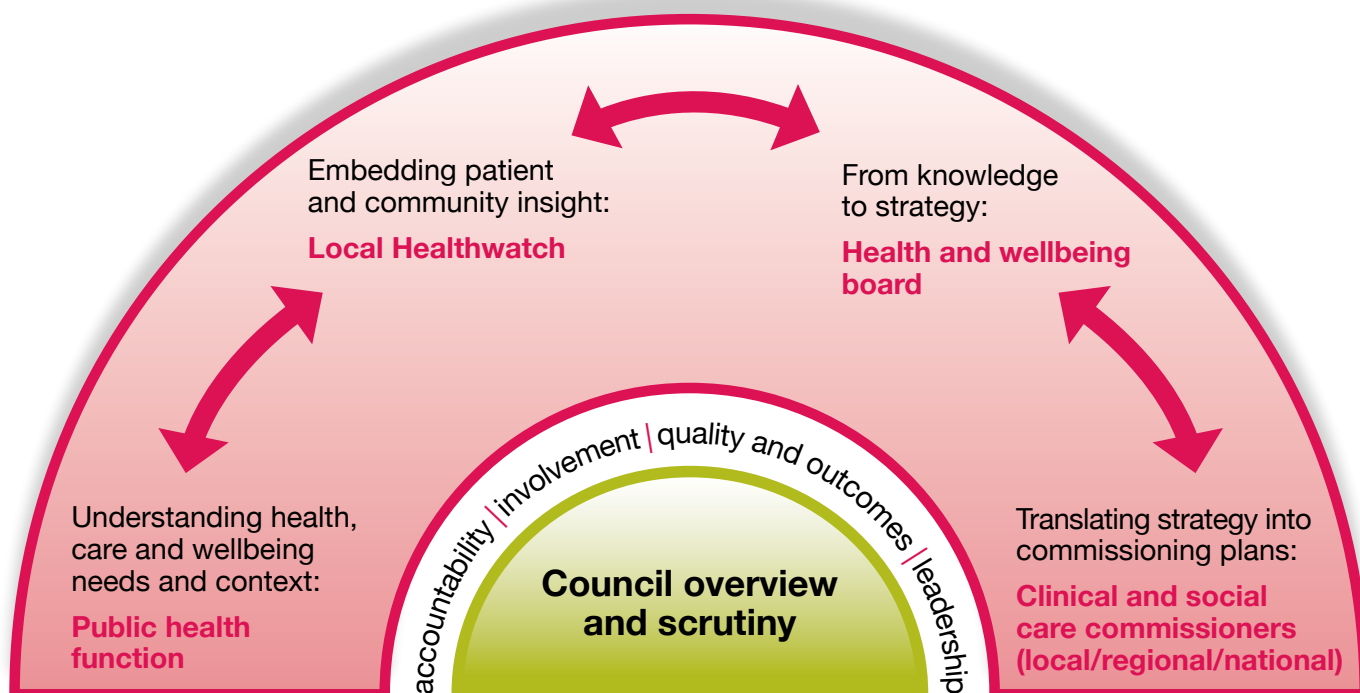


# Spanning the system

Broader horizons for council scrutiny





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## The Centre for Public Scrutiny

The Centre for Public Scrutiny (CfPS), an independent charity, is the leading national organisation for ideas, thinking and the application and development of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and service users.

## Acknowledgements

This publication has been written by Sheila Marsh (Independent Consultant and CfPS Expert Adviser) and Su Turner from the Centre for Public Scrutiny. We are very grateful to the CfPS Expert Advisers that have supported the 14 Scrutiny Development Areas over the past 10 months. We would like also to thank the Councillors and Officers from the 14 Scrutiny Development Areas (see Section 4), as without their hard work and commitment this publication would not be possible.

## About this publication

This publication has been generated from the learning of the 14 areas involved in the programme (details on the back page). To complement 'Spanning the system' CfPS has also produced a further web based resource<sup>1</sup> that looks in more detail at the work of the 14 development areas. A link to this resource is also given within the links section on the back page.

As the programme ended, the Francis Inquiry into events at Mid Staffordshire NHS Trust published its report. Within his review<sup>2</sup>, Robert Francis identified that it was difficult for anyone 'on the outside' to check what was happening in Stafford hospital. However, his review recognised that scrutiny by local councillors is an important part of the framework of health service accountability, and that it should be resourced and valued. This programme shows the key role that council scrutiny can contribute to better health and care outcomes for people. It has, like the Francis Inquiry, also highlighted that everyone with a role to hold the NHS to account needs to work together to make sure they combine their powers and the information they gather so that stronger lines of accountability are developed for strategic direction and operational performance. The Inquiry report therefore provides additional important context to the conclusions of this programme and how councils should pursue their role in overview and scrutiny of health.

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1 <http://cfps.org.uk/scrutiny-and-the-health-reforms>

2 <http://www.midstaffpublicinquiry.com/>

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This publication reports on the second CfPS scrutiny development programme on the health reforms. A report on the first programme was published in November 2011 (Health Overview and Scrutiny: exploiting opportunities at a time of change<sup>3</sup>).

CfPS received funding from the Department of Health to help support accountability through council scrutiny as the health system was in transition following the Health and Social Care Act 2012. 14 Scrutiny Development Areas worked with CfPS to develop their own relationships and ways of working to provide the learning in this publication.

The first programme highlighted the following opportunities and challenges for council scrutiny in the new health and care landscape:


- ✓ **Building effective relationships** – scrutiny with ‘teeth’ as well as being a ‘critical friend.’
- ✓ **Proactive scrutiny** – early involvement and facilitating public debate about strategic direction and experience of people who use services.
- ✓ **Outcome focused** – cross-cutting issues as well as specific services, ensuring outcomes drive processes.
- ✓ **Layered scrutiny** – across tiers of government, looking at wider determinants of health and integration of services.

The second programme built on these lessons:

- **Relationship-building** – scrutiny was a catalyst for bringing stakeholders together, setting out publicly ambitions for scrutiny, relationships with other bodies and protocols for ways of working (e.g. **Birmingham, Bristol, Central Bedfordshire, Croydon, Lincolnshire, North Lincolnshire and West Sussex**).
- **Proactive scrutiny** – maintaining momentum was important, carrying out new scrutiny reviews and following up previous work on behalf of local people (e.g. **Calderdale**). This helped ensure that stakeholders stayed focused on people’s experiences of services through transition.
- **Outcome focused** – scrutiny of health outcomes had equal importance with health and wellbeing board and clinical commissioning group processes and accountability (e.g. **Bury/Oldham, Cornwall and North Lincolnshire**).
- **Layered scrutiny** – scrutiny of well-being emphasised the value of district council scrutiny to make the most of the scrutiny potential in multi tier areas (e.g. **Staffordshire, Warwickshire and West Sussex**).

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<sup>3</sup> Health Overview and Scrutiny: Exploiting opportunities at a time of change  
<http://www.cfps.org.uk/publications?item=7008&offset=50>



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The first development programme raised the following challenges for scrutiny and accountability more broadly:

- Will accountability be clear in the new landscape, including the role of council scrutiny?
- Can council scrutiny respond to cost and quality challenges, focusing on outcomes not just structures and processes?
- How can council scrutiny maximise its potential to be the 'glue' in the new system, helping new and existing organisations and groups build relationships and secure outcomes?
- How can council scrutiny and local Healthwatch best complement each other, involving councillors, people who use services and the public in decisions about strategy, commissioning, delivery and scrutiny?
- How can council scrutiny best be resourced and supported to maximise its value, mitigating the risk of ineffective checks and balances?

