Royal College of Nursing

RCN Policy Unit

Policy Guidance 07/2007

Influencing Health Scrutiny

This policy guidance was produced by Andrew Christaki, Assistant RCN Officer in the South West Regional Office, with the support of the RCN Policy Unit. Its aim is to assist regional boards and staff to work effectively with their respective Local Government Overview and Scrutiny Committees.

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1.0 Aim

The purpose of this paper is to provide advice and practical support to RCN regions in order to maximise opportunity in influencing health delivery locally by working, in partnership, with their respective County Council Health Scrutiny Committee (HSC) membership.

Consideration will also be given to the potential for public and patient involvement and influence in the process of health oversight and scrutiny and how the RCN can develop partnerships with public and patient groups as part of our approach to engaging in the HSC process.

In addition, recommendations on future planning and discussions will be given.

2.0 Background

This paper will build on the recent RCN publication 'Policy Briefing 14/2006 local lobbying: Working with Health Scrutiny'.

Information was gathered by interviewing County Council employees, who oversee the HSC function, and HSC Chairpersons, who are affiliated to a political party.

Further information was taken from government documentation and relevant web sites (refer to resource section in this paper).

This work was jointly undertaken by Policy and the South West Region. Staff cost were met by Policy.

3.0 Details

3.1 HSC membership

While co-opted members can be included from the voluntary sector, HSC membership is varied and principally made up from County Councillors and District Councillors. Hence party majority within the Council is reflected by the HSC political seating ('Policy Briefing 14/2006 Local lobbying: Working with Health Scrutiny', section 8.1).

Our ability to influence a committee depends upon our capacity to understand the process and procedure a committee has agreed. There appears to be little consistency in approach regarding these processes

and procedures in HSCs, although guidance is available in the form of the Department of Health (Overview and Scrutiny Committees Health Scrutiny Function Regulations 2002 and Health and Social Care Act 2001). Terms of Reference (ToR) or a Constitution agreed by each HSC should be available. This provides important information regarding their principle functions and expectations (**example: appendix A**).

The constitution and/or TOR, should outline the process for agenda items criteria, or reference to appropriately agreed documentation, which should include submission procedures (**example: appendix B**).

3.2 Submitting Agenda items

The process for submitting agenda items seems to be influenced by the Officer overseeing each HSC and the respective Chairperson. This situation illustrates the lack of a consistent approach across County Council HSCs.

Furthermore, submission is also dependent on locally agreed procedures which should be available either by request or web access. However this is not always the case or in some areas local processes may not have been agreed. This appears to be due to local partnership arrangements between Councillors and unless an issue, will remain the case.

This illustrates why local intelligence and familiarity with local processes are essential to the RCN and its members.

Proposals for changes in health services will be tabled if they are considered to be a '….substantial service variations….' (Overview and Scrutiny of Health – guidance 2003). As illustrated in the RCN policy briefing 14/2006 local lobbying: working with health scrutiny', section 5.1, the terminology used is subjective but what is clear, the role of the HSC is not a 'complaint's process.

With this in mind, agenda items should reflect impacts upon service delivery to the public. For example, if there are issues of redundancy, NHS organisations should identify how the reductions in staff will affect service delivery and impact on patient services. In this situation, the RCN may also wish to indicate their predictions and concerns regarding impacts on services to patients and the public.

Therefore a balance when advising/challenging health plans in terms of employment practice and the impact on patient care needs to be maintained.

However, the NHS organisation must give an account of future planning and re-organisation to ensure that services are maintained and that any reorganisation is for the benefit of patients and public. This would require

assessments to be undertaken and outcomes made available to the HSC. For example service impact assessment (**example: appendix C**), financial risk assessment and if appropriate a recovery plan should be made available.

Some NHS organisations may not feel that changes they are proposing fall into the remit of the HSC. Though, if other forums or organisations feel differently, then submitting written evidence, or (depending on partnership arrangements), discussion through other communication means e.g. direct verbal contact, can lead to the HSC requesting further information from the respective NHS organisation to give an account of their proposed actions.

Also, the public can request issues to be tabled through direct contact with their local MP or Councillor who can request that the committee consider the issues. It appears that direct contact with a member of the committee holds a distinct advantage because items will be tabled more rapidly. In contrast, individual requests hold little esteem unless they are supported by intense public lobbying; which is key.

3.3 Influencing Agenda items

A number of HSCs have agreed templates which provide the relevant information in order for discussion and debate at meetings. Also, it is expected that a representative from the NHS organisation will present the papers submitted.

Remember all HSC meetings are open to the public, though they may hold a closed session.

Evidence of consultation with the public and staff must be evident and robust and available for public scrutiny. Again remember, agenda items, minutes and supporting papers must be made public prior to HSC planned meetings.

Although the process for challenging agenda items is inconsistent across HSC (local knowledge of process is necessary), items tabled that are of concern or do not give an unbiased opinion can be challenged.

Some HSCs allocate time to the public at the meetings to raise their issues and concerns. Other HSCs do not and expect such issues to be raised prior to meetings in order to be allocated a time slot on the agenda.

What is consistent though is that any issues that are submitted in writing with supporting evidence challenging an issue in a respectable timescale has a far better chance of appearing on the agenda for discussion. This also enables the submitting organisation e.g. RCN, PPIF to present and answer any questions raised and challenge the items of concern.

