The five themed Select Committees of the Council’s scrutiny function were formally constituted in April 2009. Since that time there has been considerable change to the National Health Service through the Health and Social Care Act 2012 resulting in major structural changes which took effect from 1st April 2013. While these changes will not fundamentally change the role of HASSC, or how it conducts its business, it is important that the HASSC takes account of the relevant elements of the new NHS landscape and that the HASSC’s remit and functions have regard to the new health scrutiny powers, related legislation, and associated regulations that underpin the NHS reforms and supersede legislation and regulations previously issued by government. Attached at Appendix 1 is a revised Scheme of Delegation for the HASSC to bring it up-to-date constitutionally.

Members should note that the Constitution is currently under review so the style and format of the appended Scheme of Delegation may vary as a result of maintaining consistency of presentation of information in the new version of the Constitution. All content listed will naturally still be applicable even if not explicitly written into the final version of the constitution.

LBBD’s Joint Health Scrutiny arrangements with Havering, Redbridge and Waltham Forest will be reviewed separately and reported back to the HASSC in due course.
Recommendation(s)
The HASSC is asked to:

- Approve the revised Scheme of Delegation for the HASSC so that changes to the Constitution can be presented to the Assembly for adoption, or enacted under delegated authority by the Monitoring Officer.

Background papers

- Council Constitution
- Pulling it all together: A guide to legislation covering overview and scrutiny in English local government (Centre for Public Scrutiny, May 2012)
- Health and Social Care Act 2012
- Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002
  The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

1. Relevant Aspects of the Health and Social Care Act 2012/Explanatory notes

1.1 Before asking Members to comment on constitutional changes for the HASSC, it is worth outlining the relevant aspects of the Health and Social Care Act 2012 that have a bearing on the local authority and health scrutiny to put into context the proposed amendments to the HASSC’s scheme of delegation set out in Appendix 1.

- Extending scope of scrutiny
  The health scrutiny powers have been extended and now apply to ‘relevant NHS bodies’ or ‘relevant health service providers’. This covers CCGs, the NHSCB and providers of health services (including independent sector providers). This is a landmark step in strengthening health scrutiny and ensures that any organisation commissioning or providing health services must cooperate with scrutiny by supplying information, or attendance of relevant persons, upon request.

- Localism
  As part of the localism agenda health scrutiny powers are now conferred on the local authority not on an individual Overview and Scrutiny Committee; allowing for Councils to discharge scrutiny through different models. This means that the HASSC does not directly inherit powers and functions for health scrutiny; instead these powers and functions must be delegated to the HASSC by Assembly.

- Referrals to the Secretary of State for Health
  The Department of Health’s response to the consultation on the Health Scrutiny Regulations indicated that local authorities would need to use the National Commissioning Board as an intermediary when making a referral to the
Secretary of State. However, on publishing the Regulations there was no mention of this requirement. The regulations do state that when making a referral the local authority must demonstrate it has taken all reasonable steps to resolve the dispute locally. This would include seeking advice and input from the National Commissioning Board which could work with all parties to broker an agreement. We await guidance on the exact role of the National Commissioning Board in supporting the referral process. Nevertheless a direct line to the Secretary of State remains.

It should be noted that the referral power is also extended to include other commissioners (not the CCG) proposing a substantial variation to local health services. This provision takes account of the National Commissioning Board’s role as commissioner of key health services ensuring local democratic accountability.

- **Healthwatch**

  From 1st April 2013 Healthwatch will replace the LINk with an enhanced remit to act as a consumer champion for patients and service users. A separate paper is being presented to the HASSC to explore the functions of Healthwatch and how it might work productively with HASSC, given their overlapping remits with respect to accountability in health and social care. For the purposes of this report it is important to note that the power for LINks to make referrals to OSCs is passed onto Healthwatch, along with the obligation on the Overview and Scrutiny Committee to respond and act upon any referral in a timely fashion.

- **Health and Wellbeing Board**

  Health and Wellbeing Boards are established as statutory committees of the Council to drive integration and partnership working and to exert strategic influence over local commissioners. The Boards consist of the key leaders from across the local health and social care economy. The primary functions of the Boards are to produce the Joint Strategic Needs Assessment and Health and Wellbeing Strategy, documents that will underpin commissioning decisions and drive improvements. The HASSC will be expected to hold the local H&WBB to account for the delivery of these functions and feed concerns gathered from the scrutiny forum up to the H&WBB for action.

  Naturally, as an executive committee of the Council, the Board is subject to scrutiny in the same way as Cabinet. Therefore the power for elected members to call-in a decision of the Board applies. For simplicity where a decision owned by the H&WBB is called-in, the HASSC will respond. That said, the Call-in process will be made inclusive so that relevant Members and senior officers from other Select Committees/Directorates get the opportunity to feed into the HASSC’s response to the Call-in.

- **Public Health**

  Public Health and health improvement is now the responsibility of the local authority. Elected members will now have a direct role in decisions about the commissioning of public health initiatives and responsibility for the delivery of public health services. This will mean that when scrutinising public health issues it is the Council that will be under the microscope rather than the NHS. Public
Health comes under the portfolio of Cllr Worby with Matthew Cole (Director of Public Health) as LBBD’s accountable officer.