The second programme has generated insights in relation to these challenges, and these are reported in the following sections:

### **Section 1** Accountability and transparency

- Public health: understanding the local health, care and wellbeing context
- Local Healthwatch: embedding public and patient insight
- Health and wellbeing boards: effective strategies to meet health, care and wellbeing needs and aspirations
- Clinical commissioners: effective commissioning plans that deliver outcomes

### **Section 2** Critical factors for progress

- Seeing the big picture
- Focus on quality and outcomes
- Leadership and relationships

### **Section 3** Conclusions

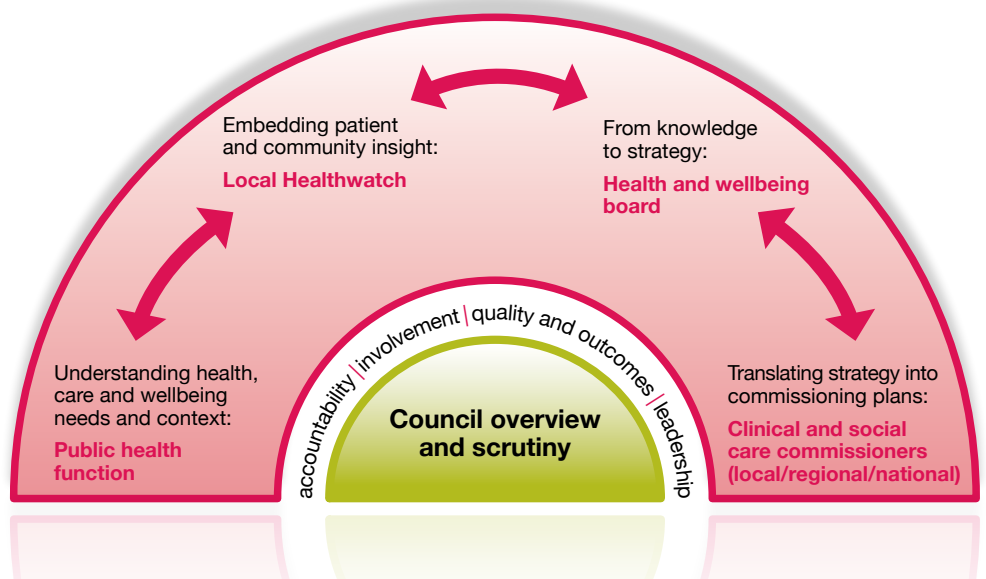
### **Section 4** Links and tools

## Section 1: Accountability and transparency

*“The most important accountability is to the public – don't forget it!!”*

**SDA Participant January 2013.**

During transition it is easy for health and wellbeing boards, local Healthwatch and clinical commissioning groups to focus exclusively on governance, structures and processes to deliver their functions. Whilst this helps them become established quickly, it risks missing a longer-term view about transforming services to achieve better outcomes for local people. CfPS has supported 14 areas to navigate local changes; to embed the principles of accountability and transparency; and highlight the value of council scrutiny to connect up fragmented systems and services, developing better relationships. This section explains how the areas began to draw lines of accountability and provides helpful hints about developing accountable and transparent foundations for local arrangements after April 2013.



This diagram represents the learning from the programme and illustrates the role that scrutiny has across the spectrum of health, care and wellbeing: from helping to understand the local context, through embedding the insights of patients and communities, to checking that strategy, commissioning and delivery are actually improving outcomes.



## Creating an accountable system

With lots of activity around organisational ‘form’ and little attention on ‘function’, focusing on accountability can be hard. Council scrutiny can bring people together to better understand what they need to do and how to do it effectively together, with improved outcomes as a common goal. Organisations may have different motivations for improvement – a council might want people to be independent for as long as possible in their community; a clinical commissioning group might want fewer people needing hospital treatment.....same goal – different motivation. Everyone has a responsibility to develop effective relationships to achieve goals, not just engage formally. Good relationships lead to good communication and a better understanding of where value can be added – as trust and understanding are built so too is understanding of the value of working together.

The programme has shown the importance of defining and communicating the scrutiny role in relation to working with a number of new and existing organisations. Below is a look at what the 14 areas have learned about the lines of accountability between scrutiny and:

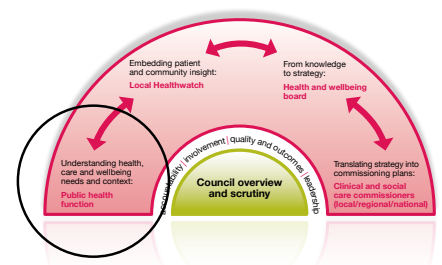
- Public health
- Local Healthwatch
- Health and wellbeing board
- Commissioning

### Public health: understanding the local health, care and wellbeing context

In 2011, **Peeling the Onion**<sup>4</sup> began to explore the role of public health and the scope of its work:

*“Public health has its primary focus on the health of populations rather than, as is the case for a GP say, on the health of an individual patient. So Directors of Public Health look at how measures of health and wellbeing, disability and disease are distributed in the population they have responsibility for”*

**Peeling the onion 2011.**



4 Peeling the Onion - [http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin\\_1\\_1\\_.pdf](http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf)

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The transfer of public health to local councils signifies an important step in work on public health – public health encompasses information, evidence and action that affects health, care and wellbeing for a locality and its communities.

A number of areas reported good working relationships between scrutiny and Directors of Public Health and were seeking to build on this during the transfer of public health functions to councils, for example inductions about scrutiny for public health teams.

But there were some tensions too about how influence and accountability were affected by the positioning of public health teams in the organisational hierarchy. In some areas, council scrutiny explored expectations and resources: ‘What do public health people actually do?’ How are resources allocated? Some held special meetings; others suggested shadowing public health staff.

Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are key mechanisms for developing a better understanding about health and care needs that can be built in to commissioning and delivery. Some county councils worked with district councils on broader determinants of health and wellbeing as well as involving Directors of Public Health.

**Croydon** has sought to solve the dilemma of who scrutiny should be holding to account on pieces of work. Should it be the Director of Public Health or, for example, the Director of Adult Social Care? Croydon’s overview and scrutiny committee is putting together a checklist of what the Director of Public Health does and what part of their role relates to which body and how reporting lines should work – a draft scheme of delegation (see **Section 4**).

There was a strong public health strand to the work in **Lincolnshire**, where they focused on scrutiny of the public health budget, which led to a greater understanding of members and officers on the role and function of public health in the new system as well as the impact of public health budgets. This knowledge and insight led to the development and delivery of a Public Health Awareness Councillor Development Session, open to all county councillors and members of the Health Scrutiny Committee.



## What you can do to work effectively with public health professionals:

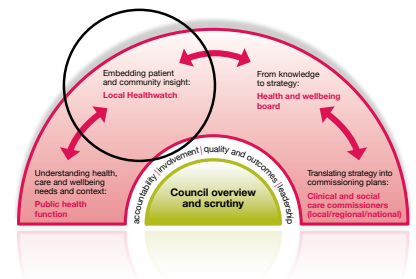
- Help public health professionals to appreciate scrutiny as an asset and an opportunity not a barrier or opponent.
- Show them the added value to be gained by working across complementary functions in public health and the council, and with district/ borough partners.
- Hold 'get-to-know-you' sessions (and not just at the most senior level) so that public health professionals, council officers and members learn more about each other.
- Plan how best to use public health data and intelligence.
- Create opportunities for Directors of Public Health and scrutiny members to jointly plan and set priorities for scrutiny.

## Local Healthwatch: embedding patient and community insight

Local Healthwatch has been the least developed aspect of the health reforms but the programme has clarified some aspects of the relationship between local Healthwatch and scrutiny. For example, health scrutiny can:

- Test arrangements made by councils for local Healthwatch.
- Check the effectiveness and value councils secure from local Healthwatch arrangements.
- Welcome evidence from local Healthwatch.
- Keep local Healthwatch informed about progress with referrals.
- Be clear about work programmes – avoiding duplication but combining activity where appropriate.

Scrutiny and local Healthwatch are not mutually exclusive – they are both important aspects of accountability and can work together to amplify the voices and concerns of people who use services. Scrutiny and local Healthwatch should not only be reactive – they can ensure that commissioners and providers involve communities in health and wellbeing decisions (**Plymouth**).





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In our publication, **Local Healthwatch, health and wellbeing boards and health scrutiny – Roles, relationships and adding value**<sup>5</sup> we began to explore the independent, but complementary, roles and responsibilities of council health scrutiny, local Healthwatch and health and wellbeing boards. This highlighted that there was great added value to be gained from being transparent and communicating well and also in respecting their separate contribution to improving health and wellbeing. This programme grappled with the same shadow state, however conversations moved to thinking about their USP – and how to take advantage of powers of scrutiny and local Healthwatch.