In addition, agenda items tabled with an outcome can be revisited by the HSC, if additional information is given that would have influenced their initial decision.

3.4 Partnership working with HSC

HSCs do not have the power to overrule NHS organisations decisions, but it is clear they have a potential to influence because they can refer issues to the Secretary of State.

Items to be discussed are usually researched by the overseeing officer, to gather background information and opinions from other organisations.

Seeking opinions from other areas seems to be based on local practice and procedure. There is no universal list of contacts or consultees and requirements vary across HSCs.

The RCN's potential for informing the work of HSCs is not commonly understood although our image is well-recognised, there appears to be a lack of awareness regarding the RCN's role and our capacity to influence at local level.

It is also evident that HSCs are very keen to engage with the RCN. Opportunity to gather evidence regarding health delivery is complex to access from other forums and organisations since there could be an element of a personal agenda. Hence an over-arching strategic view, although sought by HSCs, can be limited.

However, such engagement could give the opportunity within the RCN forums a higher profile with HSC's in terms of their specialist input. Indeed the specialist nurses eg. Diabetes and MS etc. will have close ties with national and local patients' groups/charities e.g. Diabetic Association.

3.5 Political influencing

The approach to partnership working with HSCs needs to consider the political party affiliation of the committee. Although the attitude within the committees is intended to be impartial, it would be prudent to hold a degree of caution.

Therefore, the political party make-up of HSCs (refer to section 3.1) may dictate their approach and indeed anticipate their response, especially if local or national elections are close and party manifestos and campaigning becomes the priority.

Whether issues and agendas are influenced by a party's stance remains to be fully tested and evidenced within HSCs. However, to date, health

reforms remain a political issue and will always be seen as a topic for debate within the public arena.

Indeed, observations of HSCs' commitment to health changes seem to reflect the national political party in power. That is, opposing parties appear keen to hear issues if it can be used to challenge their counterparts. Whether this is acceptable is arguable, since there are pros and cons. With this in mind, the RCN must remain aware of such approaches and remain focused on patient care and supporting its members. The RCN's image as an organisation, which is not affiliated to any political party, must be maintained.

Nevertheless, if it is evident that the HSC outcomes are biased towards party politics, this can be challenged by approaching the County Council Executives and implementing their complaints process, which in turn could raise local press interest.

3.6 NHS and future politics

Our role in lobbying at national level is fundamental to the RCN's mission statement, and needs to be extended to include local government activity. This is a necessity in order to move with the apparent devolution of accountability in decision making for health services. The RCN can help to ensure fairness and transparency regarding health reforms and delivery of care to the public and members.

Government policy on how health will be commissioned suggests that decisions on health services will be focused locally. This is demonstrated by:

- The Department of Health appears to be 'downsizing'.
- SHAs are given responsibility for strategic commissioning of services and ensuring how services are monitored within their expanded region.
- PCTs, are encouraged to separate provider role from commissioning role.
- Social services and County Council boundaries are in line with new PCT boundaries, in the majority of cases.
- NHS Foundation Trust status is expected for all acute NHS trusts by the end of 2008.
- The potential for community foundation trusts is being discussed.

- A recent Government White paper, 'Strong and Prosperous Communities', outlines an increase to local government responsibilities and accountabilities. The paper makes provisions for a number of proposals including:
    - Stronger local partnership
    - A wider and stronger role for Scrutiny Committees
    - Changes to public involvement in health

Indeed, Foundation Trusts are considered to be autonomous bodies, evidenced by national lobbying not having much of an impact. As Foundation Trust Status criteria outlines, they are answerable directly to the community they serve. Hence the influencing role of the HSC is critical.

This also highlights that; further consideration must be given as to whether 'Health and the NHS' will remain a national political issue in the future.

In light of this, it would be naïve to think that partnership working between HSCs, PCTs and SHAs will not increase and become more influential around commissioning. If not then the role of HSC will merely be a reactive committee.

Politics will probably remain within health but its influence may not be as strong due to the government's keenness to give local people the power to decide. So, shifting responsibility away from national politicians and central government.

This raises further issues regarding the experience and expertise of the HSC committee. Commissioning health care can be a complex and arduous task. Deciphering information and analysing business cases requires knowledge and expertise. Such expertise is not evident within the committee makeup. Therefore, the committee can request independent advice thereby offering opportunity to reinforce the RCN's image and strengthen our input in developing partnership working.

3.7 Public involvement

As stated previously, how the public engage with the devolution of power is still not clear. The recent DH publication 'Strong and Prosperous Communities' raises further issues around opportunities for local communities to influence the planning and commissioning of their health services, and whether they will have a sufficiently strong voice.

In comparison present arrangements through PPIF seem to be held in high regard due to the powers they hold to inspect NHS properties and the

influence they hold within the HSC structure through annual planning of the agenda and their ability to raise issues affecting patient/client care.

The 'Local Government and Public Involvement in Health Bill', which builds on the DH publication 'Strong and Prosperous Communities', is being discussed in Parliament and, relate to reforming the current arrangements for patient and public involvement (PPI). It appears that this Bill aims to:

- Remove the Commission for Patient and Public Involvement in Health (CPPIH) and patient forums.
- Create local involvement networks (LINks) with one in each local authority.
- Give role of LINks to inform HSC on local views regarding health and social care services.