- **Regulatory regime**

  The Health and Social Care Act 2012 introduces a new regulatory regime to reflect new commissioning structures and a broader range of providers operating with NHS funding. As such the HASSC will need to have regard to the remits of several regulators whose roles are summarised below.

  - **Care Quality Commission (CQC)**
    
    CQC is the regulator of health and social care for England. It registers, and therefore licenses, care services if they meet essential standards of quality and safety and monitors them to ensure they continue to meet these standards. Healthwatch England will be part of the CQC.

  - **Monitor**
    
    Monitor is the regulatory body for NHS Foundation Trusts. Under the Health and Social Care Act 2012, Monitor’s key role will be to promote and protect patients’ interests. It has statutory powers in relation to cooperation and competition and will be required to support the delivery of integrated care where this would improve quality or efficiency.

  - **NHS Commissioning Board (NHSCB)**
    
    The NHSCB is a national body created under the Health and Social Care Act, whose role will include supporting, developing and holding to account the system of clinical commissioning groups, as well as being directly responsible for some specialist commissioning.

  - **National Institute for Health and Care Excellence (NICE)**
    
    NICE (formerly known as the National Institute for Health and Clinical Excellence) is the body responsible for providing research, evidence and guidance on what medication, treatments and interventions should be available through the NHS and, in the case of public health, through local authorities. Under the Health and Social Care Act 2012 the role of NICE has been expanded to bring high-quality guidance and standards to the social care sector. Despite the name change the acronym remains the same.

1.2 It is not necessary to cite these regulators or make reference to the regulatory regime when describing the role and functions of the HASSC. However, interaction with these bodies may prove crucial if it becomes necessary to escalate a matter to the Secretary of State. The referral process, as outlined in the regulations, demands that Local Authorities take all reasonable steps (which might include engaging with regulators) to resolve the matter before asking the Secretary of State to intervene and asks that any submission from the Local Authority explains those steps taken.

1.3 The diagram overleaf depicts the NHS landscape in the post Health and Social Care Act 2012 world showing where the local authority sits in relation to other agencies and parts of the system.
APPENDIX 1

SECTION F – THE HEALTH AND ADULT SERVICES SELECT COMMITTEE

Further to the general powers of scrutiny outlined elsewhere in the Constitution the functions and powers of the HASSC are as follows:

1. Scrutinising any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents.

2. Requesting information from NHS bodies and any health service provider. Exempt from this power are requests for information that are confidential (i.e. information that identifies a living person or is prohibited under any enactment) or relate to NHS Trusts in special administration.

3. Requesting attendance from any member or employee of a relevant NHS body or health service provider to attend before it to answer any questions; provided those questions do not relate to confidential information or information that they would be entitled to refuse to provide in a court of law. The request for attendance may also be refused if reasonable notice has not been given.

4. Acting, on behalf of the Authority, as the statutory consultee where NHS bodies propose substantial developments or variations in the provision of services and thus have a duty to consult with the local authority before taking a decision. When being consulted with, the HASSC must notify the relevant NHS body of its response to the consultation and any intention to refer the matter to the Secretary of State within the timescales agreed by both parties.

5. Exercising, on behalf of the Authority, the Council’s right of referral to the Secretary of State on substantial variations to local health services. The HASSC will have regard to the criteria and process for making a referral to the Secretary of State which are prescribed in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

6. Receiving referrals from the local Healthwatch on matters relating to the planning, provision, and operation of health services in the borough, acknowledging receipt within five working days. Further to the regulations, Healthwatch can expect a referral to be discussed at the next formal meeting of HASSC, or at a formal meeting within three months (whichever is most timely). In accordance with the regulations the HASSC is obligated to keep the referrer informed of any action taken in relation to the matter.

7. Holding to account the Health and Wellbeing Board for the delivery of its functions, and in doing so, having particular regard to the robustness of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy as effective documents to ensure commissioning of health and social care services is reflective of local need.

8. Presenting recommendations arising from scrutiny investigations in accordance with the Council’s agreed processes, submitting recommendations to the relevant decision-maker as determined by Council’s Scheme of Delegation.
Where recommendations or reports are issued to NHS bodies/health service providers, that Body or provider must, if requested to do so, respond to the HASSC within 28 days.

9. Monitoring progress of implementation of recommendations in accordance with the Council’s agreed processes, ensuring that decision-makers have due regard to findings and recommendations arising from scrutiny investigations.

10. Addressing any Call-ins as allocated by the Statutory Scrutiny Officer in accordance with Article 5A. On occasions where the decision called-in is owned by the Health and Wellbeing Board the HASSC will by default be the receiving Select Committee of that Call-in regardless of the subject of the decision.

11. Addressing any Councillor Calls for Action as allocated by the Statutory Scrutiny Officer in accordance with Article 5B

12. Considering petitions in accordance with the Council’s Petition Scheme which can be found on the Council’s website. http://www.lbdd.gov.uk/CouncilandDemocracy/Information/Pages/Petitions.aspx

13. Representing local people and bringing local concerns and feedback about health and social care services to the attention of leaders within the local health and social care economy, formally advising the Health & Wellbeing Board of any such concerns in the process.