**Cornwall** highlighted a potential conflict of interest for local Healthwatch in its membership of the health and wellbeing board and its relationship with scrutiny. **North Lincolnshire** concluded that the relationship scrutiny has with local Healthwatch needs to be built on their different powers – for example the ‘enter and view’ powers of local Healthwatch and the referral powers of scrutiny.

For many areas the processes to establish local Healthwatch had only just begun (e.g. **Calderdale, Central Bedfordshire**). **Staffordshire** undertook to scrutinise the commissioning process to demonstrate accountability to local communities. The relationship between scrutiny, health and wellbeing boards and local Healthwatch is a development opportunity; and will become more evident as we reach April 2013 and beyond. A key recommendation within the Francis Report relates to establishing better working between health and wellbeing boards, Healthwatch and council scrutiny through improved collaboration.

**Bristol** concluded that health scrutiny, the health and wellbeing board and Healthwatch have common goals and should work together:

- Value their independence and keep control of their own agendas.
- Share work plans, coordinate activity and avoid duplication.
- Collaborate, complement and support each other, to add value to each other’s work.

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5 Local Healthwatch, health and wellbeing boards and health scrutiny: Roles, relationships and adding value - <http://www.cfps.org.uk/publications?item=7195&offset=0>

## What you can do to work effectively with local Healthwatch:

- Get involved with the procurement process and its scrutiny.
- Work out how the potential data base and research capabilities of the new Healthwatch might be supported and used by both organisations and their partners - achieve collaborative advantage!
- Explore the powers of 'enter and view' and the Healthwatch presence on the health and wellbeing board and how they could be best used for scrutiny.
- Recognise the power of joint working around developing clinical pathways as well as the strength that Healthwatch's national contacts may potentially bring.
- Share information thoroughly with Healthwatch.

## Health and wellbeing boards and scrutiny: moving from knowledge about health, care and wellbeing needs to meaningful strategy

Health and wellbeing boards are different from previous local partnership arrangements. Enshrined in legislation, they are council committees with membership drawn from elected councillors, council officers, partners and communities (through local Healthwatch). This new arrangement presents opportunities to secure improvements in health and wellbeing but also some challenges for accountability. Health and wellbeing boards as a whole will be held to account for the scope and accuracy of their Joint Strategic Needs Assessment, and for the ambition within their Joint Health and Wellbeing Strategy. Boards will operate differently in response to local circumstances. Across the 14 areas, boards were mixed in their response to scrutiny. The shadow nature of boards made it difficult in some places to move beyond theoretical approaches to scrutiny. But in others this has been an opportunity to develop relationships with board members:

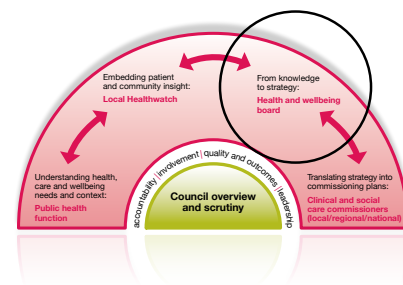
*"Our health and wellbeing board feels it is not accountable to anyone! So we've developed relations with the partners involved in the health and wellbeing board..."*

**SDA participant.**

*"They [health and wellbeing board] are in an operational vacuum and don't seem to think they've to be accountable"*

**SDA participant.**

The localism agenda within the health reforms has created a 'fog' and variation in arrangements across the country. Some shadow boards have met in private. In some places the rationale for this hasn't been clear. The executive nature of boards' decisions has not always been clear. In contrast, some boards have met in public from the start and others will after April 2013.



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In a number of development areas scrutiny took the lead to think through how arrangements will work in practice by using scenarios – using these to work out who needs to do what and when.

*“It’s a murky relationship with health and wellbeing boards because there are lots of the same players – and understanding where one bit ends and another begins has been difficult! We are developing a protocol to provide some structure and to try to avoid duplication”–*

**SDA participant.**

*“Our scrutiny committee are concerned that there is no real challenge at health and wellbeing board on their reports, and it has therefore drafted a protocol – and is seeking access for scrutiny and attendance at the health and wellbeing board’s ‘Executive sub-group’”*

**SDA participant.**

There is a general feeling that Joint Health and Wellbeing Strategies have a helpful aspirational quality to them but little that can be used to make effective commissioning decisions. Again there was a range of involvement of council scrutiny in emerging Health and Wellbeing Strategies – see web resource link.

**Cornwall** held workshops to explore the different responsibilities and expectations of organisations, and how they fit together, avoiding duplication. They were clear that the health and wellbeing board is responsible for the Health and Wellbeing Strategy, but also that the scrutiny committee could contribute evidence to the Joint Strategic Needs Assessment and review delivery of the Health and Wellbeing Strategy. The Cornwall Joint Strategic Needs Assessment is a “live” document on their website which is “themed” and anyone can comment on it (although it’s validated for quality assurance purposes).

**North Lincolnshire** lobbied for key scrutiny members and the scrutiny officer to receive observer status on the Board, which was granted. They now receive all paperwork for the Board and can request any other papers from the sub-committees. This provides them with a fuller understanding of forthcoming issues, the context that decisions are being taken in, and how policy is formulated. A draft protocol between the health and wellbeing board and scrutiny will be presented by the Chairman of the Health Scrutiny Panel to the health and wellbeing board and agreed early in 2013.



## What you can do to work effectively with health and wellbeing boards:

- Explore your respective roles with health and wellbeing board members to ensure all are clear.
- Propose a protocol if you think that will help develop relationships (see Section 4).
- Contribute to the Joint Strategic Needs Assessment and Health and Wellbeing Strategy processes.
- Make it clear you are scrutinising commissioning priorities and health, care and wellbeing outcomes, not individual Board members.
- Is the health and wellbeing board's leadership role effective – are they demonstrating leadership in improving outcomes?

## Commissioning and the role of scrutiny: translating strategy into commissioning plans

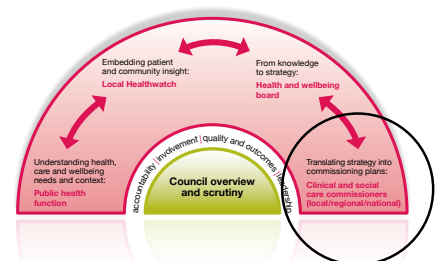
Commissioners across health and social care services have been around for some time. This programme had a particular focus on clinical commissioning groups who are new to accountability and scrutiny, yet they are at the heart of the changes – taking on significant financial and decision making responsibilities for people's health. In 2011, CfPS and the BMA produced a discussion paper<sup>6</sup> that began to explore the changes and identified that good effective relationships could only be created if there was mutual knowledge and understanding of GPs and councillors of their roles and cultures.

Relationships with the NHS Commissioning Board will be equally important, especially around primary care and specialised services but at present it feels remote although relationships were starting to emerge with Local Area Teams. The national commissioning picture is still developing for example with the creation of Clinical Senates and Quality Surveillance Groups.

Overall the 14 areas concluded that there were good relationships with emerging clinical commissioning groups, and an appetite to work together to improve outcomes. In some areas clinical commissioning groups recognised scrutiny as a platform for public accountability.

**Central Bedfordshire** clinical commissioning group came to council scrutiny for a review of a local hospital.

**Birmingham** clinical commissioning groups asked for views from scrutiny about their ideas for the future health and care system for the city.



<sup>6</sup> Accountability and the new structures: <http://www.cfps.org.uk/domains/cfps.org.uk/local/media/downloads/as.pdf>

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**Calderdale** engaged the Clinical Commissioning Group on a dementia strategy review. This led to representation on the Clinical Commissioning Group's Dementia Strategy Group, an opportunity for councillors to observe them in action; and for GPs to engage with local councillors to help them understand their work and build relationships.