New proposals to merge this independent representation will undoubtedly dilute their present position and voice as representatives of the patient and public. Specific issues will be difficult to table and their opinions will only come from one source, that being the proposed LINks. Work undertaken by PPIF can be quite specific and focused, something that will be lost with present LINks proposals.

Representation of Trusts and Independent organisations will not be evident and therefore the public's voice diluted. Hence it is difficult to understand if the Government is keen to give local responsibility with one hand but temper the public's voice with the other.

Indeed, the RCN, through the Policy Unit, have already responded to Government consultation papers that discuss the role of patient and public involvement, highlighting these concerns.

A further area that needs exploring is whether issues to be raised can be proposed directly by an employee of the organisation. This is especially so, if conflict of interest is evident.

Recommendations

The following are recommendations the RCN need to consider if we are to ensure our activity remains inline with health development and reforms, putting nurses and nursing at the forefront of patient care.

Initial contact:

- Template letter to HSC raising RCN profile and willingness to engage (**appendix F**).

- Meeting with Officer of HSC and Chair and Vice Chair – template or guidance on questions to ask to understand process and influencing process (**Example appendix D**)

Ongoing contacting

- Links with patient and public forums
- Mapping/creating a data base of patient/public groups
- Regular meetings with HSC members
- Influence yearly planning of committee.

Monitoring and evaluating:

- Obtain relevant agreed documentation e.g. ToR, Constitution, Impact assessment forms, guidance etc
- Mapping HSC agenda items, identifying relevance and timing responses
- Process in place within Regional Offices to monitor HSC activity and initiate responses and attending meetings.
- Check list process chart developed to ensure consistency and engagement (**Example appendix E**)

Future actions/discussions:

- Guidance for members on how to effectively engage with their HSC
- Further discussions on political approach maintaining RCN position as non-party preference.
- Increase local lobbying activity
- Develop Commissioning criteria frame work.

The support from Policy, PND, Parliamentary, ERD and Communications also need to be established, if we are to get closer, build relationships and influence HSC regions.

Resources

- Health and Social Care Act 2001

  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4006257&chk=NoDbs2

- Overview & Scrutiny of Health – Guidance. Department of Health, July 2003

  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4009607&chk=eSdfrn

- A guide to the NHS for Members and Officers of Scrutiny Committees. Department of Health, November 2003

  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4071435&chk=AF4Kcq

- Process, progress and making it work – Health Overview and Scrutiny in England, 2005...Centre for Public Scrutiny.

  http://www.cfps.org.uk/health/

- Patient & Public Involvement Forums – general information on Patients' forum activity, FSOs and contact details can be found at: http://www.cppih.org

- Research undertaken analysing HSC development http://www.refer.nhs.uk/ViewRecord.asp?ID=1674

- Statutory Instrument 2002 No. 3048 The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 http://www.opsi.gov.uk/si/si2002/20023048.htm

- A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services

  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4137040&chk=U6PSmq

- Our health, our care, our say: a new direction for community services

  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXIecj

- Strong and Prosperous Communities (full text)

  http://www.publications.parliament.uk/pa/paBills/200607/local_government_and_public_involvement_in_health.htm

- Strong and Prosperous Communities (briefing paper)

  http://www.ncvo-vol.org.uk/lgwhitepaper

- The 'Local Government and Public Involvement in Health Bill'

  http://www.publications.parliament.uk/pa/cm200607/cmbills/016/20070016.pdf

Appendix A

Terms of reference/Constitution - Example

The Protocol for Health Scrutiny

1. Scrutiny contacts

In the course of its work scrutiny will have contact with officers and elected members from the county council and the district councils; representatives from the local health community and patient forums as well as individuals, businesses and community groups. Outside contact with scrutiny may take a number of forms:

- As a representative of a group, service or organisation which is the subject of scrutiny;
- As a person, group or organisation bringing an issue to be scrutinised;
- As an expert, or person with information of interest, appearing before the scrutiny committee or task group.

The scrutiny process may relate to a service, an event, a decision or an issue. In all cases people can reasonably expect to know how matters will be conducted and how they will be treated. The Committee's procedures reflect the constitution of the County Council. This protocol explains various procedures and particularly matters relating to working arrangements with local NHS bodies.

2. Committee meetings

Committee meetings are formally constituted and follow a set structure that includes an order of business (agenda). Order is maintained through the chair who manages the debate and ensures that everyone who wishes has the opportunity to take part in the discussion. However regardless of the necessary formalities, the objective of scrutiny is to be constructive and not judgmental, always treat people with respect and listen to the things they wish to say and provide feedback on outcomes.

All committee meetings are open to the public and media unless the Committee takes a decision to exclude the public and media when discussing confidential or exempt information. Confidential information is information given to the council by a government department or agency in terms that forbid its public disclosure or information that cannot be publicly disclosed by Court Order. See Appendix A for a description of exempt information**.**

The dates of all ordinary committee meetings will be agreed in advance with the chairperson and included in the County Council diary of meetings. Notice of the meeting dates will be supplied to elected members, officers and the Health Service Trusts annually.

The public notice of meetings is published monthly. Notices of meetings are published five clear days before meetings take place and agendas and reports for meetings are made available to the public five clear days before meetings take place.

