

The implementation of local authority scrutiny of primary health care: 2002-2005

This is a summary of the final report that looked at the implementation of local authority scrutiny of primary health care (2002-2005). The research was carried out by the National Primary Care Research and Development Centre (NPCRDC) at The University of Manchester. The full report can be downloaded at: www.npcrdc.man.ac.uk

Background

The Local Government Act of 2000 introduced the executive/scrutiny split in local government with those in the non-executive role scrutinising the authority's decisions. Powers of Overview and Scrutiny Committees (OSCs) were extended to include scrutiny of the local NHS, creating a new dimension to relationships between local government and the NHS. The nature of the scrutiny process was not prescriptive in detail.

The aim of this research has been to examine the implementation of local authority scrutiny of health (health scrutiny) over its first three years. We also wanted to identify factors affecting its development and its impact on local partnerships, accountability and governance.

Methods

Two postal surveys were conducted with local authorities in England, with social services responsibilities, before the introduction of health scrutiny (late 2002) and two years into its development (late 2004). These provided a national picture against which in-depth case study work was carried out in local authorities and their associated Primary Care Trusts (PCTs). This qualitative work included interviews, observations and documentary analysis in five chosen sites.

The Statistical Package for the Social Sciences (SPSS)¹ was used to analyse the postal surveys. The data gathered from the various sources during the qualitative work was entered on to the qualitative analysis package, NVivo² to aid data management and analysis.

Results

National postal surveys

The results of the postal surveys (achieving 86% and 89% response rates respectively) were written up during 2005 as a separate NPCRDC executive summary, entitled 'Health under scrutiny?' This can be downloaded at:

<http://www.npcrdc.man.ac.uk/Publications/executive%20summary%2034.pdf?CFID=664996&CFTOKEN=48744646>.

We concluded from the surveys that the operation of health scrutiny had indeed developed between 2002 and 2004:

- Structures were in place to facilitate health scrutiny;
- Representatives from other organisations were being co-opted on to OSCs to link district councils and external agencies into the process and expert witnesses were being used as a source of further information;

- In many areas, the focus of health scrutiny reviews was changing from individual organisations (e.g. PCTs or NHS Trusts) and/or specific services (e.g. NHS dental services) to broader public health-related issues (e.g. health improvement, and inequalities in access to services or smoke free initiatives).

However:

- There was a lack of resources (time, officer support, finances etc) to directly support health scrutiny;
- Resources were put under further pressure by the large volume of NHS consultations and joint scrutiny carried out by two or more local authorities on issues that crossed boundaries such as ambulance services;
- Training problems remained for both local authorities and the NHS;
- There was a lack of clarity in both local authorities and the NHS over the relationship between health scrutiny and the wider patient/public policy agenda.

Case study research

Five local authorities and their associated PCTs were selected for in-depth study. These sites were chosen to reflect: the different types of local authorities and OSC structures, the number of associated PCTs, the type of officer support, local politics and proposals for health scrutiny in the following 12 months. At least one full scrutiny review was observed within each site, despite the sites being at very different stages of development in terms of this policy.

The research included a total of 85 face to face interviews (split equally between 2003 and 2005) across the five sites, ongoing observational work (2003-2005) of health scrutiny related meetings, training etc (84 separate observations), ad hoc conversations, e-mail correspondence and documentary analysis (minutes, agendas, training documentation, reports etc).

The case study results suggested two ways of describing health scrutiny:

- As part of the democratic process ('scrutiny-as-democracy'), increasing public involvement, directly and indirectly via councillors, in health related decision making;
- As a cross-cutting exercise involving a wide range of local agencies to promote local well-being ('scrutiny-as-integration').

Both approaches were observed and there was a degree of tension between them. However, 'scrutiny-as-integration' was generally more prominent in the case studies.

The research shows that the objectives of health scrutiny could be achieved by using different mechanisms within specific local contexts. However, what works in one local area may not work as well elsewhere. Despite this, learning from others' experiences and adapting this to local circumstance will be essential to the success of the policy in the longer term.

Conclusions

Some positive outcomes can be identified, despite the policy being in its infancy, but the majority of the ultimate goals of health scrutiny (e.g. improving health and reducing inequalities) will take much longer to resolve.

Local authorities and PCTs in different localities have implemented health scrutiny differently because of the flexibility of the original guidance³. This resulted in different structures, ways of working and outcomes around the country.

Structures have been successfully established over the last three years to allow health scrutiny to operate, but these are under continual review, particularly after annual local elections, and may cause instability in the system.

Review topics have changed to include broader, cross-cutting, health improvement issues as well as specific organisations and services.

Health scrutiny still suffers from a lack of resources, training, officer support and recognition of the process by council executives, NHS bodies and the public.

Using expert witnesses and people from other organisations can widen the expertise available. However, it could also lead to a loss of independence if representatives from PCTs and other health organisations go unchallenged.

Direct involvement of patients and the public in the health scrutiny process is at best sporadic.

Health OSCs found it difficult to forge effective links with patient and public involvement structures (e.g. patient and public involvement forums).

Recognition of good practice and successful reviews carried out should encourage the development of the process further.

Implications for future research

Health scrutiny research should focus more strongly on outcomes rather than processes, in the longer term.

Research should be broadened to include NHS organisations beyond those related to primary care.

There is a need for ongoing research as change continues to affect the structure of NHS bodies and potentially that of local authorities.

Policy relevance

Official policy documents have presented health scrutiny as both an aspect of democratisation and as integrating the work of health and local authority bodies. However, this research shows a predominance of 'scrutiny-as-integration' as compared to 'scrutiny-as-democracy'.

If it is assumed that 'scrutiny-as-integration' is a worthwhile process then the following points are of relevance for policy:

- Matching local authority boundaries with those of PCTs and/or utilising OSCs, which look at both social care and health issues, could help 'scrutiny-as-integration';
- 'Scrutiny-as-integration' has allowed more informed debate and less focus on predetermined positions. However, substantial developments and variations to service (SDVs) can at times pose a considerable challenge to this;
- Health scrutiny has forged links between PCTs and non-executive elected councillors. However, much of its value has been dependant on the links between the executive and non-executive in local authorities;
- Greater difficulties (conflicts of interest, time etc) were generally experienced by local authority officers who did not have a discrete scrutiny role;
- Health services are currently provided by NHS bodies and other organisations such as those in the voluntary and independent sectors. OSCs can question these non-NHS providers, however, they are under no obligation to cooperate. They are currently held to account via the commissioners of the service. This may become increasingly difficult to manage as more of these providers supply services in the NHS.

- Greater roles for elected councillors are suggested in the White Paper ‘Your health, your care, your say’⁴. These will need to be integrated with their current health scrutiny roles in the future.

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