So there was a sense of clinical commissioning groups being keen to engage with scrutiny, but at the same time a concern that once the system goes 'live', things will get more difficult. For example, future issues around budgets, particularly when clinical commissioning groups span different areas, or there are multiple clinical commissioning groups within one authority. Questions about how money is parcelled out and how equity will be achieved are then raised.

Following their work on this programme, **Central Bedfordshire** scrutiny committee is developing a framework for scrutiny of a clinical commissioning group (**see section 4**). The framework will focus on six domains asking key questions to ensure that the commissioning decisions are robust and effective. The six domains are:

- Improving outcomes
- Joint commissioning
- Enhancing responsiveness
- Narrowing health inequalities
- Information and choice
- Financial probity

In **West Sussex** the work had quite narrow, specific objectives – to review existing scrutiny guidance on NHS service change. However this actually helped to enable a much wider discussion around NHS reform, the impact on scrutiny and relationships in the new system. By focusing on a very practical issue (i.e. how potentially controversial service change will be scrutinised), the work helped to tease out some of the tensions and challenges in the system - and to begin the dialogue around how to resolve these locally. The use of an online survey and confidential follow-up interviews meant that more detailed views and opinions could be gathered from a wide range of stakeholders, including those who could otherwise be hard to reach, particularly the clinical commissioning groups.



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### What you can do to work effectively with commissioners:

- Accept this is all new and will not be like any previous relationship.
- Develop more focus on primary care.
- Build on all approaches and positive offers from clinical commissioning groups/commissioning bodies.
- Aim to work with both the managers and with the GPs involved in clinical commissioning groups.
- Make contact with the Local Area Team of the NHS Commissioning Board.
- Don't forget social care commissioners! Don't forget district councils!



Accountability across the spectrum – summary table		What council scrutiny can do to hold them accountable
Organisation/ function	Role	
Public Health	<b>Understanding broader health and wellbeing needs &amp; context:</b> focusing on population data, public health evidence, prevention, health information, reducing health inequalities & galvanising action on wider determinants of health.	<p>Ensure public health teams are aware of the role of scrutiny &amp; understand their duties.</p> <p>Ensure scrutiny is aware of the role of public health.</p> <p>Connect their work to the Joint Strategic Needs Assessment and Health &amp; Wellbeing Strategy to review the needs and context analysis and focus on outcomes.</p> <p>Understand and analyse public health spending – ensuring that funding is allocated appropriately.</p>
Local Healthwatch	<b>Embedding patient and community insight:</b> creating multiple ways for individuals, groups and communities to shape planning, commissioning, design, delivery and review of health and care services in the locality.	<p>Ensure local Healthwatch representatives are clear of their role in terms of voice and also a health and wellbeing board member.</p> <p>Collaborate with local Healthwatch to gather evidence of impact and experience of people who use services and communities affected by health and care strategy locally.</p> <p>Consider utilising the complementary powers of local Healthwatch's 'enter and view' and scrutiny's call in and referral powers.</p>
Health and wellbeing board	<b>Translating knowledge about health, care and wellbeing needs into meaningful strategy:</b> through its meetings that draw the commissioning system together and through key tools: the Joint Strategic Needs Assessment and Health and Wellbeing Strategy.	<p><b>The Board itself</b></p> <p>Ensure that the Board is effective and that its work is improving outcomes.</p> <p>Ensure Board members work together and with others to balance treatment and prevention and to integrate budgets and provision.</p> <p>Ensure that there is equality in the board - is local Healthwatch an equal partner?</p> <p>Challenge the Board around the integration of health and social care.</p>
Clinical and social care commissioning	<b>Translating strategy into commissioning plans:</b> drawing on the health and wellbeing strategy to ensure provision on the ground meets its aims.	<p><b>The Joint Strategic Needs Assessment</b></p> <p>Be proactive and provide some of the evidence base through outcomes from scrutiny reviews.</p> <p>Scrutinise the extent to which the Joint Strategic Needs Assessment reflects the needs and aspirations of communities for their health, care &amp; wellbeing.</p> <p><b>The Joint Health and Wellbeing Strategy</b></p> <p>Check that strategic priorities are evidence-based, respond to patient and community insight and reflect a high level of ambition to improve local health and care.</p> <p>Ensure that there is a commitment to narrowing the gap in health inequalities as well as improving outcomes for all.</p> <p>Ensure clinical commissioning groups, the NHS Commissioning Board and councils work together to translate identified needs and strategic priorities into services.</p> <p>Check that commissioned services are leading to improved outcomes for people who use services and to integrate care.</p>

## Section 2 Critical factors for progress

### Seeing the bigger picture

The health and care reforms present an opportunity to redefine relationships between patients, users of services, communities and their representatives, clinicians and professionals. Reducing central control; focusing on outcomes; aspiring to increase patient and public influence; improving people's health and wellbeing – all of these have potential to create the right environment for local solutions to emerge for local health and care challenges. If they result in greater co-design of commissioning plans, improved pathways of care and shared decision-making in service design and delivery, then we could take a step towards people becoming 'fully engaged' in health and care in their areas.

Council scrutiny can involve a wider stakeholder audience and this programme demonstrates this important way to consider strategic approaches to wellbeing and wider public health challenges, as well as keep in touch with the experience of people who use services.

Three key themes emerged:

#### ☑ **Wider involvement making a difference to the impact of scrutiny**

The 14 areas focused on how wider involvement could make a difference to council scrutiny and concluded:

- Start scrutiny **early** before too much is set in stone.
- **Topical** issues can help bring people together, but don't overlook less popular but important issues.
- It helped to view **action and research as simultaneous** i.e. just getting people together to discuss and contribute created new actions that improved things.
- **Appreciative** methods can help to draw people in, looking at assets not just problems.<sup>7</sup>
- Wide involvement helps build an **evidence-base** to support recommendations.
- Be **creative** about how to reach a wider audience – think about the wider volunteering/civil society community.
- Work with respected individuals and organisations but don't forget to hear quiet voices too.
- Ask for evidence to support statements about progress – does the experience of people who use services reflect what professionals say?

<sup>7</sup> Appreciative scrutiny <http://cfps.org.uk/publications?item=7145&offset=0>



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**Plymouth** concluded that, ‘...local democratic involvement in health presented a huge opportunity, and it was timely to explore how we did scrutiny and how we gathered evidence when there are a myriad of providers. This has led to the panel rewriting its work programme so that it focuses on outcomes rather than duplicate the work of the health and wellbeing board and its focus on strategic commissioning decisions.

*It is important to emphasise scrutiny should include the wider determinants of health; wellbeing is greater than the delivery of healthcare. Therefore it is important to scrutinise health and social care together but also understand how the scrutiny of issues such as housing could prove important for peoples’ wellbeing.*

*Scrutiny of health and social care needs an ethical agenda when working with patient experience; there is also the challenge of reviewing experience when participants might have poor recollection. The Scrutiny panel are meeting with the Care Quality Commission to develop this further and will also consider recommendations from the Francis Inquiry.’*

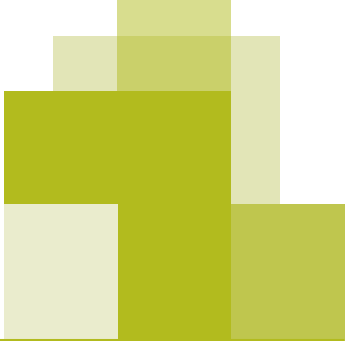
☑ **Wider involvement ensuring a focus on the wider public health agenda**

CfPS developed a **stakeholder engagement wheel** as part of its Health Inequalities Programme<sup>8</sup> – this type of approach can be useful to understand who can help scrutiny to understand the wider determinants of health and public health issues. It helps scan the whole system and decide who needs to be involved and how they can add value.

- Patient and public – who are the relevant groups, organisations, and people?
- Commissioners and decision makers – who are the relevant local and/or national commissioners?
- Providers – which are relevant, across all sectors (not just health and social care)?
- Scrutineers – which other scrutiny bodies can add value?
- Regulators – which organisations have an interest in the issue?