Committee papers are collated and distributed according to a specified timetable for despatch to members seven days in advance of a meeting. The final version of a report should be provided to the Scrutiny Team nine days before the date of a committee meeting.

Task group meetings are informal although each has an elected chair to lead the process and maintain order.

3. Providing information to the Committee

Local NHS bodies must provide the Committee with such information about planning, provision and operation of health services as it reasonably requires to conduct effective overview and scrutiny notwithstanding the provisions concerning confidential and exempt information.

Each Health Care Trust will designate a Liaison Officer to be the first point of contact between the Body and the Committee. The Committee's designated officer will be the Scrutiny Team Manager.

The Scrutiny Team Manager will send a written request for information to the designated Health Service Liaison Officer. The written request will be sent 15 working days before the information is required unless there is an agreement with the Liaison Officer that notice can be waived.

Information supplied to the Committee will normally be provided in writing.

4. Committee reports

Written reports to the Committee should follow a standard format. The Scrutiny Team will supply a template.

Elected members who are not members of the committee/task group are welcome to attend and may participate or provide information on any item under discussion at the discretion of the chairperson.

Officers attending to present reports and/or give information are encouraged to join in the discussion on their item.

5. Attendance at meetings

The Regulations enable the Committee to request the attendance of any officer from a local NHS body to attend a meeting and answer questions.

The Committee will put all such requests in writing to the appropriate Liaison Officer twenty-eight days before the meeting in question. The request will include an indication of the issues to be considered and if possible the potential line of enquiry to enable identification of the most appropriate person to attend the meeting. On occasion the Committee may request the attendance of a particular officer to help with a review.

The Liaison Officer will respond in seven days to confirm the name of the officer who will attend the meeting. In the case of a request involving a particular officer, the Liaison Officer will confirm that the request can be complied with or will offer an alternative person to attend the meeting.

The Chairs of the NHS Trusts will be invited to attend at least 1 meeting of the Committee each year at a mutually agreed date, to discuss issues of governance and policy.

People with expert knowledge of a particular subject or issue or people with knowledge or experience of an event, may be asked to attend a Committee meeting to answer questions or tell of their experience. If such people are not councillors, council officers or officers of the Local NHS bodies, their attendance at a meeting is entirely voluntary.

Appendix B

Submitting evidence - example

Criteria for Developing the Work Plan

Introduction

The Department of Health guidance has not been prescriptive in specifying criteria for identifying issues to include in the work plan. Considering the Committee's wide remit and the likelihood of competing local issues the Committee agreed that in order to produce a viable work plan it was imperative to agree a set of criteria against which prospective topics could be tested before being selected.

The Committee's programme will need to maintain a degree of flexibility to allow the Committee to be responsive to urgent issues that arise. This section brings together a range of criteria, from various sources to assist the Committee in prioritising item for the work plan.

Criteria - national

While the national guidance is not prescriptive, it does offer outline criteria for Overview and Scrutiny Committees (OSC) to support prioritising. These include:

- Ability to make a distinct and positive impact through the scrutiny function
- Topics that are timely and relevant, but not already under review elsewhere
- Achieving positive outcomes such as improved understanding of services, breaking access logjams, or finding creative solutions to complex problems.

Criteria - local

The Committee may identify a number of broad categories as a starting point for developing criteria. These categories could be:

- Participation in consultation on reconfiguration of service provision

- References from patient involvement bodies
- Issues arising from annual reports
- Issues prioritised by Healthy Living Partnership
- Quick Wins

This list also picks up the other element in work planning, which is the need to combine projects that the committee itself initiates and those in which it is responding to NHS activity.

Other Authorities Experience

The criteria used by a number of other authorities that are more advanced in the health scrutiny process have been considered. These tended to be in very similar territory to the local discussion above. Some examples, where they add to the criteria above are:

- A mix between themed reviews, service reviews and health outcome studies;
- A balance between scrutiny initiated by the Committee and scrutiny in response to NHS major changes or new government guidance or legislation;
- Tackling known health inequalities; e.g. higher than average incidence of coronary heart disease in a particular area;
- Relevant to health improvement initiatives, not just health services; e.g. access to physical activity as a contribution to reducing obesity
- Exert a positive influence on NHS developments;
- Represent areas of joint working where the local authority and NHS can make a difference; e.g. joint working on children with disabilities
- Link to other strategies – community strategies (LSP), NHS development plans (LDP), local public service agreement goals; e.g. delivery of more intensive care at home for older people
- A balance of examining policy, monitoring performance and investigation of issues
- Areas where scrutiny can add value and make a difference in a relatively short period of time;

