Item No. 10
Appendix 1

Health Scrutiny Support Programme – 2007

Session One – Understanding how to scrutinise 'substantial variations' in the current NHS context

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Summary of points raised during discussion

Health scrutiny committees can:

Force the NHS to consult
Force the NHS to reply to its queries and concerns

Health scrutiny committees cannot:

Force the NHS to change its mind

There is a conflict in the role of health OSCs in that they are expected to represent the views of their constituents, whilst taking a strategic overview of health and health related services.

It is right a proper for health OSCs to take a different stance from that of the council when necessary. For the NHS, talking to the council is not the same as talking to the health OSC, and vice versa.

Section 7 of the Health & Social Care Act, 2001, places a duty on scrutiny committees. It also includes the duty for NHS bodies to consult OSCs about substantial variations, but OSCs and NHS bodies often disagree about what is substantial.

Section 11 of the Act places a duty on NHS bodies, including independent sector treatment centres (ISTCs).

An OSC can agree that a change is substantial and needs to be consulted on without having to carry out an indepth review into the issue. It can decide that, as consultation has been carried out that is enough and it is satisfied that the NHS has done its job.

If an OSC doesn't limit its role it will get swamped.

If a trust is making changes, but saying there is no service change, the OSC can note it and come back to it in a couple of months to make sure there have been no effects on services.

When trusts make decisions based on clinical safety or risk, instead of getting bogged down in asking why, OSCs can go back to basics and ask instead about what is the clinical need for the population served and are the right services being commissioned.

It is not the OSCs job to be happy with every decision, but it will have to accept that some decisions take by trusts are reasonable and rational, even if they are not liked.

It is not possible, or desirable, to challenge every decision, based on whether the committee dislikes them. Rather it is more productive to challenge the worst decisions and encourage the NHS to behave in a more reasonable and rational way.

It is reasonable to carry out checks, e.g, “you said this was how X would be delivered, so how has it been delivered?”

Clinical issues have to be seen within a financial context.

Motives for change are usually to save resources so that they can be deployed elsewhere to good effect, which is perfectly reasonable.

If a trust is following national guidelines there is no room for an OSC to criticise or object.

OSCs will have to accept sometimes that Peter will be robbed to pay Paul.

The current White Paper that is going through Parliament will put a greater duty on the NHS and Local Authorities to work more closely together.

An OSC can refer straight to the Independent Reconfiguration Panel:

Informally
Formally via the Secretary of State
If something is going really badly the IRP can be called in to mediate

Background to recent NHS changes

Populations of 5 million are good for planning purposes, so that is why SHAs were merged.

Under Patient Choice patients should be given 5 choices of where to go for treatment, including one independent sector provider.

The Government aspiration is that 10% of activity should be privately provided.

The Payment by Results tariffs mean that money should follow the patient.

Super GP conglomerates are envisaged as emerging to provide a wide range of services locally. However they will not be the same as the old fundholding GPs and so some GPs have no interest in Practice Based Commissioning. Groups of GPs could commission for broad bands of patients.

Community hospitals should be a focus for a whole range of GP activity for a population of 100,000 people. They will not be the old style cottage hospitals of the past.

Pharmacists will be pushed to deliver a wider range of services.

Future Work for the OSC

Health OSCs should have regular question and answer sessions with Chief Execs of NHS bodies in twice yearly sessions.

Investigations into issues/services should have more of a commissioning focus and less of a pure service provision focus.