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<sup>8</sup> Tipping the scales (engagement wheel) <http://www.cfps.org.uk/publications?item=7137&offset=0>



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**Bury and Oldham** used a simple guide to start discussions with partners at a scrutiny development event. The event aimed to: improve everyone's understanding of the health reforms and to suggest improvements; and facilitate discussions between overview and scrutiny and other key bodies affected by the health reforms about what was needed in a working protocol post April 2013. The event was well attended by a cross section of local agencies and groups, including voluntary, community and faith organisations. The event was lively. The excellent mixture of people (spanning two council areas) and informal participative style provided great opportunities for people to get to know and learn from one another. It provided good opportunities to identify questions participants wanted to explore further and a model for future events. A draft protocol is now being developed from the outcomes of the conversations at the event.

**Wider involvement offering an opportunity to integrate and streamline involvement work**


Council scrutiny is well placed to help avoid fragmented involvement activity. Scrutiny can:

- Help others to understand roles and responsibilities regarding engagement. What are the legal / moral reasons to engage people individually and communities collectively - and the importance of credible responses?
- Provide the opportunity to link with different agencies on a specific issue, this could lead to maintaining relationships to deal with future problems on same the issue and develop partnership working on other issues.
- Identifying where closer working together will help – how can different parts of the system work together better and add value?<sup>9</sup>

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<sup>9</sup> Local Healthwatch, health and wellbeing boards and health scrutiny: Roles, relationships and adding value - <http://www.cfps.org.uk/publications?item=7195&offset=0>

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**Staffordshire** had identified that they needed to work collaboratively with the new commissioners to promote a wider understanding of the role and potential value of scrutiny amongst GPs and their new clinical commissioning groups. They also wanted to broaden the scrutiny functions understanding of how scrutiny might 'partner' Healthwatch. As a two tier local authority area, they also wanted to work through how the county, district and boroughs could best work together in these areas to ensure better outcomes for local people. At an event they began to explore the strategic overview role of the County Council and how local action and ambitions were managed – ranging from population based approaches to identified individual community improvements. The theme of on-going preventative work and public health education, working at both county and district level, also emerged strongly in the discussions. The key areas of challenge to closer working to improve health were identified as being related to communication and understanding.

### What you can do to work with the bigger picture

- Start with service users and ensure that involvement is about two-way relationships – ongoing, informal, 'no surprises' – TRUST!
- Understand how your activity impacts on others: work out and respect the role of different players.
- Be clear and focused whilst at the same time being flexible in your approach.
- Use a variety of media to get your message across and encourage wider involvement – however, make sure your language is appropriate.
- Collaborate - include everybody at every stage - bringing key people together in a proactive way.
- Meet people on their own territory.
- Aim to reach users directly – be creative to reach the 'disconnected.'



## Section 2 continued

### Quality and outcomes

Council scrutiny needs to tackle the **cost vs quality** challenge facing clinical and council commissioners. In the new environment where clinical commissioning groups are finding their way, where the role of the National Commissioning Board is still evolving through Local Area Teams and other structures, quality and outcomes for local people remain vital for council scrutiny.

The Francis Inquiry Report puts NHS culture and values centre stage in the drive for quality. The challenges of efficiency and quality are not easily reconciled but NHS services that are transparent, inclusive, accountable and open to local scrutiny will be able to demonstrate the centrality of patients to their work. Scrutiny has a key role in ensuring that services are commissioned according to need and that providers are providing quality services that are delivering an improvement in health and care outcomes.

Some of the 14 areas tackled this issue head-on by focusing their development work on a real and complex issue that had to do with quality and outcomes for local people:

- **North Lincolnshire** focused on a major reconfiguration of services, learning a great deal about early involvement and being proactive.
- **Calderdale's** review of dementia services produced a constructive and direct partnership with GPs and the clinical commissioning group.
- **Staffordshire** was working to consider hospital mortality against the background of the Francis Review – they found that leadership combined with a clear process were key in keeping scrutiny focused on outcomes.

**Warwickshire** used Quality Accounts as a focus within their development work and as an experiment in partnership working. They established Quality Accounts Task and Finish Groups related to each of the five NHS trusts in the County. The groups included representatives of the county and district/borough councils and Warwickshire LINK, and for the two overlapping trusts, representatives from Coventry City Council and Coventry LINKs. They are working with each of the Trusts to evaluate the effectiveness of the past year's quality accounts and to help set priorities for the coming year. As a result of this work a decision was taken to hold four meetings per year with each of the trusts to continue this useful dialogue. This will not only make the Quality Accounts process more effective, but will develop members of the committee as "champions" for the different trusts they are working with, creating a system of working groups linked to each trust. These partnership groups now work widely across quality issues.

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Other areas reported a sense that they had been in the ‘calm before the storm’ in the shadow period, that relationships were relatively easy to make at this stage and that after 1 April 2013 *‘reality will strike and people will not have such good relationships in the face of really difficult decisions’*. People talked about ‘murkiness’ remaining. But there was also a willingness to tackle a lack of focus on outcomes by others: *‘we didn’t like the format of the health and wellbeing board strategy – too fluffy... Councillors didn’t like it. While it picked up key issues it was hard to see commissioning intentions. Now they are doing more action planning as a result of scrutiny’s comments’*.

The 14 areas came together to consider what their experience suggested was important in order to keep a focus on quality and outcomes, not only on structures and commissioning processes. Their **top issues** were:

- **Stimulate the system** – *‘If we say we will do something, others get on board. We said we would look at TB rates, and suddenly there was a Strategy! It provoked a response, merely by highlighting planned work’*.
- **Support patient and community experience of quality and outcomes** – for example nursing practice and hygiene.
- **Concentrate on outcomes at each stage**. Make sure nothing gets ‘lost in transition’. Emerging strategies such as dementia or improving discharge procedures are very vulnerable at this time of change. Chase progress on implementing past recommendations and set up consistent monitoring systems to follow up cross-cutting issues.
- **Don’t forget social care!** Amid the ‘noise’ of healthcare reform, scrutiny has an important role to focus on the quality of commissioning and provision of adults and children’s social care.
- **Don’t forget district councils!** They can influence the wider determinants of health and have close connections to local communities.
- **Spot and use opportunities** – Local Accounts in social care and Quality Accounts in healthcare; involve Monitor and the Care Quality Commission and share knowledge and information with them. The Care Quality Commission and local Healthwatch have inspection powers that help them talk to people who use services.
- **Continuing to review public health or service issues** will build and develop relationships, provide essential learning, and show how health scrutiny can influence change and add value.
- **Increase focus on GPs and other primary providers** rather than keeping scrutiny’s tendency to focus on secondary care providers. This will mean understanding scrutiny not only of the clinical commissioning group, but of the NHS Commissioning Board.

- **Highlight engagement.** Ensure all players/parties involve local Healthwatch. Don't forget that you also have Patient Advice and Liaison Service/Voluntary Sector Forums, health and wellbeing board stakeholder groups and social care forums to draw information from.
- **Get assurance that procedures are in place, known and understood** to implement quality outcomes. Scrutiny can find out about protocols of a hospital trust, see if the staff are aware of them, see if they are followed, make recommendations from health scrutiny, and help stop failure in service or quality from happening. Is a protocol in place? Is it known about? If it is not working, ask how it will be put right? Then monitor if that happens. When there are 'never events' or other public interest issues, 'how can you assess quality in the system given the noise of the media?' When there is 'moral panic' in the press, it becomes a political issue, and health scrutiny needs to judge how to respond.
- **Make explicit the benefits of working together on quality/outcomes:** council scrutiny can tease these out and can evidence them by measuring the difference the interaction with scrutiny makes. This can include: reflecting these benefits in the report; using the language of learning and reflection; re-visiting the patient experience to show changes; and in the longer term via performance data. Examples that demonstrate these process outcomes give scrutiny a real value.