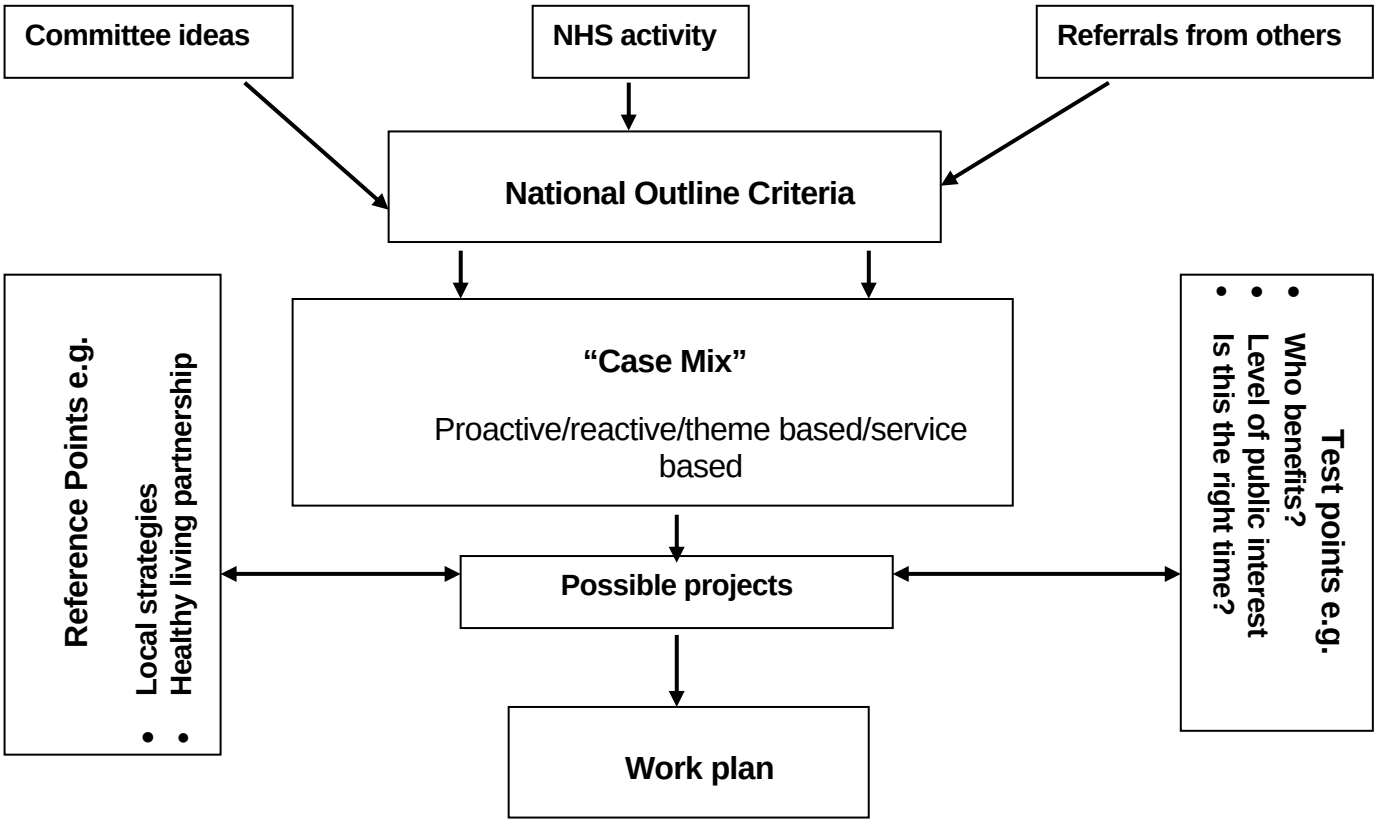
These general criteria also relate to the work planning advice underpinning the general overview and scrutiny process for local authorities. Where authorities have identified more specific criteria they tend to focus on a local context. The following list has some examples attached of local issues that would fall into one of these categories.

- Issues identified by members as key issue (e.g. through members' surgeries and other constituency activities);
- Poor performing service/ High level of user/general public dissatisfaction with service; e.g. access to NHS dentistry
- Service ranked as important by community (through market research, citizens' panels and so on); e.g. prevention of drug use
- Public interest issue highlighted in local media; e.g. joint responsibilities with SSD for care of older people
- Consistency between the agenda of the health partnership body and the committee; e.g. mental health related topics
- Emphasis on the whole system, not just a single service or organisation, but the experience of people with a particular condition or from a particular group
- Balance between service and policy developments

No authorities have developed a formal "weighting" system for their prioritising process, preferring to work through discussion and negotiation in the full committee and/or a smaller group advising the Chair. A number of authorities do, however, work with the NHS to identify priorities, particularly early in their scrutiny activity. West Sussex is also exploring a more sophisticated approach with a clearing house for information, including public health data, and a process for data analysis to identify issues for the OSC to investigate. They hope to include a Director of Public Health on the clearing house.

Method

To use the various types of criteria outlined above as a set of "filters" and related reference points: they are not mutually exclusive.



Methods of Working

Approaches to Scrutiny reviews

The Committee needs to consider the range of ways in which scrutiny activity can be carried out. The OSC has limited dedicated resources, so always needs to think about the resources needed to support a particular approach, and ensure that its chosen programme is deliverable. The range of approaches open to the Committee, singly or in combination, includes:

- Full committee discussion based on presentations and research
- Short-term sub-groups on a themed or area basis, with additional co-options from experts, local representatives for task and finish projects.
- Focus groups, either ad hoc, or standing groups
- OSC –led consultation events

- Joint events with e.g. local voluntary organisations
- Inquiry style hearings

For all projects, thought would need to be given to the involvement of stakeholder groups. The other key support is the gathering and organising of information from national and local sources, and commissioning research where appropriate. Links formed by the Project Officer to the NHS and to District Council leads will be important in maximising use of current resources.

