

The future of Health Overview and Scrutiny in England

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Abstract

This paper argues that the future role of Health Overview and Scrutiny in England, as carried out by local authorities, is increasingly uncertain. Continuing changes in the structure of the NHS, and the increasing integration of health with adult social care will also perpetuate further change, ambiguity and ineffectualness. Local authorities and their Councillors will need to be far more proactive if they are to not only cope with this pace of change, but also continue to perform their overview and scrutiny function effectively. The NHS itself also needs to provide more guidance to Overview and Scrutiny Panels so that they can better understand the changing health and adult social care landscapes.

Keywords: Health, Overview, Scrutiny, Francis Inquiry, Sustainability and Transformation Partnerships (STPs)

Introduction

The important role of Overview and Scrutiny was first introduced by s.22 of the *Local Government Act* (2000) as a key function of local authorities in England (Wales, Northern Ireland having a range of alternative governance models). The Act also created a range of Executive (Cabinet) models for local authorities. Council's with one of these Executive arrangements is required to create an Overview and Scrutiny (O&S) Committee (sometimes called a Commission) which is made up of councillors who are not on the Executive Committee of that council. The great virtue of this system is that even where a Council is dominated by a single party, there can (and should) still be effective overview and scrutiny of the actions of the Executive.

O&S covers the full spectrum of policy areas, but also includes public services delivered by external organisations, such as health. Indeed, since 2003 Health O&S Committees have had the power to call in witnesses, and make recommendations to, and require a response from, NHS bodies (Healthwatch England, n.d.). Alongside Health O&S sit local Health Watch organisations. These are consumer groups commissioned by Councils. The table below outlines their set-up, role and powers¹⁷:

Council Scrutiny	Local Health Watch
Set-up: • elected councillors • democratic legitimacy • appointed by council	Set-up • social enterprise • must be representative • commissioned by council
Role • public scrutiny of health and social care issues • separate from health and wellbeing board • no powers to 'enter and view' • overview of health and social care needs and inequalities • scrutinise impact of health and social care services • require information and attendance from council and NHS staff • consulted about substantial service changes	Role • information about health and social care services • seat on health and wellbeing board • able to 'enter and view' • submit evidence for joint strategic needs assessment • ask people's views on health and social care services • ask for information and get an answer but no requirement to attend meetings • contribute views to joint health and wellbeing strategy
Powers • make recommendations and require a response • not a route for individual complaints • refer some proposals for service changes to Secretary of State for Health	Powers • refer issues of concern to council scrutiny and be kept up to date • make recommendations and receive a response • can deal with complaints if commissioned by council • refer issues to Healthwatch England

¹⁷. Source: Healthwatch England (n.d.)

Recent criticisms of Health Overview and Scrutiny

Despite the apparent clarity of role and powers, Health O&S has not been without its critics.

In 2009, when the then Labour government were exploring options to increase Council's scrutiny power, Communities Secretary John Denham described Council scrutiny as "the lion that had failed to roar" and that "councils should be able to apply their democratic mandate to act as a champion for citizens" (Williams, 2009). The feeling being that they required more powers to carry out their roles effectively, indeed, Andy Sawford, Chief executive of the Local Government Information Unit is quoted as saying further reforms would be worthwhile only "if they had real teeth" (*ibid*, 2009).

In addition to limited powers, O&S has suffered limited and indeed declining resources (Hammond, 2013). This has materialised in fewer dedicated O&S Council Officers. This is impacting on O&S Councillor's ability to make informed observations and recommendations, and also to follow up on them at a later date.

Finally, the most high-profile criticism of Health O&S is the case of Mid Staffordshire NHS Foundation Trust. Between 2005 and 2008 a number of cases of appalling patient care were reported at the Trust. Staffordshire County Council and Stafford Borough Health O&S Committee had not asked for details of complaints. The Francis Report notes:

"The Overview and Scrutiny Committees (OSCs) in Stafford were happy to take on a role scrutinising health services but did not equate this with responsibility for identifying and acting on matters of concern; and they lacked expert advice and training, clarity about their responsibility, patient voice involvement, and offered ineffective challenge" (p. 481, Francis Report, 2013).