In summary there are **six key roles** for council scrutiny in improving **quality and outcomes** for local people within the new system:

1. Scrutiny is a **broker** – with honest relationships with providers and commissioners and the public.
2. Scrutiny is **part of an 'alert' system** in the local health and social care economy, through maintaining and having an honest dialogue with all partners.
3. Scrutiny has a **public role** in 'working through reality' in a public forum with public outcomes/ recommendations. It is public facing and one of the most accessible points of the new system, with the advantage of being able to ask questions from a different viewpoint e.g. 'what can I do when I use a service as patient/visitor/staff?'
4. Scrutiny **gathers the hard information**. This encompasses understanding the system plus gathering the learning from mistakes. (Then disseminating the results to the right place in the system via its recommendations).
5. Scrutiny is the **local monitoring body for quality and outcomes** in the new system. '*We monitor the monitors – not carry it all out.*' It should define and understand who else monitors the system and how.
6. Scrutiny **provides the balance and patient view** around 'value for money' and quality vs costs.

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## What you can do to improve quality and outcomes

- Tell everyone in the system what you are concerned about and planning to work on – it may just produce the action you want!
- Develop a conversation about what ‘quality’ means to all involved – there are many perspectives and types of valuable information that are overlooked.
- Have good progress chasing systems so you don’t lose the impact of previous good work.
- Don’t forget social care! Don’t forget primary care! Don’t forget districts and boroughs!
- Invite involvement from Monitor and Care Quality Commission – use their work to reduce yours.
- Pay attention to local protocols and procedures for quality not just media ‘noise.’
- Make sure people know how scrutiny has improved quality and how.

## Section 2 continued

### Leadership and relationships

Although the first SDA programme on the health reforms emphasised relationship building and the potential role of council scrutiny in the new landscape, the importance of naming leadership as critical for how council scrutiny should take up its role and build relationships became clearer in this recent work by the 14 areas:

*'You can't underestimate the importance of leadership'*

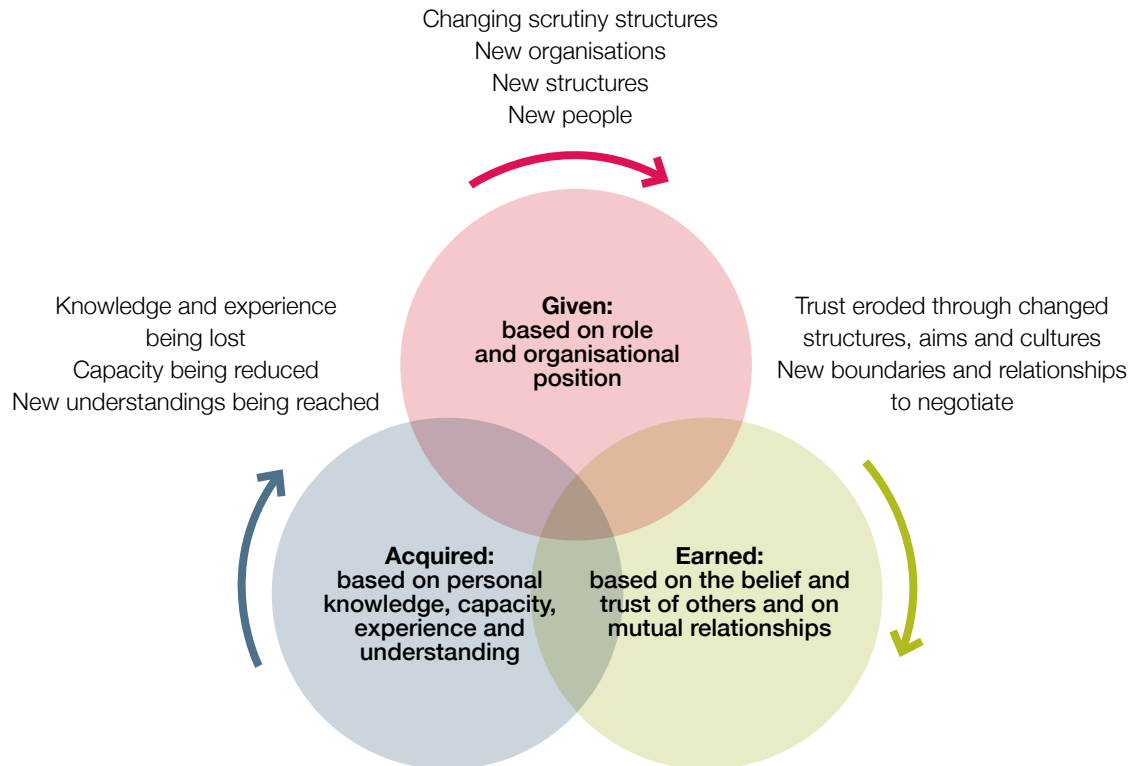
#### **SDA participant.**

The Francis Inquiry report made a number of recommendations around improving the leadership of NHS organisations; and scrutiny is well placed to support the effective development of this drive for improvement.

Figure 1 shows three dimensions of power and influence that leaders deploy in any setting and how the transition to the health reforms has **de-stabilised** each of these dimensions for all involved. To recover even partially is taking time and effort. Changing structures, people and organisations, the rupturing of prior relationships based on trust and mutuality, and the leeching away of knowledge, experience and understanding through attrition and changing roles of, especially, senior staff, have all played a part in the de-stabilisation. In addition, councils are facing their own structural, constitutional and electoral changes (e.g. Bristol, Warrington and county councils). Shifts to a mayoral system, reconfigured scrutiny arrangements and changes to select committee style working have all placed demands on councils while dealing with the health reforms, coupled of course with changes resulting from regular election cycles.



**Figure 1 Dynamic dimensions of power and influence for leaders in the new environment**



Reference: Adapted from material developed by Cath Saltis, CfPS Expert Advisor Team

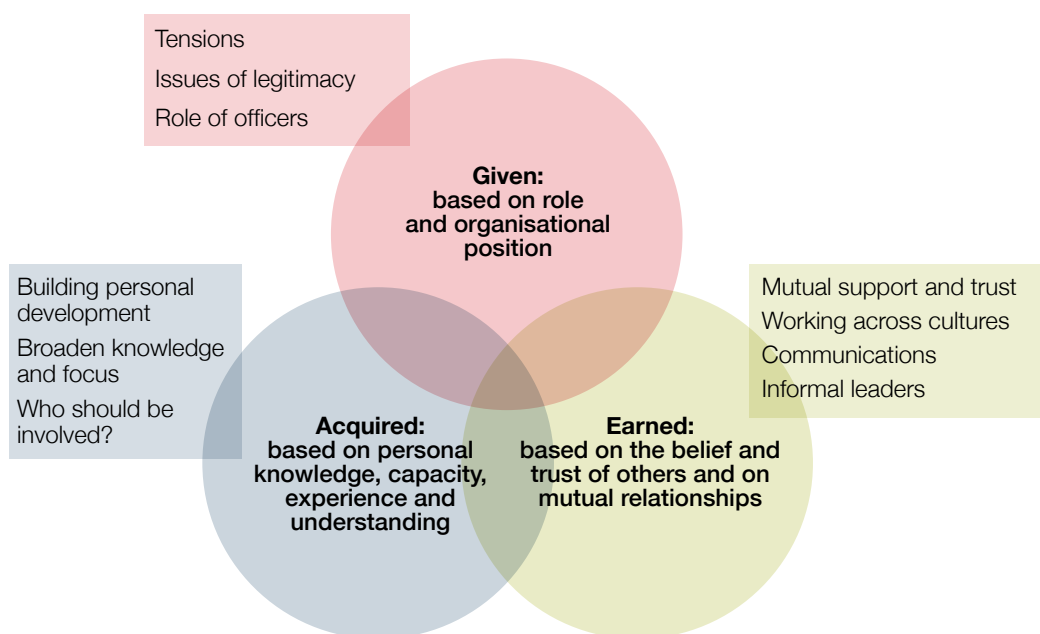
In addition, the new landscape demands an increase in knowledge, new understandings and a broadening of capacity, just when resources are reducing and possibilities for development and building capacity are shrinking. Programme participants experienced to a greater or lesser extent a leadership vacuum locally in relation to the health reforms, illustrated vividly by the long wait for guidance and regulations from government and continuing lack of clarity about roles in the new structures.