Method

Different approaches will be suited to different types of topic and the Committee may find a matrix, such as that shown below, is useful in deciding what approach to use once their programme is agreed. The ideas shown are intended to show how the matrix would be used in practice they do not necessarily represent agreed topic areas.

Topic	Method				
	Inquiry	Full Committee	Theme sub-group	Area(s) sub-group	Consultation event
NHS consultation on service change		**X**			
Rural access to hospital services			**X**		**X**
Health inequality issue				**X**	
Joint working on children with disabilities	**X**				

Review process

The Committee will also need an outline process to carry out each review. The following table comes from a study by the Office of the Deputy Prime Minister on developing an effective approach to planning

overview and scrutiny. Although not all 10 steps will have equal weight in every review**,** the methodology builds on work planning and selection of methods.

Table 1 - The 10 steps to undertaking a successful in-depth scrutiny investigation	
Step 1	Be sure that the subject is significant
Step 2	Project plan the investigation
Step 3	Determine the nature of member involvement
Step 4	Engage partners, public and local media
Step 5	Gather secondary evidence and primary written evidence
Step 6	Get the witness package right
Step 7	Gather oral evidence
Step 8	Adopt other methods
Step 9	Prepare draft report, disseminate and route the report
Step 10	Follow-up

General issues

Key Challenges and opportunities

This is a relatively new role in a complex environment, and faces these challenges and opportunities:

- Scrutiny across authorities and boundaries
- Members' roles
- Community involvement
- Links to the Council executive(s) and other planning and performance arrangements
- Cultural change
- Resources and support for health scrutiny
- Media relations
- Management issues and monitoring change

Member Commitment

Good scrutiny is time consuming and, with new learning to absorb in this case, health care scrutiny requires a significant commitment from

members. The OSC is established on the basis on 6 meetings each year. How members decide to carry out the reviews they agree on will influence what other time is needed to do the work effectively, e.g. sub-groups, training and briefing, consultations etc.

Resources

Role of the project officer – This role is to service and attend meetings of the OSC and to develop an information network, compile research data and prepare briefings for the Committee.

Role of Lead Chief Officer – Executive Director: Social Services are responsible for directing the project officer and for overall management of the work of the Committee.

Other available resources – All participating organisations have access to current information, planning and research facilities. All are also members of the Maiden database that can analyse and present information. The voluntary and community sectors have strong networks and may be valuable sources of advice or consultation opportunities. The CHC exists until December, and also has a resource bank that they are willing to pass on to the NHS scrutiny function.

Costs of Scrutiny Reviews – when planning reviews the costs of the process need to be considered, such as: expenses for witnesses, co-optees, focus group members, costs of consultation events etc.

Appendix C

Changes to NHS Services

Impact Assessment - Example

1. Impact assessment details

Name of Trust/PCT	
Name of proposal or service development	
Name of Trust/PCT person completing the form	
Date Impact Assessment scores completed	

2. Brief description of current position and proposed changes

3. Comments from service provider on impact assessment scores

The scoring shall be undertaken on a five point scale, ranging from major negative impact (-3) to major positive impact (+3), using the matrix set out below.

A service variation or development shall be considered substantial where any aspect is deemed to have a major negative impact (i.e. scored – 3) or where the total score in any one of the five impact areas is – 7 or less of +7 or more.

Proposal		
NHS Body		
Impact Range	-3	Major negative impact
	-2	Medium negative impact
	-1	Minor negative impact
	0	No impact
	+1	Minor positive impact
	+2	Medium positive impact
	+3	Major positive impact

3.1 Changes in Accessibility

Ref	Aspect	Proposed Change	Do Nothing
A	Reduction/Increase in Service		
B	Local Provision Accessibility		
C	Relocation of Service		
D	Withdrawal of Service		

3.2 Impact on the Wider Community

Ref	Aspect	Proposed Change	Do Nothing
A	Other Partner Agencies		
B	Transport		
C	Community Safety		
D	Local Economy		
E	Environment		
F	Regeneration		
G	Social Services		

3.3 Patients/ Carers Affected

Ref	Aspect	Proposed Change	Do Nothing
A	Number of Patients/Carers		
B	Proportion Affected		
C	Equality and Diversity		
D	Social Exclusion		
E	Views from Patients Forum etc		

3.4 Methods of Service Delivery

Ref	Aspect	Proposed Change	Do Nothing
A	Change in Setting		
B	Change in Technology		
C	Change in Practitioner		
D	Change in Care Process		

3.5 Financial and Other Factors

Ref	Aspect	Proposed Change	Do Nothing
A	Financial Impact on NHS body		
B	Financial Impact on Local Authority and other agencies		
C	Other material factors		
D	Cumulative effect of change		

Summary

Ref	Impact Area	Proposed Change	Do Nothing
1	Changes in Accessibility		
2	Impact on the Wider Community		
3	Patients Affected		
4	Methods of Service Delivery		
5	Financial and Other Factors		

4. Comments from PCT on impact assessment scores

4.1 Changes in Accessibility

Ref	Aspect	Proposed Change	Do Nothing
A	Reduction/Increase in Service		
B	Local Provision Accessibility		
C	Relocation of Service		
D	Withdrawal of Service		

