regulations. The existing provisions meet the needs of local authorities as can be demonstrated in Nottinghamshire. The Joint Committee with Nottingham City and Nottinghamshire County works particularly well. Under the existing regulations we have arrangements in place to establish joint committees with other neighbouring local authorities. However we would consider it more appropriate for Trusts engaging in a consultation across a whole region to engage with existing joint committees (and other committees as necessary).

Guidance might serve to usefully reduce duplication of effort and the time spent to by Trusts explaining changes in great detail to both county and district health scrutiny committees. In Nottinghamshire where a substantial variation/development affects only one particular District, we consider delegating the matter to the district council. Where there is a wider strategic

aspect the health scrutiny will be undertaken by the County Council Health Scrutiny Committees. In this instance we have a means of co-option so that district councillors can participate in the review. Guidance should be provided to ensure that the local NHS body is clear of the level of engagement required with different committees.

The suggestion that referrals should be endorsed by full council would seem to bring particular issues with it for Joint Committees. What happens when one full council refers and the other does not? The Independent Reconfiguration Panel might draw negative inferences from a Joint Committee referral from a single council. See question 7.