Councils taking part in the programme agreed that the purposes of leadership in relation to these changes include principally:

- The need to focus on **outcomes** for people – ‘**good leaders need to rise above structures and processes**’ to do the job of ‘joining the dots’ in order to achieve good outcomes.
- Leadership is important to **get things done**.
- The challenge of trying to **change** policy and strategy (and managing the risk that some people will be left on the outside).
- Being **proactive** rather than only reacting to negative things (e.g. closures).

To achieve these, council scrutiny had to develop all three dimensions of power and influence in its **leadership role locally**. Figure 2 shows the issues that emerged from the 14 areas that are now considered in turn.

**Figure 2 What emerged from the programme about power and influence for leaders**



Reference: Adapted from material developed by Cath Saltis, CfPS Expert Advisor Team

## Developing 'given' power/influence

'Given' power/influence is about roles, positions and structures. The health reforms make huge changes in these locally that each authority struggled to make sense of: *'People understand what's in each box [in the new structure] but not how they interrelate'*. There was also frustration at the vacuum created by combination of lengthy transition, a 'shadow' system and minimal guidance: *'the government has opened the door but there's nothing to step into.'* **Three important tensions** were noted that authorities have to manage:

**1. Membership of new bodies:** The health and wellbeing board includes elected members and executive officers, all with votes. For many, this is novel and hard to deal with. It also raised questions: who should be part of health and wellbeing board subgroups; how far can members and the council be responsible for actions of a council committee where others are voting members? Participants felt this remained very unclear, with apparent conflicts of interest e.g. if Healthwatch or health and wellbeing board members are also part of council scrutiny, or Healthwatch is contracted to the council but a member of scrutiny and/or of health and wellbeing board!

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However, there were also examples of the role of officers in enabling new bodies to function: *‘Our Chair of health and wellbeing board was fearful at first until she realised she had ‘expert’ support’, ‘we made good use of the statutory scrutiny officer’.*

**2. Overlapping roles:** council scrutiny and local Healthwatch have potentially similar and confusing roles - exacerbated by the role of Healthwatch as a member of health and wellbeing board, itself subject to council scrutiny. Also some authorities see health and wellbeing boards as the replacement vehicle for community leadership and partnerships of the Local Strategic Partnership, which they are not. These confusions were often cited as barriers to progress. Although using scenarios of potential situations to explore how roles might work in practice (**Birmingham, Bristol, Cornwall**) offered some help in dispelling anxiety, there remained concern that ‘real life’ would be very different once systems take off in April 2013.

**3. Use of statutory powers:** many felt that leading in such confusion and vacuum meant council scrutiny must draw on the legitimacy of their statutory powers for scrutiny. Several authorities took the initiative, set out their expectations of the new system in ‘straight talking’ and promoted these to partners (**Birmingham, Bury/Oldham, Cornwall, Lincolnshire and North Lincolnshire**). Several drew on their statutory powers to get cooperation and all participants agreed that, while a last step, this ‘clout’ was important and not to be forgotten.

*‘We had a bit of a lightbulb moment. We decided to take the initiative and drafted a protocol and sent it out there explaining who we, the Health Overview and Scrutiny Committee, were, and our operating framework. We felt a bit of a vacuum and decided to do something’.*

This action followed a stakeholder event where all parties shared their priorities and agreed joint priorities – using a simple but effective thematic approach: prevention, whole system, working together and innovation. From the outset partners were open in inviting the Health Overview and Scrutiny Committee to ‘challenge the way we create the new system in **Birmingham**.’ Bi-lateral meetings subsequently showed that council’s scrutiny’s commitment to the shared priorities was vital in keeping others on track, given their inevitable focus on their internal changes and the pressures of reform and delivery.

Committee members concluded that they should promote how they saw scrutiny, what they would focus on and how they expected others to work with them. Along with a newsletter about activity, partners have welcomed this approach.



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## Developing ‘acquired’ power/influence

‘Acquired’ power and influence is about people’s knowledge, experience, capacities and understandings. Participants in the programme saw that what they needed to take on was expanding enormously yet resources were shrinking. Three focuses helped them deal with this:

**1. Personal development:** Areas recognised the need to have good communicators. In some cases leaders were in place with self confidence to make relationships work with different bodies. For others, members need to be equipped as community leaders building relationships. One area (**Staffordshire**) was using a development programme for members.

**2. Broadening knowledge and focus:** Councillors already span a wide range of issues in their work: ‘*A Trust member had no idea that councillors got involved in so many things*’ but the reforms make this wider still: getting to grips with what a strategy for health and wellbeing should include, while at the same time understanding the impact of major re-configurations and scrutinising the commissioning process is definitely a challenge, especially where committees have many new members. However the resilience of participants in the programme was vivid, with their **commitment to ‘business as usual’** focusing on outcomes for local people and leading local health and wellbeing work – especially if others were not taking up the role e.g. the health and wellbeing board.

**3. Prioritising and who does what:** Many authorities are developing new ways to work, for example using a select committee style for scrutiny. Equally, deciding what not to do, when simply to keep a watching brief, is becoming more important in prioritising work in the new environment. Participants recognised others’ experience and knowledge added to the role of scrutiny (see earlier section on seeing the big picture) including informal local community leaders (**Central Bedfordshire, Staffordshire**). They also found the Chairman role very important in respect of leadership, as well as encouraging members to communicate internally when they have local intelligence that can help other members.

**Calderdale** developed closer, more effective relationships with their clinical commissioning group. This led to: the Scrutiny Chair participating in selecting non-executive clinical commissioning group members ; the Scrutiny Officer being asked to join the clinical commissioning group led Dementia Strategy Implementation Group; the Scrutiny Panel’s first invitation to attend the Practice Leads Meeting. Calderdale chose shadowing as part of a development package which gave better insight into roles for scrutiny members and also GPs.

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## Developing 'earned' power/influence

This aspect is about trust and belief – the intangibles of leadership and influence. Often this is summed up as about 'culture', which simply consists of everything that people do and say. Actions demonstrate culture and talking to people face to face was what people relied on for trust in the programme. And everyone involved agreed that **developing trust** is the key. In one authority members referred to incoming public health staff as 'this gang', reflecting the gulf between groups that have no experience of each other, don't understand the cultures involved and so find it hard to build trust.

Understanding cultures and working differently with them was important for many areas (**Bristol, Cornwall, Lincolnshire, Central Bedfordshire, Warwickshire**). Areas realised that people needed to work together differently to combat the build-up of new barriers between new organisations and to build mutual trust. Creating **less formal environments** and explicitly opening up space for 'not agenda'd' discussion with members and others, including in working groups, worked very well (**Cornwall**) and was 'absolutely invaluable' and 'gave time to think' (**Birmingham**). In **Bury**, the chair of scrutiny goes to working groups but doesn't chair them so they stand back and enable thinking, as well as open up discussion by others.

To **create time to get to know each other**, most of the areas held multi-stakeholder events, clinical commissioners, health and wellbeing board members and community participants all welcomed this proactive approach, attending in large numbers. People were extremely keen to discuss the complexities and confusions they felt they faced.

At the same time, scrutineers need to 'challenge comfortably, and be comfortable with the challenge and accepted in that role'; relationships 'must not be too cosy.' Council scrutiny must not be too close to the clinical commissioning group management, but a critical friend, and not 'managed' by the clinical commissioning group or NHS bodies. Similarly, NHS partners do not want to feel 'summonsed' to council scrutiny yet need to understand its power and their duty. Councillors do not want to be 'intimidated' by health service managers or clinicians. Negative experience, e.g. nearly being referred to the Secretary of State or clamorous press interest might bring in NHS bodies, but better to build relationships, understanding on all sides, mutual interest and partnership through **communications and a shared journey** through development and authorisation.



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**Warrington** is in the promising position of already having established the foundations of a good working relationship between the Health Overview Scrutiny Committee, the health and wellbeing board and the Clinical Commissioning Group. In addition to the changing health sector, the council was also in the process of developing new committee arrangements under the Localism Act, and a move to a hybrid type model. They used this programme to help them to have a better understanding of where and how health scrutiny might develop to ensure that there was continuity of the relationships already established – reaffirming effective health scrutiny. They also identified a joint leadership challenge of addressing and changing embedded cultures at the same time as clearly identifying and working through ways to improve health.