4.2 Impact on the Wider Community

Ref	Aspect	Proposed Change	Do Nothing
A	Other Partner Agencies		
B	Transport		
C	Community Safety		
D	Local Economy		
E	Environment		
F	Regeneration		
G	Social Services		

4.3 Patients/ Carers Affected

Ref	Aspect	Proposed Change	Do Nothing
A	Number of Patients/Carers		
B	Proportion Affected		
C	Equality and Diversity		
D	Social Exclusion		
E	Views from Patients Forum etc		

4.4 Methods of Service Delivery

Ref	Aspect	Proposed Change	Do Nothing
A	Change in Setting		
B	Change in Technology		
C	Change in Practitioner		
D	Change in Care Process		

4.5 Financial and Other Factors

Ref	Aspect	Proposed Change	Do Nothing
A	Financial Impact on NHS body		
B	Financial Impact on Local Authority and other agencies		
C	Other material factors		
D	Cumulative effect of change		

Summary

Ref	Impact Area	Proposed Change	Do Nothing
1	Changes in Accessibility		
2	Impact on the Wider Community		
3	Patients Affected		
4	Methods of Service Delivery		
5	Financial and Other Factors		

Assessment Led by (Name)	
Date Undertaken	
Substantial (Yes/No)	
Relevant PCT	
Date Passed to Relevant PCT(s)	

Declaration

Assessment Led by (Name)	
Date Undertaken	
Substantial (Yes/No)	
Date Passed to OSC	

Royal College of Nursing

Appendix D

Health Scrutiny Committee: example of Questions to ask.

Agenda and submission

1. Do you have protocols/procedures agreed? For example:
    - Processes
    - Constitution
    - Agenda criteria – examples?
    - Terms of Reference
    - Impact assessment form
2. If so how are they accessed?
3. How is the agenda created?
    - Is there yearly planning for the year?
    - If so can this planning of the agenda be influenced by third parties?
4. How are papers submitted?
5. What information needed? – Including criteria – type of content
6. Do you allow third party comments?
7. What is the time scale for submission of papers?
8. Are all papers publicly accessible?
9. Can committee request further information regarding agenda items?
    - Can organisations refuse to submit?
10. Are matters arising an agenda item?

11. What types of issues would require action plans set up?
12. Can Emergency items be submitted?
    - If so how?

Decision making process

13. Who makes decisions about agenda item submissions?
14. What is the process for decision making?
    - Is there a timescale?
15. Can decisions be overruled within the Committee?
16. Can an item be revisited and challenged if decisions made not adhered to?
    - Who monitors this?
    - What is the process?

Third party involvement

17. What Link does the committee have with National Government?
18. Can the RCN help/support in any way?
19. How will the committee work with the Strategic Health Authority?
20. What links to the committee have with independent providers? E.g. Charities, Age Concern, Nursing homes, etc.
21. Who do the Committee seek professional advice, regarding agenda items related to health?
22. How can the public influence?
    - Can they just turn up?
    - Can they submit paper?

Committee structure and process

23. How often do you meet?

24. What is the Committee's catchments area?

25. What is the role of the Chair and Officer overseeing the HSC?

26. How is membership of committee selected – balance of political parties within Council?

    - Does this influence agenda and outcomes?

27. What is the membership of the Committee e.g. seats for public and patient forums?

Appendix E

Process flow chart and Checklist for Health Scrutiny Committees

Checklist

Step 1 - Gather relevant information

- RCN staff member identified to undertake initial tasks and lead on future HSC developments. **Yes/No**

The following information can usually be accessed via the County Council's web site

- Information on Terms of References and/or Constitution **Yes/No**
- List of committee membership **Yes/No**
- Identify Officer who oversees Committee **Yes/No**
- Identify Committee meeting dates **Yes/No**
- Contact details **Yes/No**
- Obtain agenda items for the year **Yes/No**
- Review past minutes, decisions made and relevance **Yes/No**