There was also considerable disparity in resources devoted to Health O&S between the County and Borough Councils. While the County Council has an annual budget of £1.5 billion, an experienced team of Council Officers devoted to scrutiny and training for its Councillors, the Borough Council had an annual budget of only £54 million, and a single scrutiny officer who supported all of its scrutiny functions (Francis Report, 2013).

Despite the Francis Report highlighting issues of limited powers, resources, training and limited stakeholder involvement, these issues do not appear to have been sufficiently

addressed by new legislation, regulation or additional resources from central government. Indeed, these issues have been left for local authorities to decide how they will respond. The reduction in central government grants to local authorities has led to belt-tightening, with back-office functions like O&S being badly hit.

The changing National Health Service landscape

Since its creation in 1948 the National Health Service (NHS) has been a political football. Debates have raged about the purpose, structure, efficiency and effectiveness of the NHS, debates which continue to this day. For example, Enoch Powell's 1962 Hospital Plan separated the NHS into three parts – hospitals, general practice and local health authorities (NHS, 2017). The plan also created district general hospitals, the model of secondary/acute which has endured to this day. This plan was bitterly opposed by clinicians at the time.

Since 1997 the pace of change in the NHS has increased. In 2002, the structure of the NHS was radically changed again with the introduction of Primary Care Trusts (PCTs) which oversaw 80% of the total NHS budget, commissioned 37,000 GPs and 21,000 NHS dentists as well as other private sector providers.

PCTs were abolished in 2013 (due to the Health and Social Care Act 2012), further fragmenting the NHS into NHS England (commissioning primary care such as GPs, pharmacists and dentists), Clinical Commission Groups (CCGs) (responsible for commissioning most secondary care services such as planned, urgent and emergency care) and Public Health England (tasked with improving health and reducing health inequalities through more preventative measures).

On the 22nd December 2015, NHS Planning Guidance was issued calling for the creation of Sustainability and Transformation Plans (STPs) which are:

- "based on a 'place' footprint rather than single organisations, covering the whole population in this footprint, which is agreed locally
- multi-year, covering October 2016 to March 2021
- umbrella strategies, spanning a range of delivery plans which may cover different geographies or types of services
- required to cover the full range of health services in the footprint, from primary care to

specialist services, with an expectation that they also cover local government provision

- to address a number of national challenges, such as around seven day services, investment in prevention, or improving cancer outcomes.” (Local Government Association, 2017)

These changes pose a series of challenges to how Councillors and Council officers are going able to keep abreast of these changes, and deliver effective overview and scrutiny.

Firstly, the footprint areas cover multiple local authority areas. How are multiple local authorities to coordinate their O&S activities? Or are Local Authorities going to accept possible duplication across the STP footprint?

Secondly, health O&S has traditionally focused on external overview and scrutiny. The convergence of health and adult social care being delivered by the NHS and local authorities blurs the lines of accountability, and raises the question of whether health O&S should sit separately to adult social care O&S? Would merged health and social care O&S have additional resources to cope with their increasing duties?

Finally, the STP's focus on delivering national challenges such as a seven day service, preventative care and improving cancer outcomes are strategic objectives potentially beyond the expertise of Councillors. Could any lay person be expected to provide O&S of NHS services aimed at improving cancer outcomes? Perhaps with the support of clinicians, or specially trained O&S officers, but as has already been identified in this paper, local authorities are already struggling to deliver their current O&S services.

Conclusion

This paper has demonstrated that the often-maligned function of Health Overview and Scrutiny is set to become increasingly challenging. A lack of resources on one hand and a dramatically changing NHS and social care landscape on the other places Councillors involved in O&S between a rock and a hard place. Councils, already faced with difficult decisions in these austere times will need to decide how they respond. Further funding from central government to support local government and O&S specifically appears unlikely in the short or medium term. Many local authority O&S committees may be reduced to fire-fighting of emerging O&S issues. It can only be hoped that nothing on the scale of Mid-Staffs happens in the meantime.

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