### What you can do to develop leadership

- Know your boundaries and structures: who covers what?
- Use scenarios or live examples to explore how roles will/could work.
- Don't dither or get bogged down in the formalities, committee updates and consultations. Be proactive and create plenty of informal time for discussion.
- Keep up with what others are doing, but keep focused on the health issues, not organisational ones.
- Continue to be the champion for the public through the changes. Lead if the health and wellbeing board is not doing this. *'Local health and wellbeing issues won't go away while the deck chairs are being moved.'*
- Recruit others to work with you who have the right knowledge and experience. Involve informal leaders and share information mutually with other agencies.
- Always be clear about your role and communicate this consistently.

## Section 3: Conclusions and remaining questions


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In summing up the experience of the 14 areas during 2012, it is clear there are issues to do with both the national health reforms process and also to do with local changes that have been hugely influential on the work. These have formed the backdrop to the detailed work councils taking part in the programme were able to do with local stakeholders and have framed the possibilities for making progress towards a clarified system being in place.

**Council scrutiny has found it must ‘span the system’ in helping to create new arrangements, as well as in its role once these are established after April 2013.**


Five related conclusions can be drawn from this programme:

1. **Council scrutiny must continue to do its job** throughout and regardless of the health reforms process: the core aims of holding the system to account for the benefit of the public do not change just because the system is changing: using important reviews and concerns to build and test the new system can be an excellent way to make progress.
2. **Continuing attention to relationships is vital** when there is a constant ‘dripfeed’ of emerging policy and decisions from central government; so many matters are only now being clarified and at time of writing regulations and guidance are still awaited on critical issues. In this context, people not only crave clear leadership, but also fear ‘getting it wrong’ and may be unwilling to commit to action. Council scrutiny can play a leadership role in brokering discussion and agreements.
3. **Council scrutiny is also subject to massive changes** which councils themselves are making in response both to crises of funding and constitutional reforms: areas were grappling with changes to their own scrutiny arrangements – so new models were emerging. Shifting committee structures/methods and reducing scrutiny structures and resources occurred within many councils in the programme and meant new thinking for scrutineers, both members and officers. Others changed and strengthened council scrutiny activity (**Warwickshire** and **Staffordshire**); others have involved districts and boroughs more closely in health scrutiny, widening involvement and the range of input (**Warwickshire, West Sussex**); **Bristol** moved to a mayoral system. These changes affect how council scrutiny can construct its work and role in relation to health and wellbeing, forcing difficult prioritisation decisions in trying to ‘span the system’.
4. Unless council scrutiny took up the issues of the health reforms locally there was a **real danger of a vacuum** in leadership, planning and preparation that spanned the system. Areas found their leadership and initiatives were welcome, stakeholders responded positively in all areas. But the context described above and the sheer demands of the structural changes would otherwise have blocked dialogue and preparation during the lengthy evolution of the reforms.

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5. **The most testing time may still be ahead:** across the areas, people felt the ‘calm’ would come to an end when difficult decisions were faced after April 2013 when the system goes ‘live’. People feared the positive relationships and sense of shared vision for their area that many experienced during the programme would revert to a bunker mentality and silo thinking based on individual organisational interests rather than a whole system, integrated approach.

Essentially for many the question remains: **how will this system *really* work?**

The experience of authorities and their partners in this programme suggests that over the next year council scrutiny could usefully focus on four sets of questions in order to contribute to building and testing the system:

- **What are the shared priorities for our local health, care and wellbeing system?** How can we focus all our work on progressing these to avoid being distracted by structural change? If there are not clear shared priorities, what can we do to develop some?
  - **How can we focus on the key elements of the spectrum,** rather than on scrutinising individual bodies and organisations? Which parts of the spectrum are making progress? Which parts are weak? Who is responsible for improving and developing these and how can we best demonstrate our concerns and influence them?
  - **Who are we working with directly and who should we be developing direct links with?** How can we broker healthy relationships across the system? If relationships break down, how can we ‘bang heads’ if required, but also create the common ground to re-establish them?
  - **How is our own structure and way of working going to affect our capacity to ‘span the system’?** What impact can we make in the new environment through council scrutiny work? Where should we best focus this year, next year? How can we create informal spaces for discussion and learning alongside our more formal work?
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## Section 4: Links and tools

Scrutiny Development Area	Contact details	Products and tools that areas have generated
Birmingham City Council	Rose Kiely Rose.kiely@birmingham.gov.uk	Newsletters Principles, Priorities and Protocols for working with partners
Bristol City Council	Romayne De Fonseca romayne.de.fonseca@bristol.gov.uk	Protocol with health and wellbeing board
Bury and Oldham Councils	Andrea Tomlinson and Sangita Patel a.j.tomlinson@bury.gov.uk sangita.patel@oldham.gov.uk	Guide for councillors Protocol with clinical commissioning groups, and health and wellbeing board Healthwatch and Public Health
Calderdale Council	Mike Lodge Mike.lodge@calderdale.gov.uk	An approach personal development - shadowing Clinical commissioners
Central Bedfordshire Council	Jonathon Partridge jonathon.partridge@centralbedfordshire.gov.uk	Draft protocol and framework for working with clinical commissioning groups Framework for working with Bedford Borough Council on health scrutiny, social care and children's services
Cornwall Council	Leanne Martin lmartin2@cornwall.gov.uk	Case studies and communications Live JSNA online
Croydon London Borough	Solomon Agutu Solomon.Agutu@croydon.gov.uk	Draft scheme of delegation for Public Health (checklist for director of Public Health)
Lincolnshire County Council	Simon Evans simon.evans@lincolnshire.gov.uk	Protocol for working with clinical commissioning group
North Lincolnshire Council	Dean Gillon Dean.Gillon@northlincs.gov.uk	Protocol with health and wellbeing board and clinical commissioning group Toolkit for scrutiny on substantial variation and reconfiguration
Plymouth City Council	Ross Jago Ross.Jago@plymouth.gov.uk	Protocol with clinical commissioning group, health and wellbeing board, Healthwatch and Devon based councils
Staffordshire County Council	Nicholas Pountney nicholas.pountney@staffordshire.gov.uk	Protocol with Districts/Boroughs and Healthwatch Framework in progress for clinical commissioning groups
Warrington Borough Council	Julia Nelson jsykes@warrington.gov.uk	Legacy report
Warwickshire County Council	Ann Mawdsley annmawdsley@warwickshire.gov.uk	Protocol with district councils New Quality Accounts Process with district/borough councils and LINK
West Sussex County Council	Helen Kenny Helen.Kenny@westsussex.gov.uk	Protocol for scrutiny of NHS substantial change and service reconfigurations

### **Spanning the system – case studies**

<http://cfps.org.uk/scrutiny-and-the-health-reforms>

### **Health overview and scrutiny:**

#### **Exploiting opportunities at a time of change**

[www.cfps.org.uk/publications?item=7008&offset=50](http://www.cfps.org.uk/publications?item=7008&offset=50)

### **The Mid Staffordshire NHS Foundation Trust – Public Inquiry**

[www.midstaffspublicinquiry.com/](http://www.midstaffspublicinquiry.com/)

### **Peeling the Onion**

[http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin\\_1\\_1\\_.pdf](http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf)

### **Local Healthwatch, health and wellbeing boards and health scrutiny**

[www.cfps.org.uk/publications?item=7195&offset=0](http://www.cfps.org.uk/publications?item=7195&offset=0)

### **BMA and CfPS discussion paper –**

#### **Accountability and the new structures:**

[www.cfps.org.uk/domains/cfps.org.uk/local/media/downloads/as.pdf](http://www.cfps.org.uk/domains/cfps.org.uk/local/media/downloads/as.pdf)

### **Appreciative scrutiny**

<http://cfps.org.uk/publications?item=7145&offset=0>

### **Tipping the scales (engagement wheel)**

[www.cfps.org.uk/publications?item=7137&offset=0](http://www.cfps.org.uk/publications?item=7137&offset=0)