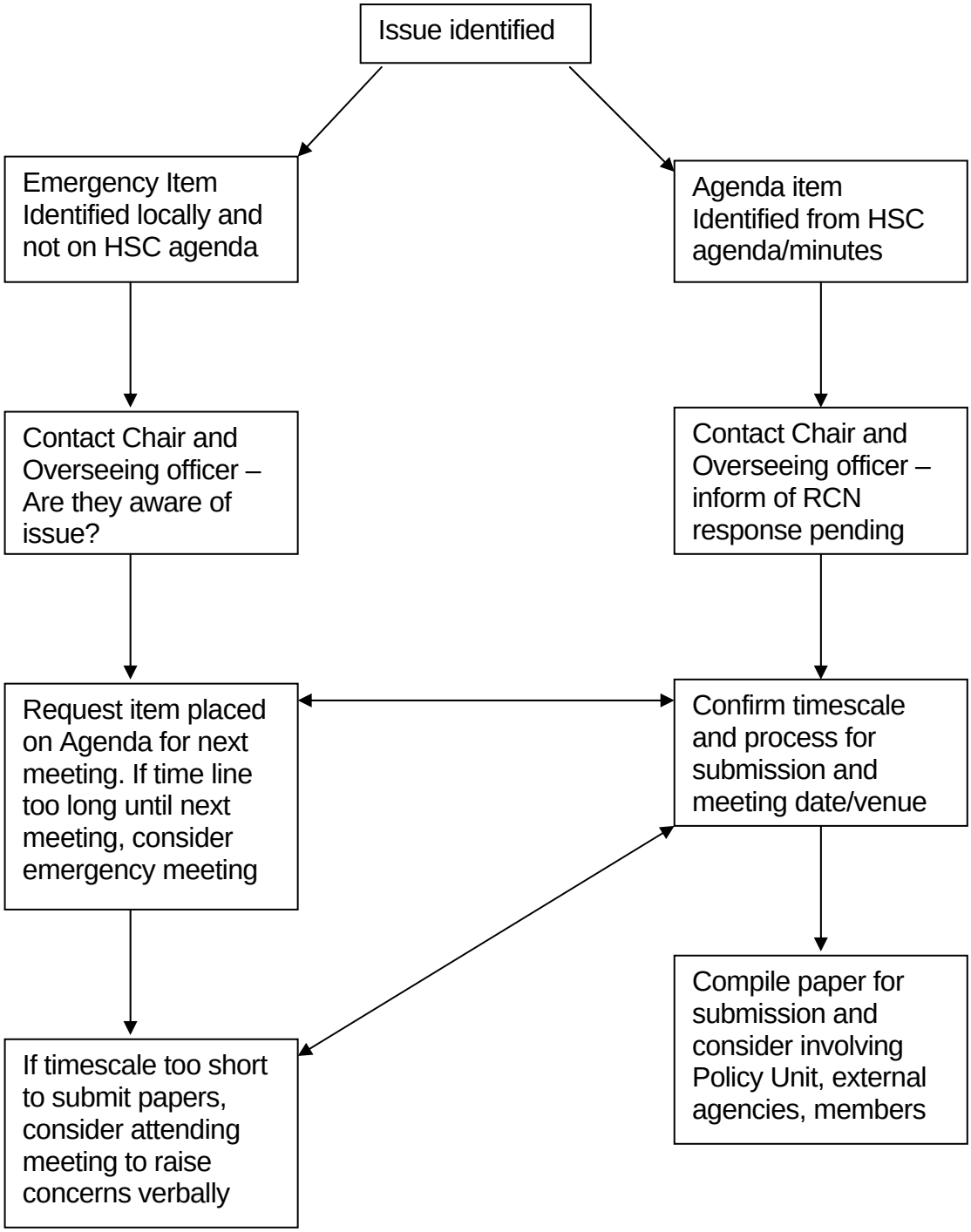
Step 2 – initial contact

- Arrange meeting with overseeing Officer and Chair of Committee **Yes/No**
- Use Appendix D to structure meeting and outcome **Yes/No**
- Identify agenda items for year planned that may allow an RCN response **Yes/No**

- Consider regular links/meetings **Yes/No**

Step 3 - Identify issues and monitor activity

- Consider response to agenda items and minutes relevant to the
- RCN's purpose. **Yes/No**
- Consider local issues that may need HSC influence/awareness **Yes/No**
- Identify meeting date that will outline the Committee's agenda
- for the year and consider influencing agenda **Yes/No**
- Monitor agenda items for upcoming meetings and identify issues
- needing RCN input **Yes/No**
- Analyse minutes to establish outcomes that may need RCN input
- or involvement. **Yes/No**
- Submit evidence – consider support from policy unit HQ **Yes/No**
- Ensure time-line to submit evidence adhered to. **Yes/No**
- Identify Committee members' to approach, to raise issues. **Yes/No**


Issue identified
Emergency Item Identified locally and not on HSC agenda
Agenda item Identified from HSC agenda/minutes
Contact Chair and Overseeing officer – Are they aware of issue?
Contact Chair and Overseeing officer – inform of RCN response pending
Request item placed on Agenda for next meeting. If time line too long until next meeting, consider emergency meeting
Confirm timescale and process for submission and meeting date/venue
Compile paper for submission and consider involving Policy Unit, external agencies, members
If timescale too short to submit papers, consider attending meeting to raise concerns verbally

Appendix F

Dear

The Royal College of Nursing in the XXXX region represents over XXXX nurses.

Membership is diverse and extends across NHS Acute Trust Organisations, Mental Health Organisations, Primary Care Trusts, Foundation Trusts, and Strategic Health Authorities to name but a few. Furthermore, our membership expands throughout the independent sector; this includes nursing homes, hospices, prison services, privately run hospitals and clinics.

To support our membership and influence health issues, within the XXXX region we have promoted and developed partnership working with many organisations and consider this approach to be the most effective and productive when discussing health provisions, ensuring the welfare of staff and patients remain priority.

However, scrutinising health and indeed health commissioning can be a complex task and seeking expert advice on issues raised by patient and public forums or clarity regarding organisational changes to services can be challenging.

Analysing health needs is a task that the XXXX region has been undertaking for many years – giving advice and support and at times further evidence regarding proposals under scrutiny at local, regional and national level.

We fully recognize the importance The Health Scrutiny Committee hold and the role it continues to undertake in scrutinising health reforms within the community it serves. We also understand the political agenda on health shifting to local level and therefore we are very keen to engage with you, working in partnership.

I would like to propose that we arrange to meet up to discuss further, giving me the opportunity to provide you with more details.

You can contact me by telephone or e-mail address given at the top of this letter.

I looking forward to hearing from you

Yours